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Board/Committee Meetings
January 18-19, 2018

All meetings at CPCA Office

Thursday, January 18, 2018

8:00 – 8:30a **Finance / Ventures Finance**

- Approval of Financials
- Other Business

- Ventures Loan Report

8:30 – 9:00a **Governance Committee**

- Applications for Membership (2)
- Review Emeritus Nominations (2)
- Review Committee Accomplishments
- Membership Satisfaction Survey

9:00 – 10:00a **Special Populations Agricultural Rural Committee (SPARC)**

- Year in Review
- Medi-cal Managed Care Procurement
- CMSP Update
- Combating the Opioid Epidemic
- Champions for Access and Rural Practice Transformation
- Migrant Health
- Rural Health Events

10:00 – 10:15a **BREAK**

10:30 – 11:30p **Government Programs**

- Year in Review
- 340B
- Lifeline Grant Program
- OSHPD 3
- Licensing
- Managed Care
- Behavioral Health
- Emergency Preparedness
- 2703 PCHH
- Oral Health

11:30a – 12:30p **Workforce Committee**

- Year in Review
- California Future Health Workforce Commission
- Goal 2: Advancing Primary care Training
- Goal 6: Growing & Diversifying HC Professions; and
- Goal 7: Serving as a Catalyst and Coordinator

12:30 – 1:00p **LUNCH**

1:00 – 2:00p **330 Committee**

- Year in Review
- Payment Reform
- DHCS Update
- Acupuncture
- Pay-for-Performance
- A&I Challenges – Progress Update
- Legal Update: Retrospective Dental Claims Litigation

2:00 – 3:30p **Legislative Committee**

- Year in Review
- Federal Landscape
- State Landscape
- Health System Visioning
- Advocacy & Communications

3:30 – 3:40p **BREAK**

3:40 – 4:40p **Consortia Policy Group**

- Policy Prioritization – Process Review & Next Steps
- Federal Advocacy
- NACHCs Policy & Issues Forum 2018
- State Politics, Legislation & Advocacy

3:40 – 4:40p **Executive Committee (Meeting in CPCA Conference Room)**

- CEO Report
- Epic Partnership Update
- Emeritus Requests (2)
- Closed Session

5:00 – 7:30p **Membership Reception at Cafeteria 15L co-sponsored with HANC to honor new Board Chair Scott McFarland (15th & L Streets, Sacramento)**

Friday, January 19, 2018

8:30 – 10:00a Clinicians Committee

- CMO Report
- Integrated Care/Behavioral Health
- Legislative Update
- Workforce Update
- Cp3 & Data Report
- Value Based Care

10:00 – 10:15a BREAK

10:15a – 12:15p Board of Directors

- Board Financial presentation
- CEO Report
- Speaker: Brianna Lierman, CEO, LHPC
- Epic Partnership Update
- Strategic Plan Update
- Committee Reports
- NACHC Update
- RAC Update
- Closed Session

Board Ventures

- CEO Report

12:15 – 12:45p LUNCH

12:45 – 1:45p CaliforniaHealth+ Advocates Board of Directors

- Financial Report
- Policies for the c4
- Policy Priorities 2018
- Fundraising
- Political Action Committee Process
- Political Endorsements Process
- Public Affairs Peer Network Update

Finance Committee

Thursday, January 18, 2018
8:00am – 8:20am
David B. Vliet, Chair

CPCA Finance Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		David B. Vliet	I
II. Approval of Agenda		David B. Vliet	A
III. Approval of Minutes	• October 10, 2017	David B. Vliet	A
IV. Approval of Financials	• Financials ending November 30, 2017	Sandy Birkman	D/A
V. Other Business		Sandy Birkman	I
VI. Adjournment		David B. Vliet	A

CALIFORNIA PRIMARY CARE ASSOCIATION

FINANCE COMMITTEE
October 10, 2017

Committee Members Present: Kevin Mattson, Chair, Linda Costa, Cathy Frey, Kerry Hydash, Christine Noguera, Paulo Soares, Dean Germano

Guest: Nichole Mosqueh, Christine Velasco, Reymundo Espinoza, Tracy Garner

Staff: Sandy Birkman, Janelle Mollgaard, Cindy Keltner, Ginger Smith, Val Sheehan

I. Call to Order
Kevin Mattson, Chair, called the meeting to order at 9:00 am.

II. Approval of Agenda
A motion was made and seconded to approve the agenda as presented. **The motion carried.** (Frey/Germano)

III. Approval of Minutes
A motion was made and seconded to approve the minutes of July 13, 2017 as presented. **The motion carried.** (Germano/Hydash)

IV. Approval of Financials
A motion was made and seconded to approve the financials ending August 31, 2017. **The motion carried.** (Frey/Hydash)

V. Review Insurance Coverage & Investment Policy
Birkman provided a review of the current coverage and policy.

VI. Cash Reserve
Birkman reviewed the policy. A motion was made and seconded to remove a specific dollar amount and leave statement of 3 months operating expenses. **The motion carried.** (Hydash/Germano)

VII. Other Business
Birkman reviewed the Board presentation of the financials and audit that would be presented at the Board meeting.

VIII. Adjournment
The meeting was adjourned by Kevin Mattson, Chair at 9:15am

Respectfully submitted,

Janelle Mollgaard
Recording Secretary

CALIFORNIA PRIMARY CARE ASSN
Profit & Loss
April through November 2017

	Apr - Nov 17
Income	
4500.00 · Dues	1,308,333.32
4600.00 · Grants	1,966,692.19
4621.00 · Contributions	1,175,000.00
4749.00 · Licensing Fees- Health+	8,200.00
4750.00 · Sponsorship	5,000.00
4751.00 · Affinity Partnership Income	9,687.24
4900.01 · Interest	6,720.04
4950.01 · Clinic Operations Support	962,295.52
4955.00 · Miscellaneous Income	36,722.20
4956.00 · Legal Fund Donations	18,500.00
4960.00 · Conference Income	768,593.15
4999.99 · Training Income	763,157.50
Total Income	7,028,901.16
Gross Profit	7,028,901.16
Expense	
6100.00 · Salaries	2,664,209.60
6300.00 · Employee Benefits	598,122.36
6500.00 · Occupancy	249,565.46
6505.10 · Building Repair	4,523.23
6510.10 · Communications	33,313.26
6520.10 · Postage & Delivery	6,105.71
6530.10 · Supplies	43,472.33
6540.00 · Printing	16,815.51
6552.10 · Equipment Lease/Maintenance	14,133.57
6554.10 · Small Equipment	35,000.32
6560.10 · Insurance	25,806.01
6565.10 · Dues & Licenses	9,648.25
6570.10 · Subscriptions/Pubs	81,015.03
6580.10 · Marketing and Outreach	87,301.67
7010.10 · Audit/Accounting	26,511.26
7020.10 · Legal Services	8,291.49
7040.10 · Temporary Staffing	44,617.65
7110.10 · Board of Directors	59,348.28
7200.10 · Travel & Registration Fees	208,179.40
7200.20 · Travel - Non Staff	45,760.82
7275.00 · Staff Development	23,208.39
7300.00 · Meetings	75,588.26
7350.00 · Training Expense	448,482.79
7450.00 · Annual Conference	606,326.37
7500.00 · Consultants	982,286.31
7500.99 · Contracted Operations Support	452,435.56
7800.00 · Sub-Grants	300,000.00
7900.10 · Bad Debt	1,450.00
8888.88 · Holding Account Advocates	0.00
9900.00 · iMIS Store Orders	0.00
9999.99 · Holding Account	0.00
Total Expense	7,151,518.89
Net Income	**-122,617.73**

CALIFORNIA PRIMARY CARE ASSN
Profit & Loss Budget vs. Actual
April through November 2017

	Apr - Nov 17	Budget	$ Over Budget	% of Budget	
Income					
4500.00 · Dues	1,308,333.32	1,308,333.32	0.00	100.0%	
4600.00 · Grants	1,966,692.19	2,156,033.61	-189,341.42	91.22%	
4621.00 · Contributions	1,175,000.00	2,210,202.30	-1,035,202.30	53.16%	Dec/Jan renewals
4750.00 · Sponsorship	13,200.00	145,066.64	-131,866.64	9.1%	January agreements
4900.01 · Interest	6,720.04	6,000.00	720.04	112.0%	
4950.01 · Clinic Operations Support	519,547.20	572,026.53	-52,479.33	90.83%	
4955.00 · Miscellaneous Income	36,722.20	39,466.64	-2,744.44	93.05%	
4956.00 · Legal Fund Donations	18,500.00				from other PCAs
4960.00 · Conference Income	768,593.15	550,000.00	218,593.15	139.74%	expenses were also higher
4999.99 · Training Income	763,157.50	543,333.32	219,824.18	140.46%	UDS training in Dec.
Total Income	6,576,465.60	7,530,462.36	-953,996.76	87.33%	
Gross Profit	6,576,465.60	7,530,462.36	-953,996.76	87.33%	
Expense					
6100.00 · Salaries	2,676,845.93	2,974,026.13	-297,180.20	90.01%	
6300.00 · Employee Benefits	598,122.36	778,147.57	-180,025.21	76.87%	
6500.00 · Occupancy	249,565.46	234,714.53	14,850.93	106.33%	
6505.10 · Building Repair	4,523.23	6,344.66	-1,821.43	71.29%	
6510.10 · Communications	33,313.26	33,878.29	-565.03	98.33%	
6520.10 · Postage & Delivery	6,105.71	5,999.92	105.79	101.76%	
6530.10 · Supplies	78,472.65	76,590.52	1,882.13	102.46%	
6540.00 · Printing	16,815.51	32,133.29	-15,317.78	52.33%	
6552.10 · Equipment Lease/Maintenance	14,133.57	18,923.92	-4,790.35	74.69%	
6560.10 · Insurance	25,806.01	12,249.92	13,556.09	210.66%	New Insurance Policy for contractual work
6565.10 · Dues & Licenses	9,648.25	10,279.28	-631.03	93.86%	
6570.10 · Subscriptions/Pubs	81,015.03	29,099.88	51,915.15	278.4%	
6580.10 · Marketing and Outreach	87,301.67	66,666.60	20,635.07	130.95%	$22K to NACHC not budgeted
7010.10 · Audit/Accounting	26,511.26	24,027.76	2,483.50	110.34%	
7020.10 · Legal Services	8,291.49	5,000.00	3,291.49	165.83%	personnel matters
7040.10 · Temporary Staffing	31,981.32	35,000.00	-3,018.68	91.38%	
7110.10 · Board of Directors	59,348.28	46,666.64	12,681.64	127.18%	Extra meeting
7200.10 · Travel & Registration Fees	208,179.40	151,200.76	56,978.64	137.68%	
7275.00 · Staff Development	23,208.39	30,000.00	-6,791.61	77.36%	
7300.00 · Meetings	75,588.26	172,888.80	-97,300.54	43.72%	
7350.00 · Training Expense	448,482.79	433,333.32	15,149.47	103.5%	
7450.00 · Annual Conference	606,326.37	643,333.32	-37,006.95	94.25%	
7500.00 · Consultants	1,028,047.13	1,153,431.71	-125,384.58	89.13%	
7800.00 · Sub-Grants	300,000.00	466,666.64	-166,666.64	64.29%	
7900.10 · Bad Debt	1,450.00	3,333.04	-1,883.04	43.5%	
Total Expense	6,699,083.33	7,443,936.50	-744,853.17	89.99%	
Net Income	**-122,617.73**	**86,525.86**	**-209,143.59**	**-141.71%**	

Financial Presentation 11.30.17

	March 31, 2017				November 30, 2017			
	CPCA	**Ventures**	**Advocates**	**Combined**	**CPCA**	**Ventures**	**Advocates**	**Combined**
Statement of Financial Position								
ASSETS:								
Current Assets								
Cash & Equivalents	$ 3,090,327	$ 4,168,171	$ 1,063	$ 7,259,561	$ 2,527,005	$ 2,567,949	$ 224,278	$ 5,319,232
Grants Receivable	$ 510,692			$ 510,692	$ 272,280		$ -	$ 272,280
Dues and Accounts Receivable	$ 324,242			$ 324,242	$ 561,313		$ -	$ 561,313
Current Portion of Loan Receivable		$ 2,278,200		$ 2,278,200		$ 2,278,220		$ 2,278,220
Prepaid Expenses/Undeposited Funds	$ 186,649		$ 846	$ 187,495	$ 37,484		$ -	$ 37,484
Due from (to) affiliate	$ 99,241	$ (128,849)	$ 29,608	$ -	$ 235,026	$ (238,470)	$ 3,444	$ -
Noncurrent Assets								
Certificates of Deposit	$ 806,713			$ 806,713	$ 873,372		$ -	$ 873,372
Loan Receivable, Net		$ 4,099,373		$ 4,099,373		$ 5,876,092	$ -	$ 5,876,092
Property and Equipment, Net	$ 4,871,647			$ 4,871,647	$ 4,871,647		$ -	$ 4,871,647
TOTAL ASSETS	**$ 9,889,511**	**$ 10,416,895**	**$ 31,517**	**$ 20,337,923**	**$ 9,378,127**	**$ 10,483,791**	**$ 227,722**	**$ 20,089,640**
LIABILITIES & NET ASSETS								
Current Liabilities								
Accounts Payable	$ 215,905			$ 215,905	$ 27,686	$ -	$ 400	$ 28,086
Accrued Expenses	$ 275,029			$ 275,029	$ 598,174	$ -	$ -	$ 598,174
Deferred Revenue	$ 427,794			$ 427,794		$ -	$ -	$ -
Current Portion of Loan Payable	$ 131,925	$ 44,954		$ 176,879				$ -
Loan Payable (net)	$ 3,635,667			$ 3,635,667	$ 3,682,686	$ -	$ -	$ 3,682,686
								$ -
TOTAL LIABILITIES	**$ 4,686,320**	**$ 44,954**		**$ 4,731,274**	**$ 4,308,546**	**$ -**	**$ 400**	$ 4,308,946
								$ -
TOTAL NET ASSETS	**$ 5,203,191**	**$ 10,371,941**	**$ 31,517**	**$ 15,606,649**	**$ 5,069,581**	**$ 10,483,791**	**$ 227,322**	**$ 15,780,694**
Unrestricted	$ 3,062,255	$ 10,371,941	$ 31,517	$ 13,465,713	$ 3,891,838	$ 10,483,791	$ 227,322	$ 14,602,951
Temporarily Restricted	$ 2,140,936			$ 2,140,936	$ 1,177,743	0	0	$ 1,177,743
Cash on Hand - how many days organization could operate with no further cash				*257 days*				*195 days*
Current Ratio - compares current assets to current liabilities to show ability to meet short-term financial obligations				*9.64*				*13.53*
-								
Profit and Loss								
Total Income	$ 9,693,951	$ 200,582	$ 703,017	$ 10,597,550	$ 7,028,901	$ 116,792	$ 795,552	$ 7,941,245
Total Expenses	$10,128,130	$ 151,986	$ 703,017	$ 10,983,133	$ 7,151,519	$ 4,963	$ 599,747	$ 7,756,229
Net Income	**$ (434,179)**	**$ 48,596**	**$ -**	**$ (385,583)**	**$ (122,618)**	**$ 111,830**	**$ 195,805**	**$ 185,017**

CPCA VENTURES

Ventures Finance Committee

Thursday, January 18, 2018

8:20am – 8:30am

David B. Vliet, Chair

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		David B. Vliet	A
II. Approval of Agenda		David B. Vliet	A
III. Approval of Minutes	• October 10, 2017	David B. Vliet	A
IV. Approval of Financials	• Financials ending November 30, 2017	Sandy Birkman	A
V. Ventures Loan Report	• Loan Report – NCB Capital Impact • Loan Report – internal	Sandy Birkman	I
VI. Other Business		Sandy Birkman	I
VII. Adjournment		David B. Vliet	A

CALIFORNIA PRIMARY CARE ASSOCIATION

VENTURES FINANCE COMMITTEE
October 10, 2017

Committee Members Present: Kevin Mattson, Chair, Linda Costa, Cathy Frey, Kerry Hydash, Christine Noguera, Paulo Soares, Dean Germano, Nik Gupta

Guest: Nichole Mosqueh, Christine Velasco, Reymundo Espinoza, Tracy Garner

Staff: Sandy Birkman, Janelle Mollgaard, Cindy Keltner, Ginger Smith, Val Sheehan

I. Call to Order

Kevin Mattson, Board Chair, called the meeting to order at 9:15am.

II. Approval of Agenda

A motion was made and seconded to approve the agenda as presented. **The motion carried.** (Gupta/Frey)

III. Approval of Minutes

A motion was made and seconded to approve the minutes of July 13, 2017 as presented. **The motion carried**. (Frey/Hydash)

IV. Approval of Financials

A motion was made and seconded to approve the financials ending August 31, 2017. **The motion carried.** (Gupta/Frey)

V. Ventures Loan Report

A review of the loan reports were given by Sandy.

VI. Other Business

No other business at this time

VII. Adjourn

Business being concluded, a motion was made to adjourn at 9:20am

Respectfully submitted,

Janelle Mollgaard
Recording Secretary

CPCA Ventures
Balance Sheet
As of November 30, 2017

	Nov 30, 17
ASSETS	
Current Assets	
Checking/Savings	
1000.00 · Cash	2,567,949.29
Total Checking/Savings	2,567,949.29
Accounts Receivable	
1450.00 · Current Portion Loans Receivabl	2,278,219.73
1461.00 · Acct. Rec. Loan - Long Term	6,259,085.18
Total Accounts Receivable	8,537,304.91
Other Current Assets	
1465.00 · Loan Loss Reserve	-382,993.00
Total Other Current Assets	-382,993.00
Total Current Assets	10,722,261.20
TOTAL ASSETS	**10,722,261.20**
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
2020.00 · Due to CPCA	238,470.15
Total Accounts Payable	238,470.15
Total Current Liabilities	238,470.15
Total Liabilities	238,470.15
Equity	
3000.00 · Opening Bal Equity	-0.13
3900 · Retained Earnings	10,371,961.32
Net Income	111,829.86
Total Equity	10,483,791.05
TOTAL LIABILITIES & EQUITY	**10,722,261.20**

CPCA Ventures
Profit & Loss Budget vs. Actual
April through November 2017

	Apr - Nov 17	Budget	$ Over Budget	% of Budget
Income				
4900.00 · Other Income	116,792.41	133,333.32	-16,540.91	87.6%
Total Income	116,792.41	133,333.32	-16,540.91	87.6%
Expense				
6100.00 · Salaries	77,865.10	79,492.64	-1,627.54	98.0%
6300.00 · Employee Benefits	17,389.31	20,668.00	-3,278.69	84.1%
6500.00 · Occupancy	7,271.07	9,806.64	-2,535.57	74.1%
6505.10 · Building Repairs	24.13	4,105.32	-4,081.19	0.6%
6510.10 · Communications	895.21	500.00	395.21	179.0%
6520.10 · Postage & Delivery	0.00	0.00	0.00	0.0%
6530.10 · Supplies	898.59	1,500.00	-601.41	59.9%
6540.00 · Printing-general	0.00	666.64	-666.64	0.0%
6552.10 · Equipment Lease/Maintenance	410.57	779.32	-368.75	52.7%
6554.10 · Small Equipment/Furniture	436.90			
6560.10 · Insurance	450.70	666.72	-216.02	67.6%
6565.10 · Dues & Licenses	0.00	388.00	-388.00	0.0%
6570.10 · Subscriptions/Publications	192.29	816.64	-624.35	23.5%
7010.10 · Audit/Accounting	2,395.00	1,500.00	895.00	159.7%
7110.10 · Board of Directors	0.00	3,333.32	-3,333.32	0.0%
7200.10 · Travel & Registration Fees	0.00	3,333.32	-3,333.32	0.0%
7300.00 · Meetings & Trainings	664.03	0.00	664.03	100.0%
7500.00 · Consultants	3,102.93	5,776.64	-2,673.71	53.7%
7950.00 · Interest	92.72	0.00	92.72	100.0%
8000.00 · Loan Funds/Reserves	-107,126.00			
Total Expense	4,962.55	133,333.20	-128,370.65	3.7%
Net Income	**111,829.86**	**0.12**	**111,829.74**	**93,191,550.0%**

CAPITAL IMPACT QUARTERLY REPORT TO CPCA
Quarter Ending 9/30/2017

1. Loans Outstanding

	Amount Outstanding	Loan Category	Interest Rate	Date Closed	Date Funded	Risk Rating	Original Loan Amount
[redacted]	$ 41,086.99	CL	3.175%	03/04/2015	03/04/2015	3	$ 200,000.00
	$ 42,880.92	CL	3.175%	10/16/2012	10/16/2012	4	$ 300,000.00
	$ 656,816.68	ISLP	3.175%	03/23/2015	03/23/2015	1	$ 750,000.00
	$ 239,382.71	CL	3.175%	11/04/2014	11/04/2014	3	$ 420,000.00
	$ 14,382.97	CL	3.175%	04/19/2012	04/19/2012	2	$ 400,000.00
	$ 558,321.26	CL	3.175%	05/26/2015	05/26/2015	2	$ 835,000.00
	$ 549,644.28	CL	3.175%	09/17/2015	09/17/2015	2	$ 750,000.00
	$ 200,000.00	CL	3.175%	02/08/2017	02/08/2017	4	$ 200,000.00
	$ 226,578.16	CL	3.175%	05/19/2014	05/19/2014	4	$ 500,000.00
	$ 14,393.05	CL	3.175%	05/08/2012	05/08/2012	2	$ 400,000.00
	$ 11,678.52	CL	3.175%	12/16/2014	12/16/2014	3	$ 100,000.00
	$ 214,976.18	CL	3.175%	03/18/2015	03/18/2015	4	$ 400,000.00
	$ 226,578.16	CL	3.175%	04/24/2014	04/24/2014	2	$ 500,000.00
	$ 650,000.00	CL	3.175%	05/25/2017	05/25/2017	1	$ 650,000.00
	$ 34,555.42	CL	3.175%	05/01/2014	05/01/2014	3	$ 93,000.00
	$ 1,000,000.00	CL	3.175%	7/28/2017	7/28/2017	2	$ 1,000,000.00
	$ 51,831.19	CL	3.175%	08/13/2012	08/13/2012	2	$ 482,000.00
	$ 32,354.63	CL	3.175%	08/10/2011	08/10/2011	1	$ 600,000.00
	$ 732,858.92	ISLP	3.175%	09/15/2015	09/15/2015	1	$ 1,000,000.00
	$ 549,644.28	CL	3.175%	09/18/2015	09/18/2015	3	$ 750,000.00
	$ 339,867.37	CL	3.175%	05/21/2014	05/21/2014	2	$ 750,000.00
	$ 750,000.00	CL	3.175%	06/24/2016	06/24/2016	3	$ 750,000.00
	$ 8,202.20	CL	3.175%	09/24/2014	09/24/2014	3	$ 275,000.00
Total	**$ 7,146,033.89**						**12,105,000**

2. Loan Volume by Risk & Weighted Average Risk of Portfolio

Risk Rating	# of Borrowers	Amount Approved	Amount Outstanding	% of Total Outstanding	% Reserve	Recommended Reserve	
1	4	$ 3,000,000	$ 2,072,030	29%	0%	$ -	
2	8	$ 5,117,000	$ 2,755,018	39%	3%	$ 82,651	
3	7	$ 2,588,000	$ 1,634,550	23%	10%	$ 163,455	
4	4	$ 1,400,000	$ 684,435	10%	20%	$ 136,887	
5	0	$ -	$ -	0%	50%	$ -	
Total	**23**	**$ 12,105,000**	**$7,146,034**			**$ 382,993**	

Portfolio	Compliance	Maximum	Actual
Loans rated "3" "4" or "5":	Y	65%	32%
Loans rated "4" or "5":	Y	20%	10%

3. New Loans Approved in the Quarter

Health Center Name	Amount Approved	Loan Category	Approval Date	Closing Status
[redacted]	$ 1,000,000	CL	7/10/2017	Closed in 07/31/2017.
	$ 720,000	CL	8/28/2017	Closed in 10/05/2017.
Total	**$ 1,720,000**			

4. Applications Under Review

Health Center Name	Amount Requested	Loan Category	Date Received	Underwriting Status
[redacted]	$ 400,000	CL	9/25/2017	In underwriting, projected closing date is 10/31/2017.
	$ 1,000,000	CL	9/8/2016	In underwriting, projected closing date is 10/20/2017.
Total Loans in Process	**$ 1,400,000**			

5. Applications Denied in the Quarter

Health Center Name	Amount Requested	Date Received	Date Denied	Reason for the loan decline
N/A				

6. Loan Modifications or Waivers in the Quarter

Health Center Name	Risk Rating	Loan Category	Effective Date	Description of loan modification or waiver
N/A				

7. Changes to Risk Ratings in the Quarter

Health Center Name	Original Rating	New Rating	Effective Date	Reason for the risk rating change
N/A				

8. Non-Performing Loans in Portfolio

Health Center Name	Outstanding Amount	Days Past Due	Non-accrual Y/N	Updates on repayment plan
N/A				

CPCA Ventures Loan Program
11/30/2017

	TOTAL
INCOME	
Grant	**$ 10,500,000**
Investment Interest	**$ 1,020,664**
Miscellaneous Income	**$ 854,666**
Principle Repayments	**$ 48,265,308**
Interest on Loans	**$ 3,368,075**
TOTAL INCOME	**$ 64,008,713**
DIRECT OUTLAYS	
CPCA Operating	**$ 5,117,542**
IS Loans	**$ 9,614,502**
Capital Loans	**$ 46,096,732**
Healthy California	**$ 865,054**
Emergency	**$ 506,382**
TOTAL OUTLAY	**$ 62,200,212**
LOAN LOSS RESERVE	**$ 382,993**
BALANCE	**$ 1,425,508**

	Info Systems	Capital	Healthy CA	Emergency	TOTAL
PRIOR YR's TOTAL	**$ 9,614,502**	**$ 40,520,184**	**$ 865,054**	**$ 506,382**	**$ 51,506,122**
2016/2017					
6/9/2016		$ 750,000			**$ 750,000**
6/28/2016		$ 700,000			**$ 700,000**
12/20/2016		$ 300,000			**$ 300,000**
2/8/2017		$ 200,000			**$ 200,000**
TOTAL	**$ 9,614,502**	**$ 42,470,184**	**$ 865,054**	**$ 506,382**	**$ 53,456,122**
2017/2018					
6/16/2017		$ 256,548			$ 256,548
6/21/2017		$ 650,000			$ 650,000
8/1/2017		$ 1,000,000			$ 1,000,000
10/5/2017		$ 720,000			$ 720,000
11/22/2017		$ 1,000,000			$ 1,000,000
TOTAL	**$ 9,614,502**	**$ 46,096,732**	**$ 865,054**	**$ 506,382**	**$ 57,082,670**

Governance Committee

Thursday, January 18, 2018
8:30am – 9:00am
Ben Flores, Chair

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Ben Flores	I
II. Approval of Agenda		Ben Flores	A
III. Approval of Minutes	• October 10, 2017	Ben Flores	A
IV. Applications for Membership	• Southside Coalition of Community Health Centers • San Fernando Community Health Center	Sandy Birkman	D/A
V. Review Emeritus Nominations: - Steve Schilling - John Gressman	• Emeritus Membership Qualifications	Ben Flores	I
VI. Review Committee Accomplishments	• Summary of Committee Accomplishments 2017	Sandy Birkman	I/D
VI. Membership Satisfaction Survey	• 2017 Membership Satisfaction Survey Results	Sandy Birkman	I/D
IX. Adjournment		Ben Flores	A

CALIFORNIA PRIMARY CARE ASSOCIATION
GOVERNANCE COMMITTEE
October 10, 2017

Committee Members Present: Cathy Frey, filled in for Chair, Dean Germano, Nik Gupta, Kerry Hydash, Kevin Mattson, Louise McCarthy, Danielle Myers, Paulo Soares,

Guests: Tony Weber, Christine Noguera, David Vilet, Anitha Mullangi, Christine Velasco, John Price

Staff: Sandy Birkman, Janelle Mollgaard, Ginger Smith, Val Sheehan, Mike Witte

I. Call to Order

Cathy Frey, called the meeting to order at 9:33am.

II. Approval of Agenda

A motion was made and seconded to approve the agenda. **The motion carried.** (Matson/Gupta)

III. Approval of Minutes

A motion was made and seconded to approve the minutes of July 13, 2017 as presented. **The motion carried.** (Matson/Myers)

IV. Applications for Membership:

I. Health to Hope Clinics

A motion was made and seconded to forward the membership application to the Board of Directors. **The motion carried.** (Gupta/Hydash)

V. Review Board Attendance

Birkman reported all Board members fulfilled policy on attendance. Discussion ensued with consensus to strongly encourage Board member participation in committees.

VI. Implementation of Bylaws changes

Birkman reviewed the results from the member survey to approve all suggested bylaws changes and for them to go into effect immediately. The affiliate membership will be completely phased out as of March 31, 2018.

VII. Membership Satisfaction Survey

Birkman reviewed 2016 survey and notified the group 2017 would go out in early November to have a report for January 2018 meeting.

VIII. Other Business

Birkman reviewed the election background and current years return rate of 47%. She suggested that next year an email goes out prior to the election to notify delegates the election would be beginning and to also have the votes weighted in an effort to increase participation.

Adjourn

Business being concluded, meeting was adjourned at 9:58am.

Respectfully submitted,
Janelle Mollgaard, Recording Secretary

CALIFORNIA PRIMARY CARE ASSOCIATION
BYLAWS AND NOMINATING COMMITTEE
NEW MEMBERS ELIGIBILITY DETERMINATION CHECKLIST

Applicant Name: Southside Coalition of Community Health Centers

Date Application Submitted:

Membership Category: ***Community Health Center Consortia and Associations***

Supporting Documents Submitted

- ✓ **Completed application**
- ✓ **Resolution by organization's governing body authorizing membership**
- ✓ **Copy of organization's chartering documents which describes involvement in the delivery of primary care services in underserved areas**
- ✓ **Copy of 501(c) (3) tax exempt status**
- ✓ **Current roster of organization members**
- ✓ **Board roster indicating community affiliation**
- ✓ **Sponsor letter**
- ✓ **Staff Summary - Below**

Application is: ☑ **Complete** **Incomplete**

Comments: Represents eight FQHC's in South Los Angeles, all of which are members of CPCA. Richard Veloz, CEO, South Central Family Health Center, has provided the letter of support.

Prepared by: Jodi Johnson **Date: 11/20/2017**

Action by Committee: ☐ **Application Conforms. Recommend Presentation to the Board.**

☐ **Application Does Not Conform – No Presentation to the Board at this Time.**

Rationale: _____

_____

Date: _____/_____/_____

SCFHC
South Central Family Health Center
a californiahealth center

4425 S. Central Avenue
Los Angeles, CA 90011

October 24, 2017

Ms. Jodi Johnson
Deputy Director of Operations
California Primary Care Association
1231 I Street, Suite 400
Sacramento, CA 95814

Dear Ms. Johnson:

As the Chief Executive Officer of South Central Family Health Center, a CPCA member in good standing, I attest that I have reviewed the CPCA membership criteria and have reviewed the sufficient background information to confirm that each criterion is met by the Southside Coalition of Community Health Centers for membership as a Regional Consortia and Association Member. If accepted into membership, I will serve as a mentor for this new CPCA member.

The following is a brief summary regarding the applicant: The Southside Coalition of Community Health Centers is a non-profit organization established to sustain, coordinate and improve health care access and delivery to the impoverished and vulnerable community members of South Los Angeles. Their goal is that through the Coalition's efforts the South Los Angeles community will see improved health care that is networked to build capacity; is focused to strengthen access to primary and preventive care, health promotion, and health education; and eliminates health disparities. The Southside Coalition serves South Los Angeles, which we define as Service Planning Area 6 in the City of Los Angeles plus the cities of Inglewood, Hawthorne and Lennox. The Southside Coalition comprises the largest community clinic safety-net in South Los Angeles. The members of the Southside Coalition are: Central City Community Health Center; Eisner Pediatric & Family Medical Center; St. John's Well Child and Family Center; South Bay Family Health Care; South Central Family Health Center; T.H.E. Clinic, Inc.; (To Help Everyone); UMMA Community Clinic (University Muslim Medical Association) and Watts Healthcare Corporation, Inc.

Questions about this applicant can be directed to me by email at Richardv@scfhc.org or (323) 908-4247.

Sincerely,

Richard Veloz, MPH, JD
Chief Executive Officer
South Central Family Health Center
1111 E. Vernon Avenue
Los Angeles, CA 90011

CALIFORNIA PRIMARY CARE ASSOCIATION

GOVERNANCE COMMITTEE

NEW MEMBERS ELIGIBILITY DETERMINATION CHECKLIST

Applicant Name: San Fernando Community Hospital dba San Fernando Community Health Center

Date Application Submitted: 12/11/2017

Membership Category: ***Community Health Clinic***

Supporting Documents Submitted:

- ✓ Completed application
- ✓ Resolution by organization's governing body authorizing membership
- ✓ Copy of clinic license from principal site
  - ❑ Exempt under Section 1206 of the Health & Safety Code
- ✓ Copy of organization's bylaws
- ✓ Copy of organization's most recent "Annual Utilization Report of Clinics" required by the Office of Statewide Health Planning and Development
- ✓ Copy of Articles of Incorporation
- ✓ Copy of IRS 501 (c)(3) letter
- ✓ Annotated Board Roster
- ✓ Letter of Support
- ✓ Summary of staff interview - below

Application is: ☑ Complete Incomplete

Comments: This FQHC operates two sites in the San Fernando Valley. Philip Solomon, CEO, Samuel Dixon Family Health Center has provided the letter of Support.

Prepared by: Jodi Johnson **Date:** 12/12/2017

Action by Committee: ☐ Application Conforms. Recommend Presentation to the Board.

☐ Application Does Not Conform – No Presentation to the Board at this Time.

Rationale: _____

_____

Date: _____/_____/_____

Samuel Dixon
Family Health Center, Inc.

25115 Avenue Stanford, Suite A-104, Valencia, CA 91355
(661) 257-2339 Fax: (661) 257-2384
www.sdfhc.org

11/16/17

Membership Committee
California Primary Care Association
1231 I Street, Suite 400
Sacramento, CA 95814
Attn: CPCA By-Laws Committee

As the Chief Executive Officer of Samuel Dixon Family Health Center, Inc. a Federally Qualified Health Center and a CPCA member in good standing, I attest that I have reviewed the CPCA membership criteria and have reviewed sufficient background information to confirm that each criterion is met by the San Fernando Community Health Center for membership as a Community Clinic/FQHC with under 20,000 users. If accepted into membership, I will serve as a mentor for this new CPCA member.

The following is a brief summary regarding the applicant:

San Fernando Community Hospital dba San Fernando Community Health Center SFCHC) opened in 2013 and received a New Access Point (NAP) award in August 2015. As a Federally Qualified Health Center (FQHC), SFCHC operates two sites in the San Fernando Valley of Los Angeles (LA) County. SFCHC offers primary care, oral health and behavioral health services. One of the sites serves a largely homeless population. The leadership and staff of SFCHC is active in the community that they serve; providing leadership and collaboration to other non-profits, while working to assure access to care to the most vulnerable in our community.

Questions about this applicant can be directed to me at
25115 Avenue Stanford, A104
Valencia, CA 91355
661-257-2339 x307

Sincerely yours,

Philip Solomon
Chief Executive Officer
Samuel Dixon Family Health Center, Inc.

To: Governance Committee
From: Sandy Birkman, Director of Finance & Operations
Date: 9/7/12
Subject: Emeritus Members

Under the membership category of CPCA's Bylaws is "Emeritus Members".

This category was established to honor and recognize past board members who have contributed their time and expertise to CPCA.

The following guidelines were adopted by the Board for eligibility standards and expectations:

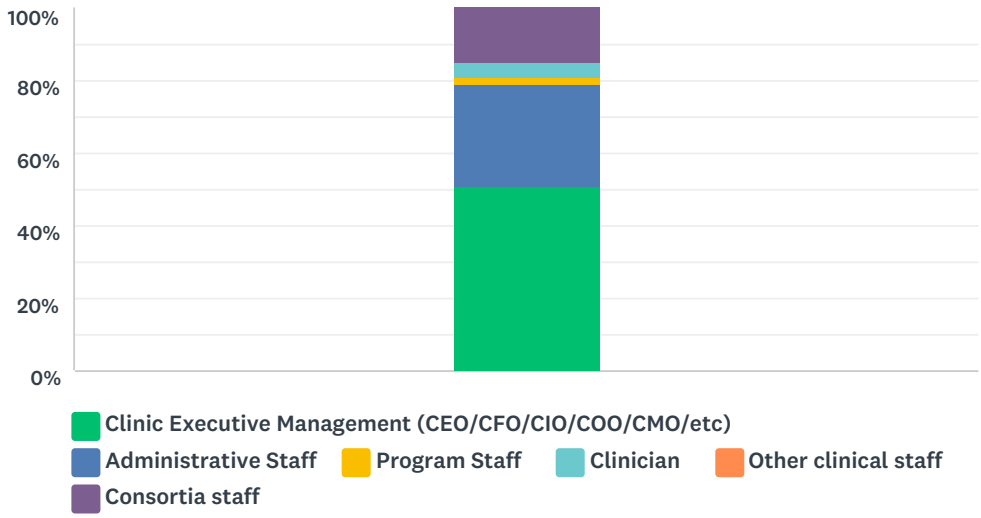
1) Emeritus Board Member consideration is limited only to those CPCA Board Members in "good standing" who have demonstrated an "active" involvement in both CPCA Board meetings, CPCA Committee meetings, and other functions over a prolonged period of time.
2) Board Members who are being considered for Emeritus status will have served a minimum of at least two terms on the CPCA Board and have chaired at least one Board Committee over that time.
3) Individuals wanting consideration of Emeritus status, must ask the Chair to announce their nomination to the Board and the Governance Committee will review their eligibility prior to being put on the agenda for Board consideration.
4) Once a Member is elected to Emeritus status, he/she can no longer be considered eligible for future CPCA Board Election. The Emeritus status is for life or until an individual resigns.
5) While Emeritus status is typically considered for those at or near retirement, there is no requirement of this.
6) Emeritus Board Members may continue to serve and vote on CPCA Board Committees. They may serve as a Committee Chair and in that capacity may bring Committee recommendations in the form of a motion to the full Board for Board consideration.
7) Emeritus Board Members will be kept informed about board activities as any other member. Other expectations will be mutually agreed upon between the Emeritus Board Member and the Chair.

Summary of Governance Committee Accomplishments 2017

Governance Committee *There will be a Governance Committee composed of Members that will be responsible for:*	**Actions Taken 2017**	**Recommended Action for 2018**
1) Review of Board structure, function and membership and make recommendations as necessary to ensure the Board continues to meet the needs of the CPCA Members	• No changes made in 2017.	
2) Administer the election process for both CPCA Board of Directors and CPCA Board Officers	• Longstanding activity of the committee. • Successful election was completed in 2017 using an electronic voting method.	• Administer election electronically in 2018. Use weighted votes.
3) Review and recommend for approval applications for membership to CPCA	• Regular agenda topic, as applications are received. • 5 applications in 2017 were reviewed. One was not forwarded. The remaining four were approved by the Board for membership.	• Continue to review applications
4) Review, propose and recommend changes to CPCA Bylaws as necessary	• Bylaws changes were taken to the membership in August and approved. Major change was to delete affiliate memberships.	
5) Plan Board education including Member orientation and development of on-going Board education needs. Develop Director job description and code of ethics policy	• A new member orientation by web was conducted in 2017. No changes made to job description or code of ethics policy.	• Conduct orientation when necessary. A new board member orientation will be presented in January newly elected Board member.
6) Administer a yearly Board Self Assessment	• A Board Self-Assessment was conducted in 2017 and reviewed in July. 19 Directors participated.	• Administer survey May 2018
7) Review Corporate Compliance activities of the organization	• No corporate compliance activities were reviewed during 2017.	• Review corporate compliance activities
8) Review and recommend action on inappropriate behavior of CPCA Members and CPCA Board Members	• No inappropriate behavior of CPCA members or Board were referred to committee	
9) *Administer regular Membership Satisfaction Survey.*	• Membership Assessment was completed in late 2017 and will be reported on in January 2018.	• Administer survey in September 2018.

Q1 What is your job function?

Answered: 53 Skipped: 9

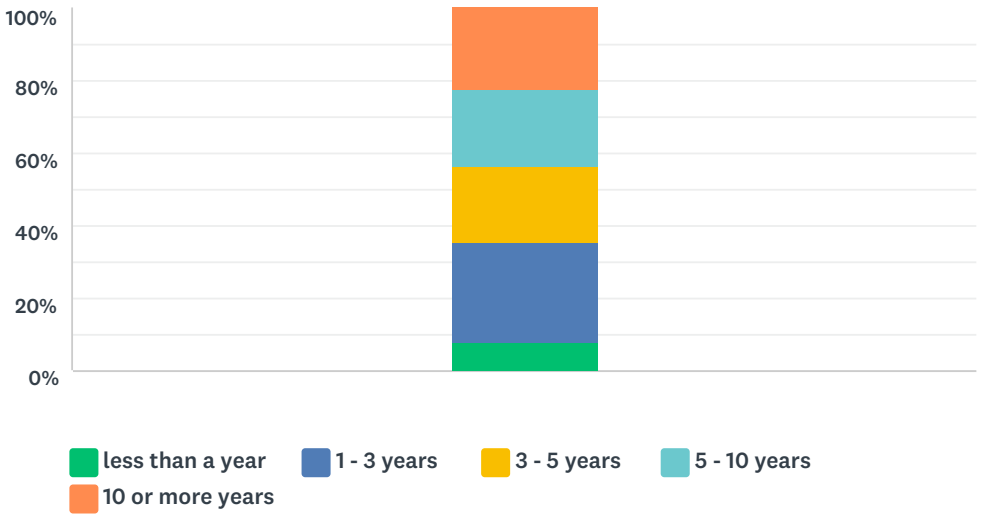


ANSWER CHOICES	RESPONSES	
Clinic Executive Management (CEO/CFO/CIO/COO/CMO/etc)	50.94%	27
Administrative Staff	28.30%	15
Program Staff	1.89%	1
Clinician	3.77%	2
Other clinical staff	0.00%	0
Consortia staff	15.09%	8
TOTAL		53

#	OTHER	DATE
1	Director of Behavioral Health Operations	11/3/2017 9:50 AM
2	Consortia Chief Executive Officer	11/1/2017 10:49 AM
3	Community Health Worker	10/31/2017 8:02 AM
4	Accounts Payable	10/31/2017 7:53 AM
5	Community Outreach Manager	10/30/2017 4:17 PM
6	Government Affairs/Policy	10/30/2017 11:04 AM
7	Director of Nursing	10/30/2017 10:14 AM
8	Patient Services Manager	10/30/2017 10:08 AM
9	Biller	10/30/2017 10:00 AM
10	Credentialing Specialist	10/30/2017 9:58 AM

Q2 How long have you been employed by your health clinic/center?

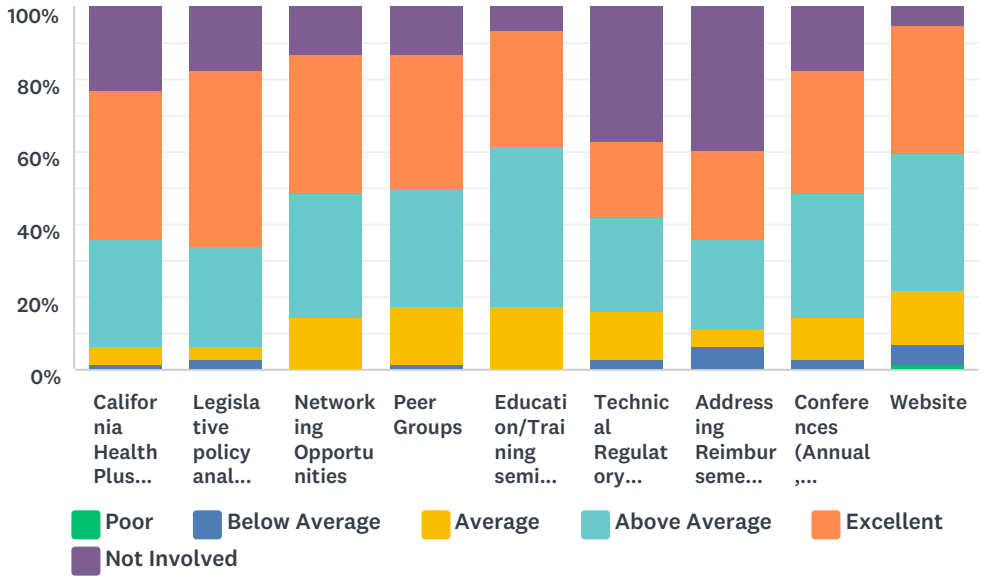
Answered: 62 Skipped: 0



ANSWER CHOICES	RESPONSES	
less than a year	8.06%	5
1 - 3 years	27.42%	17
3 - 5 years	20.97%	13
5 - 10 years	20.97%	13
10 or more years	22.58%	14
TOTAL		62

Q3 Please rate your satisfaction with CPCA's performance in this area using the following scale:Core Services

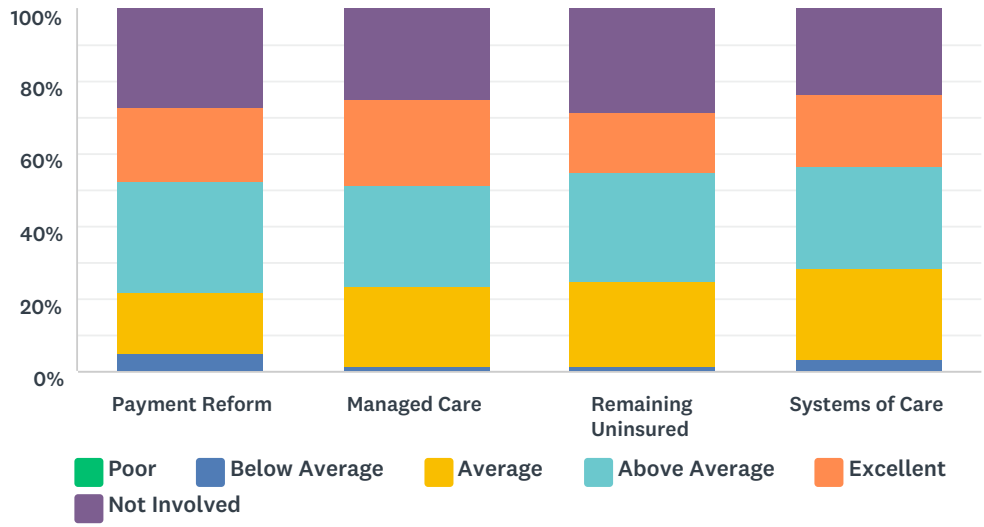
Answered: 62 Skipped: 0



	POOR	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	EXCELLENT	NOT INVOLVED	TOTAL
California Health Plus Advocates	0.00% 0	1.64% 1	4.92% 3	29.51% 18	40.98% 25	22.95% 14	61
Legislative policy analysis/advocacy	0.00% 0	3.23% 2	3.23% 2	27.42% 17	48.39% 30	17.74% 11	62
Networking Opportunities	0.00% 0	0.00% 0	14.52% 9	33.87% 21	38.71% 24	12.90% 8	62
Peer Groups	0.00% 0	1.61% 1	16.13% 10	32.26% 20	37.10% 23	12.90% 8	62
Education/Training seminars/webinars	0.00% 0	0.00% 0	17.74% 11	43.55% 27	32.26% 20	6.45% 4	62
Technical Regulatory Assistance	0.00% 0	3.23% 2	12.90% 8	25.81% 16	20.97% 13	37.10% 23	62
Addressing Reimbursement Issues	0.00% 0	6.56% 4	4.92% 3	24.59% 15	24.59% 15	39.34% 24	61
Conferences (Annual, Billing Managers, CFO, Quality Care, Region IX Clinical Excellence)	0.00% 0	3.23% 2	11.29% 7	33.87% 21	33.87% 21	17.74% 11	62
Website	1.69% 1	5.08% 3	15.25% 9	37.29% 22	35.59% 21	5.08% 3	59

Q4 Please rate your satisfaction with CPCA's performance in this area using the following scale:Transform the Health System

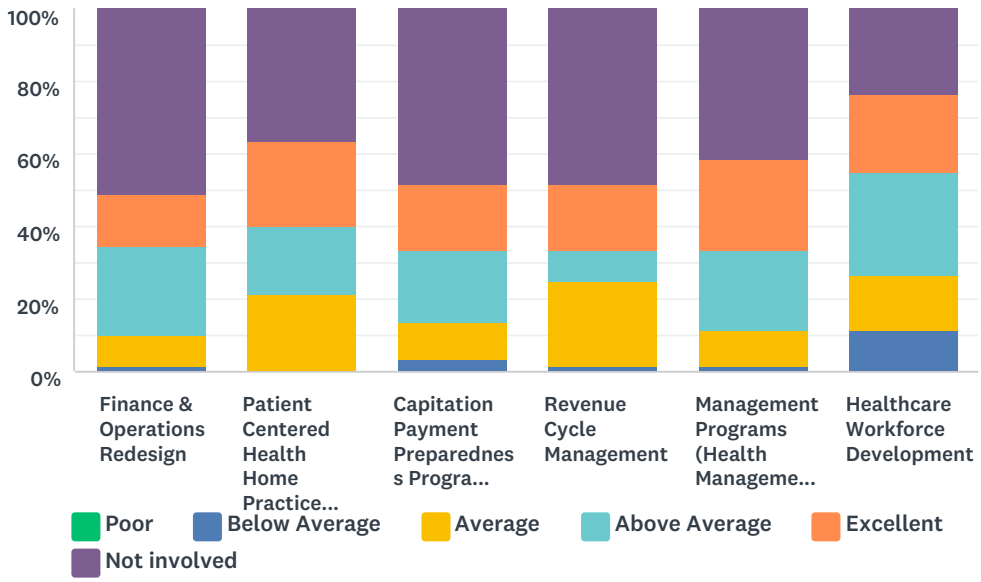
Answered: 60 Skipped: 2



	POOR	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	EXCELLENT	NOT INVOLVED	TOTAL	WEIGHTED AVERAGE
Payment Reform	0.00% 0	5.08% 3	16.95% 10	30.51% 18	20.34% 12	27.12% 16	59	4.47
Managed Care	0.00% 0	1.67% 1	21.67% 13	28.33% 17	23.33% 14	25.00% 15	60	4.48
Remaining Uninsured	0.00% 0	1.67% 1	23.33% 14	30.00% 18	16.67% 10	28.33% 17	60	4.47
Systems of Care	0.00% 0	3.33% 2	25.00% 15	28.33% 17	20.00% 12	23.33% 14	60	4.35

Q5 Please rate your satisfaction with CPCA's performance in this area using the following scale: Health Center Transformation

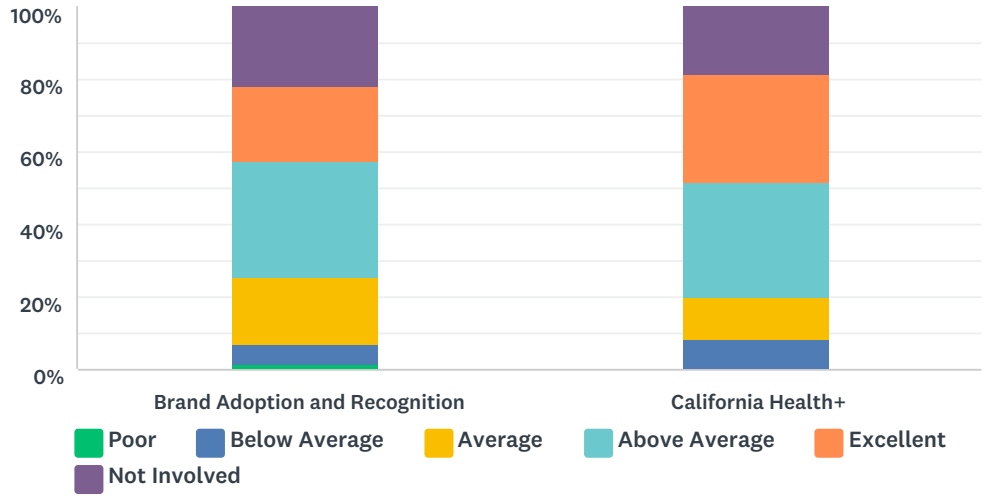
Answered: 61 Skipped: 1



	POOR	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	EXCELLENT	NOT INVOLVED	TOTAL	WEIGHTED AVERAGE
Finance & Operations Redesign	0.00% 0	1.64% 1	8.20% 5	24.59% 15	14.75% 9	50.82% 31	61	5.05
Patient Centered Health Home Practice Transformation	0.00% 0	0.00% 0	21.67% 13	18.33% 11	23.33% 14	36.67% 22	60	4.75
Capitation Payment Preparedness Program (CP3)	0.00% 0	3.33% 2	10.00% 6	20.00% 12	18.33% 11	48.33% 29	60	4.98
Revenue Cycle Management	0.00% 0	1.67% 1	23.33% 14	8.33% 5	18.33% 11	48.33% 29	60	4.88
Management Programs (Health Management+, Financial Management+)	0.00% 0	1.67% 1	10.00% 6	21.67% 13	25.00% 15	41.67% 25	60	4.95
Healthcare Workforce Development	0.00% 0	11.67% 7	15.00% 9	28.33% 17	21.67% 13	23.33% 14	60	4.30

Q6 Please rate your satisfaction with CPCA's performance in this area using the following scale:Promote the Value of Community Health Center

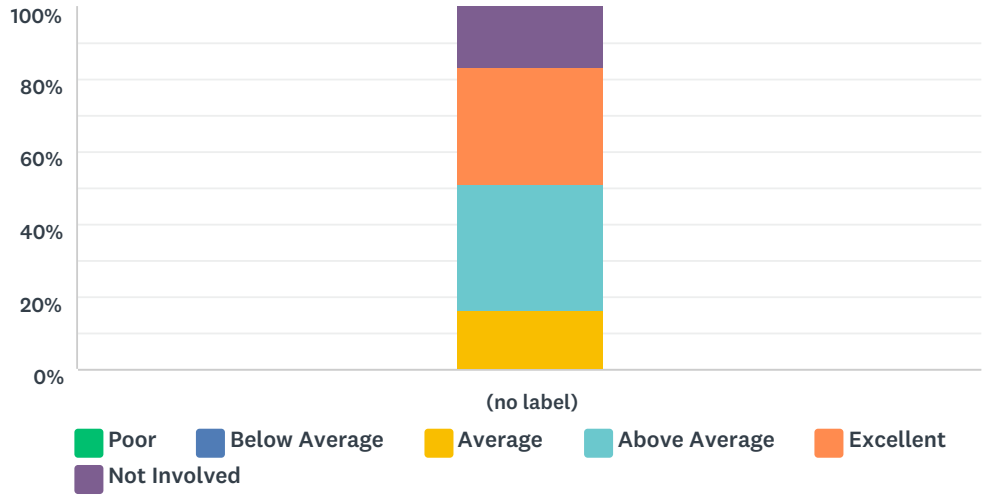
Answered: 61 Skipped: 1



	POOR	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	EXCELLENT	NOT INVOLVED	TOTAL	WEIGHTED AVERAGE
Brand Adoption and Recognition	1.69% 1	5.08% 3	18.64% 11	32.20% 19	20.34% 12	22.03% 13	59	4.31
California Health+	0.00% 0	8.33% 5	11.67% 7	31.67% 19	30.00% 18	18.33% 11	60	4.38

Q7 Overall, how would you rate the effectiveness of the leadership provided by the CPCA Board of Directors?

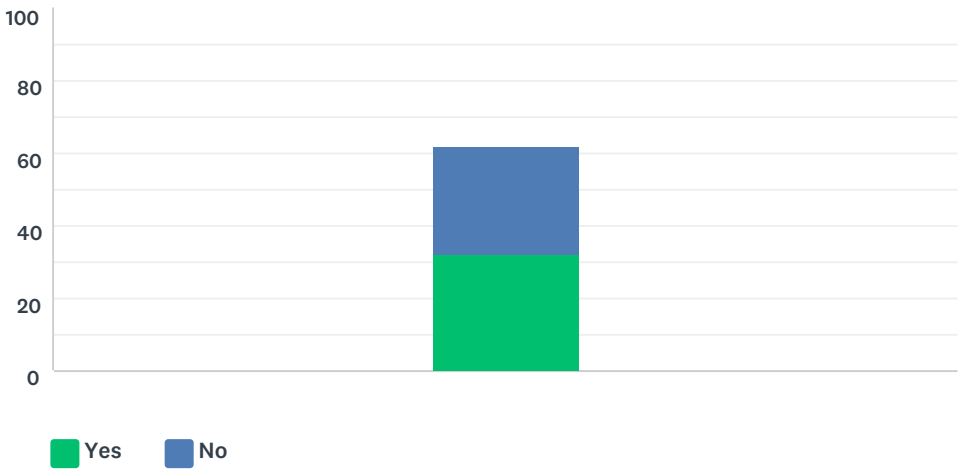
Answered: 61 Skipped: 1



	POOR	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	EXCELLENT	NOT INVOLVED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	16.39% 10	34.43% 21	32.79% 20	16.39% 10	61	4.49

Q8 Do you attend CPCA's Annual Conference?

Answered: 62 Skipped: 0



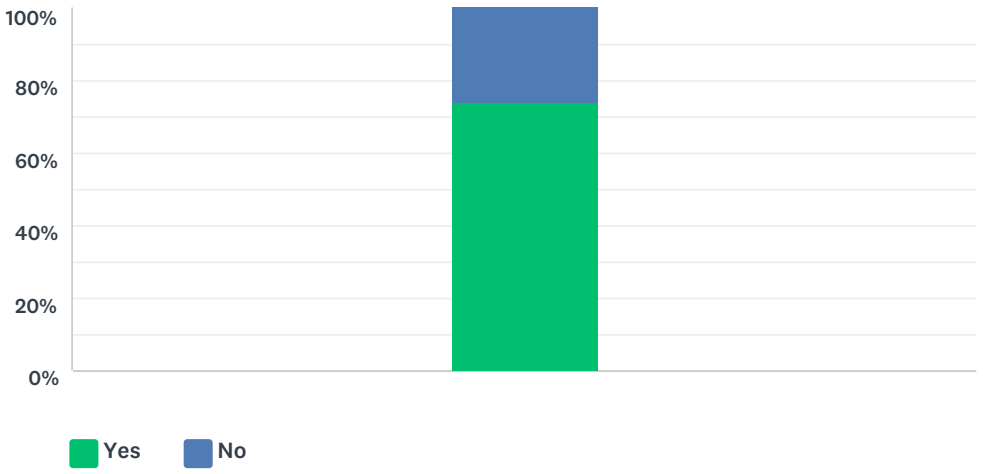
ANSWER CHOICES	RESPONSES	
Yes	51.61%	32
No	48.39%	30
Total Respondents: 62		

#	IF NOT WHY? (TIME, COST, LOCATION, CONTENT, OTHER)	DATE
1	Some years I do some not	11/3/2017 1:56 PM
2	I was just hired, will attend next year.	11/2/2017 12:08 PM
3	Typically yes but not this year.	11/1/2017 10:49 AM
4	It is not considered to be part of my job	11/1/2017 6:46 AM
5	Depends if it is pertinent to procurement.	10/31/2017 2:45 PM
6	other staff attended and brought back information	10/31/2017 7:45 AM
7	I try to go every other year when it is held in Sacramento.	10/30/2017 9:53 PM
8	time and location.	10/30/2017 3:26 PM
9	Cost	10/30/2017 3:01 PM
10	Content is not specific enough to inform my work.	10/30/2017 2:43 PM
11	Emergency prevented me from attending this year. I usually always attend.	10/30/2017 1:31 PM
12	Attended the Board Committee meetings	10/30/2017 12:53 PM
13	Location. It has been located in S. California the past 2 years.	10/30/2017 12:30 PM
14	Staff do	10/30/2017 12:04 PM
15	Attend the CFO Conference instead. Time and location is difficult as well.	10/30/2017 11:41 AM
16	Other	10/30/2017 11:38 AM
17	Usually allow other managers to attend.	10/30/2017 11:08 AM
18	I will sometimes go to a few sessions if it is driving distance, but our upper level management attends.	10/30/2017 11:04 AM
19	Cost and location. I make attending the QI conference a priority.	10/30/2017 10:55 AM

20	conference does not have content relevant to my position at my health center	10/30/2017 10:42 AM
21	Relevance to my job function did not warrant attendance	10/30/2017 10:41 AM
22	Quite a few representatives already going from the company	10/30/2017 10:38 AM
23	cost , location	10/30/2017 10:14 AM
24	I have been too busy to do this.	10/30/2017 9:58 AM
25	Location, cost	10/30/2017 9:58 AM

Q9 Do you participate on committees/workgroups?

Answered: 62 Skipped: 0

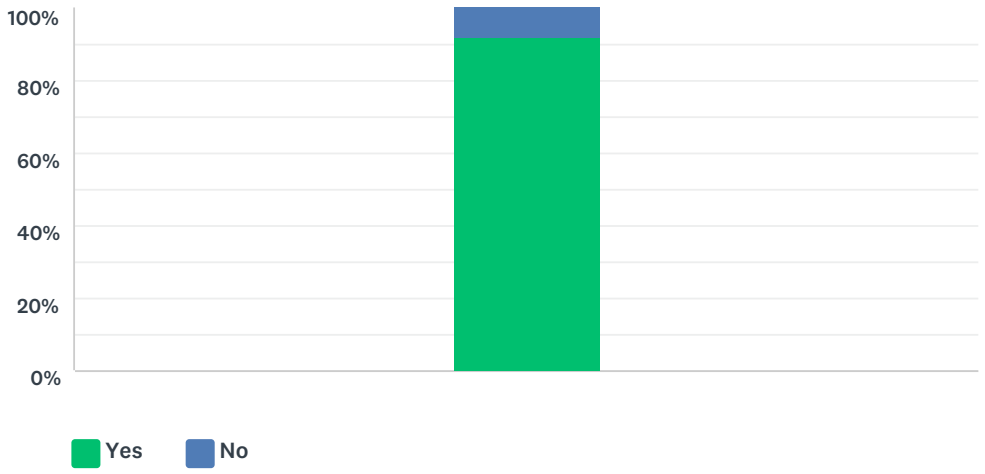


ANSWER CHOICES	RESPONSES	
Yes	74.19%	46
No	25.81%	16
TOTAL		62

#	IF NOT WHY? (TIME, COST, LOCATION, CONTENT, OTHER)	DATE
1	Time	11/8/2017 12:22 PM
2	Not yet - however requested and received information on the SDoH Taskforce I will participate in.	11/3/2017 9:50 AM
3	Other staff are involved	11/3/2017 8:43 AM
4	We are too leanly staffed.	11/1/2017 9:38 AM
5	Have never been asked	11/1/2017 6:46 AM
6	Too much on my plate already.	10/30/2017 9:53 PM
7	Cost	10/30/2017 3:01 PM
8	committees and workgroups very valuable	10/30/2017 12:58 PM
9	Need to know where, when.	10/30/2017 12:05 PM
10	staff do	10/30/2017 12:04 PM
11	Time	10/30/2017 11:41 AM
12	time	10/30/2017 11:38 AM
13	location - most workgroups are in Northern California	10/30/2017 10:42 AM
14	Relevance to my job function did not warrant attendance	10/30/2017 10:41 AM

Q10 Do you or your staff attend CPCA trainings (in-person or webinars)?

Answered: 62 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	91.94%	57
No	8.06%	5
TOTAL		62

#	IF NOT WHY? (TIME, COST, LOCATION, CONTENT, OTHER)	DATE
1	Cost	11/3/2017 9:50 AM
2	Especially when they are free!	11/1/2017 6:46 AM
3	Trainings offered are geared toward medical staff not administrative needs unless it is billing	10/31/2017 2:45 PM
4	Sometimes.	10/30/2017 7:24 PM
5	Cost	10/30/2017 3:01 PM
6	Staff do	10/30/2017 12:04 PM

Q11 Are there any areas you are concerned with CPCA's performance?

Answered: 26 Skipped: 36

#	RESPONSES	DATE
1	Webinars don't seem to be the high quality of the past	11/3/2017 1:56 PM
2	None	11/3/2017 9:50 AM
3	Health Information Technology. CPCA doesn't have the expertise to run the programs it's exploring.	11/2/2017 12:28 PM
4	A concern expressed by several colleagues at a regional meeting of local FQHCs, which I agree with, are the vendors who support CPCA that are not vetted by CPCA. For example, dissatisfaction the recruitment firm, Merritt Hawkins, was expressed by several health centers regarding high costs for their services, low turn out of qualified candidates for positions, the fact that all Merritt Hawkins does is send out post cards and advertise for candidates and connects them to your facility without vetting the candidate. They have a marketing strategy that is sometimes not 100% in representing what your facility is looking for, needs, or can offer a candidate. They are not appropriate for a FQHC type facility that has a limited budget, as lots of money can be funneled to them without ever getting a candidate or adequate candidate. Another firm PMG, a billing company, has been less than optimal. After entering into a three-year contract, we are half way through and are not finding service to be satisfactory. Managers assume there is some credibility with the firms that support and sponsor CPCA. There were CPCA representatives in attendance at our recent gathering of local FQHCs and they heard several complaints that some of the advertisers/sponsors are not what we think they will be. This doesn't apply to all the sponsors. We have had great success with QIExpress (a HIPAA HITEQ organization), Feldsman Tucker (attorney firm with HRSA experts that provides education for FQHCs), and BKD. There are just a few bad apples that get out there into our Clinics and create headaches for us. It might be good for CPCA to get feedback on their sponsors so other FQHCs can see what they think. Sort of like a "Yelp" for CPCA sponsors!	11/2/2017 12:26 PM
5	None	11/2/2017 12:08 PM
6	Our use of the HR recruiting section of the CPCA website has not been all that satisfying.	11/1/2017 9:38 AM
7	Push around same day billing for medical and BH. Current is not aligned with Practice Transformation and I do not see much movement or CPCA pushing this when it is the right thing to do. 340B is a huge benefit to FQ's to cover cost and I feel it needs alot more attention to address.	11/1/2017 2:53 AM
8	It could be more. Its strategic plan could be more. It could be more anticipatory and forward thinking. It could be more planful and more organized. It could include bolder partnerships, centralized core services, MSO-like functions. It could have stronger state administrative relationships and stronger membership relationships, big and small. Seek to engage all members equally.	10/31/2017 3:37 PM
9	I concerned with the push to create a business line around contracting with EPIC. This is not a core competency of the organization. I think that CPCA is underestimating its true cost and the amount of human capital/skill sets required to run a TSO. These can be outsourced, but then CPCA will be cavitate to the outsourcer. The upfront costs are very high and given the relative skinny financials of CPCA, there is little room for error.	10/31/2017 2:57 PM
10	Would like a peer group for procurement and contract negotiations	10/31/2017 2:45 PM
11	Making sure that Rural gets equal attention as urban	10/30/2017 9:53 PM
12	NONE	10/30/2017 4:17 PM
13	NO	10/30/2017 3:01 PM
14	I think we need a more robust grassroots effort. Email /advocacy alerts work well for staff and Board members, but we need tools and strategies for mobilizing our patients. Templates for postcards to legislators on legislative priorities that clinics can print and distribute to patients would be great. Or cards with scripts in Spanish / English that has the legislators phone number and can be handed to the patient with encouragement that they call and read the script, would help us mobilize our patients and many patients would appreciate the opportunity to engage.	10/30/2017 2:43 PM

15	No. On the contrary, I feel better about the skill and acumen of our trade association than I have in years. We greatly appreciate all of the work of the CPCA team on behalf of our patients and health center organizations.	10/30/2017 1:31 PM
16	I feet that CPCA's own staff is great, but that they do not do an excellent job handling contractors - for example, the mistakes made by Capital Link generating fact sheets for consortia was not satisfactorily addressed.	10/30/2017 12:58 PM
17	It is important for CPCA to address the State dislike for FQHC's. We have many battles with A&I as well as other concerns.	10/30/2017 12:53 PM
18	Locations for in person trainings seem to be in Southern California and quite a distance from an airport requiring an additional hour plus drive to get to training site.	10/30/2017 12:30 PM
19	Several large clinics question whether or not CPCA's advocacy has value for them. CPCA seems to be more focused on Immigration and Immigrant rights as opposed to health policy issues. CPCA appears reluctant to advance the litigation necessary to make state-level changes. CPCA is generally perceived as not effective with DHCS. CPCA is not as tough as needed on advocacy issues.	10/30/2017 12:04 PM
20	CPCA provides a number of learning and informational webinars that is invaluable for us to keep informed about financial impact issues.	10/30/2017 11:41 AM
21	I'd like to see CPCA's website and communication improve a little bit. Often only one person in my department will get emails even though we are all subscribed. Also, we are often not notified when workgroup and peer network calls are cancelled. Just a little bit better communication, and some updating of the website would be nice.	10/30/2017 11:04 AM
22	CPCA often gets really focused on the money making potential of a service or product. It is often listed as 'good for the health centers' and it also takes away considerable staff time to research and implement the product/service. When the next 'thing' comes along they start the process all over. Examples include: Centenne partnership for rural counties, PCMH coaching and TA, DRVs, Revenue Cycle Management, and now its EPIC. I am also concerned about the sponsors and whether these companies are paying to get endorsed or if they have an actual product that is helping the majority. How can we support 4 different insurance companies, for example is CPCA/NACHC aware of how challenging Merritt Hawkins has been for health centers? Pharma booths and sponsors for conferences?	10/30/2017 11:01 AM
23	none	10/30/2017 10:42 AM
24	Some of the TA around payment reform has been repetitive and not high value.	10/30/2017 10:39 AM
25	many webinars require a fee to attend; topics look good, but no budget	10/30/2017 10:14 AM
26	No	10/30/2017 9:58 AM

Q12 What are the three main reasons your organization is a member of CPCA?

Answered: 38 Skipped: 24

#	RESPONSES	DATE
1	Assists us in keeping current and gaining new knowledge	11/6/2017 7:25 AM
2	Up to date information, education, peer networking	11/3/2017 1:56 PM
3	We are FQHC - CPCA is an excellent advocate for our patients, resource for us, and supports networking and collaboration/coordination among all healthcare organizations to so we can have a unified voice for policy.	11/3/2017 9:50 AM
4	Policy/Advocacy Leadership around critical issues impacting health centers Participation on committees, etc.	11/3/2017 8:43 AM
5	Advocacy Policy and regulatory support Networking	11/2/2017 12:28 PM
6	Networking with other FQHCs across the state Networking within peer groups and increasing knowledge through peer groups Keep abreast of issues affecting FQHCs	11/2/2017 12:26 PM
7	CPCA provides future direction with accuracy.	11/2/2017 12:08 PM
8	1. Support from CPCA on a variety of important areas ranging from policy/advocacy, health center operations, regulatory issues, etc. 2. Networking with other clinic and consortia and sharing of best practices. 3. Extraordinary leadership from CPCA that keeps health centers and low-income patients in the forefront of policy makers' minds.	11/1/2017 10:49 AM
9	Networking and getting in touch with others who have launched the programs we're looking into CPCA webinars Conferences.	11/1/2017 9:38 AM
10	Advocacy Stronger voice together Ability to influence healthcare in California	11/1/2017 2:53 AM
11	Collaboration Advocacy	10/31/2017 4:10 PM
12	Members expect it and some members cannot afford to be. To support the movement and the mission because its the right thing to do. To be aware of thought processes and activities across the state.	10/31/2017 3:37 PM
13	Advocacy Networking Peer groups	10/31/2017 2:57 PM
14	Not sure	10/31/2017 2:45 PM
15	Legislative tracking, updates, and advocacy Education and training through CPCA Peer Workgroups	10/31/2017 7:35 AM
16	Education Support Networking Advocacy	10/30/2017 9:53 PM
17	-FQHC	10/30/2017 4:17 PM
18	To update Health Care matters.	10/30/2017 3:01 PM
19	Trainings/Webnirs and peer groups. Assistance with technical issues.	10/30/2017 2:43 PM
20	leverage advocacy efforts keep up to date with all things health care appreciates connecting with people dealing with the same issues.	10/30/2017 2:19 PM
21	1.Advocacy 2. Strength in numbers 3. Timely information	10/30/2017 1:31 PM
22	1. CPCA does great advocacy work that supports the health and well-being of the patients we collectively serve. 2, CPCA does great advocacy work at the State level and with HRSA on behalf of community health centers and keeps me abreast of developments in the policy, regulatory and health care environment areas. 3. CPCA enables the opportunity to work collectively towards a common mission, vision of health care access.	10/30/2017 1:23 PM

23	1. Information and advice : CPCA staff has been very helpful when we have an issue as a consortium and need to figure out how others have solved it - both individually and in workgroups, CPCA has helped us make progress on many issues. 2. Political connections- CPCA encourages us and gives us tools to connect in DC and Sacramento, including coordinating day at the capitol, etc. . 3. Together we have more of a voice and greater recognition.	10/30/2017 12:58 PM
24	To keep up with what the state is up to. Payment reform	10/30/2017 12:53 PM
25	Networking Trainings Education	10/30/2017 12:30 PM
26	1) Issues concerning Government Affairs / Advocacy 2) Resource for technical support for FQHCs 3) Excellent source for information and analysis for issues of the day.	10/30/2017 12:07 PM
27	Advocacy Networking Training	10/30/2017 11:56 AM
28	1) Very good instructional organization with its webinars and seminars 2) Timely updates on issues affecting FQHC's 3) Good CFO and Billing conferences	10/30/2017 11:41 AM
29	advocacy networking up to date information	10/30/2017 11:38 AM
30	- Learning from other FQHC's - Networking with other clinics - Advocacy	10/30/2017 11:08 AM
31	Unsure, but I think for technical assistance, monitoring of state level programs and policy, and legislative things.	10/30/2017 11:04 AM
32	1. Having community heath center representation in Sacramento that compliments the local activities, not vice-versa. 2. Ability to meet other health center contacts for peer support, best practices and solidarity on issues. 3. One vehicle paying attention to the impacts of Federal legislation on CA health centers.	10/30/2017 11:01 AM
33	1. Long-time California-based FQHC 2. State organizational body to represent and be the voice of CHCs 3. resources available	10/30/2017 10:42 AM
34	1) Advocacy 2) Networking 3) Economies of scale	10/30/2017 10:39 AM
35	Advocacy Trainings/seminars Peer groups	10/30/2017 10:38 AM
36	1. network 2. resources 3. professional affiliation	10/30/2017 10:14 AM
37	Learning new information Trainings/webinars	10/30/2017 9:58 AM
38	1. Trusted source of information 2. Breaking source of information 3. Webinars that are insightful and timely	10/30/2017 9:58 AM

Q13 What programs or services that CPCA currently provides do you find most valuable?

Answered: 41 Skipped: 21

#	RESPONSES	DATE
1	Compliance Officers Peer Network (COPN)	11/8/2017 12:22 PM
2	HR Peer group and trainings	11/6/2017 7:25 AM
3	peer networks and advocacy	11/3/2017 1:56 PM
4	keeping me updated on potential changes in legislation that could impact our services or patient care, requesting our feedback and participation in the process	11/3/2017 9:50 AM
5	Advocacy Operations support (Ginger)	11/2/2017 12:28 PM
6	Trainings	11/2/2017 12:08 PM
7	1. Policy and advocacy team is extraordinary and we would have difficulty functioning without them. 2. Responsiveness to member issues is amazing - CPCA often anticipates our needs. 3. The work Meaghan did on managed care and shoring up pay for performance criteria and programs was exceptional. 4. Andie's work to better align policy work at CPCA with consortia since the election also extraordinary and a game changer in how we work together.	11/1/2017 10:49 AM
8	Conferences Educational offerings	11/1/2017 9:38 AM
9	Committee meetings Technical assistance with licensing and other state issues Advocacy, but don't always feel they push what is critical for CHC's	11/1/2017 2:53 AM
10	Trainings	10/31/2017 4:10 PM
11	Weekly Government Affairs phone calls. Committee meetings and the information shared there.	10/31/2017 3:37 PM
12	Peer groups Health+ Operational Tech support	10/31/2017 2:57 PM
13	The 340B peer group	10/31/2017 2:45 PM
14	immigration workgroup	10/31/2017 7:45 AM
15	Legislative advocacy Education, training and a resource library	10/31/2017 7:35 AM
16	Usually the peer networking and Billing group meetings. Love the Dental Support program!	10/30/2017 9:53 PM
17	CP3	10/30/2017 7:24 PM
18	HEALTH ADVOCACY PROGRAM	10/30/2017 4:17 PM
19	Everithing	10/30/2017 3:01 PM
20	Peer groups and technical assistance with State regulation /compliance/ Rate setting issues.	10/30/2017 2:43 PM
21	Board committee meetings are very valuable for staying abreast on the most pressing issues facing our organizations. The weekly update is very valuable and an effective format for combining a variety of relevant topics for us in one location.	10/30/2017 1:31 PM
22	1. Board Committees- 330, government programs. 2. Webinars/Training- 3. Public Policy and Advocacy	10/30/2017 1:23 PM

23	Health Plus Advocates /Government Affairs team is now top notch - really assists us in making progress on all advocacy efforts, negotiations with the state administration etc, thinking through state and federal issues, etc. . Workgroups are very helpful - for example, we were floundering on how to deal with unseen patients but now there is a CPCA workgroup where staff is bringing in each group that has been successful in making progress to share their techniques - very helpful to us. also 340 b workgroup and many others. Staff is very responsive , timely, helpful- I am impressed how quickly I get an answer when I have a question: for example, in a negotiation with the health plan someone referred to a set of regulations I wasn't familiar with and CPCA staff helped me get a copy of the regs in time for the next meeting - there are a lot of little things like this - all of a sudden we had a question about how mental health services could be billed and we got an answer the same day!	10/30/2017 12:58 PM
24	Payment reform and the Risk incentive possibly to be included in the PPS Reconciliation	10/30/2017 12:53 PM
25	Peer network groups	10/30/2017 12:30 PM
26	1) Liaison with the state addressing sensitive issues such as P4P, A&I issues, etc. 2) Advocacy up-dates and tools for health centers. 3) Technical assistance: OSHPD3, Immigration issues, Scope changes, etc.	10/30/2017 12:07 PM
27	Advocacy	10/30/2017 11:56 AM
28	Webinars	10/30/2017 11:41 AM
29	CPCA and Health+ Advocates provide a myriad of value-added services, and staff members have been consistently responsive and professional. Some of the programs and services that have proven most valuable: All of the post-election advocacy support and communications--calls to action, templates for messaging, press releases. Staff have been very supportive on all of these efforts. 340B Calls Wrap Cap Calls/Webinars Weekly Government Affairs Calls--great to get weekly updates from Angie RAC Consortia Calls Outreach and Enrollment Calls Immigration Work Group Calls and Webinars Public Affairs Peer Network Annual lobby days: NACHC P&I support from our statewide association, and DAC planning and convening There are probably many others that I'm just not remembering at this time.	10/30/2017 11:38 AM
30	conferences consultation (i.e. PCMH recognition)	10/30/2017 11:38 AM
31	- Reimbursement/DHCS questions - Licensure questions	10/30/2017 11:08 AM
32	Information about policy and advocacy, programs, etc.	10/30/2017 11:04 AM
33	Committee and board meetings, policy analysis of current legislation, training opportunities on statewide content.	10/30/2017 11:01 AM
34	Love the SQIC group.	10/30/2017 10:55 AM
35	webinars, trainings, online letter of support inquiry/form	10/30/2017 10:42 AM
36	Webinars and on-site trainings	10/30/2017 10:41 AM
37	Advocacy	10/30/2017 10:39 AM
38	Peer groups	10/30/2017 10:38 AM
39	webinars, education,networking	10/30/2017 10:14 AM
40	Training/Webinars	10/30/2017 9:58 AM
41	Webinars and conference calls.	10/30/2017 9:58 AM

Q14 What service does CPCA NOT provide, but if they did would make a significant positive impact on your organization?

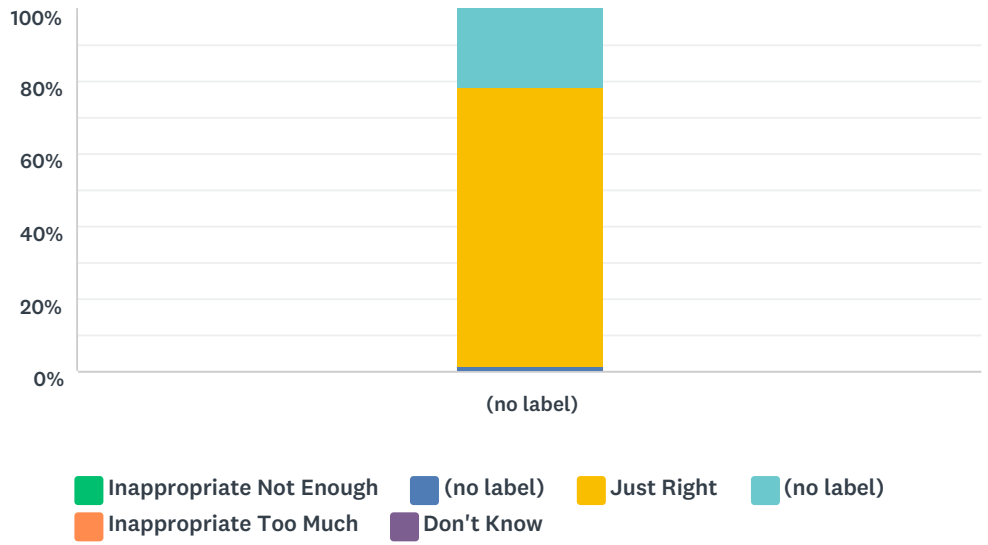
Answered: 23 Skipped: 39

#	RESPONSES	DATE
1	None that I can think of right now	11/3/2017 9:50 AM
2	1. Raising a bunch of money for us - Just Kidding! 2. Have a stronger communications team that is responsive to member needs and works better to coordinate messaging from clinics and consortia with CPCA on a whole variety of subjects.	11/1/2017 10:49 AM
3	No comment at present	11/1/2017 9:38 AM
4	Support around revenue diversification Healthcare workforce, not sure what it does other train our staff but really need help with Pipeline	11/1/2017 2:53 AM
5	Aspire to dream bigger for community health centers. Take the plan out of the box and imagine what could be? How could members' patients -- Californians -- live healthier lives? In the process, leverage these better relationships to pave the way with community partners, hospital systems, specialty groups, health plans and foundations to elevate primary care and community health centers. And, leverage these better relationships to cause the members of the administration and the legislature to do the heavy lifting on behalf of community health centers to positive effect (e.g. integrate statewide data repositories and exchanges with community health center data repositories, to better position the brand and tell the story). There is power in the volumes of services provided. Develop and share scenario plans with the membership in anticipation of the new administration's health care policy and finance directives regarding Medicaid, PPS, APM, contracting and reimbursement.	10/31/2017 3:37 PM
6	Group purchasing of Benefits Credentialing Services Compliance Support	10/31/2017 2:57 PM
7	more assistance with standard procurement	10/31/2017 2:45 PM
8	N/A	10/30/2017 9:53 PM
9	NONE AS OF THIS TIME	10/30/2017 4:17 PM
10	Sometimes, Free seminars	10/30/2017 3:01 PM
11	More grassroots organizing tools - ones that are simple and don't require a full-time staff person to support.	10/30/2017 2:43 PM
12	Training resources to bring to our clinics.	10/30/2017 2:19 PM
13	A health benefits plan that we could offer to our staff. Could CPCA help us form a large enough risk pool that we could provide better benefits to our employees at competitive prices? As our number of employees grow across the state how can CPCA help us provide the most robust package to our employees? Are there economies of scale for different offerings that we haven't explored? This could be a complementary effort to the current workforce development focus. We want to make sure our future workforce trained, but then we have to be able to attract them and retain them. This is challenge when we try to compete with the offerings of large health systems.	10/30/2017 1:31 PM
14	You are doing it already but continue the work with 340 b understanding regulations and working with the State to keep this benefit for health centers.	10/30/2017 1:23 PM
15	More of a deep dive into what data is really needed to prepare for payment reform, and what tools we should pursue.	10/30/2017 12:58 PM
16	Not sure	10/30/2017 12:53 PM
17	See above. Suggest a large clinic sub-governance group with issues geared not for associations, but truly for the large-scale clinics. Limit votes of associations whose clinic members are not members of CPCA.	10/30/2017 12:04 PM

18	Free training. It is still hard to accept that we have volunteer health center staff that are willing to present on topics that their organization invested in them to learn only to have CPCA go and charge $90 for others to hear it. That doesn't spread knowledge for the majority, it makes money for CPCA. How much does it really cost to have someone launch WebEx and open a meeting? Could this not be grant funded so the information could be spread to the majority? How about charging for CME for providers and let others participate as part of their member dues? I would take fewer full-catered receptions to offset the costs for more free training for the members.	10/30/2017 11:01 AM
19	none	10/30/2017 10:42 AM
20	Not sure	10/30/2017 10:39 AM
21	MA education, more information on RNs in FQHCs	10/30/2017 10:14 AM
22	Credentialing trainings	10/30/2017 9:58 AM
23	Expand communications between consortiums.	10/30/2017 9:58 AM

Q15 On a scale of 1-5, Do you receive the appropriate amount of communication from CPCA?

Answered: 60 Skipped: 2



	INAPPROPRIATE NOT ENOUGH	(NO LABEL)	JUST RIGHT	(NO LABEL)	INAPPROPRIATE TOO MUCH	DON'T KNOW	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	1.67% 1	76.67% 46	21.67% 13	0.00% 0	0.00% 0	60	3.20

#	COMMENTS:	DATE
1	The branding feels icky, with all the photos of the CEO...	11/2/2017 12:28 PM
2	I read what I can read, but I find the combination of emails good.	11/1/2017 10:49 AM
3	GREAT JOB THROUGH THE YEARS CPCA !	10/30/2017 3:01 PM
4	Thank you!	10/30/2017 1:31 PM
5	11;00 advocates call very helpful and efficient weekly update very helpful	10/30/2017 12:58 PM
6	Brand CPCA--stop branding the CEO (pictures, messages, etc.). Make communications more informational for the positions--not the promotion of individuals. It is not the amount of communications, it is the relevancy of the communications	10/30/2017 12:04 PM
7	Personally feel that CPCA as an organization does a fine job lobbying Sacramento and keeping the association members apprised of any issue that will affect their financial and operational functions.	10/30/2017 11:41 AM
8	Not regarding my above comment, I think info from CPCA is informative and helpful	10/30/2017 11:04 AM
9	I would like to know more about Credentialing.	10/30/2017 9:58 AM

SPARC Committee

Thursday, January 18, 2018
9:00am – 10:00am

Tim Rine, Chair

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Tim Rine	A
II. Approval of Agenda	• Executive Summary	Tim Rine	A
III. Approval of Minutes	• October 2017 Rural Committee Meeting • October 2017 Agricultural Committee meeting	Tim Rine	A
IV. Year in Review	• Year in Review Memo	Meaghan McCamman Liz Oseguera	I
V. Medi-Cal Managed Care Procurement	• CHCF Report: Medi-Cal Brings Managed Care to CA's Rural Counties (linked) • Performance Dashboard	Scott McFarland	D
VI. CMSP Update		Laura Sheckler Melinda Rivera	D
VII. Combating the Opioid Epidemic		Margaret Kisliuk, Partnership Health Plan	D
VIII. Champions for Access and Rural Practice Transformation (CHART)	• CHART Concept Summary	Mark Simon, UC Davis Dr. Tonya Fancher, UC Davis	D
IX. Immigration	• Immigration memo	Liz Oseguera	I
X. Migrant Health	• Migrant Health Update	Liz Oseguera	D
XI. Rural Health Events	• Running List	Meaghan McCamman	I
XII. Adjourn		Tim Rine	I

California Primary Care Association

Executive Summary

Date: January 18, 2018
To: Special Populations, Agricultural, and Rural Committee (SPARC)
From: Meaghan McCamman, Assistant Director of Policy; Liz Oseguera, Senior Policy Analyst

MEMORANDUM

Medi-Cal Managed Care Procurement

- DHCS has announced that all commercial Medi-Cal managed care plans in the state will be re-procured over the next few years.
- Some rural parts of the state have up to two commercial plans that will be re-procured
- This discussion will include ideas for leveraging the procurement to ensure that plans in rural areas serve as good partners to CCHCs.

CMSP Update

- Consortia from CMSP counties are advocating to streamline and improve the CMSP pilot projects
- Major asks include expansion of CMSP to undocumented residents under 138% FPL; improving or removing the AMM reservation system for the primary care benefit; and providing more fiscal transparency to stakeholders.

Combating the Opioid Epidemic in Rural Communities

- In November 2016, CMS approved a portion of the 1115 Waiver that gave counties the option of vastly expanding the Drug Medi-Cal delivery system under the Organized Delivery System (ODS) waiver
- In the rural northern Partnership Counties, the MCP has agreed to implement the ODS waiver on behalf of the counties. This is the first time that counties have delegated their behavioral health responsibility onto a partner MCP
- A Partnership Health Plan representative will attend the SPARC meeting to provide an update on implementation of the DMC-ODS.

Champions for Access and Rural Practice Transformation (CHART)

- The new Center for a Diverse Healthcare Workforce is seeking to submit a HRSA grant proposal for a new leadership practice transformation program that is targeted to community health center staff and rural and frontier communities across the state.
- The Champions for Access and Rural Practice Transformation (CHART) Program seeks to engage three cohorts of 8 clinician champions in designing and implementing practice transformation projects during a two-year training program, lead a practice transformation team at their home health center, and receive targeted coaching to ensure success in charting a course to project implementation.

- The grant proposal is due on January 31, 2018. To be successful, UCD would like to identify some health centers that are willing to demonstrate support for this grant proposal.

Immigration

- Congress has yet to pass legislation that would create a path to citizenship for DACA recipients.
- On December 4, 2017, the Supreme Court ruled to allow the Trump administration to fully enforce the third Muslim ban while the case undergoes litigation. In consequence, the ban now applies to all foreign nationals, even those with a bona fide relationship with a person or entity in the United States.
- CPCA, in collaboration with Children's Partnership and The California Program on Access to Care (CPAC) is evaluating the data collected through our provider survey to capture the mental health of immigrant children and their parents. The report should be ready in February.

Migrant Health

- As a co-chair for LHA, CPCA has been leading efforts to convene stakeholders interested in educating and outreaching to migrant workers, especially H-2A visa holders, regarding their health, legal and labor rights.
- To help fund our immigration work, we've decided to compile our immigrant resources into a toolkit that will be sold to out of state organizations.
- CPCA will be presenting on immigration in two sessions during the NWRPCA 2018 Western Forum for Migrant & Community Health.

Rural Health Events List

- This is a list of all rural health events coming up in 2018

CALIFORNIA PRIMARY CARE ASSOCIATION
RURAL COMMITTEE
October 10, 2017
10:30am – 11:00am

Members: Lucresha Renteria, Chair, Cathy Frey, Dean Germano, Kerry Hydash, Dave Jones, Nichole Mosqueda, Danielle Myers, John Price, Tim Rine, Paulo Soares, Tony Weber

Guests: Christine Noguera, Leslie McGowan, Connie Kuk, Christine Velasco, Linda Costa, Isabel Becerra, Melissa Eidman, Jason Vega, Tracy Garmer, Henry Tuttle, Deanna Stover, Vernita Todd, Tim Fraser, Margie Martinez

Staff: Meaghan McCamman, Daisy Po'oi, Liz Oseguera, Michael Helmick, Mike Witte, Beth Malinowski, Cindy Keltner

I. Call to Order
Lucresha Renteria, Chair, called the meeting to order at 10:32am

II. Approval of Agenda
A motion was made to approve the agenda as presented. **The motion carried. (C. Frey, D. Myers)**

III. Approval of Minutes
A motion was made to approve the minutes of July 13, 2017. **The motion carried. (D. Myers, D. Germano)**

IV. CMSP Update
CPCA staff provided update on CMSP pilot programs and workforce investment. The committee requested that CPCA continue to push CMSP to provide primary care benefits to undocumented persons below 138% FPL, and to explore the possibility of presumptive eligibility for the primary care benefit program. The committee also requested that CPCA contact the Weitzman Institute about potentially administering the NP/PA residency investment.

V. HPSA Score Redeterminations: Who has requested, how are they going?
The state will put scoring on hold based on the new methodology. The committee will revisit this in 2018.

VI. Restructuring the Rural Committee & activating rural participation
The Rural committee agreed to combine with the Ag committee and include other special population issues. A schedule of the 2018 Rural Roundtable will be set in advance so that hot topics are discussed prior to attending CPCA's quarterly board and committee meeting.

VII. Combating the Opioid Epidemic
CPCA recently hosted a meeting with Aegis and discussed some ideas of what health centers can ask for and what is needed such as building trust with other community partners and using an infrastructure that is sustainable. The $45 million grant from 21st Century Cures Act has been awarded and is targeted toward rural SUD.

VIII. Rural and Behavioral Health
A list of upcoming Rural Health Events was provided to give the committee an opportunity to share and coordinate travel.

IX. Rural Health Events
A list of Rural events for 2017-18 was provided.

X. Adjourn
The meeting was adjourned at 11:00am. **The motion carried. (T. Rine, D. Jones)**

Respectfully submitted,
Daisy Po'oi, Meeting Minutes Recorder

CALIFORNIA PRIMARY CARE ASSOCIATION
AG WORKER HEALTH COMMITTEE
October 10, 2017
3:00pm – 3:30pm

Members: Leslie McGowan, Chair, Cathy Frey, Kerry Hydash, Nichole Mosqueda, Danielle Myers, Christine Noguera, John Price, Paulo Soares, Christina Velasco, Tony Weber

Guests: Doreen Bradshaw, Tim Rine, Dave Jones, Dean Germano, Anitha Mullangi, Linda Costa, Tina Jagtiani, Mary-Michal Rawling, Jessica Prechtl, Tim Fraser, Deanna Stover, Henry Tuttle, Tracy Garmer, Vernita Todd

Staff: Elizabeth Oseguera, Daisy Po'oi, Meaghan McCamman, Jana Castillo, Andrea Chavez, Cindy Keltner, Mike Witte, Sandy Birkman, Erin Perry

I. Call to Order
Leslie McGowan, Chair, called the meeting to order at 10:01am.

II. Approval of Agenda
A motion was made to approve the agenda as presented. **The motion carried. (D. Myers, C. Noguera)**

III. Approval of Minutes
A motion was made to approve the minutes of July 13, 2017. **The motion carried. (C. Frey, P. Soares)**

IV. Immigration Update
Elizabeth Oseguera provided an overview of SB 54 (De Leon) legislation, which requires the Attorney General to create model policies and procedures for a various of state entities, including state health care facilities, to help insure all Californians, including ALL immigrants, have access to public services, like health care.

V. Access 2020 Campaign
CPCA is working with NACHC to bring Access 2020 training to California. CPCA staff will send an outline of what the training will look like to the Ag committee and the entire CPCA membership. This will also include talking points on why a health center would be interested in this training if they don't receive any money.

VI. NACHC CHI Ag Committee Meeting Update
No updates were given since a good portion of the group attended CHI.

VII. NWPRCA 2017 Western Forum for Migrant & Community Health
The NWPRCA 2017 Western Forum is taking place on February 22-24, 2018 in Seattle, WA. CPCA submitted two abstracts and is considering being a sponsor at this conference.

VIII. Open Forum
The Ag committee agreed to merge with the Rural committee to include special populations. Doreen Bradshaw suggested the Ag committee do some pre-work within their own groups in advance of CPCA's board and committee meetings so that folks can bring action items and hot topics to the committee meetings.

IX. Migrant Health Coordinator

Elizabeth Oseguera provided an update on DACA program and LHA efforts in creating resources that will help inform migrant workers of their health and legal rights.

X. Adjourn

The meeting was adjourned at 10:25am.

Respectfully submitted,

Daisy Po'oi
Meeting Minutes Recorder

California Primary Care Association

Special Populations, Agricultural and Rural Committee (SPARC) 2017 Year in Review

Date: January 18, 2018

To: Special Populations, Agricultural, and Rural Committee (SPARC)

[redacted]

2017: The Year Ahead (projected from 2016) = *What we projected*

- Economic Impact of CCHCs to the Rural Community
  - The Trump administration presents a danger not only to the ACA, but to health center, hospital, and other health care funding. However, Republicans in Washington tend to be sympathetic to rural communities and may be willing to create policies which will protect rural and frontier areas and lessen the economic and social impact of repealing the ACA.
  - Rural CCHCs in California should be prepared to show the economic and social benefit that they have on their communities as a job creator and economic engine, as well as their important roles as sole community providers, server of the uninsured, answer to the opioid epidemic, and cornerstone of the community.
  - Rural CCHCs should be preparing to band together with other rural voices to push Congress and the Trump Administration to protect rural from the devastating impact of ACA repeal.

- Network Adequacy
  - Network adequacy issues will continue to be a hot topic at DHCS, DMHC, and CMS. DMHC in particular is evaluating telehealth, especially tele-psychiatry, to determine if telehealth may be a solution in areas where adequate provider networks simply do not exist.

- Substance Use Disorder
  - Partnership Health Plan continues to explore administering a multi-county regional approach to implementing the Drug Medi-Cal Organized Delivery System waiver in the rural North. If PHC moves forward with this model, it will be the only MCO administrator and only regional model in the state that we are aware of.

- Workforce
  - The $4.5 million in state loan repayment funds and allied health loan repayment funds will be administered by OSHPD on behalf of CMSP.
  - CMSP staff is in the midst of exploring how to administer the NP/PA residency support, which we expect to see move forward in 2017.

- Deferred Action for Childhood Arrivals (DACA) and Deferred Action for Parents of U.S. Citizens and Lawful Permanent Residents (DAPA)
    - CPCA will continue to support efforts to support DACA / DAPA.
    - CPCA will continue to support efforts to promote health for all.

- Increasing Partnerships
    - CPCA has been working closely with Farmworker Justice, Covered California, the Mexican Consulate and the California Immigrant Policy Center around H-2A visa workers.
    - Continue to increase partnerships

- Ag Worker Access 2020 Campaign
    - Work more closely with CVHN to provide trainings and learning opportunities for members.

- Hispanic Advocacy Program
    - Integrate new tools into CPCA's advocacy infrastructure
    - Continue to inform members about the program

- Open Forum
    - Maintain this item on the agenda to help the committee develop goals.
    - Arrange for speakers to come in and discuss topics of interest.

2017: Committee Year-in-Review = *What happened*

- Protecting the Rural Health Delivery System
    - The RAC of the rural north led a concerted effort to collect and analyze the data needed to demonstrate the social and economic importance of CCHCs to their rural communities.
    - Three rural convenings were held soon after the November election for the purpose of bringing together cross-industry collaboration to serve as a voice for rural health under the new Administration.
    - Capital Link was commissioned and published a report documenting the findings related to the importance of rural clinics to their communities.

- Combating the Opioid Epidemic
    - The impact of the opioid epidemic in rural America garnered national attention
    - The state was awarded a $45 million grant from 21st Century Cures act and targeted the funds toward rural SUD
    - Many of the "Hubs" have expressed strong interest in working with FQHCs as "spokes"

- CMSP
    - The CMSP pilot programs rolled out and were of mixed success
    - Funds were made available for CMSP counties to expand the SLRP

- The efficacy of the Primary Care Benefit Program was limited by the inability of undocumented residents with incomes under 138% FPL to utilize the benefit
- The Rural Committee began discussions about how to strategically prepare CMSP counties for the possibility of ACA repeal.

- Deferred Action for Childhood Arrivals (DACA)
  - CPCA has helped to advocate for the DACA program through advocacy alerts and taking position on federal bills.
  - CPCA has provided members with resources that have helped them understand and defend the program, both as employers of DACA recipients and advocates for the program.
  - CPCA has continued to support efforts to promote health for all.

- Increasing Partnerships
  - This year CPCA has worked very closely with its immigrant partners to help protect our immigrant communities under the current anti-immigrant atmosphere.
  - Our partnerships created through the Latino Health Alliance has helped us inform the Employment Development Department of the healthcare services available for migrant patients at clinics.

- Ag Worker Access 2020 Campaign
  - CPCA worked with CVHN and the National Center for Farmworker Health, Inc. to establish a training on the Access 2020 campaign. However, members expressed little interest in the training, thus it was not held.

- Hispanic Advocacy Program
  - CPCA promoted the HAP and HACE program during our Ag Committee meetings.
  - We also had Golden Valley Health Center present to the Ag Committee on how to become a member of the HAP/HACE program.

- Education and Outreach to Migrant Workers
  - As co-chairs of the Latino Health Alliance (LHA), CPCA is helping to create educational resources on the legal, health, and labor rights of migrant workers.
  - Through LHA, CPCA is leading a stakeholder group comprised of state and federal partners interested in disseminating information to migrant workers, especially to H-2A visa workers.

- Restructuring the Rural and Agricultural Committees
  - Rural and Ag Committees were combined and expanded to cover other special population. The Special Populations, Agricultural, and Rural Committee (SPARC) was born.

2018: The Year Ahead

- Health Care Reform
  - The ACA is not out of danger, and the imminent threat of repeal will color conversations about CMSP, coverage of undocumented residents, articulating the health center value proposition, and delivery system reforms.
  - Even if the ACA remains, the federal deficit is likely to force a national conversation on entitlement reform which will include Medicaid.

- Patient Centered Health Home (PCHH) / Section 2703
  - HHP will launch in Partnership counties in July 2018
  - As the initial cohort of counties, all eyes will be on the rural north to demonstrate cost savings as soon as possible, which it must do in order to remain a benefit in perpetuity.

- CMSP
  - The demonstration programs will be coming to an end in 2018. Advocacy may be necessary to keep and expand the successful demonstrations while revising the ones that were less successful.
  - Not including undocumented residents under 138% FPL in the CMSP program and primary care benefit was, in part, due to a feeling that undocumented residents were soon to be covered at the state level. This has proved more difficult than expected, so another conversation about expanding CMSP to the undocumented under 138% FPL may be necessary.
  - CMSP staff may feel the need to continue to grow their reserves given the potential danger of ACA repeal.

- Medi-Cal Commercial Procurement
  - Commercial procurement for rural North counties has been delayed until 2024.
  - This provides ample opportunity for health centers in rural areas to meet with, and negotiate partnerships with health plans that seek contracts for their counties.

- Immigration Policy & Resources
  - Continue to develop resources and trainings that will help health centers prepare themselves, staff and patients for an unlikely possibility of an ICE raid.
  - Work closely with immigrant partners to continue influencing immigration policy, while also working to advocate for healthcare coverage for all.
  - Help our immigrant partners and patients advocate for the DACA program.

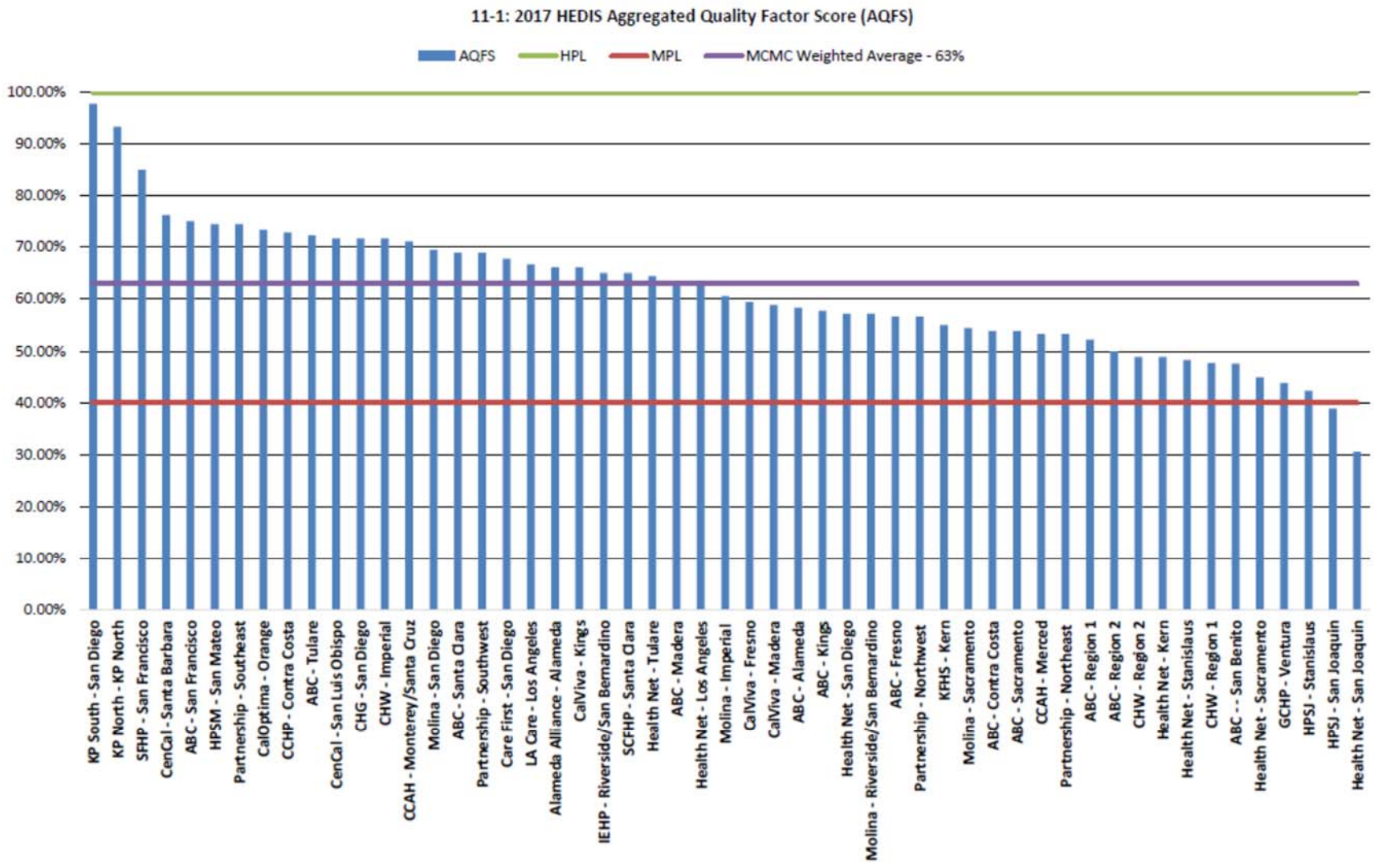
- Education and Outreach to Migrant Workers
  - Through LHA, continue to foster partnerships with organizations, including state, federal and international entities, to educate and encourage migrants to seek care at our health centers.

- Increase Partnerships
    - Continue to create and grow relationships with organizations in order to better assist and advocate for our diverse patient population.

- Social Determinants of Health (SDOH)
    - CPCA will continue to promote the integration of community health workers and Promotoras into clinical health teams to help address the SDOH for our patients, especially those with needing culturally and linguistically appropriate care.
    - Through the Alternative Payment Method (APM) pilot program, we will continue to work with our members to ensure we are providing care that helps address barriers created by SDOH.

- Homelessness
    - CPCA will provide members updates on legislation that may help address the issue of homelessness, which some of our patients face.

Medi-Cal Managed Care Performance Dashboard
Released September 14, 2017



Note: The Aggregated Quality Factor Score (AQFS) is a single score that accounts for plan performance on all DHCS-selected Health Effectiveness Data and Information Set (HEDIS) indicators. It is a composite rate calculated as percent of the National High Performance Level (HPL). The High Performance Level is 100%. The Minimum Performance Level is 40%. The State Average is 63%.

Champions for Access and Rural Practice Transformation – CHART

UC Davis, UC San Diego and the California Primary Care Association will collaborate to recruit, train and coach 24 fellows from clinics serving rural and frontier communities across the state. The Champions for Access and Rural Practice Transformation (***CHART***) program will engage three cohorts of 8 clinician champions (***CHART Fellows***) in designing and implementing practice transformation projects with measurable impacts in patient access, quality of care and cost effectiveness. Fellows from each cohort will participate in a two-year training program, lead a Practice Transformation Team at their home clinic and receive targeted coaching to ensure success in *charting a course* to project implementation.

CHART's core objectives include:

- Develop academic-community partnerships between UC Davis, UC San Diego and 20 community healthcare centers
- Train and support 24 practicing primary care clinicians to lead health care transformation and enhance teaching in community- based settings
- Build the operational capacity of 24 community healthcare centers to design, implement and sustain practice transformation projects
- Measurably improve health outcomes and reduce disparities for underserved populations in community- based settings across California

The CHART experience will combine on site visits to clinics by CHART coaches, virtual meetings of training participants and in-person convenings of participants. During each two-year training cycle, a cohort of 8 ***CHART Fellows*** will complete an intensive process that includes 12 months of practice transformation training followed by 12 months of project implementation and capacity building.

<u>Practice Transformation Training</u>

- Monthly videoconference cohort learning sessions to engage with and learn from cohort peers, CHART coaches and guest trainers on specific topics.
- Five in-person trainings including two 2-day trainings in Sacramento focused on specific strategies for healthcare improvement and three day-long meetings in San Diego to develop and track progress on practice transformation plans while learning first hand from experienced practice transformation veterans.
- Training in a comprehensive range of practice transformation topics with an emphasis on adaptations for rural and frontier clinics, including leadership, team-based integrated health care, quality improvement, population health, telehealth and connected health strategies, social determinants of health, health policy, and education.
- Training in best practices for rural and frontier clinics in pressing clinical issues, including opioid abuse, mental health, and childhood obesity.
- Rotating monthly clinical case studies from each Fellow's primary care site.

<u>Project Implementation and Capacity Building</u>

- Completion of a needs assessment at each clinic to inform the project to be designed and undertaken.
- Guidance and support for each Fellow and their Practice Transformation Team to develop a detailed project plan with clear timeline and concrete indicators of success.
- Coaching provided virtually and in-person from CHART staff to direct and support Fellows and their Practice Transformation Team in designing and implementing a practice transformation project at their sponsoring community health center while fostering a clinic-wide culture of transformation and learning.

- Consultation by evaluators in shaping and tracking metrics to measure impact in patient access, quality of care, cost effectiveness.
- Access to a "menu" of specialist consultants, with up to 30 hours per clinic of expert guidance directly related to each clinic's project and needs.
- Support in sustaining, scaling and replicating each practice transformation project.

Participating clinics will commit to three inter-connected elements:

1. Clinic leadership and administration choosing to have their clinic participate in the practice transformation effort
2. A designated clinic champion who is connected to (or a part of) clinic leadership, so that they share a common vision (the designated ***CHART Fellow***)
3. Willingness to establish a clinic Practice Transformation Team of 3-4 individuals, including the Fellow

	Cohort 1	**Cohort 2**	**Cohort 3**
Preparation & Recruitment			
Recruit CHART Fellows	Sep-Oct '18	Sep-Oct '19	Sep-Oct '20
Update CHART curriculum	Sep-Oct '18	Sep-Oct '19	Sep-Oct '20
Year 1 – Didactic Training			
In person kick off in San Diego	Nov '18	Nov '19	Nov '20
Begin monthly Zoom ***training*** calls – training topics by Practice Transformation Specialists and case studies by Fellows	Dec '18	Dec '19	Dec '20
Each Fellow begins to convene their Practice Transformation Team	Jan-Feb '19	Jan-Feb '20	Jan-Feb '21
Healthcare Improvement 2-Day Course in Sacramento	Mar '19	Mar '20	Mar '21
Needs Assessment	Apr-June '19	Apr-June '20	Apr-June '21
Begin development of Practice Transformation Plan	July '19	July '20	July '21
Complete Practice Transformation Plan	Oct '19	Oct '20	Oct '21
HRSA annual in-person meeting for grant recipients and fellows (actual date TBD by HRSA)	*Oct '19*	*Oct '20*	*Oct '21*
Year 2 – Project Implementation			
In person in San Diego – present Practice Transformation Plan	Oct '19	Oct '20	Oct '21
Practice Transformation Teams begin project implementation	Nov '19	Nov '20	Nov '21
Begin monthly Zoom ***project implementation*** calls – training topics and case studies	Nov '19	Nov '20	Nov '21
Evaluate preliminary progress and impact	Feb '20	Feb '21	Feb '22
Fellows and Practice Transformation Teams (optional) present work to date at Healthcare Improvement 2-Day Course in Sacramento	Mar '20	Mar '21	Mar '22
Intensified support from coaches, practice transformation specialists and evaluator to build clinic capacity for project success	Mar-Sep '20	Mar-Sep '21	Mar-Sep '22
Completion of CHART projects	Oct '20	Oct '21	Oct '22
End of course – Fellows and Practice Transformation Teams (optional) give final presentations	Nov '20	Nov '21	Nov '22

NOTE: Colored boxes represent gatherings with 2-3 cohorts present

California Primary Care ASSOCIATION

INFORMATIONAL

Date: January 9, 2018

To: SPARC Committee

From: Elizabeth Oseguera, Senior Policy Analyst

Re: Immigration Update

MEMORANDUM

I. Federal Immigration Update

The next few months may see significant changes to Federal immigration policy that could render thousands of immigrants who are currently allowed to work and live in the United States subject to deportation.

Deferred Action for Childhood Arrivals (DACA)

On September 5, 2017, Attorney General Jeff Sessions announced that the Trump Administration was rescinding the Deferred Action for Childhood Arrivals (DACA) program through a 'phase out' process. The President has met with Democratic and Republican leaders, to discuss possibly moving legislation that codifies the DACA program into law before its expiration date on March 5, 2018, but nothing has yet been decided. Our immigrant partners have been working to advocate for a clean Dream Act, meaning that the DACA program should not be used as a bargaining chip to support anti-immigrant policies. However, on January 4, the President said he would not support DACA legislation unless it was tied to funding for a border wall.

In the meantime, the California Attorney General as well as the University of California system have filed lawsuits against the administration for ending the DACA program. As proceedings progress, the U.S. Supreme Court granted a request by the Trump's administration to block the release of documents concerning his decision to end the DACA program, documents that the California Attorney General had requested as part of the law suit. According to plaintiffs, blocking the release of these documents could hinder the lower court's ability to rule on the case before the program expires.

If DACA were to end, both the California Immigrant Policy Center (CIPC) and the National Immigration Law Center (NILC) have received confirmation from the Department of Health Care Services (DHCS) that DACA recipients will continue to be eligible for full-scope Medi-Cal. For more information please see the resource section below.

Temporary Protective Status

The Trump administration terminated the Temporary Protected Status (TPS) designation for various countries, impacting more than 265,000 individuals thus far. The intent of the TPS program is to provide temporary refuge to migrants from countries with ongoing armed conflict, an environmental disaster, an epidemic or other extraordinary and temporary conditions. The designation is initially granted for up to

18 months, but previous administrations have extended it for some countries. However, the Trump administration is taking a new approach that could cause thousands to lose their legal status:

- TPS has ended for about 60,000 Haitians. The administration provided them 18 months to return home or be deported starting July 22, 2019.
- In November, the administration announced that it would end TPS for about 2,500 Nicaraguans. They were given 14 months to leave the United States (January 2019).
- On January 8, 2018, the Trump administration decided to end TPS for more than 200,000 Salvadorians. Salvadorian TPS holders will have until September 9, 2019 to leave the country.
- The administration is still evaluating if it will end TPS for 57,000 Hondurans, which currently expires July 5, 2018.

According to NILC, the law that created TPS explicitly says that TPS recipients are not to be considered PRUCOL (Permanently Residing in the U.S. Under Color of Law). The term PRUCOL refers to noncitizens who are residing in the United States permanently and that have a good faith belief that U.S. Citizenship & Immigration Services (USCIS) knows of their presence in the U.S. and does not intend to deport them. To be clear, PRUCOL is not an immigration status or a path to citizenship; rather, it is a public benefits eligibility category through which certain undocumented immigrants can apply for public benefit programs, like Medicaid.

<u>H-1B Visa Extension</u>

Many health centers utilize H-1B visas to bring providers from other countries to help fill opened positions that have not been filled given the Nation's healthcare workforce shortage. H-1B visas are an employer-sponsored nonimmigrant visa that allows persons who are not citizens or permanent residents of the U.S. to work in a specialty occupation for up to six years.

According to reports from McClatchy's DC Bureau, the Department of Homeland Security is considering new regulations to implement Trump's 'Buy American, Hire American' Executive Order, that would prevent H-1B visa extensions. This would mean that folks employed under an H-1B visa will not be permitted to maintain their visas while their green card applications are pending; a process that can take years. The change in policy may exacerbate the healthcare workforce shortage.

<u>Executive Orders on Immigration</u>

- *Travel Ban*

  The Trump administration issued a proclamation, "Enhancing Vetting Capabilities and Processes for Detecting Attempted Entry into the United States by Terrorists or Other Public-Safety Threats," that indefinitely banned travel from Iran, Libya, Syria, Yemen, Somalia, Chad and North Korea. Certain government officials from Venezuela will also be barred. This proclamation was signed on September 24, 2017, when the 90 day travel ban for the six Muslim countries was due to expire. Lawsuits quickly followed against the proclamation, allowing lower courts to block portions of the ban while the case underwent litigation.

  However, On December 4, 2017, the Supreme Court ruled to allow the Trump administration to fully enforce the proclamation while the case undergoes litigation. In consequence, the ban now applies to all foreign nationals from the banned countries, even those with a bona fide relationship with a person or entity in the United States. This means that grandparents, grandchildren, brothers-in-law, sisters-in-law, aunts, uncles, nieces, nephews, and cousins no longer qualify to enter the country through the bona fide relationship exemption.

Thus far, the Ninth Circuit court has reviewed the lawsuits against the proclamation and decided that the order went beyond the president's power to control the flow of immigration. Once the lower courts issue an opinion, it will allow the Supreme Court to hear the case against the third attempt of the Muslim ban.

- *Sanctuary Jurisdictions*
  On January 2, 2017 the director Immigration and Customs Enforcement, Thomas Homan, announced that the Trump administration is considering prosecuting state and local officials that have deemed themselves as sanctuary cities / jurisdictions and have decided not to fully cooperate with ICE. However, according to legal experts, the problem with Homan's lawsuit plan is that there are no grounds for criminal prosecution of public officials in these situations. According to Thomas Saenz, President and general counsel of the Mexican American Legal Defense and Educational Fund (MALDEF), Laws that merely limit cooperation with ICE don't amount to illegal harboring of undocumented immigrants.

  Additionally, on September 15, 2017 U.S. District Judge Harry Leinenweber ruled that the Trump administration may not withhold public-safety grants to so-called sanctuary cities / jurisdictions. The judge issued a temporary nationwide injunction that prevents the Justice Department from withholding grant money until there is a final determination in the lawsuit.

II. State Legislative Update

CaliforniaHealth+ Advocates, on behalf of CPCA, is closely monitoring legislation that impacts immigrants and is working with our immigration advocacy partners to support policy that ensures California has in place proper safeguards to prevent patient information collected by a health center or public benefit programs from being shared with immigration enforcement.

CaliforniaHealth+ Advocates, on behalf of CPCA, is working with Assemblymember Muratsuchi's office, who has expressed interest in authoring a bill to protect immigrant patients in health centers. With the guidance of the Immigration Peer Network, we are looking to sponsor a bill that would prohibit state or county public benefit programs from requiring health centers to maintain any documentation that contains the immigrant status of patients.

III. CPCA Strategy to Address Immigration Issues

At the direction of members, CPCA has been working diligently to develop materials that provide information on the legal rights of clinics, and their patients, in regards to immigration enforcement.

Immigration Resources for Patients and Clinics

CPCA has been leading an effort with other state PCAs, NACHC, and immigration partners, to develop materials that can help health centers prepare themselves and patients for an encounter with immigration enforcement. Through these efforts CPCA created an immigration resource page where we've compiled immigration resources for clinics and patients. At the moment you may access the immigration resource page through our CaliforniaHealth+ Advocates website, http://capca.nationbuilder.com/immigrant resources. However, given that the immigration resource page is primarily meant to provide technical assistance to members, the content will be moved to CPCA's website.

Also, through the guidance of our Immigration peer network, CPCA has created a reporting template to help clinic staff inform CPCA and the consortium of any sightings of immigration officials at or around the clinic. You can access the template in the resource section below.

Immigration Peer Network

CPCA has created an Immigration peer network to help gather member feedback on the immigration resources that we are developing as well as guide the policy work we are undertaking. This is also a great space for members to share the resources they've gathered/produced and to ask any questions that may be coming up for clinics and their patients.

At the moment the peer network is interested in gathering data regarding the fears that immigrant patients have been expressing as well as clinic's implementation of the sample policies and procedures that CPCA released around immigration.

Please contact Daisy Po'oi at dpooi@cpca.org if you would like to join the peer network.

Provider Survey: The Mental Health of Immigrant Children and their Parents

CPCA, in collaboration with Children's Partnership and The California Program on Access to Care (CPAC) is evaluating the data collected through our provider survey to capture the mental health of immigrant children and their parents. We've also collaborated with various behavioral health partners, including The California Association of Social Rehabilitation Agencies, Mental Health America, the California Mental Health Planning Council, and California Association of Marriage and Family Therapists, to have this survey shared with their members.

We should have the final report ready for distribution in February, and hope to host a webinar to review the findings.

Past Immigration Trainings for Members

In response to requests from members, CPCA has hosted 4 webinars that were part of the immigration webinar series. The first webinar, which took place in June, provided an overview of the FAQs and best practices for implementing the recommendations included in the FAQs. The two subsequent webinars, held on September 13 and September 20, provided an in depth overview of the sample policies and procedures and the last webinar provided an overview of how community health workers can help reduce fears in immigrant patients.

You may access the free recordings of these webinars through CPCA's website or via our Immigration Resource Page.

IV. Resources

- Guidance for DACA Employers and DACA Recipients
- Immigration Official Sighting Reporting Template
- Sample Policies and Procedures

INFORMATIONAL

Date: January 2, 2018

To: SPARC Committee

From: Elizabeth Oseguera, Senior Policy Analyst

Re: Migrant Health Update

MEMORANDUM

I. NWRPCA 2018 Western Forum for Migrant & Community Health

CPCA is on the planning committee for the Western Forum for Migrant and Community Health, and has helped develop the content for the conference. The Migrant and Community Health forum is an annual conference bringing together health professionals from migrant and community health centers and allied organizations. The Forum will be taking place in Seattle, Washington from February 22-24, 2018. For more information please visit http://www.nwrpca.org/news/358791/Western-Forum-for-Migrant-and-Community-Health-2018.htm.

I am excited to announce that both abstracts submitted by CPCA, in collaboration with our immigrant partners and members, have been selected for the conference. CPCA will be presenting with the National Immigration Law Center (NILC) and Lifelong Medical Care on February 22 at 1:30 (Session title: *Preparing Your Health Center for an Encounter with Immigration Enforcement*) to highlight the resources and services being offered by California clinics to our immigrant patients. We will also be presenting with Children's Partnership and Community Health Center Network regarding how community health workers can help reduce fears in immigrant patients while encouraging them to obtain behavioral health services (Session title: *Utilizing CHWs to Reduce Fears in Immigrant Patients*). You may access the brochure for the event under the resource section below.

II. Immigration Resource Page – mention toolkit

The immigration resource page, currently housed on the CaliforniaHealth+ Advocates website, will be relocated to CPCA's website in the upcoming months.

You may find immigration materials created by CPCA, CaliforniaHealth+ Advocates or immigrant partners on our resource page. Among the materials on our immigration resource page you will find CPCA's Frequently Asked Questions (FAQs) document, sample policies and procedures, links to recorded webinars and Know Your Rights materials for patients and clinics. Please contact Liz Oseguera, loseguera@cpca.org, with any additional resources that could be added to our webpage. Under the resource section please find the link to the immigration resource page.

III. One California Campaign

In response to the rescission of the DACA program, the legislature increased the funding available through "One California" by $30 million, bringing the total amount of funding to a historic $75 million. The "One California" Immigration Services Funding, a program administered by the CA Department of Social Services (CDSS) will increase the baseline funding from $15 million to $45 million through the 2019-2020 fiscal year. Thus far, CDSS has offered funding to 92 nonprofit organizations for Fiscal Year 2017-18. These offers total $41,157,300 for the contract period of January 1, 2017 through December 31, 2018.

Immigration services eligible for this funding include offering help in applying for naturalization, defense removal, legal training and technical assistance, and education and outreach activities. For more information please see CDSS' letter in the resource section below.

IV. Latino Health Alliance Moving Forward

The Latino Health Alliance (LHA) was created out of a desire to provide a united voice for the Latino community in critical issues affecting the health of Latinos in California. With this in mind, LHA has decided to focus its efforts on (1) developing a report on the state of Latino health in California and (2) forming a stakeholder group focused on creating resources that will help inform migrant workers, including H-2A visa workers, of their health, labor and legal rights.

As a co-chair for LHA, CPCA has been leading efforts to convene stakeholders interested in educating and outreaching to migrant workers, especially H-2A visa holders, regarding their health, legal and labor rights. On December 5 we had Covered California, Farmworker Justice, LHA members, Mexican Consulate and California Rural Legal Assistance Foundation join us for our first meeting. Please find the meeting notes under the resource section.

Additionally, CPCA has been cultivating stronger relationships with Farmworker Justice (FWJ), Covered California and the Employment Development Department (EDD) to help migrant workers obtain health care services in community health centers. CPCA has helped create an FAQ, co-branded by LHA and Covered California, to help answer questions that EDD staff had around the health care services available for migrant workers. Please find the FAQs in the resource section below.

EDD oversees labor worker programs in California and work very closely with growers and farmworkers to ensure both are aware of their rights and legal obligations. To do this EDD has been using 24 outreach workers located throughout the state. CPCA is particularly excited to have presented to EDD managers and outreach workers regarding the services offered by community health centers and clinics. CPCA is working to ensure that EDD outreach workers understand the role of community clinics, so they can refer migrant workers to seek healthcare services at our clinics.

CPCA is also helping to lead discussions with FWJ, on behalf of LHA, to gauge the possibility of having our organizations apply for grant funding to support our work. There may be a possibility to apply for education and outreach funding through EDD in the near future.

V. Resources

- Western Forum for Migrant and Community Health Brochure

- Immigration Resource Page
  - http://capca.nationbuilder.com/immigrant_resources

- CDSS' Tentative Award Announcement Letter

- LHA Update
  - Migrant Stakeholder Convening Meeting Notes
  - FAQs for EDD

California Primary Care ASSOCIATION

Date: January 18, 2018
To: Special Populations, Agricultural and Rural Committee (SPARC)
From: Meaghan McCamman, Assistant Director of Policy
Re: Rural Events 2018

MEMORANDUM

Educational Conferences

Before transitioning to become SPARC, the CPCA Rural Committee requested that staff maintain a list of rural-specific conferences in order to ensure that California Rural is represented whenever possible in rural educational, networking, and policy venues. The following is a list of upcoming rural-specific conferences:

Bi-Partisan Policy Center: Reinventing Rural Health Care: A Case Study of 7 Upper Midwest States
Jan 17, 2018
Washington, DC

National Academies of Sciences, Engineering, and Medicine: Improving Health Research on Small Populations: A Workshop
Jan 18 - 19, 2018
Washington, DC

Arizona Center for Rural Health: 2018 Annual Arizona Rural & Public Health Policy Forum
Jan 24, 2018
Phoenix, AZ

American Hospital Association: 2018 31st Annual Rural Health Care Leadership Conference
Feb 4 - 7, 2018
Phoenix, AZ

California Hepatitis Alliance: The Opioid Crisis & Related Public Health Issues in the Rural Northern California Counties: A Summit to Discuss Solutions
Feb 5 - 6, 2018
Santa Rosa, CA

NRHA Rural Health Policy Institute
Feb. 6-8, 2018 in Washington D.C.
Omni Shoreham Hotel

Western Center for Agricultural Health and Safety: Cannabis and Farmworker Health and Safety
Mar 5, 2018
Davis, CA

National Association of Rural Health Clinics: 2018 Annual National Association of Rural Health Clinics Spring Institute National
Mar 19 - 21, 2018
San Antonio, TX

California Hospital Association's 2018 33rd Annual Rural Health Care Symposium
Mar 21 - 23, 2018
Sacramento, CA

2018 Annual Northwest Regional Rural Health Conference
Mar 26 - 28, 2018
Call for Poster Presentations - Deadline: Jan 31, 2018
Spokane, WA

NRHA Annual Rural Health Conference
May 8-11, 2018 in New Orleans, La.
New Orleans Marriott Hotel

NRHA Health Equity Conference
May 8, 2018 in New Orleans, La.
New Orleans Marriott Hotel

NRHA Rural Medical Education Conference
May 8, 2018 in New Orleans, La.
New Orleans Marriott Hotel

NRHA Rural Quality and Clinical Conference
July 18-20, 2018 in Washington D.C.
Omni Shoreham Hotel

NRHA Rural Health Clinic Conference
Sept. 25-26, 2018 in Kansas City, Mo.
Sheraton Kansas City Hotel at Crown Center

NRHA Critical Access Hospital Conference
Sept. 26-28, 2018 in Kansas City, Mo.
Sheraton Kansas City Hotel at Crown Center

Government Programs Committee

Thursday, January 18, 2018
10:00am – 11:30am

Robin Affrime, Chair

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Robin Affrime	A
II. Approval of Agenda	• Executive Summary	Robin Affrime	A
III. Approval of Minutes	• October Meeting Minutes	Robin Affrime	A
IV. Year in Review	• Year in Review	Meaghan McCamman	I
V. 340B	• 340B Memo & FAQs (linked)	Andie Patterson	D
VI. Lifeline Grant Program	• Grant Program Memo	Michael Helmick	I
VII. OSHPD 3	• OSHPD 3 and Licensing Strategies Memo	Michael Helmick	I
VIII. Licensing	• Licensing Memo	Emily Shipman Ginger Smith	I
IX. Managed Care	• Managed Care Update	Meaghan McCamman Nenick Vu	D
X. Behavioral Health	• BH Update Memo • MHSA Update Memo	Meaghan McCamman Liz Oseguera	D
XI. Emergency Preparedness	• Wildfires Update	Emili Labass	I
XII. 2703 PCHH	• 2703 PCHH memo	Allie Budenz	I
XIII. Oral Health	• Oral Health Memo	Emili Labass	I
XIV. Adjourn		Robin Affrime	A

California Primary Care Association

Executive Summary

Date: January 18, 2018
To: Government Programs Committee
From: Meaghan McCamman, Assistant Director of Policy

MEMORANDUM

340B

- The state budget proposes to ELIMINATE 340B from the Medi-Cal FFS and Managed Care Programs.
- The state argues that the current 340B program costs more than it should because providers bill not at acquisition cost but at higher prices, which drives up managed care rates.
- The state also argues that claims are not being properly identified, which prevents DHCS from receiving rebates and puts the state at risk of double discount liability.
- A full blown advocacy strategy is underway, including further legal analysis on whether the state can eliminate a federal program such as 340B from the Medicaid program.
- In addition, legal counsel believes that there may be special protections for FQHCs to utilize contract arrangements to meet their federal obligations, such as the FQHC obligation to provide pharmacy services.

Lifeline Grant Program

- CPCA hosted a webinar for the members to request feedback on how they would prefer the Lifeline Grant Program be designed.
- CPCA sent a letter to the Treasurer's office highlighted the feedback that we gleaned from the webinar and offered several recommendations.
- CPCA has been continually communicating with the Treasurer's staff to push them for an expeditious release of the grant funds.
- CPCA will be attending the upcoming CHFFA meeting on January 25th and will update members accordingly.

OSHPD 3 and Licensing Strategies

- CPCA has developed a strategic plan which will guide Staff's activities for the upcoming year.
- Strategies were designed to alleviate some of challenges health centers face in regards to OSHPD and building codes.
- Staff improved or developed communication and relationships with OSHPD and the Building Standards Commission.
- CPCA updated the Licensing workgroup to include OSHPD 3 to ensure that Staff if receiving continuous feedback and information from health centers regarding our OSHPD 3 strategies.

Licensing

- CAU is making progress in filling vacant positions and expects to see meaningful progress on the

licensing backlog by March, aided by the release of an electronic applications process coming early 2018.
- CPCA is working to introduce legislation this year to amend the Welfare & Institutions Code to allow for consolidated licensees to bill under a shared license and PPS rate, should they choose to do so.

Managed Care

- CPCA is launching 2018 with a Managed Care Strategy summit with all of the RAC to examine the changing managed care landscape, including the commercial procurement, new administration, and major market changes
- We continue to work on key existing priorities such as unseen patients, network adequacy, provider directories, and plan relations.

Behavioral Health

- CPCA has key successes under our belt and high hopes for the future in removing regulatory barriers such as billing for MFTs, provider Drug Medi-Cal and Specialty Mental Health Services, and Same day Billing.
- CPCA continues to work with state mental health and counties to ensure that FQHCs are recognized for their important role in the behavioral health delivery system, and receive behavioral health resources commensurate with that role.

MHSA

- The Mental Health Services Oversight and Accountability Commission (OAC) released its updated amendments to the PEI and Innovation regulations. CPCA is very pleased that the OAC has accepted its recommendations.
- The OAC has released its second request for applications (RFA) for funding under the Triage grant, if you're interested in applying please contact your County or City behavioral health department

2703 PCHH

- DHCS notified SPA to implement ACA Section 2703 HHP approved by CMS with minor, non-substantive modifications to language.
- Draft rates from DHCS to MCPs in negotiation, expected to be finalized in March.
- T/TA contract with Harbage Consulting expanded to include webinar series and learning

Oral Health

- CPCA joined CPEHN and other stakeholders as Core Group members in the development of a new California Oral Health Network.
- The Dental Transformation Initiative enters its third Program Year with steadily increasing participation from FQHCs.
- CPCA remains a committed partner in the National Oral Health Integration and Innovation Network (NOHIIN), which focuses on increasing the visibility of oral health on the national stage by strengthening ties with and among PCAs, CHCs and community partners/stakeholders, and leverage that power for change, while continuing to support oral health in the health care safety net.

CALIFORNIA PRIMARY CARE ASSOCIATION

GOVERNMENT PROGRAMS COMMITTEE
October 10, 2017
11:00am – 12:30pm

Members: Isabel Becerra – Chair, Antonio Alatorre, Linda Costa, Doreen Bradshaw, Trisha Cooke, Irma Cota, Reymundo Espinoza, , Benjamin Flores, Cathy Frey, Jane Garcia, Franklin Gonzalez, Britta Guerrero, Nik Gupta, Haleh Hatami, , Kerry Hydash, Tina Jagtiani, Deena Lahn, David Lavine, Deborah Lerner, Marty Lynch, Kevin Mattson, Louise McCarthy, Scott McFarland, Leslie McGowan, Danielle Myers, Christine Noguera, , Tim Pusateri, Tracy Ream, Tim Rine, Melinda Rivera, Corinne Sanchez, Paulo Soares, Graciela Soto-Perez, Terri Lee Stratton, Vernita Todd, Henry Tuttle, Christina Velasco, David Vliet, Nichole Mosqueda

Staff: Carmela Castellano-Garcia, Andie Patterson, Meaghan McCamman, Daisy Po'oi, Elizabeth Oseguera, Andrea Chavez, Michael Helmick, Mike Witte, Allie Budenz, Cindy Keltner, Jana Castillo, Sandy Birkman, Ginger Smith, Val Sheehan

I. Call to Order
Isabel Becerra, Committee Chair, called the meeting to order at 11:05am.

II. Approval of Agenda
A motion was made to approve the agenda as presented. **The motion carried. (C. Frey, D. Vliet)**

III. Approval of Minutes
A motion was made to approve the minutes of July 13, 2017. **The motion carried. (P. Soares, T. Rine)**

IV. 340B
CPCA along with the California Hospital Association and the California Association of Public hospitals met with DHCS to continue discussion in mid-September on how to develop a 340B reporting process for covered entities that utilize contract pharmacies in Medi-Cal managed care. The state remains concerned that there is no value to the state to allow contract pharmacies in 340B. CPCA is engaging legal counsel to better understand DHCS' assertions regarding the 340B program. CPCA is also working on a 1-2 day training with Sue Veer from NACHC in January 2018.

V. Licensing
CPCA met with Licensing & Certification leadership in September to go over process improvements related to licensing application checklists, backlog within the Centralized Applications Unit, and licensing process challenges. Through this meeting, CPCA successfully established the prioritization of clinic applications and immediate assignment of affiliate and consolidated applications to analysts for processing. CPCA will partner with CDPH to provide members with training on how to complete a good application and will partner with L&C to offer training on licensing processes for clinics.

VI. OSHPD3
Staff have conducted a legal, regulatory and legislative analysis of OSHPD3 and ascertain there is no quick and easy way to exempt health centers from OSHPD 3 requirements. Staff have however outlined a multi-pronged approach to help alleviate the challenges of OSHPD 3, all of which help to lay the ground work for a future legislative attempt to exempt health centers.

A motion was made and seconded for CPCA staff to pursue a multifaceted approach that positions health centers for a future legislative play to exempt health centers from licensing. **The motion carried. (D. Germano, R. Veloz)**

VII. Managed Care

CPCA's Unseen Patients Workgroup is currently tracking several managed care plan pilots, and is evaluating several policy strategies, each of which could potentially impact a portion of the unseen patient population. CPCA is tracking the DHCS commercial Medi-Cal procurement, and is reaching out to each of the impacted health plans to understand their strategy for the procurement and leverage their incentive to improve quality and data reporting. CPCA is tracking the investments made as a result of the recent managed care mergers. Opportunities for low-cost loans will be available soon.

VIII. Behavioral Health

CPCA and CaliforniaHealth+ Advocates have developed a three-pronged approach to meeting our behavioral health goal of supporting CCHCs in providing the behavioral health services needed by their communities. The approach includes 1) removing regulatory barriers, 2) expanding access to resources, and 3) ensuring health centers are included in all policy discussions.

IX. Pharmacy & Adult Immunizations

Meaghan McCamman provided information around barriers to FQHCs providing high-cost injectable medications such as Vivitrol and adult immunizations. The committee would like CPCA to continue exploring a vast array of billable injectable drugs. The committee will work with the clinicians committee to compile a list of injectable drugs.

X. Lifeline Grant Program

The Budget Act of 2017 established the Community Clinic Lifeline Grant Program (Lifeline Program) within the California State Treasurer's Health Facilities Financing Authority (CHFFA) for small and rural health clinics suffering financial losses. CHFFA is responsible for developing additional selection criteria and a process for awarding the grants, which may not exceed $250,000 per health facility site. Since the enactment of the Budget Act of 2017, CHFFA staff have begun work on the Lifeline Grant Program design, including regulations, selection criteria and application. CPCA is in ongoing communication with CHFFA staff and leadership. CPCA is seeking additional member feedback on a variety of implementation areas – maximum awards; eligibility criteria; evaluation criteria; eligible use of grant funds; funding distribution; and emergency regulation triggers.

XI. Immigration Update

Elizabeth Oseguera provided an immigration update on a few federal legislation CPCA has been following. On September 5, 2017, Attorney General Jeff Sessions announced that the Trump Administration was rescinding the Deferred Action for Childhood Arrivals (DACA) program via a "phase out." The committee took positions on the following.

A motion was made and seconded to oppose the Reforming American Immigration for Strong Economy Act (RAISE Act). **The motion carried. (J. Garcia, R. Veloz)**

A motion was made and seconded to support the Dream Act. **The motion carried. (D. Bradshaw, C. Frey)**

A motion was made and seconded to oppose the SUCCEED Act. **The motion carried. (D. Lahn, B. Guerrero)**

XII. 2703 PCHH

DHCS communicated that Health Homes for Patients with Complex Needs will begin in phase 1 counties in July 2018. Pilot must be cost neutral or yield savings within two years in order to keep the health homes benefit into perpetuity. CPCA leading effort to convene small workgroup of plans and providers to discuss how to best coordinate the execution and delivery of successful pilot.

XIII. Oral Health

CPCA recently participated in the first meeting of the new Medicaid|Medicare|CHIP Services Dental Association (MSDA), Center for Quality, Policy and Financing's FQHC Dental Policy Workgroup, a workgroup designed to find national solutions for dental audits and other challenges impacting oral health access for the underserved.

XIV. Adjourn

The meeting was adjourned at 12:30pm.

Respectfully submitted,

Daisy Po'oi
Meeting Minutes Recorder

California Primary Care Association

Government Programs Committee
2017 Year in Review

Date: January 18, 2018

To: Government Programs Committee

[redacted]

2017: The Year Ahead (projected from 2016) = *What we projected*

- Health Care Reform
  - The Trump Administration promises big changes ahead for the health care system. Please see CPCA's "2017 Health Care Analysis" for detailed information about what we expect to see in the coming years.

- Patient Centered Health Home (PCHH) / Section 2703
  - The 2703 program refers to Section 2703 of the Affordable Care Act, and is in danger of being a part of any Republican "repeal and replace" package.
  - Even if the program is not technically repealed, it may not be funded at the federal level.
  - If the program sees no changes under the Trump Administration, the DHCS timeline has the program beginning to roll out in July 2017. A link to the timeline can be found here.

- Licensing/OSHPD 3
  - Administrative Procedure Act challenge of underground licensing regulations within current requirements.
  - Continued engagement with CDPH to streamline the licensing application process, including implementation of online application procedure.

- Managed Care, Mergers, and Network Adequacy
  - While the Blue Shield/Care 1st and Centene/Health Net mergers were approved, neither the Anthem/Cigna nor the Aetna/Humana mergers appear to be successfully moving forward at the federal level.
  - DMHC and CDI will continue to work with the state's managed care plans on the creation of accurate provider directories until the final deadline for standardization in 2020.
  - We may continue to see a push for a statewide, multi-plan directory in the future.

- Public Health/Prevention
    - CPCA continues to work closely with partners on new legislation and approaches to addressing sugary sweetened beverage consumption and create new funding to support a healthier California.

- Oral Health
    - CPCA will continue to work closely with DHCS to ensure that safety net clinics are able to continue smooth participation in the Dental Transformation Initiative as it begins its implementation phase in 2017.
    - CPCA looks forward to continuing to partner with CDPH and the state dental director, Dr. Jayanth Kumar as participants in "The California Partnership for Oral Health" (Partnership) to oversee implementation and evaluation of the Plan.
    - CPCA, working with COH and Steering Committee members, looks to continue rebuilding OHAC.
    - CPCA will enter a new phase of PCA oral health leadership with funding from the DentaQuest Foundation for participation in the "National Oral Health Integration and Innovation Network" (NOHIIN) initiative. This program focuses on increasing the visibility of oral health on the national stage by strengthening ties with and among PCAs, CHCs and community partners/stakeholders, and leverage that power for change, while continuing to support oral health in the health care safety net.

2017: Committee Year-in-Review = *What happened*

- Health Care Reform
    - The Republican Congress was unable to pass a comprehensive repeal of the ACA although they tried three times, but unfortunately they were successful in repealing the individual mandate as a part of tax reform.
    - Dismantling the Medicaid program became a central element of the debates. Block grants or per capita caps for Medicaid are favored by the administration and appointed leadership although the American public is not supportive of any major changes to the entitlement program.
    - The original HHS director Tom Price left early on after allegations regarding his use of tax payer dollars and private jets. A new director is in the pipeline- Azar, who is from the pharmaceutical industry.
    - CMS Director Seema Verma has been clear in her priorities to provide more flexibility to states, as well as her desire to see more restrictions on the Medicaid program.
    - HHS and CMS have moved slowly due to the administration changes, changes in leadership, and many vacancies.

- 340B
    - The Governor proposed to eliminate the 340B Medi-Cal managed care program in January, and then revised the proposal to just eliminate the use of contract pharmacies.

- Both proposals were fought back and today 340B continues to operate as it did before the Governor's proposals.
- The Governor and DHCS remains concerned about the program, duplicate discounts, and not securing all that they could if 340B was not allowed in managed care.
- There is still no clear rules for how covered entities, managed care plans and the state track and report 340B claims.

- Patient Centered Health Home (PCHH)/Section 2703
  - DHCS notified SPA to implement ACA Section 2703 HHP approved by CMS with minor, non-substantive modifications to language. The contract for state matching funds with the California Endowment has been signed, allocating approximately $45 million across 8 quarters of the demonstration.
  - Draft rates from DHCS to MCPs in negotiation, expected to be finalized in March.
  - T/TA contract with Harbage Consulting expanded to include webinar series and learning collaborative; CPCA and members invited to participate.

- Licensing
  - Assembly Bill 2053 allowing for consolidated licensure went into effect at the beginning of this year, providing another licensure option for clinics within 0.5 miles of an existing location.
  - CPCA undertook membership-wide surveys on the impacts of the State licensure process and OSHPD 3 building standards compliance to inform respective work plans in each of these areas, utilizing the Licensing Workgroup to guide these efforts.
  - Based on identified challenges, CPCA met with Licensing leadership regularly throughout the year and was successful in securing priority processing for some types of clinic applications as well as suggesting modifications to application forms and checklists in order to streamline the current process.

- OSHPD 3
  - CPCA developed a strategic plan to explore health centers' options for relief from OSHPD 3. This plan looks at administrative, legislative, and regulatory changes that could assist health centers
  - CPCA identified 2 possible exemptions from OSHPD 3 standards. We have identified health center volunteers who are being vetted to determine whether they are suitable 'test cases' for attempting to utilize the standards for health centers
  - CPCA staff worked to expand and develop further relationships with OSHPD and the Building Standards Commission and engage in triennial building standards code development and process.

- Managed Care, Mergers, and Network Adequacy
  - Early in 2017, DHCS announced that they will be re-procuring all of the state's commercial Medi-Cal managed care plans, with a focus on improving quality.
  - A health center in San Mateo is involved in a protracted legal battle with DHCS over the definition of 'incentive' that can be excluded from reconciliation.

- Only two of the four managed care mergers were successful. The Blue Shield/Care1st merger has resulted in a strategic change in the focus of the Blue Shield of California Foundation's programs, away from core support for FQHCs and toward delivery system reform. CCHC representatives have been actively involved in ensuring that the Health Net/Centene merger undertakings benefit the safety-net delivery system.

- Behavioral Health
  - CPCA successfully passed SB 323 to ensure that FQHCs have a streamlined and well understood process to participating in the Drug Medi-Cal and county-based specialty mental health programs.
  - CPCA and the County Behavioral Health Directors Association worked together to complete a toolkit, "Models of Partnership: Counties and Federally Qualified Health Centers Improving Patient Access to Specialty Mental Health and Substance Use Disorder Treatment," which is currently being formatted for publication. CPCA staff, FQHCs, and counties have co-presented models of county partnership at several venues around the state.
  - CPCA successfully advocated with the State Department of Housing and Community Development to ensure that applications for No Place Like Home funds are rated extra points when they explicitly include a linkage to primary care.

- Oral Health
  - CPCA continued to work closely with DHCS to ensure that safety net clinics are able to continue smooth participation in the Dental Transformation Initiative as it begins PY2 in 2018.
  - CPCA continued to partner with CDPH and the state dental director, Dr. Jayanth Kumar as participants in "The California Partnership for Oral Health" (Partnership) to oversee implementation and dissemination of the State Oral Health Plan.
  - CPCA successfully completed a new phase of PCA oral health leadership with funding from the DentaQuest Foundation for participation in the "National Oral Health Integration and Innovation Network" (NOHIIN) initiative. This program focuses on increasing the visibility of oral health on the national stage by strengthening ties with and among PCAs, CHCs and community partners/stakeholders, and leverage that power for change, while continuing to support oral health in the health care safety net.
  - In March of 2017, CPCA submitted an application for an oral health grant jointly funded by the DentaQuest Foundation and the California Wellness Foundation. This grant would provide up to three years of continuous funding for an entity to coordinate a statewide oral health coalition – the California Oral Health Network. Unfortunately, CPCA was not selected and instead the Network is led by the California Pan-Ethnic Health Network (CPEHN), a statewide multicultural health policy organization that promotes health equity by advocating for public policies and sufficient resources to address the health needs of communities of color.

2018: The Year Ahead

- Health Care Reform
  - ACA repeal is still desired by some in the Republican Party, but many do not see it as politically feasible and want to move on to other projects. Unlikely major policy will pass but small destructive policies may be included as riders in other legislation.
  - HHS and CMS likely to exert their regulatory authority to challenge the ACA, and move Medicaid into a more restrictive space.
  - The federal deficit is likely to force a national conversation on entitlement reform which will include Medicaid.

- 340B
  - At the federal level the results of the covered entities audit will be revealed.
  - The Trump Administration, and Azar if appointed to lead HHS, likely to push for changes to the 340B program- and likely will receive a lot of push back from advocates.
  - CPCA hopes to either enter into conversations with the state or help foster county conversations between plans and health centers to ensure that reporting on 340B drugs is done clearly, consistently and timely.

- Patient Centered Health Home (PCHH) / Section 2703
  - HHP will launch in group 1 counties in July 2018
  - Without state guidance, there will be challenges in sharing patient data between MCPs, counties, and CB-CME's in an effort to coordinate care for shared patients.
  - The pilot will struggle to demonstrate cost savings in the next two years, which it must do in order to remain a benefit in perpetuity. Data from previous iterations of complex care management programs demonstrate a minimum of 18 months before cost savings are realized.

- Licensing
  - CPCA will continue our efforts to support licensing process improvements, including individualized technical assistance, ongoing dialogue with Licensing leadership, and legislative efforts as necessary.
  - Increased staffing at CAU will reduce wait times for application processing
  - An electronic application process will be released for primary care clinics

- OSHPD 3
  - CPCA, with the support of outside counsel, will identify, vet, and support a health center or centers through the process of obtaining a 1206(g) exemption and/or 1231(a) exemption from OSHPD 3.
  - CPCA will continue to work with the state and engage in the building standards regulatory cycle.
  - CPCA will continue to work with members to understand and make tangible the impact that OSHPD 3 has on health centers.

- Managed Care
    - The Medi-Cal commercial plan procurement offers an enormous opportunity to leverage CCHC market power and CPCA political power to influence the selection of Medi-Cal managed care plans
    - CPCA and RAC will continue a coordinated effort to push Medi-Cal managed care plans toward the IHA standardized P4P program.
    - CPCA will push DHCS to have a clear and more inclusive process around important policy changes

- Behavioral Health
    - MFTs will become billable providers in FQHCs as of July 1, 2018
    - CPCA will support health centers in expanding their scope to include Drug Medi-Cal, MAT, and specialty mental health
    - The FQHC Partnership Toolkit and recent regulatory changes that encourage county engagement with community-based partners will provide an opportunity to increase CCHC/county partnerships for specialty mental health, MHSA, No Place Like Home, and SB 82 triage.

- Oral Health
    - CPCA looks forward to continuing to work with DHCS and health centers to increase participation in the Dental Transformation Initiative for Program Year 3.
    - While CDPH moves forward with official departmental approval of the State Oral Health Plan (Plan) under the state dental director, Dr. Kumar, CPCA will continue to support the Oral Health Department in communicating and implementing the Plan.
    - CPCA has recently submitted its application for participation in its second year of the National Oral Health Integration and Innovation Network and expect approval later on this month. We look forward to continuing to champion oral health issues locally and across the country.
    - CPCA is excited to continue to actively participate in the California Oral Health Network as a member of its Core Group working towards developing the Network's goals and foundation.

California Primary Care ASSOCIATION

DISCUSSION

Date: January 10, 2018

To: Government Programs Committee

From: Andie Patterson, Director of Government Affairs

Re: 340B Update

MEMORANDUM

I. Overview

The state budget proposes to ELIMINATE 340B from the Medi-Cal FFS and Managed Care Programs.

CPCA and our partners in advocacy, the California Association of Public Hospitals and California Hospital Association, have yet to discuss the proposal with DHCS. The last meeting we had with DHCS was in September. A meeting was scheduled for November but the state cancelled and asked to reschedule for a future date. The future meeting date has not yet been set.

At the September meeting the state made many assertions, most of which were incorrect per CPCA's legal counsel. The main assertion DHCS insisted upon was that SPA 17-002 applies to 340B in managed care and thus any provider that did not have an approval from the state to do 340B was out of compliance. This is not correct. There is no requirement that covered entities secure approval from the state to engage in 340B in Medi-Cal managed care.

The new budget language appears to entirely disregard the process we were pushing that would include better reporting, and instead completely eliminates the program. The state appears to want to sidestep any responsibility to oversee the program, and to ensure that they can secure the full Medicaid Drug Rebates. The budget detail argues this move helps the state comply with federal requirements and that it will not impact Medi-Cal patients' access to drugs. The state argues that the current 340B program is a cost to the state because providers bill not at acquisition cost but at higher prices, which drives up managed care rates. Further, the state argues that claims are not being properly identified, which prevents DHCS from receiving rebates and puts the state at risk of double discount liability.

Further detail is expected to be released by the Department of Finance around February 1.

II. Strategy

Over the course of the fall CPCA spent further time researching 340B, better understanding the legal obligations of the state and health plans, understanding the ways in which 340B could be

undermined, and thinking through an offensive strategy to protect the program for health centers.

A full blown advocacy strategy is underway, and it includes further legal analysis because we are not clear if the state can eliminate a federal program that is the right of covered entities to leverage. Legal counsel believes that there may be special protections for FQHCs to utilize contract arrangements to meet their federal obligations, such as the FQHC obligation to provide pharmacy services.

We are resolved that there is a path to making the program work for everyone, and we are willing partners in helping the plans and state to develop improved data reporting.

III. Resources

Using the legal opinion CPCA sought in the fall, we have developed an FAQ for members.

California Primary Care ASSOCIATION

INFORMATIONAL

Date: January 18, 2018

To: Government Programs Committee

From: Michael Helmick, Senior Policy Analyst

Re: Clinic Lifeline Grant Program

MEMORANDUM

I. Background

The Clinic Lifeline Act of 2017 was signed into law by the Governor on July 10th, 2017 and established the Clinic Lifeline Program within the State Treasurer's Health Facilities Financing Authority (CHFFA). The Lifeline Program appropriated $20 million from the Health Expansion Loan Program (HELP) in order to create a grant program with the goal of assisting small health center locations (sites with a budget under $10 million) and rural health facilities in case they were adversely financially affected by a reduction or elimination of federal government assistance. Applicants can apply for grants of up to $250,000 per health center location, and there is no limit to the number of location applications, as long as the location meets all of the criteria.

II. Update

CPCA, along with PPAC, have worked with CHFFA to enhance the breadth of health centers who would be eligible for the grant program, influence the application and selection criteria, and educate CHFFA on identifying events which could be considered federal triggering events to release the grant funds. CHFFA has interpreted the Act to require a federal 'triggering' event, which would then lead to the issuance of emergency regulations and the eventual dissemination of the funds. Once the grants are 'triggered' by an event, CHFFA can begin the emergency rulemaking process. This process would take roughly 30 days to finalize and the regulations would automatically repeal after 180 days, unless an extension of 90 days is granted, which can happen no more than twice. If CHFFA is unable to expend the funds within the regulatory timeframe then the funds would revert back, the emergency regulations would be repealed and there would need to be another triggering event and emergency regulations process.

CPCA is actively looking into the different federal events which could be applied by CHFFA as the triggering event. The fiscal cliff is one of the events which we have looked into utilizing as the triggering event for the clinic lifeline grant. CPCA has partnered with NACHC to mine HRSA data in order to develop a clear picture of the financial impact that the fiscal cliff would cause on health centers. Health centers with start dates of January 1, February 1, and March 1 have

received NOAs from HRSA which guarantee funding through the end of March. However, starting on April 1, 108 health centers with start dates from January to April will no longer receive their 330 grants for a total of $237.5 million. Although we acknowledge that the clinic lifeline grant fund amounts to a drop in the bucket in comparison to the fiscal cliff we see this as an opportunity that could buy additional time for health centers who may not have access to an abundance of available reserves.

III. Next Steps

On January 26th CHFFA will host their first meeting of 2018 where it is expected that they will present for approval an outline of the rules and requirements that will govern the grant program. CPCA will continue to engage CHFFA to highlight the needs among health centers and push for the prompt dissemination of these funds once we determine there is an event that would fit CHFFA's criteria.

California Primary Care ASSOCIATION

INFORMATIONAL

Date: January 18, 2018

To: Government Programs Committee

From: Michael Helmick, Senior Policy Analyst

Re: OSHPD 3 and Licensing Strategies Update

MEMORANDUM

I. Background

At the September 26, 2017 CPCA Board Meeting, the Board of Directors approved a staff recommendation to adopt a comprehensive strategy to examine legislative, regulatory, and administrative opportunities to reduce the burden of OSHPD 3 building standards.

The comprehensive strategy approved by the board includes:

- Examining licensing inefficiencies;
- Evaluating the use of 1206(g) licensure exemptions for CHCs affiliated with an institution of higher learning;
- Researching 1231(a) flexibility waivers in CDPH to determine usage among health centers;
- Participating in the OSHPD 3 triennial cycle; and
- Filling seats on the CA Building Standards Commission (CBSC) with FQHC-knowledgeable commissioners.

CPCA is also in the process of determining how to improve the consolidated licensing process. This will include legislation that would allow health centers to choose to either bill under the parent site's rate or go through a separate rate setting process for a new facility site under a consolidated license.

Consolidated Licensing Update

CPCA has been working with several health centers who were issued licenses with multiple facilities listed on a single license prior to AB 2053. These licenses have been questioned by DHCS and DPH and were told to move to a consolidated license, which typically would require the health centers to bring their buildings into compliance with 2017 OSHPD 3 standards instead of the building requirements from time of initial licensure. CPCA recently received notice that our advocacy efforts were successful, and that the first of the health centers was approved to apply for a consolidated license under the OSHPD 3 building standards in place at the time of initial licensure.

II. OSHPD 3 and Licensing Strategies Update

1. Examining licensing inefficiencies
   - Staff are developing the scope for a potential research report examining the efficacy of the state's licensure process
   - Little Hoover Commission and Legislative Analyst's Office are two potential research bodies

2. Evaluating the use of 1206(g) licensure exemptions
    - Health and Safety Code (HSC) 1206 lists the situations in which licensure is not needed. Most of these sections are either implausible or unhelpful to health centers.
        - CPCA has identified the HSC 1206(g) licensure exemption as one possible option for health centers.
        - 1206(g) states "A Clinic operated by, or affiliated with, any institution of learning that teaches a recognized healing art and is approved by the state board or commission vested with responsibility for regulation of the practice of that healing art."
    - Four health centers have volunteered to be test cases for the HSC 1206(g) exemption.
        - CPCA has begun working with outside counsel to examine the specifics of each of the four identified health centers, and the viability of their securing an exemption.
        - Once vetted internally, CPCA will work closely with those health centers and legal counsel as they move through the exemption process.

3. HSC 1231(a) flexibility waivers
    - HSC 1231(a) allows CDPH flexibility to approve an exception to a clinic based on an "alternate concept, method, procedures, techniques, space, equipment, personnel qualifications, or the conducting of pilot projects."
        - Only a small number of FQHCs have successfully applied for and been granted such a waiver. We believe that this concept has been used more widely by hospitals.
        - Staff is in the information gathering stages to determine the most effective path forward for increasing the viability of such waivers for non-hospital aligned FQHCs.

4. Triennial cycle
    - Staff continues to engage OSHPD in order to weigh in throughout the building code development cycle. The cycle is still in the very beginning stages for the current 3 year period, giving CPCA the opportunity to impact future OSHPD3 building standards.

5. CA Building Standards Commission Seat
    - Staff is researching the current makeup of the CBSC to determine if there are any gaps on the board and what qualifications would make an FQHC-knowledgeable candidate successful.

6. CPCA is in the process of identifying an author for legislation that would improve on AB 2053 (Gonzalez-Fletcher), which was passed in 2016. We have had extensive dialogue with Assemblywoman Gonzalez-Fletcher's staff regarding the need for the bill and are optimistic that we will have an author finalized before the deadline to submit legislation next month. The legislation would:
    - Allow for FQHCs to add an additional location to their current primary care license.
    - Allow an FQHC the option to apply utilize the same PPS rate, or at their discretion, apply for a new rate.
    - Allow for an FQHC to enroll the new location utilizing the existing provider number.

California Primary Care ASSOCIATION

INFORMATIONAL

Date: January 18, 2018

To: Government Programs Committee

From: Emily Shipman, Senior Program Coordinator of Health Center Operations

Re: Licensing

MEMORANDUM

I. Background

Beginning in July 2015, the Centralized Applications Unit (CAU) of the Licensing and Certification Division (L&C) of the Department of Public Health (DPH) began consolidating facility licensing functions that were previously handled by District Offices. The effects of this massive change include a backlog in licensure applications that has delayed the processing timeline far beyond the 30 days specified in state law. Unclear and outdated application guidance from CAU also contributes to incomplete and inaccurate applications, which further compound delays.

II. Licensing Strategy Update

CPCA is pursuing an aggressive administrative strategy to push licensing process improvements forward:

- CPCA is meeting regularly with L&C leadership to escalate challenges and force continuous improvement;
- CPCA offered extensive comment on L&C's draft application checklist, which will result in the issuance of a streamlined and consistent set of application requirements;
- CAU staff has increased from 6 people at the time of the consolidation to more than 30 at this time. CPCA has ensured that 6 analysts are fully dedicated to processing primary care clinic applications. CAU believes that now that they are fully staffed, we are likely to see meaningful improvement on the backlog as early as mid-February or March of 2018.
- CAU is finalizing development of a platform to publically display processing metrics that will show current processing timeframes and allow for the tracking of specific applications through the process.
- An electronic application for primary care clinics is expected to go live in early 2018. This process will initially only be available for full primary care clinic applications, but affiliate and consolidated will be added in the future. Paper applications will continue to be accepted until further notice.

III. Consolidated Licensing

The consolidated clinic licensure option made available through AB 2053 went into effect January 1, 2017. As CPCA has worked with the CDPH to implement this bill and educate members on the process, we learned that the Department of Health Care Services (DHCS) does not interpret the bill's provisions to allow for billing under a parent site, and instead is requiring all consolidated sites to secure their own PPS rate through the traditional rate-setting process. To allow for consolidated sites to bill under a parent's rate as the bill intended, we need additional legislation. We have already begun conversations

with DHCS to amend the necessary sections as soon as possible, and will be introducing a legislative fix in 2018.

For community health centers with an existing licensed site, the consolidated licensure option remains the most streamlined way to license an adjacent site, with a 30-day timeframe for review by the Centralized Applications Unit and exemption from full licensure application.

IV. Existing Licensees: Multiple Buildings on Shared License

It has recently come to our attention that DHCS has recently begun interpreting Welfare and Institutions Code (WIC) 14132.100 in a manner that prevents clinic sites from billing Medi-Cal under a shared PPS rate with the exception of intermittent sites and mobile units.

This situation began when two health centers attempted a Change in Scope of Services Request. DHCS flagged each request and encouraged the health centers to contact CDPH to rectify the situation. In discussions with CDPH, it was determined that, in previous years, CDPH District Offices had incorrectly issued licenses which allowed the health centers to combine multiple clinic building addresses onto the same license.

CPCA is working with the affected health centers to remedy their situation and ensure that they have written assurances from the state to allow for some flexibility to secure licensure and continue operations.

California Primary Care Association

DISCUSSION

Date: January 18, 2018
To: Government Programs Committee
From: Meaghan McCamman, Assistant Director of Policy
Nenick Vu, Associate Director of Managed Care
Re: Medi-Cal Managed Care Update

MEMORANDUM

I. Background

Implementation of the ACA's Medicaid Expansion and policy changes at California's Department of Health Care Services (DHCS) have resulted in significant growth in Medi-Cal managed care enrollment. In addition, the creation of Covered California means that approximately 1.4 million low income Californians, once likely un-or-under-insured, now receive coverage through a managed care plan. In line with this vast growth in managed care enrollment, CPCA's work in the field of managed care has grown substantially, with additional changes foreseen in 2018.

CPCA has been successful in forwarding our managed care policy priorities, which include strengthening relationships between CCHCs and their managed care partners, increasing managed care plan investment in quality improvement, and increased state oversight of beneficiary access and network adequacy. Updates on current work can be found in the "2017 Recap and Current Managed Care Work" section of this memo.

II. Managed Care Goal Setting & Prioritization

Unlike much of the policy work that we do, which relies on the administration and legislature to drive changes, managed care policy is largely delegated to California's licensed health plans, within broad federal and state parameters. These health plans, in turn, delegate portions of their work to risk-bearing organizations, IPAs and providers. This means that a simple change in law or practice might be implemented hundreds of different ways, and an extensive coordination effort must be undertaken to ensure that when we advocate, we are advocating effectively with RBOs and IPAs, with health plans, with DHCS, and with regulators.

In light of the substantial growth in managed care, CPCA and the regional consortia are beginning a process of setting specific managed care goals, identifying priorities, and developing a workplan for the future. A thoughtful coordination strategy is necessary to ensure that policy priorities are carried through the full chain of organizations and agencies responsible for the delivery of care to health center patients.

III. 2017 Recap and Current Managed Care Work

Below are some of the key managed care policy issues that CPCA is tracking and/or working on with the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), managed care plans, and other provider and consumer stakeholders:

- *P4P Quality Incentive Programs*
    - Increasing managed care plan investment in incentivizing continuous quality improvement;
    - Encouraging managed care plans to adopt the standardized P4P metrics developed by IHA;
    - Educating FQHCs, plans, and delegated groups on "best practices" for FQHC participation in quality incentive programs.
- *Unseen Patients*
    - Working with plans to determine how to ensure patients are assigned to the health center at which they seek care; enhance the accuracy of patient contact information; and reduce the burden of reconciling member assignments versus health center patients.
- *Provider Directories*
    - Creation of a set of standards and process for ensuring the accuracy of provider directories, eventually culminating in a statewide single directory. Our goal is to ensure that the process is minimally burdensome to providers and reflects the unique role of FQHCs as PCPs.
- *Timely Access and Network Adequacy*
    - DMHC is creating a process and script for health plans to survey their provider networks to determine timely access to care. DHCS has recently adopted an additional methodology where state workers will also be surveying providers for timely access, on top of the DMHC plan surveys. Our goal is to reduce the burden of this duplicative system and ensure that both systems account for the unique FQHC delivery system.
- *Managed Care Mergers*
    - Tracking investment undertakings to ensure that CCHCs are positioned to take advantage of merger-funded programs, grants, and low-interest loans.
- *Medi-Cal Commercial Plan Procurement*
    - Tracking procurement information/timelines;
    - Meet with statewide/multi-region plans to understand their strategy for procurement (data gathering);
    - Our goal is to work with RAC to ensure that any plans selected via the procurement process be strong CCHC partners.

California Primary Care Association

DISCUSSION

Date: January 18, 2018
To: Government Programs Committee
From: Meaghan McCamman, Assistant Director of Policy, Allie Budenz, Associate Director of Quality Improvement, Liz Oseguera, Senior Policy Analyst, Michael Helmick, Senior Policy Analyst
Re: Behavioral Health Update

MEMORANDUM

I. Background

It is CPCA's goal to support CCHCs in providing the behavioral health services needed by their communities by removing regulatory barriers, expanding access to resources, and ensuring health centers are included in all policy discussions. This memo provides an update on the various efforts and successes CPCA, and our affiliate, CaliforniaHealth+ Advocates, have had in supporting health center's behavioral health integration.

II. Removing Regulatory Barriers

CPCA's goal in this space is to remove barriers to CCHC participation and reimbursement for the full spectrum of behavioral health care.

SB 323 (Mitchell)

CaliforniaHealth+ Advocates, on behalf of CPCA, sponsored SB 323, a bill which clarifies that FQHCs may provide behavioral health services within their PPS rate, or may elect to carve out specialty mental health and/or Drug Medi-Cal and provide those services under contract with the county mental health plan (MHP) and/or the Drug Medi-Cal system. This bill was signed into law and went into effect January 1, 2018. An overview of the legislative changes was offered via webinar and is linked to the resources section of this memo. Two future webinars on the financial and programmatic considerations for health centers determining whether to exercise the option to 'carve out' Drug Medi-Cal or Specialty Mental Health services will be held in early 2018.

Billing for MFTs (AB 1863)

CPCA continues the work to implement AB 1863 no later than July 2018, which allows FQHCs to utilize and bill for MFT services for Medi-Cal enrollees. Conversations with DHCS around implementation are taking place in the context of updating the SPA (refer to 330 Committee). CPCA has yet to see draft SPA language for MFTs.

Same Day Billing for Medical and Behavioral Health

California Health+ Advocates, on behalf of CPCA, has begun conversations with the Steinberg Institute and other behavioral health stakeholders about the possibility of sponsoring or co-

sponsoring legislation to allow for same day billing of medical and behavioral health services. Discussion on this topic will take place during the Legislative Committee meeting.

Billing for Vivitrol as a Pharmacy Benefit

DHCS has officially announced that Naltrexone for extended-release injectable suspension (Vivitrol) has been expanded to full-scope pharmacy benefit as of December 1, 2017. Whereas previously, Vivitrol as a pharmacy benefit was only available for criminal justice involved patients, it may now be billed as a pharmacy (and also medical) claim for ALL beneficiaries. Any pharmacy that is contracted with Medi-Cal, including FQHC in-house pharmacies, can submit a TAR for authorization to administer and bill as a fee-for-service claim. In practice for FQHC providers, this means providers may incorporate Vivitrol as a complimentary medication for their MAT programs. Health centers will want to work with their local pharmacies to agree upon process for filling and administering the medication

President's Commission on Drug Addiction and the Opioid Crisis

The Commission had initially released a draft report that would have *mandated* that all FQHCs require their physicians, NPs, and PAs to hold an X-waiver to prescribe buprenorphine. CPCA, NACHC, and other advocates were successful in getting the FQHC mandate removed from the final report. A copy of CPCA's comments to the President's Commission can be found in the resources section of the memo.

Confidentiality Regulations and Guidance

Along with SUD providers around the country, CPCA successfully advocated for federal changes to 42 CFR Part 2, which streamline data sharing requirements between SUD providers and other physical, behavioral, and social service providers. Additionally, CPCA was a reviewer for the CalOHI State Health Information Guidance (SHIG) on Sharing Sensitive Health Information. This document provides state level guidance in plain language that explains when, where, and why mental health and SUD information can be exchanged and also provides clarification on state and federal laws. The original SHIG was published in June 2017 and was updated and republished in December 2017. The re-published CalOHI guidance can be found in the resources section, below.

III. Expanding Access to Resources

CPCA's goal is to ensure that FQHCs receive the resources necessary to support the provision of behavioral health services. Historically, counties have received the bulk of BH funding in California and have had great flexibility in their expenditure and use of funds, with little reporting and even less accountability. CPCA's advocacy priorities in this space include ensuring that FQHCs are able to pull down resources requisite to their participation in the BH system, and ensuring that counties are held accountable to use their funds to provide robust access and thorough coordination of care within and outside of the county system.

Proposition 64

CPCA is active in a coalition led by the California Association of Alcohol and Drug Program Executives (CAADPE) to develop a thoughtful proposal that will advise how the approximately $650 million that will be available for SUD education, prevention, intervention, and treatment

for youth through Proposition 64 funds should be spent. The funds are unlikely to start rolling in until approximately 2019.

The coalition has decided to allow individual organizations to sponsor legislation specifying how Proposition 64 funding should be used so long as the legislation is aligned with the coalition's core principals, which are not yet finalized.

CPCA is working with coalition members of the workforce subcommittee to develop a legislative plan that ensures primary care providers serving underserved communities are leveraged as a part of the youth SUD spectrum of care, especially around education, prevention, and early intervention.

California Hub and Spoke Services (H&SS) Funds

Under the 21st Century CURES Act, California was awarded $90 million in grants over two years to curb the opioid epidemic by improving access to MAT. Eighteen Narcotic Treatment Programs and one FQHC were awarded grant funds to develop a network of Hubs and Spokes designed to coordinate care for opioid addicted patients in underserved and rural communities with the high rates of drug overdose deaths. "Hubs" have funds available to support care coordination with 'spokes,' and many Hubs have indicated a wish to work with local FQHCs. CPCA has developed a document for FQHCs interested in working with Hubs, which can be found in the resources section of this memo.

No Place Like Home (NPLH)

The 2016 initiative dedicates a portion of Mental Health Services Act (MHSA) funds to secure $2 billion in bond proceeds to support the construction and rehabilitation of permanent supportive housing for individuals who are in need of mental health services and are homeless, chronically homeless, or at-risk of homelessness. California Health+ Advocates, on behalf of CPCA, successfully advocated to ensure that the application for NPLH funds includes a requirement that residents of the supportive housing be linked to a primary care provider.

There has been little progress since the department filed a Notice of Validation in Superior court. This notice would legally validate Housing and Community Development's (HCD) right to authorize, issue, and sell the bonds associated with NPLH. The court decision is expected to be finalized by Spring 2018, and as long as there is no continuation of the court proceedings,HCD is hoping to release the Notice of Funding Availability by the Summer of 2018. Interested health centers should begin to have conversations with their county colleagues and become active in any local NPLH, or county housing, planning processes.

IV. Raising awareness

CPCA and California Health+ Advocates are focused on ensuring that the critical role of CCHCs is recognized and leveraged by the counties and the state. Through effective advocacy in the legislature and the administration, CPCA will continue to encourage counties to increase their partnerships with clinics and other community organizations.

V. Resources

- **Link to SB 323: What's Next Webinar Recording**
- **Link to SB 323: Implementation FAQs**
- **Link to SB 323: Flow Chart**
- **CPCA's letter to the President's Commission on the Opioid Crisis**
- **CalOHI Guidance**
- **Principles of Hub and Spoke Funding**

California Primary Care ASSOCIATION

DISCUSSION

Date: January 2, 2018

To: Government Programs Committee

From: Elizabeth Oseguera, Senior Policy Analyst

Re: Mental Health Services Oversight and Accountability Commission

MEMORANDUM

CPCA, in collaboration with CaliforniaHealth+ Advocates, has been working to increase the visibility of health centers in the behavioral health sphere to ensure stakeholders, partners and governmental entities are aware of the crucial role health centers play in providing behavioral health services.

This year we have grown our relationship with the Mental Health Services Oversight and Accountability Commission (OAC) staff and commissioners, and through these relationships we've been able to influence policy and increase the recognition of clinics as important and valuable providers of mental health services. This is especially seen through OAC's decision to adopt our recommendations concerning the Triage grant and Prevention and Early Intervention (PEI) and Innovations regulations.

I. PEI and Innovation Regulations

On December 6 the Mental Health Services Oversight and Accountability Commission (OAC) released its updated amendments to the PEI and Innovation regulations. On behalf of CPCA, CaliforniaHealth+ Advocates provided public and written comment to OAC Commissioners and staff to ensure that counties report demographic information, with the exemption of sexual orientation, on children 12 and under. Reporting demographic information helps the OAC and state ensure that services are directed and accessed by the whole community. CPCA was very pleased that the OAC accepted our recommendations for *all* MHSA program participants.

We were also gratified to see that the OAC will now be collecting data regarding the number of referrals made to non-county providers for behavioral health services under the Innovation and PEI programs. This is an important step that will allow the OAC, and behavioral health community, to better understand the utilization of non-county behavioral health providers in MHSA funded programs, including CCHCs.

II. Triage Grant

On December 29 the OAC released its second request for applications (RFA) for funding under the Triage grant, which was implemented by SB 82, the Mental Health Wellness Act. This act designated $32 million to be made available yearly, over a three year period, to County Mental Health

departments via a competitive grant process to develop and implement Mental Health Triage programs.

In meeting with OAC staff, including the Executive Director, Toby Ewing, and the OAC Chair, John Boyd, CPCA was able to persuade the OAC to specifically name FQHCs as a potential partner for counties. This is a huge achievement, considering that the OAC did not include FQHCs as a partner in the first Triage RFA and hardly acknowledged clinics as behavioral health providers in the past. The OAC also increased the points awarded to counties who partner with community entities, like clinics and schools, from 70 points to 250. We hope that this will encourage counties to increase their partnerships with clinics and other community organizations.

If your clinic is interested in accessing these funds please contact your counties Behavioral Health Director. If you have any issues please notify Liz Oseguera, loseguera@cpca.org.

III. Changes at the OAC

This year the OAC elected a new chair (Commissioner John Boyd) and vice chair (Khatera Aslami-Tamplen). Commissioner Boyd is Sutter Health's Chief Executive Officer of Mental Health Services while Commissioner Aslami-Tamplen is the consumer empowerment manager at Alameda County Behavioral Health Care Services. CPCA has met with the new chair to ensure he understands the role that clinics have in providing prevention and early intervention services, among others, in behavioral health.

Mayra Alvarez, the President of Children's Partnership, has been appointed to be the Attorney General's designee on the OAC. CPCA has a great relationship with Children's Partnership, and is excited to have a great partner on the Commission. We will be meeting with Ms. Alvarez to discuss our concerns around MHSA.

IV. Resources

- OAC's PEI and Innovation Regulations
  - OAC's Proposed Amendments to Prevention and Early Intervention Regulations
  - OAC's Proposed Amendments to Innovation Regulations
  - CPCA's Comment Letter

California Primary Care ASSOCIATION

INFORMATIONAL

Date: January 18th, 2018

To: Government Programs Committee

From: Emili LaBass, Senior Program Coordinator of Health Center Operations, Ginger Smith

Re: Emergency Preparedness Response

MEMORANDUM

2017 California Wildfire Season:

Over the past few months, the worst fires in California's history have burned hundreds of thousands of acres of land, thousands of homes have been lost, and thousands of people have been displaced. In October 2017, the Tubbs Fire was one of more than a dozen large fires that broke out in eight Northern California counties. By the time of its containment on October 31st, the fire was estimated to have burned 36,807 acres and caused 22 deaths in Sonoma County. The fire incinerated more than 5,100 structures, including Santa Rosa Community Health Center's largest site, Vista Clinic. In Santa Rosa alone, the fire claimed more than 2,800 homes, many of which belonged to health center staff and their families.

Before we had had a chance to catch our collective breath, on December 4th, 2017, the Thomas Fire erupted in the heart of Ventura County. Strong Santa Ana winds and extremely dry conditions fueled the fire north and west unchecked to the Pacific Ocean. As of January 3nd, the fire has burned over 281,800 acres and stands at 92% containment, making it the second largest wildfire in modern California history. More than 104,000 people have been forced to evacuate their homes, including health center staff and their families, and communities have been plagued with intermittent power and water outages. Meanwhile, as the Thomas Fire continued to ravage Ventura County and Santa Barbara County, multiple fires broke out and were contained in Los Angeles, San Diego, and Riverside Counties

Health Center Impact and Response

We don't often think about health centers as first responders, but as we have seen across the state from Sonoma to San Diego, health centers are quick to engage with their community partners to continue to deliver high quality care during and in the wake of disasters and play a significant role in community recovery. Starting with the Tubbs Fire, health centers in Northern California worked with their counties to ensure staffing of licensed medical providers at evacuee shelters. They mobilized health care teams and opened their doors to help those who had been displaced and had nowhere else to turn for care. Not only did they continue to provide primary care services, but they also are current responders in addressing the complex behavioral health needs of both their resilient patients and staff champions.

In Ventura County at the height of the Thomas fire, health centers in the region were also forced to close many of their facilities. Despite these massive setbacks, they set up space within their remaining facilities to create temporary day care centers for their employee's children when schools were closed. They also set up emergency shelters for staff and their families who had been evacuated or lost their homes. These are just a few examples of how health centers from wine country to surf country supported their communities and patients in times of immense stress and strife.

This fire season caused numerous health centers to close their doors for days due to evacuations and road closures, unhealthy air quality, power and water outages, and/or actual facility damage. Even those health centers directly impacted by the fires continued to go above and beyond to assist their community. To that end, on October 9th, Santa Rosa Community Health's (SRCHC) largest health center, the Vista Campus, was destroyed due to extensive fire, smoke, heat, and water damage as a result of the Tubbs Fire. Roughly 24,000 people who received comprehensive primary care and behavioral health services at the Vista Campus lost their medical home. Despite this massive loss to the health center and the community it serves, SRCHC has remained true to its mission to serve and has played an integral role in the region's ongoing recovery efforts. It is also worth noting that CPCA is aware of several health centers in non-impacted regions that banded together to send available resources to Sonoma County, including mobile medical vans to fire-affected areas.

We know that health centers are crucial to emergency response and recovery efforts: providing patients with necessary resources such as how to apply for CalFresh, information on Local Assistance Centers, information on how to apply for FEMA and other state and federal resources, how to obtain emergency refills for prescription drugs, and information on EDD Disaster services for patients who have lost their jobs as a result of the fires. Health centers are responsible to the most vulnerable in our state: those individuals who have been hit the hardest by these natural disasters.

Without a doubt, this fire season has caused a major disruption in the safety net healthcare delivery system. The recovery will present a years-long challenge on many fronts, and health centers will continue to play an integral role in the recovery efforts in their communities. During emergencies, health centers are not alone and are further supported by their regional associations and by CPCA.

CPCA Activities

Over the past 3 months, in a concentrated effort to assist health centers struggling with the complexity of these natural disasters, CPCA has collected and disseminated a multitude of disaster related resources. In addition, CPCA staff have provided daily technical assistance to health center and regional association staff on a variety of topics. We have worked closely with our national and local partners to quickly find and consolidate existing materials, identify gaps and missing elements, and work to create tools to fill the gaps. Pertinent information and resources were posted daily on the CPCA Emergency Preparedness website and were sent out via the CPCA Weekly Update Newsletter.

Collecting Information: In addition to resource dissemination, CPCA worked closely with the regional associations to collect and confirm health center status data during each event. With multiple information requests coming from NACHC, HRSA, DHCS, and CDPH, CPCA relied on partners at CCALAC, RCHC, HCP and HANC to collect real time data on their membership as well as confirm data CPCA was able to collect directly from health centers. Beginning October 8th and on December 4th, at the respective onslaught of the fires, CPCA made a concerted effort to quickly identify clinics in the potential "danger zones" and reach out to them directly to offer support and resources.

1135 Waiver and DHCS: CPCA continues to work closely with both CDPH and DHCS to address the urgent needs of impacted community health centers. In response to the fires across California, the U.S. Department of Health & Human Services (HHS) declared a public health emergency in California on October 15th, 2017, and authorized a Section 1135 waiver, retroactive to October 10th, 2017. A Section 1135 waiver authorizes DHCS to suspend and provide flexibility around certain provider requirements under the Medi-Cal program in order to maintain capacity to meet

beneficiary access needs. CPCA, consortia, and health centers provided feedback to DHCS on what type of flexibility would be helpful for serving their impacted communities. DHCS is still waiting for CMS to approve the Section 1135 waiver request. The Departments will continue working with health centers to prioritize the situation, providing invaluable flexibility in getting health centers the resources and assurances they need to resume and continue seeing patients throughout the affected area. For questions on CPCA's work with CDPH and DHCS as it relates to the wildfires, please contact Ginger Smith at gsmith@cpca.org.

Disaster Relief Fund: In the wake of the Northern California fires, with great assistance from RCHC, CPCA submitted a proposal for a Wildfires Disaster Relief Fund on behalf of the community health centers in the Napa, Sonoma, Mendocino, and neighboring areas. The proposal outlined the immediate and longer-term resources needed to ensure that health centers could continue to provide much needed health care, mental health services, and other social supports to California's most vulnerable populations. As stated above, the proposal was developed with direct input from health centers and was sent to a number of California statewide foundations to ask them to consider establishing a fund to assist all health centers affected by the Northern California wildfires. For questions on fundraising related to the Tubbs Fire, please contact Val Sheehan at vsheehan@cpca.org.

Legislation: CPCA's Government Affairs team has also spoken with impacted members and consortia to identify how legislative relationships can be best harnessed to support impacted health centers and be better prepared for future emergencies. CaliforniaiHealth+ Advocates has been in contact with the Governor's Office, the Treasurer's office, and elected officials in impacted communities. A small workgroup was recently convened to identify potential legislative and administrative actions that may be needed. To this end, Advocates is currently exploring sponsoring declared emergency-related legislation that could address payment for telephonic visits or other alternative touches; local jurisdictional permitting and clinic pharmacy permitting for temporary sites; and business continuity insurance challenges. For questions on CPCA's legislative strategy, please contact Beth Malinowski at beth@healthplusadvocates.org.

CPCA continues to work closely with our members to assist them with their emergency preparedness technical assistance needs. Staff are working with health centers to identify areas of opportunity for increased learning and resource development as a result of this past year's experiences. If you have any questions or concerns, or would like more information on health centers impacted by the wildfires, please contact Emili LaBass, at elabass@cpca.org.

California Primary Care ASSOCIATION

INFORMATIONAL

Date: January 11, 2018

To: Government Programs Committee

From: Allie Budenz, Associate Director of Quality Improvement

Re: Section 2703/Health Home Program Update

MEMORANDUM

HHP Status Update

The state plan amendment (SPA) to implement ACA Section 2703 Health Homes for Patients with Complex Needs (HHP) has been approved and signed by CMS. DHCS and managed care plans (MCP) are currently negotiating draft rates with final expected rates in early March 2018. DHCS has created a program guide that is being shared with MCPs and which includes: readiness requirements (network information, policy and procedure requests), deliverables, payment service codes, reporting templates, model MOU's, and training opportunities.

The California Endowment has signed a contract to provide approximately $45 million for the two year demonstration. The first cohort of counties are expected to go live in July 2018, followed by 2 and 3 in January 2019 and July 2019, respectively.

Technical Assistance Update

DHCS contracted with Harbage Consulting to provide technical assistance on outreach, education, and communications to MCPs, providers, CB-CMEs, eligible Medi-Cal beneficiaries, and other stakeholders through all 3 implementation phases of the HHP. Harbage's contract was expanded from the original scope (which was to release a series of toolkits) to now include a webinar series and a learning collaborative throughout the implementation timeline. The webinar series includes required "core" and set of optional trainings for MCP's and CB-CMEs slated to begin in February; the trainings will be recorded and published. DHCS, through Harbage, is also initiating a learning collaborative designed specifically for MCPs and has invited CPCA to participate as health center relevant topics are identified. MCPs will still need to develop a training plan for their CB-CMEs with information unique to their plan and their care management approach.

Because the pilot will only continue as a permanent benefit if there are savings across the entire program CPCA thought it prudent to find a way to bring the plans and providers in the pilot together to build a model of collaboration. In Octoberat CPCA's initiation, the health plan associations - the California Association and Health Plans and the Local Health Plans of California- and CPCA jointly convened a small workgroup of plans and providers deeply invested in the HHP to discuss how to best to coordinate the execution and delivery of a successful pilot. The group agreed on the premise of the meeting and intent, and identified a set of priorities, principally to share business models that would help plans and providers identify promising practices.

The first round of peer sharing was set to launch in January, but given the recent state developments and learning collaborative kick start, there has been concerns about duplicative work between our efforts and Harbage. At the January 16th meeting, the workgroup will discuss the future plans for the group.

California Primary Care ASSOCIATION

INFORMATIONAL

Date: January 18th, 2018

To: Government Programs Committee

From: Emili LaBass, Senior Program Coordinator of Health Center Operations

Re: Oral Health Update

MEMORANDUM

California Oral Health Network

In March 2017, the California Pan-Ethnic Health Network (CPEHN) was selected by the DentaQuest Foundation and the California Wellness Foundation to coordinate the new California Oral Health Network. CPCA joined CPEHN and other stakeholders as Core Group members in the development of this new Network. Building off of lessons learned from prior statewide oral heath collaborations like OHAC, we are currently working to develop the foundation and structure for the Oral Health Network.

As a result of this preliminary work, we have put together 4 key oral health network goals:

1. Maximize connectivity and engagement through a strong, focused, and well-resourced Network structure. We want to ensure that partners and allies are connected and aligned to maximize our collective impact for improved oral health. We seek to leverage what already exists and improve connections with advocates, consumers and partners in advancing oral health equity.
2. Use better data, knowledge and practices to develop an informed, statewide, and community-driven policy. As we become better connected and aligned, we must harness opportunities to advance shared policies and practices. We seek to help lift up those shared ideas, policies, practices, and needs to identify a policy agenda that truly addresses inequities in oral health.
3. Shift public perception, knowledge, and engagement on oral health advocacy. At every level of this work our partners are calling for more information that is culturally and linguistically appropriate to help elevate the urgency and importance of oral health. To truly advance a policy agenda and shift the imperative to improve oral health, we need more voices throughout California and for everyone to understand why disparities and inequities exist.
4. Provide opportunities for consumer and community engagement to advance oral health. The missing voice from public policy on oral health is community. We must align and connect our community partners to bring their energy, expertise, and engagement into the movement.

The Network seeks to include engaged, diverse stakeholders from multiple sectors and populations committed to advancing oral health equity for all. Together, we are working to improve overall health for Californians addressing oral health issues, especially for those who are historically underserved. The Network will maximize our collective efforts to advance systemic social change toward oral health equity.

Dental Transformation Initiative (DTI)

Up to $148 million per year over 5 years – totaling $740 million

Beginning January, the DTI will be in its third program year (PY). CPCA continues to meet with DHCS on a monthly basis and as needed to ensure active clinic participation in the DTI. CPCA uses these meetings as an opportunity to voice health center concerns and problem solve with the department on how to increase health center participation in the program.

Of note, we do not anticipate the DTI to exist past the current 1115 Waiver unless new non-federal funds can be identified. A draft memo from CMS Administrator Seema Verma in late 2017 indicates that CMS will cut off federal Medicaid spending on "designated state health programs" in states like New York, California, Oregon and Washington, all of which have collectively relied on billions of federal dollars funneled through the programs to experiment with Medicaid payment reform. From our research, only California's DTI is impacted by this decision.

National Oral Health Integration and Innovation Network

CPCA successfully completed a new phase of PCA oral health leadership with funding from the DentaQuest Foundation for participation in the *"National Oral Health Integration and Innovation Network"* (NOHIIN) initiative. NOHIIN is made up of Primary Care Associations from across the country who are engaged in oral health promotion and supported by various partners. NOHIIN's role is to act as a learning collaborative to highlight challenges and promote best practices for integrating oral health into overall health care. This program focuses on increasing the visibility of oral health on the national stage by strengthening ties with and among PCAs, CHCs and community partners/stakeholders, and leverage that power for change, while continuing to support oral health in the health care safety net.

Workforce Committee

Thursday - January 18, 2018
11:30 AM - 12:30 PM

Chair, Paulo Soares

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order			A
II. Approval of Agenda	• Agenda • Executive Summary	Paulo Soares	A
III. Approval of Minutes	• October 2017 Minutes	Paulo Soares	A
IV. Year in Review	• 2017 Year in Review	Beth Malinowski	I
V. California Future Health Workforce Commission	*Verbal Update*	Dean Germano Jane Garcia	I
VI. Goal 2: Advancing Primary Care Training	• Song-Brown Commission Update	Nataly Diaz Beth Malinowski	I/D
VII. Goal 6: Growing and Diversifying Health Center Professions & Goal 7: Serving as a Catalyst and Coordinator	• Combined Memo ✓ CLI Emerging Leaders CLIP Project: Student Initiatives ✓ UCSF Healthforce Research and Update ✓ CPCA Convening Update	Beth Malinowski Val Sheehan	I
VIII. Adjourn		Paulo Soares	A

California Primary Care Association

Executive Summary

Date: January 2018

To: Workforce Committee

California Future Health Workforce Commission

- The California Future Health Workforce Commission (Commission) convened for its second meeting on November 8, 2017 in Los Angeles.
- In addition to Jane Garcia and Dean Germano, Sara Gavin of CommuniCare joins the cadre of health center leaders adding their expertise to the California Future Health Workforce Commission's subcommittees.

Goal 2: Advancing Primary Care Training

- The Song-Brown Healthcare Workforce Training Program received a $33M installment of new funds in 2017 due to a strong coalition effort led by CaliforniaHealth+ Advocates, California Academy of Family Physicians, and the California Medical Association.
- At the November 29-30, 2017 Commission meeting, all health center primary care residency program applicants received funding amounting to $7M or 20% of the available 2017 funds.
- While more work is needed to secure additional Song Brown funding and address application issues, this is a significant victory at a critical time.
- The Continuing Resolution (CR) approved on December 21, 2017 includes limited funding for the Teaching Health Center Graduate Medical Education (THCGME) Program through March 31, 2018. This funding, along with the funding extensions of community health centers and NHSC, comes at the expense of the ACA Prevention and Public Health Fund.

Goal 6: Growing and Diversifying Health Center Professions

- Through CLI's Emerging Health Leaders Program, Beth Malinowski, Deputy Director of Government Affairs and CLI Cohort 10 participant, is aiming to lay the groundwork for a landmark CPCA student initiative.

Goal 7: Serving as a Catalyst and Coordinator

- CPCA successfully coordinated a third statewide Workforce Policy Coalition meeting in November 2017.
- The Coalition successfully ended the year by jointly agreeing to prioritize three issues areas in 2018; residency redesign, equity in education (focused on college pipeline programs), and researching primary care specific tax incentive programs
- CPCA continues to work with UCSF's Healthforce Center on a series of primary care workforce reports funded by Kaiser Permanente Community Benefit. Report #3, *Primary Care Workforce Strategies*, a look at promising practices from across the country, is in final draft form is expected to be released shortly.

CALIFORNIA PRIMARY CARE ASSOCIATION
Workforce Committee
October 10, 2017
1:00 – 2:00 PM

Members:	Dean Germano – Chair, Tony Alatorre, Anabel Arroyo, Kelly Bennett, Doreen Bradshaw, Cathy Frey, Franklin Gonzalez, Nik Gupta, Deena Lahn, Becky Lee, Joe Lee, Deborah Lerner, Louise McCarthy, Nichole Mosqueda, Danielle Myers, Christine Noguera, Joanne Preece, Tim Rine, Vernita Todd, Richard Veloz, David B. Vliet, Tony Weber
Guests:	Paulo Soares, Constance Kirk, Christin Ward, Tim Fraser, Margie Martinez, Sergio Bautista, Robin Affrime, Marty Lynch, Kevin Mattson, John Price, Dave Jones, Christina Velasco, Anitha Mullangi, Bernice Nunez Constant, Isabel Becerra, Jane Garcia, Linda L. Costa, Steve Heath, Melissa Eidman, Mary-Michal Rawling, Jennifer Polzen, Jessica Precht, Craig Pulsipher, Angie Melton, Britta Guerrero, Laura Sheckler
Staff:	Carmela Castellano-Garcia, Beth Malinowski, Kelley Aldrich, Andie Patterson, Mike Witte, Nataly Diaz, Victor Christy, Andrea Chavez, Michael Helmick, Meaghan McCamman

Call to Order
The meeting was called to order by the chair at 1:01 am.

Approval of Agenda
A motion was made and seconded to approve the agenda as written. The motion carried.

Approval of Minutes
A motion was made and seconded to approve the minutes as written. The motion carried.

California Future Health Workforce Commission – Guest Speaker
Dean Germano introduced our first guest speaker Jeff Oxendine, Co-Director of the newly formed California Future Workforce Commission. Jeff Oxendine from UC Berkeley and Kevin Barnett from Public Health Institute and a small team have been identified to serve as the key contact point for the efforts, to support the group's meetings, to prepare background materials, and to organize the work of grantees (technical consultants).

Jeff went on to explain the structure and the mission of the commission.

- A coalition of California's health funders, including The California Endowment (TCE), California Health Care Foundation (CHCF), The California Wellness Foundation (TCWF) and the Blue Shield of California Foundation (BSCF), is working to catalyze development of the Plan, and to provide funding for the staff effort supporting the work.
- The goal of this commission is to support the development of a strategic plan for building the health workforce to meet California's future needs in anticipation of new state leadership in 2019. This Plan will promote a set of practical short, medium, and longer-term solutions that

could be adopted and implemented by the state, educational institutions, employers, and other stakeholders to address current and future gaps in the health workforce. Another key goal is to establish a forum, structure, and process for effective plan implementation, with ongoing adjustment as needs change and with results reporting and accountability.
    - Health workforce planning is a forward-looking venture. The Plan should take into consideration the state's workforce needs in the medium (through 2025) to longer term (beyond 2025).
    - The Plan must emphasize changes in policy, practice, and education/training that are already underway today.

Dean Germano and Jane Garcia, who are both commissioners voiced their excitement and praise of the Plan.

Goal 7: Serving as a Catalyst and Coordinator

Aligning with CPCA's 2018 -2020 strategic plan, Beth Malinowski gave an update on the UCSF HealthForce Research - Report #3, Primary Care Workforce Strategies, a look at promising practices from across the country, noting that it is still in draft form, but will hopefully be released by October 2017.

Goal 6: Growing and Diversifying Health Center Profession – Guest Speaker

Dean Germano introduced Nicole Mosqueda, Director of Programs and Development at Camarena Health.

Nicole gave members a little background on Camarena Health and their affiliation with the A.T. Still University's Physician Assistant (PA) Program as a community health center campus for clinical education. In August of 2016, five 2nd-year PA students were placed in our health centers for their clinical learning year. The PA Clinical Residency Program provides one year of hands-on, intense clinical learning modules rotating every six weeks. The students in this program must complete and excel in the following clinical rotation areas:

- Internal Medicine
- Pediatrics
- Behavioral Health
- Family Medicine
- General Surgery
- Emergency Room
- Women's Health
- Elective in Specialty Area

The clinical residency program provides the PA students with a diverse experience, enabling each student to become better prepared for their future work as a provider in a community healthcare setting. This program was implemented in line with our core operating value of Leadership – Camarena Health is a leader in the community as well as the healthcare industry by setting the standard for quality clinical outcomes, excelling in patient satisfaction, and being proactive and responsive in meeting the diverse needs of the community.

Nicole also spoke about CTE, Health Career Pathways and how they work to "grow their own" which is an opportunity to endorse their local students, help them raise their GPA, find tutors for them in areas in which they are lacking such as math and science, lead programs, classes and seminars to help them be the best applicants. This has proven to be a very positive program, students get a full understanding of a health center, primary care and the community and in turn they are very committed. This program has changed the entire atmosphere at the clinic.

Workforce Strategic Plan Update

Beth summarized CPCA's 2017-2020 Strategic Plan approved by the board of director last May, which includes a strong commitment to develop of a robust healthcare workforce that is responsive to and reflective of California's diverse communities. The work plan includes several goals that are incorporated as headers in this new workforce committee memo, she highlighted the following:

- Promoting Community-Based Primary Care Workforce Visibility
    - UCSF Primary Care Workforce Research

- Serving as Catalyst and Coordinator Between Local, Statewide, and National Workforce Efforts

    - Workforce Policy Coalition

      As reported in July, members of the Workforce Policy Coalition agreed to prioritize the following three workforce policy areas and formed subcommittees to further discuss possible policy solutions in each area:
        - Priming the Primary Care Pipeline
        - Residency Redesign
        - Advocacy

      The *Priming the Primary Care Pipeline subcommittee* decided to break into three smaller subcommittees to focus on 1) conducting a pipeline program inventory, 2) fostering relationships with workforce development boards, and 3) increasing collegiate support and developing state funding sources for California post-baccalaureate programs. Each of these smaller groups will be reporting back to the Pipeline subcommittee on October 16.

      The full Healthcare Workforce Policy Coalition will meet one final time this calendar year on Monday, November 6. The goal of this meeting is to hear about issues that have been prioritized by each of the three subcommittees, further discuss an educational campaign strategy, and to subsequently identify possible legislative action that the Coalition would like to draft/sponsor in 2018.

Adjourn

The meeting was adjourned at 2:00 PM.

Submitted by Kelley Aldrich

Date: January 3, 2018

To: Workforce Committee

WORKFORCE COMMITTEE 2017 YEAR IN REVIEW

2017: The Year Ahead (projected from 2016)

At the start of 2017, we aimed to center our workforce initiative on the nine key primary care priorities established in the Horizon 2030: Meeting California's Primary Care Workforce Needs and that ground our workforce work in 2016.

- **PRIORITY 1:** PUBLIC AWARENESS
  CPCA staff will continue to explore the feasibility of a CaliforniaHealth+ workforce campaign to assist with workforce recruitment and retention efforts.

- **PRIORITY 2:** DOCUMENTATION & COMMUNICATION
  Partnering with UCSF Healthforce Center, CPCA will release a primary care workforce report as well as a behavioral health care workforce report.

- **PRIORITY 3:** PARTNERSHIPS
  CPCA will continue to collaborate with California AHEC leadership and will implement elements of the recently signed partnership agreement, which demonstrates our joint interest in promoting education, advocacy, and policy for a diverse and competent health workforce in California's underserved communities.

- **PRIORITY 4:** RESIDENCIES AND TRAINING
  CPCA will launch a new Residency Peer Network to provide a peer to peer learning environment. CPCA will continue with robust advocacy to protect recent FY16-FY17 Budget commitments to primary care residency and will continue working with CMA, CAFP, and OSHPD on implementation.

- **PRIORITY 5:** LOAN REPAYMENT
  Building off of AB 2048, County Medical Services Program (CMSP) Governing Board's loan repayment funding commitment, and the public/private loan forgiveness research project, CPCA will continue to evolve its loan repayment technical support and policy efforts. We will also continue our close work with NACHC on HRSA's Shortage Designation Modernization Project.

- **PRIORITY 6:** MEDICAL SCHOOLS
  CPCA will continue to explore collaborative opportunities with Kaiser Permanente School of Medicine (KP SOM) and the University of California Office of the President and Schools of Medicine.

- **PRIORITY 7:** ADVOCACY
  Working with NACHC, ACU, and AATHC, CPCA will pursue aggressive advocacy to support federally funded and administered workforce programs that are key to California's FQHCs. CPCA will continue to develop relationships with Medical Board of California and Board of Registered Nursing to guarantee timely licensure.

- **PRIORITY 8:** MULTI-YEAR STRATEGIC PLAN
  CPCA will host a workforce policy convening, *Healthcare Workforce Convening: A Pathway to Building a Long-Term Primary Care Strategy*, on March 13-14, 2017. This event will serve as a launching point for a multi-year strategic plan.

- **PRIORITY 9:** PAYMENT REFORM AND TEAM-BASED CARE
  Payment Reform and CP3 will continue to drive new approaches to team-based care.

2017: Workforce Committee Year-in-Review

- **PRIORITY 1:** PUBLIC AWARENESS
- ✓ **KEY ACTIVITY:** CPCA staff developed a CaliforniaHealh+ Workforce Video to assist with workforce recruitment and retention efforts.

- **PRIORITY 2:** DOCUMENTATION AND COMMUNICATION
- ✓ **KEY ACTIVITY:** UCSF Healthforce Center released two of three primary care workforce reports – *California's Primary Care Workforce: Current Supply, Characteristics, and Pipeline of Trainees* (February 2017), and *Forecast of Primary Care Workforce in California for years 2021 and 2026* (July 2017). CPCA partnered with the California Health Care Foundation and UCSF Healthforce Center to develop a robust behavioral health care workforce analysis (final report expected in 2018). CPCA partnered with Gallagher Integrated to participate in the national 2017 Gallagher Integrated Physician Compensation and Production Survey. In addition, nearly 140 health centers participated in the 2017 CPCA Compensation and Benefits Survey, making it a record year for this project.

- **PRIORITY 3:** PARTNERSHIPS
- ✓ **KEY ACTIVITY:** As part of a new partnership agreement, CPCA worked closely with the California AHEC to develop the FY2017 AHEC Funding Opportunity application and new CA AHEC Strategic Plan. CPCA also held a multi-part training with Vision y Compromiso and other partners to help increase Community Health Worker engagement in care teams. CPCA continues to expand its relationship with the California Community Colleges, Board of Registered Nursing, Medical Board of California, UC Davis Center for a Diverse Healthcare Workforce, and the Association of Clinicians for the Underserved (ACU).

- **PRIORITY 4:** RESIDENCIES AND TRAINING
- ✓ **KEY ACTIVITY:** In 2017, CPCA established the Residency Peer Network to create a peer to peer learning environment for residency directors and health center leaders considering residency program development. With three openings on the California Healthcare

Workforce Policy Commission (Song-Brown Commission), CPCA was successful in supporting the application and appointment of two health center leaders to the Commission. While fighting back a California FY17-18 budget proposal that threatened the $100 million secured in the FY 16-17 budget, CPCA, working with partners, participated in key funding and policy meetings of the commission to guarantee a smooth implementation of new funds. At the November 29-30, 2017 Commission meeting, all health center primary care residency program applicants received funding amounting to $7M or 20% of the available 2017 funds. While more work is needed to secure additional Song Brown funding and address application issues, this is a significant victory at a critical time.

- PRIORITY 5: LOAN REPAYMENT

✓ CPCA saw the smooth implementation of County Medical Service Program (CMSP) funded and OSHPD administered State Loan Repayment Program. CPCA, coordinating closely with NACHC and OSHPD, continued its work on the HRSA Shortage Designation Modernization Program. With funding from Kaiser Permanente Community Benefit, new research on public/private loan forgiveness programs was completed.

- PRIORITY 6: MEDICAL SCHOOLS

✓ CPCA continued work with the Kaiser Permanente School of Medicine to identify collaborative opportunities that create the next generation of primary care providers that are from and devoted to serving our communities.

- PRIORITY 7: ADVOCACY

✓ 2017 proved a critical year for primary care workforce funding advocacy. At the Federal level, health centers were forced to defend funding for the National Health Service Corp and Teaching Health Centers. After failing to meet at September 30th deadline, both programs continue with bare bones short-term funding. At the State level, the governor's proposed FY 17-18 budget eliminated the $100 million investment made in the FY 16-17 budget. Through a strong coalition, the signed FY 17-18 budget included the initial installment of $33 million.

- PRIORITY 8: MULTI-YEAR STRATEGIC PLAN

✓ In March 2017, CPCA hosted its first workforce policy convening, *Healthcare Workforce Convening: A Pathway to Building a Long-Term Primary Care Strategy*. With a strong interest among participants, CPCA went on to host a second (June) and third (November) meeting. In September 2017, the multi-foundation California Future Health Workforce Commission was launched. The commission compliments our Workforce Policy Convening work, and will draft a statewide blueprint to bolster the health workforce. Among the Commission participants are Dean Germano and Jane Garcia.

- PRIORITY 9: PAYMENT REFORM AND TEAM-BASED CARE

✓ Critical work continued to implement CP3 – CPCA's capitated payment preparedness program (*see Clinicians Committee for further details*).

2018: The Year Ahead

As we embark on the first full year of a new CPCA strategic plan that includes a goal dedicated to supporting the development of a strong health care workforce that is responsive to and reflective of California's diverse communities, CPCA plans to employ the following strategies to support primary care workforce:

- Goal #1: Foster beneficial and supportive pipeline partnerships to expand student outreach programs and increase the visibility of primary care workforce opportunities, especially in underserved areas.

- Goal #2: Develop programs and conduct advocacy efforts that support expansion and implementation of community-based training programs, residency programs and innovative GME models, and nurse practitioner and physician post-graduate programs. Additionally, partner with medical schools targeting diverse candidates committed to working in underserved areas.

- Goal #3: Explore state and federal legislative options around loan repayment and other private scholarships and grant opportunities that support loan repayment programs specific to practicing in underserved communities.

- Goal #4: Identify and remove regulatory barriers inhibiting primary care provider recruitment and provide training and resources to support recruitment efforts.

- Goal #5: Advance team-based care models, address physician burn-out issues, and advocate for policy and regulatory changes that support effective retention strategies.

- Goal #6: Network and build alliances with stakeholders, elected officials, health system employers, health plans, and consumer advocates, to engage in addressing health workforce disparities.

- Goal #7: Identify and analyze existing healthcare workforce information coming from partners and stakeholders needed to create shared advocacy messaging around building a diverse healthcare workforce, and to serve as a coordinating force between local, statewide, and national workforce efforts.

California Primary Care ASSOCIATION

INFORMATIONAL

Date: January 2, 2018

To: Workforce Committee

From: Nataly Diaz, Senior Program Coordinator

Re: Song Brown Commission Update

I. 2017 Funding Decisions

The 2017 primary care residency funding success highlights well the power of partnership and the capacity to accomplish meaningful goals by leveraging the strengths of the CaliforniaHealth+ Advocates and California Primary Care Association. The Song-Brown Healthcare Workforce Training Program received a $33M installment of new funds this year due to a strong coalition effort led by CaliforniaHealth+ Advocates, California Academy of Family Physicians, and the California Medical Association. CPCA conducted administrative advocacy at the November 28th – 29th Song Brown Commission meeting where funding decisions for the 2017 Family Medicine/Primary Care Residency applications were made.

We were happy to see that all of health center applicants were awarded funding by the Commission to support their existing and new primary care residency programs. Congratulations to:

- Shasta Community Health Center,
- Valley Health Team,
- North East Medical Services,
- Clinica Sierra Vista,
- SAC Health System,
- Family Health Centers of San Diego, and
- Borrego Health.

These community health centers are collectively bringing more than $7M or 20% of the available $35M Song Brown dollars in the 2017 application cycle to their communities for workforce development. This is a $6.4M or 956% increase in Song Brown funding for community health centers compared to the 2016 funding cycle. This great outcome was the result of strong collaborative advocacy from residency program directors, coalition partners, and CPCA.

II. Commission Funding- Procedural Challenges

Despite the tremendous awards and growth in funding community health centers received, there were procedural challenges with the overall process.

During the November 28th Song Brown Commission meeting, a decision was made to remove scoring criteria 2.2 on the "percent and number of graduates in primary care ambulatory settings five year

post residency." The Commission chose to eliminate this question with the argument that this data is hard to obtain and unreliable, despite applicants having already been scored. While this information from residency programs relies initially on attestation from applicants, it remains an important measure of a residency program's ability to achieve this important tenet of the Song Brown Program.

In addition, there were issues with the application's design that impeded some applicants from answering question 2.4 on training site payer mix. This important question measures and differentiates the degree to which training programs deliver publicly funded primary care and serve underserved patients. The application design was flawed and did not display the payer mix question for some programs based on their answers to previous questions. OSHPD staff noticed it prior to the November Commission meeting that a number of residency programs received a score of zero for the payer mix question based on their inability to fill out this information, but they did not perform an analysis or follow-up with those programs. Regardless of whether programs were given the opportunity to answer the question, all programs were scored against it. At least six program applications were affected, none with community health centers. Regardless, applicants should not be penalized for failure to complete a question that was not displayed to them.

Another major concern centered on the inconsistency of award disbursements, specifically within the New Program funding category. With $3.2M available, awardees were eligible to receive up to $800,000. The application stipulated that, for an awarded grant to be received, programs must currently possess or receive ACGME accreditation within one year. OSHPD staff's recommendation and the Commission's initial decision was to give full awards only to six out of ten applicant programs who were accredited, regardless of scoring. This decision negated the scoring criteria and superseded the agreement that a program did not have to be accredited at the point of application. In response to public comment, the Commission voted to reallocate unspent funds to award all ten new program applicants. In the end, they awarded $500,000 to each of the four unaccredited programs that initially were to receive no funds. This solution is problematic because it does not resolve the issue of programs with higher scores receiving $500,000 while programs with lower scores receiving $800,000 based on ACGME accreditation alone.

As a result of the procedural challenges, we are diligently working with our partners to share our concerns and recommendations with the OSHPD staff and Commissioners. After the November Commission meeting, CaliforniaHealth+ Advocates submitted a joint letter (link below) with the California Academy of Family Physicians and the California Medical Association with the following six recommendations:

- RECOMMENDATION #1: Correct the scores on this year's Existing Program applications by allowing all programs the opportunity to complete question 2.4 related to payer-mix.
- RECOMMENDATION #2: Restore the scoring criteria "Percent and number of graduates in primary care ambulatory settings five years post residency" in all future iterations of the application and add additional primary care measurement criteria.
- RECOMMENDATION #3: Ensure consistency in how New Program awards are disbursed, including the possibility of alternative funding disbursement strategies that ensure greater funding for programs most able to meet Song-Brown's goals.

- RECOMMENDATION #4: Significantly increase the grant size for PCR expansion slots in the next funding cycle to encourage more programs to apply.
- RECOMMENDATION #5: Include information about all applicants to the Song-Brown Program, regardless of the status of their application, in the publically-available meeting materials.
- RECOMMENDATION #6: Create a clear process for appeal that ensures applicants have adequate time in advance of the meeting to review scores and respond.

In response to CPCA's and stakeholder feedback, OSHPD staff convened a subgroup of Commissioners and stakeholders for a workgroup meeting on December 19, 2017. CPCA staff attended the Sacramento meeting and discussed ways to 1) measure graduates in primary care ambulatory settings five years post-residency, 2) address application challenges related to criterion on training site payer mix, and 3) develop Song Brown Program outcome metrics. CPCA staff continue to be engaged and will attend the upcoming January 10th Song Brown Commission meeting in Anaheim.

If you have any questions, feel free to contact Nataly Diaz at ndiaz@cpca.org.

Resources

- Joint Letter to the California Healthcare Workforce Policy Commission
- Joint Letter Regarding Song-Brown PCR Funding and Policies

California Primary Care Association

INFORMATIONAL

Date: January 2, 2018

To: Workforce Committee

From: Nataly Diaz, Senior Program Coordinator; Beth Malinowski, Deputy Director of Government Affairs; Val Sheehan, Development and External Relations Director; Christina Hicks, Deputy Director of Program Development and Evaluation; and Bao Xiong, Associate Director of Health Center Operations

Re: Workforce Strategic Plan Update

[redacted]

I. CPCA Workforce Strategic Plan Activities

- **Serving as Catalyst and Coordinator Between Local, Statewide, and National Workforce Efforts**

  - Workforce Policy Coalition

    CPCA successfully coordinated a third statewide Workforce Policy Coalition meeting in November 2017. As with the prior two meetings, participation consisted of members across multiple sectors and the meeting purpose was to discuss potential policy solutions for 2018. The Coalition successfully ended the year by jointly agreeing to prioritize three issues areas in 2018; residency redesign, equity in education (focused on college pipeline programs), and researching primary care specific tax incentive programs. Coalition members electronically self-selected into one of three workgroups that corresponded to each of the priority areas, and a series of workgroup calls were scheduled for January 2018 to further flesh out each potential policy solution.

  - California Future Health Workforce Commission

    The California Future Health Workforce Commission (Commission) convened for its second meeting on November 8, 2017 in Los Angeles. This meeting highlighted the role of technology in care and how technology can be better leveraged to address workforce shortages. Additionally, this session featured presentations on primary care and aging workforce. Carmela Castellano-Garcia, CEO of the California Primary Care Association, presented alongside Dustin Corcoran from the Leading the Way Coalition and Jennie Chin Hansen formerly with the American Geriatrics Society. Subcommittees on care for the aging, behavioral health as well as primary care and prevention have been formed and are diving into the details in these three critical areas. In addition to Jane Garcia and Dean Germano, Sara Gavin of CommuniCare joins the cadre of health center leaders adding their expertise through the subcommittee structure.

    The Technical Advisory Committee (TAC) to the Commission is scheduled to hold its next meeting on February 1, 2018. The Commission is also on track to consider preliminary recommendations in February 2018.

- Advancing Primary Care Provider and Staff Training
  - Federal Advocacy – THCGME Program

    The Continuing Resolution (CR) approved on December 21, 2017 includes limited funding for the Teaching Health Center Graduate Medical Education (THCGME) Program through March 31, 2018. This funding, along with the funding extensions of community health centers and NHSC, comes at the expense of the ACA Prevention and Public Health Fund. According to HRSA, the THCGME "patch" funding, at $15 million, is the minimum necessary to fund each program through March. This funding is not a restoration of original funding levels, is at a level significantly lower than the actual cost of residency training, and is half of the per resident amount (PRA) agreed to in an earlier 2017 House bill (the Champion Act). The instability created by the repeated short-term continuing resolutions that have been seen since September is beginning to have a devastating toll. This January, at least one THC will be closing, while other THCs are preparing to make difficult decisions regarding their ability to recruit a new class of residents. To date, with the stabilizing support of Song-Brown funding, no California THCs are among those preparing to close. We continue to partner closely with AATHC on full funding restoration and our partners remain hopeful that a restoration of PRA of at least $150,000 is an achievable goal in 2018.

  - 2017 Song Brown Family Medicine and Primary Care Residency Application

    The 2017 primary care residency funding success highlights well the power of partnership and the capacity to accomplish meaningful goals by leveraging the strengths of the CaliforniaHealth+ Advocates and California Primary Care Association. The Song-Brown Healthcare Workforce Training Program received a $33M installment of new funds this year due to a strong coalition effort led by CaliforniaHealth+ Advocates, California Academy of Family Physicians, and the California Medical Association. CPCA conducted administrative advocacy at the November 28th – 29th Song Brown Commission meeting where funding decisions for the 2017 Family Medicine/Primary Care Residency applications were made. We were happy to see that all of health center applicants were awarded funding by the Commission to support their existing and new primary care residency programs. Congratulations to Shasta Community Health Center, Valley Health Team, North East Medical Services, Clinica Sierra Vista, SAC Health System, Family Health Centers of San Diego, and Borrego Health! ***To learn more about recent Song Brown Advocacy, please see the Song Brown Commission Update Memo.***

  - CPCA Residency Peer Network

    If your health center currently trains residents or is interested in developing a new residency program, we invite you to join the CPCA Residency Peer Network. This group will continue to meet in 2018 via conference calls to:

    - Provide a peer to peer learning environment where residency directors and health center leaders can share successes and challenges, tools and resources, to improve, expand, or launch a teaching health center or other residency models

- Disseminate and discuss key policy and regulatory changes that impact graduate medical education and residency models
- Gauge trends on issues and solutions to be used to enhance the technical assistance and programmatic offerings of CPCA

Please email Nataly Diaz at ndiaz@cpca.org if you are interested in joining the distribution list and receiving call-in details. The 2018 schedule will be announced soon.

- Medical Assistant Webinar
  CPCA is partnering with the Medical Board of California to co-host a "Medical Assistants – Training, Supervision, and Scope of Practice" webinar in February 2018. This webinar will provide a review of California statutes, regulations, and scope of practice requirements for MAs. Registration details will be released soon.

- Promoting Community-Based Primary Care Workforce Visibility
  - UCSF Primary Care Workforce Research
    CPCA continues to work with UCSF's Healthforce Center on a series of primary care workforce reports funded by Kaiser Permanente Community Benefit. Report #1, *Overview of Primary Care Workforce in California Today*, a snapshot of California's primary care workforce, was published in Feb. 2017. Report #2, *Forecast of Primary Care Workforce in California for years 2021 and 2026*, a projection of primary care providers in the next decade, was released on August 15, 2017. Report #3, *Primary Care Workforce Strategies*, a look at promising practices from across the country, is in final draft form and an executive summary has been created. The report is expected to be released by January 2018. In anticipation of the release of the report, CPCA staff have developed a communications plan that includes a media statement, social media posts, a CEO message to the membership, and a communication to the State Legislature.

  - Behavioral Health Workforce Research
    CPCA partnered with the California Health Care Foundation and UCSF to develop a robust behavioral health care workforce report that will serve as a companion to Horizon 2030 and the UCSF primary care workforce report series. This report will compile and synthesize available data from multiple sources on the state's current behavioral health workforce and the current pipeline of trainees in behavioral health occupations. The report will also present projections of future supply and demand for behavioral health workers in California. The planned release for this report is spring 2018.

  - Clinic Leadership Institute (CLI) CLIP: Statewide Student Initiative Concept
    CPCA has identified the "cultivation of a robust community health center workforce," as a core component of its 2017-2020 strategic plan. Within this priority area, CPCA staff and leadership are committed to engaging students and building a stronger relationship with the institutions at the center of the primary care pipeline. Through greater engagement of California's health professions students, particularly students in institutions of higher learning, CPCA will foster a greater commitment to careers in community health.

Through CLI's Emerging Health Leaders Program, Beth Malinowski, Deputy Director of Government Affairs and CLI Cohort 10 participant, is aiming to lay the groundwork for a landmark CPCA student initiative. Beth's CLIP project will focus on the initial research needed to help engage students, trainees, community health center leaders and partners in education for the purposes of supporting CHC training efforts while fostering a greater student commitment to careers in community health. During this research phase, key stakeholder interviews, focus groups, and surveys will be utilized to design the student initiative. To date, over a dozen partners, health center leaders, and trainees have been engaged through interviews and focus groups. Additionally, over thirty health centers also participated in a brief survey. Research results and an initial program concept for a statewide interdisciplinary student initiative will be shared with this Committee.

- Community Health Center Workforce Evaluation
  California's regional clinic consortia and the California Primary Care Association (CPCA), under the leadership of RAC and the CPCA Workforce Committee, are working with the University of California, Davis (UCD) to conduct a second community clinic and health center workforce evaluation to understand workforce priorities, staffing needs, health professions training, and retention/recruitment challenges in California community health centers. This workforce evaluation will utilize a mixed method approach to obtain a better understanding of CHC workforce priorities, needs, and challenges. Consortia and UCD Center for a Diverse Healthcare Workforce (CDHW) staff will conduct qualitative interviews in the coming months with various community health center leaders located in urban and rural medically underserved areas.

- Growing and Diversifying the Health Professions
  - California Community Colleges
    The California Community Colleges are looking for skilled community health center Medical Assistants to participate in a Medical Assistant job analysis process that will examine the occupation and identify the knowledge and skills required of successful workers. This is part of a larger effort to bring together both education and industry attendees to evaluate Medical Assistant training needs and curriculum development. The meeting time/date will be scheduled upon recruitment of MAs across the state. If you know someone who can significantly contribute to this partnership or have any questions, please contact Nataly Diaz at ndiaz@cpca.org.

  - UCD Center for a Diverse Healthcare Workforce
    CPCA is actively working with the UCD's CDHW to develop innovative programs with UCSD and community health centers. More specifically, we are evaluating ways to recruit and mentor students from local underserved communities into health care careers. Preliminary conversations include the potential development of a Community of Practice (COP), which will consider ways to endorse students that are community health center leaders and interested in pursuing careers in medicine. We are also in particular exploring opportunities that focus on rural, remote and underserved communities.

  - Kaiser Permanente School of Medicine

CPCA continues to work with the Kaiser Permanente School of Medicine (KP SOM) to develop their new medical school. As a part of these important conversations, CPCA emphasizes the importance of training medical students in the community and working as a care team. The KP SOM is still undergoing accreditation, but will meet with CPCA and health center consortium leadership in the coming months.

- Area Health Education Centers (AHEC)
  CPCA attended the 2017 CA AHEC Strategic Planning meeting alongside HRSA, academic partners, and regional consortia to help inform and develop the new CA AHEC strategic plan. Staff contributed to discussions on ways the CA AHEC Program can address emerging needs in medical education and other health professions education; implement the federally mandated multidisciplinary statewide AHEC Scholars Program; and better identify and report outcomes. CPCA continues to have monthly calls with the state CA AHEC leadership.

- Health Careers Connection
  Once again, CPCA is partnering with Jeff Oxendine and his team at the Health Careers Connection (HCC) program in Berkeley to help place interns with community health centers across the state. The HCC program connects organizations in all health sectors with talented and diverse future health professionals and leaders. Their goal is to inspire and empower interns and alumni with real world exposure, experience, mentoring and networking that assists them in achieving their goals, while supporting host organizations to meet their workforce, diversity, community health and other priority goals.

  CPCA will be sending out more information to all members later this month, and will also host at least one intern in the Association's office over the summer.

- Expanding Recruitment Support
  - Federal Advocacy – National Health Service Corp Program
    The Continuing Resolution (CR) approved on December 21, 2017 includes limited funding for the National Health Service Corps through March 31, 2018. This funding, along with the funding extensions of community health centers and THCGME program, comes at the expense of the ACA Prevention and Public Health Fund. NHSC is only slated to receive $65 million, which creates large instability for the recruitment and retention of critical providers.

  - Steve M. Thompson Physician Corps Loan Repayment Program
    Applications for the Steve Thompson Physician Corps Loan Repayment Program are now open through January 31st. Allopathic or osteopathic physicians who are employed at community health center are eligible to apply. The program repays up to $105,000 in educational loans in exchange for full-time service for a minimum of three years.

- Reducing Recruitment Barriers Associated with Primary Care Providers
  - Association of Clinicians for the Underserved (ACU)
    The STAR² Center (Solutions, Training, and Assistance for Recruitment and Retention), a workforce project of the Association of Clinicians for the Underserved (ACU), released

updated individual health center recruitment and retention Data Profiles to each health center CEO in November 2017. These Data Profiles form the base of the STAR² Center's resource building, training, and technical assistance (TA) efforts by highlighting individual health center strengths and weaknesses, as well as national health center trends in recruitment and retention. Health center staff are encouraged to review their updated Data Profiles with their workforce teams, visit the STAR² Center website for useful resources and training information, and contact STAR² Center staff to discuss their workforce challenges and schedule TA.

In addition, applications are now being accepted for the STAR² Center 2018 Retention Academy. A cohort of 25-30 health center c-suite and management staff will convene for 30 minutes a week from February to April in a mix of webinars, office hours, and assignments to understand and implement organizational strategies to reduce clinician burnout. Please see the resources section below for an application link; applications are due by January 17, 2018!

- CPCA Human Resources Peer Network
  The CPCA HR Peer Network provides a place where HR staff can raise questions with their peers, share individual approaches to employee issues, and disseminate best practices. This group's conference calls moved to a quarterly schedule, with the first meeting scheduled for February 15th at 9am. If you are interested in joining the HR Peer Network, please contact Nataly Diaz at ndiaz@cpca.org.

- Supporting Effective Retention Strategies
  - Physician Compensation Webinars
    CPCA is collaborating with Gallagher Integrated to conduct a webinar series exploring compensation model design, sharing best practices, and discussing legal and regulatory considerations related to physician compensation arrangements. The series is designed to increase knowledge on designing compensation plans and strategies that fairly compensate providers, comply with legal requirements, and align with the mission and culture of community health centers. The webinar series is tentatively scheduled for spring 2018.

II. Resources

- November 28 and 29 Song-Brown Meeting Overview
- Community Health Center Workforce Evaluation
- Steve Thompson Physician Loan Repayment Program
- STAR² Center 2018 Retention Academy
- Health Careers Connection Program

330 Committee

January 18, 2018
1:00 p.m. – 2:00 p.m.
Louise McCarthy, Chair

Agenda

ORDER OF BUSINESS		RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I.	Call to Order		Louise McCarthy	A
II.	Approval of Agenda	• Executive Summary	Louise McCarthy	A
III.	Approval of Minutes	• October 2017	Louise McCarthy	A
IV.	Year in Review	• Memo: Review 2017 Successes/Challenges	Andie Patterson	D
V.	Payment Reform	• Memo: Status Update	Andie Patterson	D
VI.	DHCS Update	• Memo: DHCS - Medicaid State Plan Amendment, MEI, and Mobile Clinics	Ginger Smith	D
VII.	Acupuncture	• Memo: New Benefit	Meaghan McCamman	D
VIII.	Pay-for-Performance	• Memo: Status Update	Meaghan McCamman	D
IX.	A&I Challenges – Progress Update	• Draft Training Proposal to DHCS	Andie Patterson Ginger Smith	D
X.	Legal Update: Retrospective Dental Claims Litigation	• Memo: Legal Update	Andie Patterson	I
XI.	Adjourn		Louise McCarthy	A

California Primary Care Association

Executive Summary

Date: January 4, 2018
To: 330 Committee
From: Andie Patterson, Director of Government Affairs

MEMORANDUM

Payment Reform

- In November CPCA received a legal analysis from Feldesman Tucker Leifer Fidell (FTLF) and per the analysis staff do not recommend moving forward with the APM in an 1115 Waiver at this time.
- CPCA remains committed to the APM and payment reform, and we intend to continue developing an alternative proposal where the SPA is the vehicle for the APM.
- A meeting with a subset of health plans is already scheduled for February 2018 to begin discussions about a model where both risk and a SPA are utilized.

DHCS Update

- CPCA has concluded conversations and negotiations with DHCS on their proposed SPA changes with productivity standards, a 90-day requirement for the initial rate setting application, and the Change in Scope of Service Request.
- CPCA and DHCS will begin discussing the "Four Walls" issue next.
- DHCS' new goal is to submit their proposed SPA language to CMS for all issue areas by March 31, 2018.
- CMS released two separate transmittals for the annual rate increase; one referenced the Medicare Economic Index (MEI) of 1.2% for RHCs and the other referenced a Market Basket Rate of 1.8% for FQHCs paid a Medicare PPS.
- According to DHCS, the SPA and W&I Code does not reference the Market Basket Rate, therefore, will not drive the MEI annual rate increase.
- CPCA is exploring whether or not the Market Basket Rate should apply to Medi-Cal PPS rates and if so, would it require a change in the law.
- After a legal review of the W&I Code and SPA by DHCS, they have concluded that mobile units are prohibited from having an individual PPS rate. Mobile units, intermittent or licensed, are reimbursed at the PPS rate of an affiliated (parent) location.

Acupuncture

- DHCS has confirmed that acupuncture services provided by a licensed acupuncturist have been added to the FQHC visit definition in the State Medicaid Plan.
- No public notice has been issued on this change, nor has the provider manual been updated.
- A series of questions have been submitted to DHCS and a FAQ will be shared with members soon.

P4P

- CPCA has begun to work with health plans and health centers to share the 'FQHC incentive best practices' developed by the P4P workgroup
- CPCA has developed an array of easy-to-digest materials that we, RAC, and health centers can use to evaluate P4P programs and provide technical assistance to plans
- We continue efforts to ensure that every health center and every health plan have the information they need to implement the P4P best practices.

A&I Challenges – Progress Update

- CPCA staff have met with DHCS about the issues raised and how to resolve the challenges.
- DHCS has suggested we develop a training curriculum.
- A draft training curriculum has been shared with DHCS and efforts to build the curricula will soon be underway, with a training for CFOs and auditors hopefully mid 2018.

Legal Update: Retrospective Dental Claims Litigation

- We are waiting for the court to send us a notice setting a date for oral argument, which will likely be in early 2018.

CALIFORNIA PRIMARY CARE ASSOCIATION

330 COMMITTEE
October 10, 2017
9:00am – 10:00am

Members: Corinne Sanchez – Chair, Robin Affrime, Linda Costa, Doreen Bradshaw, Cynthia Carmona, Reymundo Espinoza, Susie Foster, Timothy Fraser, Cathy Frey, Jane Garcia, Greg Garrett, Dean Germano, Franklin Gonzalez, Nik Gupta, Steve Heath, Cathryn Hyde, Tina Jagtiani, Dave Jones, Constance Kirk, Deena Lahn, Becky Lee, Deborah Lerner, Marty Lynch, Jyl Marden, Margaret Martinez, Kevin Mattson, Louise McCarthy, Scott McFarland, Nichole Mosqueda, Danielle Myers, Christine Noguera, Jennifer Polzin, Joanne Preece, Tim Pusateri, Tracy Ream, Tim Rine, Corinne Sanchez, Paulo Soares, Terri Lee Stratton, Vernita Todd, Christina Velasco, Richard Veloz, David Vliet, Tony Weber

Guests: Sergio Bautista, Deanna Stover, Anitha Mullangi, Berenice Nunez Constant, Chi Tran, Melissa Eldman, Jessica Prechtl, Mary-Michal Rawling, Jazmin Diego, Misty Sherbundy

Staff: Carmela Castellano-Garcia, Andie Patterson, Daisy Po'oi, Meaghan McCamman, Ginger Smith, Mike Witte, Victor Christy, Elizabeth Oseguera, Val Sheehan, Cindy Keltner, Andrea Chavez, Michael Helmick

I. Call to Order
Corinne Sanchez, Committee Chair, called the meeting to order at 2:09pm.

II. Approval of Agenda
A motion was made to approve the agenda as presented. **The motion carried. (L. McCarthy, T. Rine)**

III. Approval of Minutes
A motion was made to approve the minutes of July 13, 2017. **The motion carried. (L. McCarthy, D. Myers)**

IV. Payment Reform
CPCA and CAPH met with DHCS staff Jennifer Kent, DHCS Director, Mari Cantwell, Medi-Cal Director, Lindy Harrington, Deputy Director, and Ryan Witz, Deputy Director in mid-September to discuss the alternative payment methodology (APM) approved by the Governor in October 2015. CMS will only approve the APM through an 1115 Waiver and DHCS wants to do the Waiver or move on from the effort. CPCA shared our strong reservations and concerns with waivers, but let DHCS know that, to ensure our due diligence, we have engaged legal counsel (Feldesman Tucker Liefer) to fully understand the risks and opportunities of pursuing an APM in a waiver. CPCA has already communicated to members however that we are not interested in pursuing a Waiver at this point in time, but will continue to explore and develop an APM that can be approved through a SPA that still contains risk.

V. Pay-for-Performance
CPCA formed a small workgroup to develop a series of principles around FQHC exclusion of P4P incentive revenue from the reconciliation process. The principles were vetted by CPCA's board and external partners. The workgroup recommends that CPCA undertake an effort to educate CCHCs and health plans on the principles and share best practices for successful FQHC P4P programs in Medi-Cal managed care.

A motion was made and seconded for CPCA staff to work with clinics, health plans, and IHA to ensure that all P4P programs around the state implement the best practices outlined in the P4P paper. Once best practices are implemented, the Committee will meet again to consider working with the state to promulgate guidance around FQHC P4P. **The motion carried. (K. Mattson, B. Guerrero)**

VI. Proposed State Plan Amendment
DHCS' goal is to submit their proposed SPA changes to CMS on productivity standards, 90-day requirement,

Change in Scope of Service Request (CSOSR), and MFTs by the end of 2017. DHCS provided CPCA with their proposed SPA language on productivity standards and the 90-day requirement and in turn, CPCA had a legal review conducted. Proposed edits from the legal review were given to DHCS. Once updated language is available, CPCA will review it with members.

VII. A&I Challenges – Progress Update

CPCA has been working with a small workgroup of CFOs and consultants to develop a strategy. A survey of the problem has been completed and the next step is engaging the Department in a discussion about what the "rules" are so that both CFOs and auditors use the same ones. The workgroup has crafted a draft set of rules and standards to commence the discussion with DHCS.

VIII. DHCS Update

A&I has adopted an unwritten policy only allowing a FQHC to use EHR as the qualifying event on a one-time basis. DHCS also takes the position that only an EDR separate from the EHR system may be used as a qualifying event for a separate CSOSR. CPCA will discuss the implementation of EHR and EDR as a qualifying event during upcoming conversations with DHCS on their proposed SPA changes with the CSOSR. The most important key point when contracting with a private dentist is that a patient must be an established patient of the FQHC and the FQHC refers the patient to the private dentist. The MEI effective on October 1, 2017 is 1.8%. The MEI rate increase is tentatively scheduled to be implemented in November.

IX. HRSA Notes

CPCA staff and board members met with Jim Macrae and other staff from the Bureau of Primary Health Care during the NACHC Community Health Institute conference in August. Jim shared insights on the new priorities of the Trump Administration and their planning for the fiscal cliff. There is a big push on relaxing regulatory requirements, and a desire to increase accountability. Jim wants all of the health centers to have a training program of some kind.

X. Prop 56

The Budget Act of 2017 included an agreement on a spending plan for the Proposition 56, California Healthcare, Research and Prevention Tobacco Tax Act of 2016. FQHCs will be eligible for the supplemental payments for FPACT services. FQHCs will not be eligible for any other supplemental payments, including Medi-Cal and/or Denti-Cal fee-for-service or managed care supplemental payments.

XI. Legal Update: Retrospective Dental Claims Litigation

On August 31, 2017, the State requested a third extension of time, which we opposed. The Court granted the State's request for an extension of time on September 5, 2017. A date for oral argument will likely be in early 2018. After the case is "submitted the court will have 90 days to decide the appeal.

XII. Emergency Preparedness Final Rule

On September 8, 2016 the Federal Register posted the final rule Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers. In an effort to assist FQHCs, FQHC Look-alikes, and RHCs become compliant with the rule, CPCA has created and disseminated a multitude of resources, training opportunities, and technical assistance over the past 18 months.

XII. Adjourn

The meeting was adjourned at 3:30pm.

Respectfully submitted,

Daisy Po'oi
Meeting Minutes Recorder

INFORMATIONAL

Date: January 5, 2018
To: 330 Committee
From: Andie Patterson, Director of Government Affair
Re: 2017 Year in Review

MEMORANDUM

2017: The Year Ahead (projected from 2016) – *What we projected*

SPA/PPS

- A detailed negotiation with the Department on their proposed changes to PPS.

APM

- CPCA predicts that the APM will be approved by CMS but the timeline for launch will be delayed due to the transition between administrations, thereby setting launch in 2018.
- CPCA and our actuarial firm Optumas will negotiate parameters for rate setting.
- Additional analysis on the CPT codes will need to be done, and its likely we will have to use a different coding set for services we want to deliver but are not captured with CPT codes.
- The delay will benefit health centers in cleaning up processes with their managed care plans.

DHCS

- CPCA will pursue all avenues to ensure the proposed changes to FQHC PPS billing in the forthcoming SPA are advantageous or neutral to health centers.
- CPCA will continue working with DHCS to ensure the method of adding MFTs and DHs as FQHC/RHC billable providers is implemented properly.
- CPCA will continue meeting with DHCS as appropriate to address and resolve challenges experienced by health centers.

Behavioral Health

- CCHCs in the Continuum of BH – CPCA will continue working with DHCS and the legislature to ensure that FQHCs have a streamlined and well understood process to participating in the Drug Medi-Cal and county-based specialty mental health programs. We expect to sponsor legislation around this effort in 2017.
- Growing CCHC/County Partnerships – CPCA and the County Behavioral Health Directors Association (CBHDA) are partnering with the Blue Shield of California Foundation and California Health Care Foundation to develop a plan for increasing FQHC and county partnerships around behavioral health. Our first meeting of this new partnership takes place January 20, and we hope to co-publish our toolkit, "Models of Partnership: Counties and Federally Qualified Health Centers Improving Patient Access to Specialty Mental Health and Substance Use Disorder Treatment" in early 2017.

- No Place Like Home – CPCA is working with Housing and Community Development to ensure that the NPLH funds are used on housing projects that explicitly include a linkage to primary care. We will monitor the statewide RFP process and then monitor local efforts once the funds have been awarded.
- Stemming the Opioid Epidemic – CPCA will continue working with DHCS and CHCF on the development of tools and education for providers to screen patients and refer them to treatment, and will continue pushing to expand access to MAT services at FQHCs.

Legal

- With steadfast work, we will settle the dental retrospective claims litigation. If we are unable to resolve the case, the appeal will be heard later in the year, possibly summer or fall.
- Rate setting issues due to multiple causes dominate conflicts between CHCs and the states. We may see an increase in administrative hearings and possible court action.

2017: 330 Committee Year-in-Review = *What happened*

- **SPA/PPS**
  - Worked productively with DHCS/ A&I on Productivity Standards, 90 Day Rule, and Change in Scope.
  - Met with members at times every two weeks, but at least monthly to review the conversations and proposals from DHCS.
  - Actively secured and shared feedback from members which ultimately influenced all the final decisions.
  - Productivity Standards moved from 4200 (physicians)/ 2100 (mid-levels) to 3200 (physicians) / 2600 (mid-levels) and now includes a more formalized process to secure a waiver from the standards.
  - Successful in removing DHCS' proposed change of a 3-year period to complete a Change in Scope audit and making an adjustment to every health center's PPS rate based on the most recent audited home office allocations, regardless if every health center was under audit.
- **Payment Reform**
  - CPCA and DHCS actively lobbied CMS to approve the APM through a SPA, which included a formal letter from CPCA to CMS about why the APM was legally permissible through a SPA, as well as a meeting with CMS Region IX in San Francisco.
  - CMS concluded, and DHCS accepted, that an 1115 Waiver would have to be used to implement the APM.
  - CPCA sought legal counsel on the implications of implementing an APM through an 1115 Waiver.
  - CPCA informed DHCS that we were not comfortable using an 1115 Waiver to implement the APM and commenced discussions with health plans to find a different approach to implement a capitated APM using a SPA but that still includes the risk DHCS wants.

- **P4P**
    - After a county FQHC lost an appeal before the California Department of Health Care Services relating to whether their P4P incentive payments were properly excluded from their Medi-Cal PPS reconciliation, CPCA and members began actively discussing P4P arrangements and rules.
    - A small workgroup was formed to develop a plan of action for CPCA to assist FQHCs across the state
    - In consultation with legal counsel, health plans, and IHA, CPCA with member input developed a set of best practices for P4P arrangements that will be conveyed and discussed with all FQHCs.
- **PPS/DHCS Issues**
    - CPCA successfully challenged and effectively stopped DHCS' attempt to enact a policy change to how inpatient billing can be done by FQHC/RHCs.
    - After a large discussion about A&I policies and practices at the CPCA CFO Conference in March, CPCA created a small workgroup to help inform a strategy to rectify the issues. Per the small workgroup, CPCA conducted a survey of all FQHC CFOs regarding their frustrations and challenges with A&I. The survey results essentially concluded that A&I auditors appear to be operating under a different set of rules or understanding of the rules with rate setting, and hence the workgroup developed a paper outlining the rules as FQHC CFOs understand them. The survey findings and paper were shared with DHCS to commence a discussion and DHCS has agreed to build a joint training for A&I auditors and FQHC CFOs in 2018 so that the rules are understood and followed the same way for both sides.
- **Legal**
    - The dental retrospective claims litigation continued with appeal after appeal, hopefully to be resolved in 2018.

2018: 330 Committee *= What we predict*

- **SPA/PPS**
    - Will continue working with DHCS/ A&I through March to resolve any outstanding ambiguity on 4 walls, Administrative / Executive Compensation Caps, and 3 comparable clinic rate setting, all three issues brought forward by the state in the initial SPA notice in December 2016.
    - Final SPA will be submitted that is fair to FQHCs at the end of March and will be effective beginning July 2018.
- **Payment Reform**
    - CPCA will work at first with a subset of health plans to identify manners by which capitation with risk could work if implemented through a SPA.
    - The wrap cap workgroup will vet ideas that are generated with the smaller set of plans and ultimately CPCA will take a more refined set of strategies to a larger body of health plans to discuss how to forward an APM in 2019.

    - CPCA and health plans in partnership will pitch the new idea to the new administration in late 2018.
- **P4P**
    - CPCA staff will communicate the P4P best practices and strategy to all FQHCs in California.
    - Health centers will discuss their personal P4P arrangements with health plans and make changes to conform to the best practices.
- **PPS/DHCS Issues**
    - CPCA and DHCS will agree on a training for A&I auditors and FQHC CFOs.
    - The training will be conducted in 2018.
    - Challenges during individual audits and rate settings will decline significantly after the training.
- **Legal**
    - The dental retrospective claims litigation will finally be resolved and health centers will get some of their deserved money for services provided back.

California Primary Care ASSOCIATION

DISCUSSION

Date: January 10, 2018

To: 330 Committee

From: Andie Patterson, Director Government Affairs

Re: Status of Payment Reform Work

MEMORANDUM

Background: APM Status

In mid-September, CPCA and CAPH met with DHCS staff Jennifer Kent, DHCS Director, Mari Cantwell, Medi-Cal Director, Lindy Harrington, Deputy Director, and Ryan Witz, Deputy Director to discuss the alternative payment methodology (APM) approved by the Governor in October 2015. DHCS made clear that a decision had to be made as to whether or not to implement the APM, and to do so in the manner communicated by CMS- using an 1115 Waiver. During the meeting, CPCA and CAPH conveyed our reservations about 1115 Waivers and our preference to use a State Plan Amendment (SPA) for the APM, however, committed to doing a legal analysis of an APM in an 1115 Waiver to be sure of our position.

In November CPCA received the legal analysis from Feldesman Tucker Leifer Fidell (FTLF) and per the analysis staff do not recommend moving forward with the APM in an 1115 Waiver at this time. This message has been communicated to DHCS.

Legal Analysis: APM and 1115 Waiver

CPCA contracted with the legal counsel of FTLF, specifically working with Adam Falcone, to answer the questions about the risks and opportunities of using an APM in an 1115 Waiver. The analysis and research took the legal team two months to complete. Ultimately the conclusion is one we were expecting- APM's should be implemented through a SPA to protect FQHCs in full.

1115 Waivers can be done in isolation or in conjunction with a State Plan Amendment. Depending on the construction there are ways to minimize the gradations of risk in an 1115 Waiver, however risk is always there. One central risk is how amendments or changes can be done. If an 1115 Waiver were utilized to implement a portion of the APM, the state could later amend or expand the Waiver without public input. The standard terms and conditions written to accompany the provision of the APM could include a requirement for public input, but its not statutorily required for amendments. CMS would then have sole authority to approve changes to aspects of the Wavier being amended. This could lead to, according to FTLF, unfavorable ways to broaden the scope of the 1115 Waiver, and potentially erode FQHC payment protections. Without any protections in the Waiver and if not using the SPA at all, there is a chance, according to FTLF, that the statutory payment protections otherwise available to every FQHC in California would be jeopardized.

Next Steps

CPCA remains committed to the APM and payment reform, and we intend to continue developing an alternative proposal where the SPA is the vehicle for the APM.

We have discussed the situation with a subset of the health plans and have asked that they engage with us in planning for how to advance payment reform with FQHCs but that would be done through a state plan amendment. The small group being engaged up front includes Partnership, HealthNet and LA Care.

One idea we have suggested exploring is the one mentioned in October, excerpted below:

> *Today, health centers can enter into contractual arrangements with managed care plans or third party payers to receive "incentives" should they meet certain criteria or objectives. We often refer to these as P4P or pay for performance. These incentives are held outside of reconciliation. While never done, health centers could also voluntarily enter into contractual relationships with managed care plans where they agree to take risk if they do not meet certain criteria. This risk would also be held outside of reconciliation.*
>
> *The new idea we briefly discussed with the Wrap Cap WG and DHCS was for the CA APM to be amended to remove the risk triggers and be implemented through a State Plan Amendment. If we did this, and visits from base year went up for the FQHC, at the end of the year the state and the plans would make the health center "whole." To meet the state's objectives for risk or "having skin in the game" the health center would take on risk with the plans. In this model, if we crafted it so that health centers were penalized for visits going up (as it is in the APM currently) then the health center would pay back the managed care plan. Ultimately we believe the state, who pays the plans, could make up for their additional costs of making the health center whole by figuring subtracting the cost from the next rate with the plan.*

When we pitched this idea to DHCS in the fall, DHCS indicated they were not interested. We continued to believe, however, that an alternative model has appeal for the health plans and may be interesting to a new administration post the 2018 elections.

The Wrap Cap WG will be instrumental in shaping any and all proposals. The chair, Marty Lynch, will be engaged in all the initial plan meetings and in further engaging with the members and all the plans across the state.

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MEMORANDUM

TO: Andie Martinez Patterson, Director of Government Affairs
California Primary Care Association

FROM: Adam J. Falcone, Esq.

DATE: January 4, 2018

RE: Implementation of SB 147 under a Section 1115 Waiver

Please find attached a summary of the key points from the confidential and privileged memorandum on this topic that you may share with external stakeholders.

IMPLEMENTATION OF SB 147 UNDER A SECTION 1115 WAIVER

Summary of Legal Opinion[1]

- Implementation of SB 147 would require a waiver of federal law because its proposed payment methodology is not consistent with the statutory requirement that any Alternative Payment Methodology (APM) result in payment of an amount at least equal to the amount required under the Prospective Payment System (PPS) methodology.[2]
- Even under the narrowest formulation of an 1115 Waiver necessary to implement SB 147's payment methodology, CMS would need to waive PPS protections in order to permit California to offer FQHCs, on a voluntarily basis, participation in an APM that eliminates supplemental payments and does not ensure that FQHCs receive their full PPS reimbursement rate for each visit.[3]
- Under federal law, California could later amend its approved 1115 Waiver, modifying the payment methodology in ways unfavorable to FQHCs (e.g., reducing the capitation rates), or depending upon which federal laws had been waived, broadening the 1115 Waiver (e.g., requiring all FQHCs to participate in the payment methodology).[4]
    - Although legal protections could be incorporated into the Standard Terms and Conditions (STCs) of any 1115 Waiver, FQHCs would be wholly reliant on government actors to enforce those protections, lacking any independent rights to enforce STCs.

[1] Two critical points were acknowledged at the outset of the legal opinion: (1) Any proposed waiver of FQHC payment rights set forth in Section 1902(bb) of the Social Security Act under an 1115 Waiver would be vulnerable to legal challenge; and (2) SB 147 explicitly forbids California from seeking a waiver of the statutory APM requirements, and in fact, requires implementation of an APM consistent with federal statutory requirements.

[2] Pursuant to federal law, the PPS methodology requires, in states administering managed care programs, a supplemental payment for each visit in which the PPS amount exceeds the amount received by the FQHC under its contract with an MCO. Even if an FQHC were to prospectively attest that its capitation rate was equivalent to PPS, that attestation would not abrogate a state's legal obligation to make supplemental payments, as those statutory requirements have been interpreted by CMS. *See* CMS, State Health Official Letter #16-006, FQHC and RHC Supplemental Payment Requirements and FQHC, RHC, and FBC Network Sufficiency under Medicaid and CHIP Managed Care, at 2-3 (Apr. 26, 2016).

[3] SB 147's payment methodology related to downside risk accounts for the possibility that actual utilization could exceed projections upon which an FQHC's capitation rate had been based, resulting in payment of less than the FQHC's PPS reimbursement rate for an encounter.

[4] CMS could approve amendments to an 1115 Waiver without obtaining meaningful public notice and comment; amendments to an 1115 Waiver are not subject to the Transparency Regulations. *See* Medicaid Program; Review and Approval Process for Section 1115 Demonstrations, 77 Fed. Reg. 11,678, at 11,690 (Feb. 27, 2012).

INFORMATIONAL

Date: January 3, 2018

To: 330 Committee

From: Ginger Smith, Director of Health Center Operations

Re: DHCS - Medicaid State Plan Amendment, MEI, and Mobile Clinics

MEMORANDUM

I. Background

The Department of Health Care Services (DHCS) is proposing changes to the *Prospective Payment Reimbursement* section of the California Medicaid State Plan. CPCA, along with the California Association of Public Hospitals (CAPH), are meeting with DHCS bi-weekly and sharing and securing input from members after each meeting with DHCS, and then taking back any feedback to DHCS. DHCS has committed to working collaboratively with CPCA until we get through the proposed changes. Although most of our meetings with DHCS focus primarily on the proposed changes to the California Medicaid State Plan, we use the meetings to address other topics as well.

II. Issues

State Plan Amendment (SPA)

CPCA has concluded conversations and negotiations with DHCS on productivity standards, 90-day requirement for the initial rate setting application, and the Change in Scope of Service Request (CSOSR). After a legal review of their proposed language for productivity standards and 90-day requirement, CPCA submitted edits for DHCS' consideration. We are still waiting for the final proposed language on productivity standards and the 90-day requirement.

DHCS continues to work on their draft proposed language of the CSOSR for our review. The language will include:

- Clarifying definitions for type, intensity, duration, and amount of service.
- Adding an additional practitioner to an existing line of service will not be considered for a CSOSR (does not include additional practitioners due to facility expansion or adding a new specialist for the first time).
- A full 12-months of activity before a CSOSR can be filed.
    - CPCA was successful in getting a retro effective date as part of this change. The effective date of the CSOSR will be retro to the first day of the 12-months of activity.
- Productivity standards will be applied.
- Clarifying language for EHR/EDR as a CSOSR event – using as sole reason for triggering event once and then afterwards all CSOSR criteria must be met.
- Expanded language that clarifies the 2.5% threshold for a deleted service or square footage area of a facility.

CPCA was successful in getting DHCS to remove their proposals of a 3-year period to complete a CSOSR audit and adjustment to every health center's PPS rate based on the most recent audited home office allocations, regardless if every health center was under audit.

In early 2018, CPCA and DHCS will begin discussing the "Four Walls" issue. "Four Walls" is shorthand for where the PPS can be billed. PPS can be billed inside the four walls of a health center, but there is ambiguity around when/if a FQHC may bill for FQHC services provided to Medi-Cal beneficiaries *outside* of the four-walls of a FQHC site. The impetus to why this issue is part of the negotiations, according to DHCS, they believe the statute is being interpreted in different ways and it is necessary to add clarity to ensure the rules are understood and followed appropriately by both the state and health centers.

DHCS' new goal is to submit their proposed SPA language to CMS for all issue areas by March 31, 2018. This would ensure an effective date of April 1, 2018. DHCS is required to provide a 30 day public comment period in advance of submission to CMS.

Medicare Economic Index (MEI)

In 2016 and 2017, CMS released two separate transmittals for the annual rate increase, commonly referred to as the MEI. In one of the transmittals, CMS referenced MEI, for RHCs paid an all-inclusive rate, and the other referenced a Market Basket Rate, for FQHCs paid a Medicare PPS. DHCS confirmed that the 2017 transmittal referencing the MEI of 1.2% will be used for the annual rate increase for Medi-Cal PPS rates because the State Plan Amendment (SPA) and the Welfare & Institutions (W&I) Code state that the FQHC/RHC PPS rates shall be increased by the MEI effective October 1 of each year. According to DHCS, the SPA and W&I Code does not reference that the annual rate increase will be based on the Market Basket Rate, therefore, will not drive the MEI annual rate increase. CPCA is exploring whether or not the Market Basket Rate should apply to Medi-Cal PPS rates and if so, would it require a change in the law.

The first year the annual rate increases (MEI and Market Basket Rate) were different was in 2017.

Year	MEI	FQHC Market Basket
2017	1.2%	1.8%
2016	1.1%	1.1%
2015	0.8%	Not available
2014	0.8%	Not available

The MEI rate increase was tentatively scheduled to install in December 2017. Any claims for dates of service from October 1 to the MEI implementation date will be reprocessed and paid at the correct rate through the quarterly FQHC/RHC Retro Rate Erroneous Payment Corrections (EPC).

Mobile Units and PPS Rates

Recently, DHCS shared with CPCA that a legal review of the Welfare & Institutions (W&I) Code and the California State Plan concluded that mobile units are prohibited from having an individual PPS rate. Instead mobile units, whether intermittent or licensed, are reimbursed at the PPS rate of an affiliated (parent) FQHC site. FQHCs are required to notify DHCS of the affiliated site to set the PPS rate for the mobile unit. Mobile units are still required to be licensed from the California Department of Public Health (CDPH) if operating more than 30 hours. Mobile units that previously received an individual PPS rate will remain in place. CPCA has requested that DHCS formally notify providers of this clarifying guidance.

III. Resources

- The SPA notice can be found here: http://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA17-001_PN.pdf
- When SPA language is available, it will be posted here: http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Pro_SPA.aspx
- Once submitted to CMS, the SPA will be posted in the "Pending" category here: http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Pending_2017.aspx
- CMS Transmittal – RHC Medicare Economic Index: http://cpca.informz.net/CPCA/data/images/Documents/2017%20MEI.pdf
- CMS Transmittal – FQHC Market Basket Rate http://cpca.informz.net/CPCA/data/images/Documents/2017%20FQHC%20Market%20Base%20Rate.pdf

California Primary Care Association

DISCUSSION

Date: January 18, 2018
To: 330 Committee
From: Meaghan McCamman, Assistant Director of Policy
Re: Acupuncture as FQHC Billable Visit

MEMORANDUM

Overview:

DHCS has confirmed that acupuncture services provided by a licensed acupuncturist have been added to the FQHC visit definition in the State Medicaid Plan. Per SPA 16-025, effective July 1, 2016, a "visit" for purposes of reimbursing FQHC or RHC services includes "a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, acupuncturist, certified nurse. This change occurred because of the restoration of optional benefits.

No public notice has been issued on this change, nor has the provider manual been updated. DHCS has acknowledged their error and will work with CPCA to ensure an effective communication system for future changes. CPCA is working with DHCS to issue a FAQ and update the provider manual, and is also advocating for DHCS to allow for full payment on retroactive claim submissions beyond the six month and one year limitations due to the lack of proper notice.

CPCA has received many member questions about this change, but has no additional information at this time. A series of questions have been submitted to DHCS and we are awaiting response.

Resources:

- CPCA FAQs submitted to DHCS on billing for licensed acupuncturists

DISCUSSION

Date: January 18, 2018
To: 330 Committee
From: Meaghan McCamman, Assistant Director of Policy
Re: FQHC P4P Update

MEMORANDUM

Overview:

On January 12, 2017, a county health center and hospital in San Mateo lost an appeal before the California Department of Health Care Services (DHCS) relating to whether their P4P incentive payments were properly excluded from their Medi-Cal PPS reconciliation. In response, CPCA convened a small workgroup to identify a common set of principles that we believe constitute an FQHC incentive that is justifiably excluded from reconciliation. The common set of principles was formalized in a white paper and disseminated at the July 13, 2017 330 Committee meeting.

At the request of the CPCA Board of Directors, CPCA has begun to work with health plans and health centers to share the 'FQHC incentive best practices' developed by the P4P workgroup, approved by the Board, and disseminated in the white paper. At the October Board meeting, CPCA staff was directed to:

1) Closely monitor the San Mateo appeal.
2) Continue and enhance our efforts at 'ground level cleanup.'
3) Work with the Integrated Healthcare Association (IHA) to ensure that their efforts around a standardized P4P program in Medi-Cal meet the standards promulgated in CPCA's P4P paper.
4) Upon which time CPCA member FQHCs and RHCs feel confident that their P4P incentive programs meet the standard set forth in the CPCA P4P paper, and all outstanding cost reports meet that standard, the 330 Committee may consider making a recommendation to the CPCA Board of Directors regarding formal communication about P4P standards with the Department of Health Care Services.

Current Efforts:

Stakeholder Engagement: The P4P White Paper has been shared with Medi-Cal managed care plans, plan associations, and with IHA. All stakeholders support the concepts and arguments outlined in the paper.

CPCA has developed an easy-to-digest FAQ document and powerpoint that can be shared with stakeholders and utilized by plans and health centers to refine existing P4P programs. Both documents are linked in the *resources* section of this memo.

San Mateo Appeal: The San Mateo health center at issue has hired an attorney to appeal the ALJ's decision. The attorney, Felicia Sze, has kept CPCA apprised of progress. Felicia may request an amicus brief from CPCA.

Health Plan Engagement: Many health plans have expressed interest in partnering with their FQHC providers to ensure that P4P incentive payments are excludable from reconciliation. CPCA has offered technical assistance to many health plans, and has provided information to LHPC and CAHP to share with their members.

- Health Net has made changes to some of their highest-paying incentives to meet the best practices disseminated by CPCA.
- CPCA has met with Molina QI staff to provide detailed technical assistance in revising their P4P program.
- A follow-up meeting with Anthem is scheduled for February to provide a deep dive into quality metrics.

Member Engagement: CPCA has been working with RAC as well as work groups, task forces, and SQIC to disseminate P4P information to members and partners. This is a two-pronged effort aimed at reaching CPCA's member clinics to ensure they understand their own exposure to the change in A&I's positon exemplified by the San Mateo decision, and to encourage each health center to do some internal housekeeping on their P4P incentive contracts. It also includes working with RAC to reach out to local and regional health plans across the state to encourage them to adopt "FQHC friendly" benchmark-based P4P incentive programs.

Resources:

- CPCA's P4P White Paper
- Incentives FAQs
- P4P update slide deck

Recommendations for Trainings for FQHC Clinics to Be Conducted by California Department of Health Care Services, Audits and Investigations, Financial Audits Branch (A&I)

Trainings should be separated into three categories:

I. Department Overview
II. Instructions on Form Completion
III. 15-Day Proposed Audit Findings

I. Department Overview

This training introduces the department (its organizational structure and duties), who to contact with questions, navigating the website, relevant regulations, location of various forms and reporting requirements.

II. Instructions on Form Completion

This module reviews each of the FQHC-specific forms and proper completion, identifies common errors and elaborates on specific areas that are frequent sources of confusion. Specifically:

1. *Form DHCS 3089/3089.1 – Home Office Cost Report – PPS Rate Setting*

   Emphasis on pooled cost methodology (A&I vs. clinic, reconciliation of different methods or approval to use alternate method), unallowable costs, required adjustments

2. *Form DHCS 3090 – PPS Rate Setting*

3. *Form DHCS 3096 – Change in Scope-of-Service Request*

   Emphasis on: what does and does not qualify; elaboration of Medicare reasonable cost principles; explanations and examples of a change in type, intensity, duration or amount of services; explanations and examples of the triggering events as well as documentation necessary to demonstrate each.

4. *Form DHCS 3097 – Reconciliation Request*

   Emphasis on how A&I verifies third-party payments or imputes payments that should have been received.

5. *Form DHCS 3106 – Initial Rate Setting Application Package*

   Emphasis on how A&I determines comparability for the three comparable clinic method, including explanation of "similar geographic area with respect to relevant social, health care, and economic characteristics."

6. *Form DHCS 3100 –Code 18 Rate Request*

   Emphasis on how A&I calculates the appropriate rate based on this form.

7. *Form DHCS 3104 – Code 20 Rate Request*

   Emphasis on how A&I calculates the appropriate rate based on this form.

8. *Form DHCS 3078 – Dental Hygienist*

   Emphasis on when to use this form instead of requesting a change-in-scope and clarification as to whether this form will be used for addition of MFTs or acupuncturists.

III. 15-Day Proposed Audit Findings

This section provides a step-by-step review of the 15-day proposed audit findings/adjustments report used by A&I for reconciliations, rate setting, home office cost report and scope of service changes. Review includes examples of adjustment reports, with a focus on helping clinics to understand:

- The form used by A&I
- The adjustments, with examples of common ones
- What documentation would have prevented the adjustment

Review also includes identification and discussion of sources used to justify adjustments. Specifically:

- Show how A&I uses the following regulations: Code of Federal Regulations, Federal Register, Medicaid Managed Care Final Rule, DHCS Proposed and Emergency Regulations, Completed DHCS Regulations, California Code of Regulations (CCR), Office of Administrative Law, California's Rulemaking Process, Administrative Procedure Act, California's Medicaid State Plan (Title XIX) and California's Children's Health Insurance Program Title XXI
- Demonstrate how to find the regulation section referenced in the adjustment
- Demonstrate A&I's review process for ensuring it is the appropriate section

Additionally, A&I explains how it determines whether an audit will be desk or field and provides guidance on how clinics can be better prepared for the field audit.

INFORMATIONAL

Date: January 2, 2018

To: 330 Committee

From: Andie Patterson

Re: Legal Update: Retrospective Dental Claims Litigation

MEMORANDUM

The Notice of Appeal of Judge Krueger's ruling ordering the State to process and pay the claims of the plaintiffs was filed by the Attorney General's office on behalf of Department of Health Care Services and its director on January 27, 2016. The superior court clerk took until October to put together the transcript of the superior court proceedings, and on October 27, 2016, the court ordered the State to file its opening brief on December 6, 2016.

The State obtained a total of 104 days of extensions and delays and filed their opening brief on March 21, 2017. We filed our brief on May 16, 2017. The State's brief was originally due on June 5, 2017, but the AG received extensions of time (over our objections) until September 26, 2017 to file its brief. The State submitted its reply brief on September 26, 2017.

We are now waiting for the court to send us a notice setting a date for oral argument, which will likely be in early 2018. (The three-judge panel assigned to the case will review the pleadings and make a tentative assessment of the merits of the case before setting the case for oral argument.) After the case is "submitted" (generally after oral argument is completed unless the court does not grant oral argument or asks for additional briefing on an issue), the court will have 90 days to decide the appeal.

Legislative Committee

Thursday - January 18, 2018
10:15 am - 11:45 am

Kevin Mattson, Chair

Agenda

ORDER OF BUSINESS		RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I.	Call to Order		Kevin Mattson	A
II.	Approval of Agenda	• Executive Summary	Kevin Mattson	A
III.	Approval of Minutes	• October 2017 Minutes	Kevin Mattson	A
IV.	Year in Review	• 2017 Year in Review	Beth Malinowski	I
V.	Federal Landscape	*Verbal Update*	Angie Melton Burt Margolin	D
VI.	State Landscape	State Political Landscape and 2018 Elections – *Verbal Update* • Two Year Bill Update and 2018 Bill Concepts Memo • Link to CPCA's Bill Tracking Report • 2018 Ballot Initiatives Memo	Christy Bouma Meagan Subers Beth Malinowski Victor Christy	D D I D
VII.	Health System Visioning	• Principles - *Handout*	Andie Patterson	A
VIII.	Advocacy and Communications	• NACHC's Policy & Issues Forum • Advocacy Update and Day at the Capitol 2018 • Communications Update	Angie Melton Janalynn Castillo Andrea Chavez	D D I
IX.	Adjourn		Kevin Mattson	A

California Primary Care Association

Executive Summary

Date: January 2018

To: Legislative Committee

Federal Landscape – *Verbal Update*

State Landscape

- As we enter the second year of a two year state legislative cycle, we aim to continue legislative efforts launched in 2017 while introducing and supporting additional bills that are in keeping with our 2018 policy priorities.
- Sponsored legislation in the following areas is currently being explored: Declared Emergencies; Same Day Billing; Consolidated Licensing; and Educational Equity.
- Additionally, work will continue on two-year bills, including, but not limited to, SB 456 (Pan), AB 1003 (Bloom), and AB 1250 (Jones-Sawyer).
- As of January 1, 2018, there have been 53 ballot measures submitted to the Attorney General's office for the November 6, 2018 General Election.
- Signatures must be submitted to the Secretary of State by April 24, 2018.
- Of those ballot measures filed, CPCA staff has identified 6 initiatives to be of particular interest and will continue to follow them through the qualification process.

Health System Visioning - *Handout*

Advocacy and Communications

- An increase in federal advocacy activities continued into the fourth quarter of 2017. With health center funding still in a state of limbo, we anticipate additional federal advocacy to keep the pressure on Congress to fix the cliff.
- The upcoming 2018 NACHC Policy and Issues Forum is an opportunity to maximize our advocacy efforts in Washington, DC.
- Registration is now open for CaliforniaHealth+ Advocates' Day at the Capitol. Join advocates in Sacramento and engage with legislators and legislative staff about budget and legislative priorities impacting community health centers.
- At the October 2017 Board Meeting, CaliforniaHealth+ Advocates staff presented an external communications strategy to help deliver greater impact on key priorities and since then has started to lay the foundation for the communications strategy.
- Given that the Health Center funding cliff is a top priority for health centers in California – and around the nation – Advocates will focus media relations the first part of the year on telling the health center story and the importance of Federal funding until the health center funding cliff is fixed, starting with a coordinated January media blitz.

CALIFORNIA PRIMARY CARE ASSOCIATION

Legislative Committee

October 11, 2017

10:15 am – 11:45 pm

Members:	David B. Vliet – Chair, Robin Affrime, Antonio Alatorre, Isabel Becerra, Doreen Bradshaw, Reymundo Espinoza, Ben Flores, Susie Foster, Tim Fraser, Cathy Frey, Jane Garcia, Greg Garrett, Dean Germano, Franklin Gonzalez, Britta Guerrero, Nik Gupta, Steve Heath, Sherry Hirota, Kerry Hydash, Cathryn Hyde, Tina Jagtiani, Saaliha Khan, Barbara Kidder Garcia, Constance Kirk, Esen Kurdoglu, Deena Lahn, David Lavine, Deborah Lerner, Temetry Lindsay, Marty Lynch, Jyl Marden, Kevin Mattson, Louise McCarthy, Scott McFarland, Angie Melton, Nichole Mosqueda, Danielle Myers, Joanne Preece, Tim Pusateri, Mary-Michal Rawling, Tracy Ream, Tin Rine, Gary Rotto, Corinne Sanchez, Laura Sheckler, Paulo Soares, Deanna Stover, Terri Lee Stratton, Vernita Todd, Henry Tuttle, Chad Vargas, Christina Velasco, Richard Veloz, Tony Weber
Guests:	Christy Bouma, Sergio Batista, Anitha Mullangi, Melissa Eidman, Maria Paz, Jessica Prechtl, Kelly Bennett, Katja Nelson
Staff:	Carmela Castellano-Garcia, Beth Malinowski, Kelley Aldrich, Victor Christy, Andie Patterson, Meaghan McCamman, Liz Oseguera, Andrea Chavez, Jana Castillo

Call to Order

The meeting was called to order by the chair at 10:14 am.

Approval of Agenda

A motion was made and seconded to approve the agenda as written. The motion carried.

Approval of Minutes

A motion was made and seconded to approve the minutes as written. The motion carried.

Federal Politics, Budget & Advocacy

Angie Melton of the Margolin Group gave members an overview of what's currently happening on the Federal level, which included the following:

- The current Federal landscape is crazy.
- Feinstein announcement – big difference in senior staff to freshman staff. For CA it benefits us to keep her in the senate, she has access and a working relationship with staff. Harris is great but not able to access or influence without the connections.
- Funding Cliff: For the first time, on September 30, 2017, S-CHIP, Community Health Center, National Health Service Corps, and Teaching Health Center GME program funding has

expired. As a result of aggressive advocacy, at time of writing, Senate and House bills are being marked-up, and partners are hopeful that meaningful action will occur In October.

- Continue to talk to leadership, ask them to talk to their person the Energy and Commerce Committee
- CPCA will create and send out member talking points to use when speaking to leadership.
- We need very concrete impact statements – 2 months left of HRSA funding – what happens to your health center directly.
- CHIME Act – currently 34 sponsors from CA, could be a floor vote as early as 10/23.
- We need to continue to push for a long-term bi-partisan solution.

- ACA Repeal: The Graham-Cassidy-Heller-Johnson ACA repeal bill, the third attempted ACA repeal this year, is not currently moving. Future ACA repeal and destabilization attempts are expected, with FY 2019 Budget reconciliation a likely target for this next effort. With the recent resignation of HHS Secretary Tom Price, much attention on his replacement will focus on what this selection signals for ACA repeal and Medicaid stability.
- Tax Reform: Between now and December, we expect much Congressional attention to be focused on Tax Reform
- The Continued Resolution expires on 12/8.
- 340B – We need to be very wary, they're going after 340B, similar to what California is trying to do.

Liz Oseguera updated members on CPCA's immigration work advances and recommended members take action today to formalize positions on a number of pieces of federal legislation, and the following motion was made:

A motion was made and seconded to support the staff recommended positions on the following pieces of Federal legislation:

- *Raise Act – OPPOSE (J. Garcia/N. Gupta)*
- *Dream Act – SUPPORT (J. Garcia/R. Affrime)*
- *Succeed Act – OPPOSE (C. Frey/N. Gupta)*

All three motions carried.

*Note: *all three motions were made and carried in Government Programs Committee which took place prior to Legislative Committee.*

<u>State Politics, Legislation & Advocacy</u>

Christy Bouma of Capitol Connection laid out the current landscape on the state level, highlighting the following:

- First year of a two year bill cycle. Many bills, such as SB 456 are parked until next year.
- Priority is to battle POTUS 45.
- Both the Governor and the Pro Tem are termed out next year.
- We'll have the single payer bill waiting for us in January.

- Assembly – election year. Senators terming out, could be 6 open seats.
- 36 ballot initiatives filed so far and that could double by January.
- AB 1250 is not done, SEIU has a big interest in moving this vote.

FY17-18 State Budget Implementation Summary

Beth gave a summary of implementation on the following budget wins:

- The Song-Brown Healthcare Workforce Training Program received a $33M installment of new funds. Awards will be determined during the November 29-30, 2017 Song Brown Commission meeting in Southern California.
- California Health Facilities Financing Authority (CHFFA) staff have begun work on the Lifeline Grant Program design, including regulations, selection criteria and application process.
- DHCS has outlined payment methodologies and begun submitting the State Plan Amendment (SPA) for the use of California Healthcare, Research and Prevention Tobacco Tax Act (Prop. 56) funds for supplemental payments.
- CPCA continues to work with DHCS on State Plan Amendments, one of which is the MFT implementation to become billable providers by July 2018.

Policy Prioritization

Andie Patterson reviewed this year's policy prioritization process which started in August with a call for members to provide feedback on what CPCA's policy priorities should be in 2018. The Consortia gathered feedback directly then CPCA along with the consortia synthesized it all in a mid-September meeting. This year's policy priorities echo last years, but there are fewer so that CPCA and its affiliate, CaliforniaHealth+ Advocates can be more targeted, and hopefully more successful on very challenging issues.

> *A motion was made and seconded to approve CPCA's Policy Priorities as written. (T. Rine/L. McCarthy). The motion carried.*

Advocacy and Communications

Andrea Chavez reviewed her memo on CPCA's communication strategy for 2018, which was part of the policy prioritization process. Staff recommends a focused external communications strategy for 2018 in which we will work closely with the consortia and health centers to proactively engage media and stakeholders on priority issues.

Andie gave members an update on the statewide and local advocacy plan being developed and worked on by the RAC and Imprenta. There's a strong focus on social media in CHC messaging campaign.

Jana Castillo noted the following highlights from her advocacy memo:

- Member-focused grassroots advocacy efforts preserved CA's $100 million for primary care workforce, successfully pushed CPCA's sponsored legislation to the governor's desk, and helped defeat three ACA repeal attacks.
- CaliforniaHealth+ Advocates is committed to providing CPCA membership new ways to improve advocacy infrastructure at all levels of an organization.

- At this year's CPCA annual conference, CaliforniaHealth+ Advocates will provide members with advocacy opportunities to partake in.

Adjourn
The meeting was adjourned at 11:49 am.

Submitted by Kelley Aldrich

Date: January 3, 2018

To: Legislative Committee

LEGISLATIVE COMMITTEE 2017 YEAR IN REVIEW

2017: The Year Ahead (projected from 2016)

- In 2016 we sought to build on the efforts and success of 2015. In particular, to continue addressing the workforce crisis, licensing, and social determinants of health.
    - Workforce Crisis
        - Making Clinical Pharmacists Billable Providers in Medi-Cal
        - Including the costs of a residency program in your PPS rate after a health center goes through the change in scope process.
    - Licensing
        - Assemblymember Gonzalez agreed to author a bill on consolidated licenses that will allow an existing FQHC site to add a new additional site to their current license if that is the desire of the FQHC.
        - CPCA to explore legislation that would require the California State Medical Board to participate in the multi-state Provider License Compact.
    - Social Determents of Heath
        - AB 1357(Sugar Sweetened Beverage) to be re-introduced as a new bill. Assembly member Bloom agreed to author the bill once again. The bill contains $200 million dollars in funding for health centers.
        - CPCA to work with the California WIC Association to develop legislation that will improve breastfeeding/lactation support for Medi-Cal patients and may include increased availability of lactation devices.

2017: Legislative Committee Year-in-Review

- State Affairs
    - In 2017, at CPCA's bequest, CaliforniaHealth+ Advocates sponsored and cosponsored, three bills - SB 323 (Mitchell), SB 456 (Pan) and AB 1003 (Bloom). We are excited to share that SB 323 (Mitchell) was signed into law by the Governor.
    - At a time of great uncertainty for California's health care delivery system, the Budget Act of 2017 reflects California's commitment to creating a healthy California. Through successful lobbying and advocacy, and with the tremendous leadership of our health centers and a wide array of advocacy partners, we were successful at reinstating workforce funding ($100 million), securing the Community Clinic Lifeline Grant Program ($20 million), preventing changes to the 340B Drug Discount Program, halting the implementation of the Newly Qualified Immigrant (NQI) Wrap, and greenlighting AB 1863 implementation.

- In addition to these sponsored bill and budget efforts, CaliforniaHealth+ Advocates influenced dozens of bills and participated in robust partnerships to achieve legislative success to forward CPCA's policy priorities.
- As CPCA took on a greater role protecting our immigrant patients, Advocates played an active role in supporting legislation that protected our immigrant patients, including SB 54.
- Advocates also had the challenging task of maneuvering difficult political and policy waters as it participated in an oppose campaign (AB 1250) and expressed strong concerns on a number of bills early in session. For both legislative and budget success, partnerships continued to be key to our capitol strategy.
- Advocate's tracked over 200 bills of interest, submitted letters of support on over 50 measures, and provided oral testimony on dozens of bills.
- Health center leaders were also called upon to testify in a variety of legislative hearings and briefings held since November 2016 to defend the ACA and protect California's diverse communities from federal policy threats.

- Federal Affairs
  - Working in close partnership with the National Association of Community Health Centers (NACHC), Advocates tracks and coordinates CPCA's response to federal legislation and budget actions.
  - With threats on the Affordable Care Act, Health Center Funding reauthorization, and Tax Reform, 2017 was a particularly active year for Federal advocacy.
  - From March through September, and with multiple congressional attempts, we were successful at halting a full repeal of the Affordable Care Act.
  - For the first time, Congress failed to meet key reauthorization and funding deadlines for CHIP, health center funding, and key health programs, including National Health Service Corp, Teaching Health Center Graduate Medical Education (THCGME) program, and Special Diabetes Program.
  - While the Continuing Resolution approach being utilized by Congress to provided short-term funding relief, long-term funding security remained out of reach in 2017.
  - Lastly, in December, the most significant Tax Reform measure in recent history passed Congress and, with it, the repeal of the individual mandate. This bill will also bring significant impacts to high tax states, like California. Its passage will have a ripple effect, impacting everything from Federal funding decisions to state legislation in 2018.
- Grassroots Advocacy
  - Federal threats, along with state legislative and budget responses, made for an action-packed year.
  - With just under 9,100 individuals now signed up to be health center advocates, our advocacy program continues to grow its advocacy base.
  - Health Center advocates participated in 20 actions, from letter of support campaigns to thunder claps and call-in days.
  - Coordinating closely with CPG, we learned that our most successful campaigns are those that involve continued dialogue on ways to strengthen advocacy efforts and provide feedback to CaliforniaHealth+ Advocates' staff on how to best support health centers in state and federal legislative engagement.
  - Given the repeated ACA repeal attempts in 2017, CPCA members participated in a statewide #ProtectMedicaid advocacy campaign to engage patients, health center staff,

board members, and the community with California specific messaging on why protecting Medicaid is important. The #ProtectMedicaid campaign increased our collective advocacy presence on social media and could be seen in over fifty California National Health Center Week community events.
    - Lastly, 2017 saw a revamping of our key contacts program. With 53 state key contacts, and 83 federal key contacts, we were successful at making targeted and timely requests of elected officials
- Communications
    - In coordination with RAC, hosted an ACA state-wide celebration in March and Funding Cliff day-of-action in November. During both events, Advocates partnered with local health centers and community partners to host capitol press conferences.
    - Participated in a press conference with Treasurer Chiang, announcing the Lifeline grant program.
    - Drafted and placed opinion editorials for Advocates CEO and health center CEOs on priority policy issues.
    - Coordinated state-wide media activities for National Health Center Week.
    - Coordinated a media blitz following the health center funding cliff deadline to garner media coverage on the impact.
    - Created and implemented communications around priority issues, including to "Save the ACA", reinstate $100 million workforce funding, fix the health center funding cliff and stop AB 1250.
    - Advocates sent regular member communications with summaries on legislation, talking points and social media posts.
    - Advocates coordinated media interviews with CEO Carmela Castellano-Garcia and members.
    - Working with Imprenta Public Relations Firm and the RAC, 2017 saw the launch of a new state-wide campaign that educates the public on the value of community health centers.

2018: The Year Ahead

In October 2017, the 2018 CPCA Policy Priorities, which guide CPCA's legislative program, were approved. In 2018, to promote healthy people and healthy communities, CPCA is committed to strengthening California's community clinics and health centers through the following priorities (1) Coverage and Access for All; (2) Delivery of Culturally Competent Whole Person Health Care, Preventive Care, and Support Services; and (3) Building Healthy Communities.

- State Affairs
    - Like 2017, FY 18-19 proposed budget will likely bring new challenges to state support of health and human services programs our patients rely on. Advocates will be expected to put up a strong fight to continue the $100 million primary care residency support.
    - Two sponsored bills (SB 456 and AB 1003), introduced in 2017, will continue to move through the legislative process in 2018. While AB 1003 (Bloom) is not expected to make it out of its house of origin, with greater DHCS dialog, we are hopeful we will be able to move an amended SB 456 (Pan).
    - Advocates will also be looking to introduce additional legislation to support behavioral health access (same day billing), primary care workforce (educational equity), and guarantee access to care during declared emergencies.

- Advocates, on CPCA's behalf, will again aim to work closely with immigrant partners to advance legislation to protect health center patients.
- With the 2018 elections on the horizon, Advocates will be tracking ballot initiatives closely, including initiatives that could have financial impacts on the health care delivery system.

- Federal Affairs
  - Entering 2018 in unchartered territory, and with stabilization funds just through March, securing long-term health center and health workforce (NHSC and THCGME) funding remains a top advocacy priority.
  - While we scrapped through 2017 without a full repeal of the Affordable Care Act, the individual mandate was repealed. As we enter 2018, we must stay alert and ready to act as more direct attacks threaten the ACA, Medicaid, and Medicare. Tax Reform is expected to be used as justification for significant funding cuts to these key programs.
  - Advocates, working with immigrant advocate partners, is preparing for another year of federal attacks. We look to stand united with our diverse communities to support DACA recipients and the broader immigrant community.
- Grassroots Advocacy
  - With health center funding still in a state of limbo, we anticipate federal advocacy efforts to remain a top priority. To increase attention around the health center funding cliff impact, it is imperative that membership continue collecting petition signatures and answer advocacy calls to action from Advocates' and NACHC.
  - CaliforniaHealth+ Advocates has invested in new digital advocacy platforms to increase our statewide grassroots network. To take full advantage of these new platforms, we must grow our advocacy supporter list with all of you. Stay tuned for more information on how to participate in our upcoming advocacy supporter campaign.
  - With the November 2018 elections on the horizon, voter education and registration is a great addition to strengthen statewide advocacy efforts. CaliforniaHealth+ Advocates will begin collecting feedback from members on ways we can prepare for an upcoming statewide voter registration campaign.
- Communications
  - At the October 2017 Board Meeting, CaliforniaHealth+ Advocates staff presented an external communications strategy to help deliver greater impact on key priorities. In 2018, we aim to build on this foundation.
  - For the first part of the year, given that the Health Center funding cliff is a top priority for health centers in California – and around the nation, Advocates will focus media relations on telling the health center story and the importance of Federal funding. This campaign will launch with a coordinated January media blitz. This work will continue until the health center funding cliff is fixed.
  - Additionally, staff recommends focusing external communications on the following three policy priorities that members identified as high priority during the policy prioritization process as viewed through the core message lens:

    - Access: Workforce
    - Coverage: Protecting Medicaid
    - Social Justice: Immigration – health for all

DISCUSSION

Date: January 11, 2018

To: Legislative Committee

From: Beth Malinowski, Deputy Director of Government Affairs

Re: 2018 State Legislative Approach and Sponsored Bill Concepts

MEMORANDUM

As we enter the second year of a two year state legislative cycle, we aim to continue legislative efforts launched in 2017 while introducing and supporting additional bills that are in keeping with our 2018 policy priorities.

To promote healthy people and healthy communities, CPCA will be working with CaliforniaHealth+ Advocates (Advocates) to strengthen California's community clinics and health centers through the following priorities: (1) Coverage and Access for All; (2) Delivery of Culturally Competent Whole Person Health Care, Preventive Care, and Support Services; and (3) Building Healthy Communities. In the paragraphs below, I outline two-year bills, potential sponsored bills, and additional state legislative conversations that are in keeping with CPCA's 2018 Public Policy Platform:

I. Coverage and Access for All

- *SB 562 (Lara)[Two Year Bill]* – In 2017, Senator Lara, with a track record of expanding coverage, and buoyed by activists committed to finding a California solution to federal coverage challenges, introduced universal coverage legislation. Once advanced to the Assembly, Speaker Rendon launched the Select Committee on Health Care Delivery Systems and Universal Coverage to continue thoughtful debate on this important topic. While Advocates continues to have no formal position on this bill, staff have participated in stakeholder meetings and will be tracking closely additional developments on this bill in 2018.

- *Fight4OurHealth Coalition* – CaliforniaHealth+ Advocates continues to participate in Health Access led statewide coalition to defend the Affordable Care Act, Medicaid, and immigrant communities. Similar to 2017, we expect legislation to be introduced that will respond to the changing dynamics at the federal level, including legislation to address the individual mandate repeal and further protect our immigrant patients.

- *Declared Emergencies [Potential Advocates Sponsored Legislation]* – This year too many health centers found themselves caught in dangers way. The devastating 2017 fire season has brought home the need to build additional protections to guarantee that health centers can continue to provide timely access to care during, and immediately after, a declared emergency. CPCA's Government Affairs team, in dialog with impacted members and consortia, have identified legislative solutions that are needed to better prepare health

centers for future emergencies. To this end, Advocates, on behalf of CPCA, is currently exploring sponsoring declared emergency-related legislation that could address payment for telephonic visits; local jurisdictional permitting and building standards for temporary sites, and timeliness of clinic pharmacy permitting.

II. Delivery of Culturally Competent Whole Person Health Care, Preventive Care, and Support Services

- *SB 456 (Pan) [Sponsored Two Year Bill]* – Sponsored by CaliforniaHealth+ Advocates, this bill seeks to improve the health of California's most vulnerable people by allowing FQHCs to be directly reimbursed for services that promote continuity of care and wellness in ways not covered by PPS, including services associated with innovative projects like the Whole Person Care pilots. While we expect that this bill will reduce overall costs to the health care system through better care coordination, addressing social determinants of health, and incentivizing wellness services that keep patients healthy and out of the emergency room, DHCS has significant concerns with the bill. With this in mind, and working closely with the author, it was determined that this bill would become a two-year bill effort to allow for greater discussion with DHCS. We look forward to having necessary dialog with DHCS partners this winter.

- *Same Day Billing [Potential Advocates Sponsored Legislation]* – This Fall, with strong encouragement from CPCA members and behavioral health advocates, CaliforniaHealth+ Advocates has moved forward with exploring the reintroduction of Same Day Billing. With the Steinburg Institute, Advocates is aiming to co-sponsor this critical legislation. While prior efforts have fallen short, we believe the policy environment has shifted significantly enough to warrant a renewed effort. With a raging opioid epidemic, a greater appreciation for the intersection of primary care and mental health services, and the need to increase access to behavioral health preventive and diagnostic services, Advocates is excited to be working with the Steinburg Institute on this important effort. This legislation, if introduced, will also help start an important dialog with gubernatorial candidates regarding the role of health centers in the behavioral health delivery system.

- *Consolidated Licensing [Potential Advocates Sponsored Legislation]* – In 2017, upon identifying implementation challenges with AB 2053 (Gonzalez-Fletcher, 2016), it has been a commitment of CPCA to identify the appropriate legislative or administrative path needed to see the full intended benefits of the consolidated license. After extensive research, it has been determined that legislation is the appropriate path. Advocates have been in close dialog with Gonzalez-Fletcher staff and are now working on the introduction of legislation that will (1) Allow an FQHC which chooses to add a facility through the consolidated license process to include the additional facility in their PPS rate and bill accordingly, (2) allow the new site to have choice in how their rate is determined, (3) and or allow the new site to be enrolled with Medi-Cal through the existing site. This bill would also seek to create parallel permissions for consolidated-like sites established prior to AB 2053.

- *Workforce – Educational Equity [Potential Advocates Sponsored Legislation]* – After successfully coordinating a well-attended third statewide Workforce Policy Coalition meeting in November 2017, The Coalition successfully ended the year by jointly agreeing to prioritize three issues areas in 2018; residency redesign, equity in education (focused on college pipeline programs), and researching primary care specific tax incentive programs. Advocates,

on behalf of CPCA, has already initiated conversation with legislative staff regarding these three priority areas. The area of educational equity has drawn a particular interest. Advocates is currently working with the Campaign for College Opportunity on specific legislative concepts that could be introduced to support community college students and create the necessary conditions to allow diverse students to pursue training and careers in health care. Of note, any workforce legislation introduced, will be in addition to the expected budget advocacy that will be needed to draw down the remaining $66 million of the $100 million general fund commitment.

- *Proposition 64 [Potential Advocates Sponsored Legislation]* – Proposition 64, the California Marijuana Legalization Initiative, will be allocating approximately $650 million to help fund substance abuse disorder (SUD) education, prevention, intervention, and treatment for youth. With strong encouragement from CPCA members and advocates, CaliforniaHealth+ Advocates began participating in the Proposition 64 Stakeholder Coalition that is looking at how these funds should be spent. This year, it is expected that multiple proposals, will be submitted to the legislature. While it's unlikely that introduced legislation will make it to the Governor's desk, it's probable that these bills will impact budget negotiations that take place later in the session. To best position health centers for these budget negotiations, Advocates is currently considering sponsoring or cosponsoring legislation that would direct revenues towards increasing training opportunities on SUDs for providers interested in offering this service, implementing and widely utilizing the new FaCES adolescent SBIRT tool, and increasing the utilization of ECHO, among other things.

- *AB 1250 (Jones-Sawyer) [Two Year Bill]* – In 2017, for the first time in some years, health centers were at the center of an opposition campaign (AB 1250) – Counties and Contracts for Personal Services. AB 1250 was held in the Senate Rules Committee and was not brought to the floor. While the decision to hold the bill, was seen as a significant short-term victory, this bill may resurface in 2018. Advocates, on behalf of CPCA, continues to work with a coalition of organizations opposed to the bill and has already started 2018 strategy conversations. While we cannot let our guard down, we are hopeful that political shifts in the capitol, including the change in Senate leadership, could have a significant impact on this bills future.

III. Building Healthy Communities

- *AB 1003 (Bloom) [Sponsored Two Year Bill]* – Sponsored by the Coalition for a Healthy California, to which CaliforniaHealth+ Advocates was a leading member, sought to address Type 2 diabetes, dental disease, heart disease, stroke – debilitating epidemics in California - by creating a dedicated revenue source for prevention and care. The author, aware of significant opposition at time of introduction, worked with Assembly leadership to commit this bill for assignment to the proper committee for study. This fall, the Coalition for a Healthy California, partnered with Assemblymember Bloom on the Select Committee on Diabetes and Heart Disease Prevention. The committee, tasked with examining the epidemics of type 2 diabetes, obesity, heart disease, tooth decay, and other associated health outcomes, has held two hearings and is currently planning a third hearing for later this winter. While this bill is not expected to move out of the house of origin, it has continued an important conversation.

In addition to the bill concepts and legislation listed above, CaliforniaHealth+ Advocates is also currently engaging with a variety of legislative offices, providing technical support and feedback, on elected driven conversations on a variety of topics from immigration to addressing childhood trauma. Advocates role in being a trusted thought partner is critically important to advancing health center interests and building capitol champions.

As we prepare for the year ahead, we must also reflect on the capitol environment in which we will be working. Like 2017, the destabilizing policies of the Trump Administration will continue to challenge California and, like last year, we expect state elected officials to be quick to introduce legislation in direct response to Federal Tax Reform and other threats. While we are hopeful some of the capitol unity of 2017, a unity forged in a commitment to defend California values on health care, immigration, and the environment, will continue, we must also recognize that this unity is already being challenged. While the 2018 elections, senate leadership transitions and other political jockeying, was always expected to influence this year, what could not have been forecasted was the sexual harassment news that continues to reverberate in the capitol community. As we walk into 2018, we will continue to update the membership on how the capitol environment will influences our priorities.

California Primary Care ASSOCIATION

DISCUSSION

Date: January 5, 2018

To: Legislative Committee

From: Victor Christy, Assistant Director of Legislative Affairs

Re: Proposed 2018 Ballot Initiatives

I. Overview

As of January 1, 2018, there have been 53 ballot measures submitted to the Attorney General's office for the November 6, 2018 General Election. Signatures must be submitted to the Secretary of State by April 24, 2018.

In California, one needs to complete the following four steps in order to qualify an initiative for the ballot:

- STEP 1: Proponents of an initiative file their proposal with the attorney general's office, which prepares the language used on petitions for the initiative.
- STEP 2: The measure must receive the circulating title and summary, allowing proponents to begin collecting signatures. The Secretary of State assigns the initiative with a signature filing deadline.
- STEP 3: Proponents must notify the Secretary of State's office that at least 25 percent of the required signatures have been collected for the initiative.
- STEP 4: Proponents submit signatures for a ballot initiative or referendum and Secretary of State's office verifies the unduplicated signatures.

II. Ballot Initiatives of Interest

Staff are currently tracking ballot measures as they are filed. Of those ballot measures filed, staff has identified the following 6 initiatives to be of particular interest and will continue to follow them through the qualification process.

1) Initiative #17-0014
The California Limits on Charges for Dialysis and Minimum Staffing of Clinics Initiative

- SUMMARY: The measure would establish minimum staff requirements for dialysis clinics. The minimum staffing ratios would be as follows:
  i. one nurse to eight patients (1:8) receiving direct clinic care;
  ii. one hemodialysis technician to three patients (1:3) receiving direct clinic care; and
  iii. one social worker and one registered dietician to 75 patients (1:75) per full-time equivalent schedule.

The measure would require dialysis clinics to issue annual refunds to patients or the patients' payers, such as insurers, who were charged more than 115 percent of the average cost of dialysis treatment in California and the proportional costs to improve the clinic's healthcare quality that year. Clinics that do not issue required refunds would be fined in an amount equal to 5 percent of their required refunds, but not to exceed $100,000.

- PROPONENT: The Service Employees International Union-United Healthcare Workers (SEIU-UHW)

2) Initiative #17-0015
The California Limits on Charges for Dialysis Initiative

- SUMMARY: The measure would require dialysis clinics to issue annual refunds to patients or the patients' payers, such as insurers, who were charged more than 115 percent of the average cost of dialysis treatment in California and the proportional costs to improve the clinic's healthcare quality that year. Clinics that do not issue required refunds would be fined in an amount equal to 5 percent of their required refunds, but not to exceed $100,000. The measure would also prohibit dialysis clinics from discriminating or refusing services based on a patient's payer, including the patient himself or herself, a private insurer, Medi-Cal, Medicaid, or Medicare.
- PROPONENT: The Service Employees International Union-United Healthcare Workers (SEIU-UHW)

3) Initiative #17-0019
The California Healthcare Trust Fund Exempt from Revenue Restrictions Initiative

- SUMMARY: The measure would create a healthcare trust fund called the *Healthy California Trust Fund* (HCTF). The HCTF would be used to fund, promote, support, and improve healthcare and healthcare-related goods, services, education, and outcomes in California. The HCTF would be independent of the General Fund.

  According to the *Findings and Declaration* section of the measure, the state's constitutional fiscal rules (Proposition 4 and Proposition 98) need to be amended to make "a stable, reliable universal healthcare system," such as a single-payer system, possible. The initiative itself would not establish a single-payer or other type of healthcare system; a legislative statute or a different citizen's initiative would be required.

- PROPONENT: Enact Universal Healthcare for CA, 501(c)(4) political non-profit whose mission is to educate all Californians about universal healthcare and single-payer

4) Initiative #17-0040
The California Sanctuary State Law Veto Referendum

- SUMMARY: The measure was designed to overturn the statewide sanctuary jurisdiction law, passed as Senate Bill 54 (SB 54) in 2017. SB 54, which was slated to go into effect on January 1, 2018, was designed to prohibit state law enforcement agencies from using state and local resources for the purposes of reporting, investigating, detaining, or arresting an individual to enforce federal immigration laws, unless that individual has been convicted of one of 800 crimes.

- PROPONENT: Latinos for Trump, an online organization dedicated to promoting the candidacy of Donald Trump in the 2016 presidential election

5) Initiative #17-0047
The California Tax on Incomes Exceeding $1 Million for Hospitals, Health Clinics, and Workforce Training Initiative

- SUMMARY: The measure would enact a 1 percent tax on income in excess of $1 million and distribute revenue from the tax as follows:
    i. 70 percent to the Safety Net Hospital Fund, which would be used to support *Safety-Net Hospitals*. The initiative would define a Safety-Net Hospital as nonprofit or local healthcare district general acute care hospitals that qualify as disproportionate share hospitals and are located in federally-designated medically underserved areas.
    ii. 25 percent to the Community Health Clinic Fund, which would be used to support *Community Health Clinics*. The initiative would define Community Health Clinics as nonprofit clinics that are in medically-underserved communities and where patients receive free care or are charged based on a sliding scale.
    iii. 5 percent to the Healthcare Workforce Training Fund, which would be used to fund workforce development and training projects for *frontline healthcare workers* in California. The initiative would define frontline healthcare workers as "workers who provide direct patient care and supporting services in healthcare facilities that provide primary, outpatient, or acute care, including practical and vocational nurses, nursing aides, medical assistants, patient care technicians, environmental services workers, mental health counselors and aides, medical equipment preparers, dietary technicians and aides, occupational therapy assistants and aides, administrative personnel, and others."

- PROPONENT: The Service Employees International Union-United Healthcare Workers (SEIU-UHW)

6) Initiative #17-0048
The California Managed Health Insurance Premiums Initiative

- SUMMARY: The measure would prohibit a managed health insurance company from increasing premiums if the company's tangible net equity is equal to or greater than five times the minimum reserve requirements set by the state.

- PROPONENT: The Service Employees International Union-United Healthcare Workers (SEIU-UHW)

III. Resources

1. Office of the Attorney General: https://oag.ca.gov/initiatives/active-measures

California Primary Care ASSOCIATION

INFORMATIONAL

Date: January 2, 2018

To: Legislative Committee

From: Andrea Chavez, Senior Program Coordinator of Public Affairs

Re: Update on External Communications

MEMORANDUM

External Communications Strategy

At the October 2017 Board Meeting, staff presented an external communications strategy for CaliforniaHealth+ Advocates to help deliver greater impact on key priorities, and to build and deepen CaliforniaHealth+ Advocates brand recognition.

A. Core Messages

Staff recommended that 2018 communications be focused on a core message and a few select policy objectives.

- Access: Workforce
- Coverage: Protecting Medicaid
- Social Justice: Immigration

Additionally, as this year started off with no meaningful action from Congress to fix the health center funding cliff Advocates will continue to identify media opportunities and collaborate with the RAC on telling the health center story and the importance of Federal funding until the health center funding cliff is fixed, starting with a coordinated January media blitz.

B. Health Center Spokespeople

Since the last board meeting, on behalf of CPCA, Advocates started to lay the foundation for the communications strategy by sending a Survey Monkey to members to create a master media contact list. Advocates received 32 responses to the survey from members across the state, willing to speak to media on a variety of issues.

C. Wellness Grant: Imprenta

Advocates, on behalf of CPCA, has also worked closely with Imprenta Public Relations Firm and the RAC on building a state-wide campaign that educates the public on the value of community health centers. There was agreement on a central theme of messages built upon highlighting and leveraging the value of health centers. To date the campaign has been focused in social media with coordinated content calendars. There are further plans to coordinate and increase partner engagement, media roundtables, and speaking opportunities for Carmela Castellano-Garcia. Consortia are individually working with Imprenta on communications opportunities to elevate the value of health centers.

D. Streamlined Communications for CaliforniaHealth+ Advocates

To continue to separate CPCA and CaliforniaHealth+ Advocates and to strengthen Advocates brand, Advocates will have a totally separate communication than CPCA. This will include an email weekly update, three e-newsletters (the first one which launched in November 2017), and an annual report.

California Primary Care Association

DISCUSSION

Date: January 10, 2017

To: Legislative Committee

From: Janalynn Castillo, Advocacy Coordinator

Re: Advocacy Strategy Update

MEMORANDUM

I. 2017 Assessment

Advocacy was a central driving factor to the results of 2017. Together, we defeated three ACA repeal attempts, preserved California's $100 million commitment to primary care workforce, successfully pushed CPCA's sponsored state legislation through the legislative process, and continued to fight for a long-term health center funding cliff solution.

Considering the threat that was presented with the 2016 presidential elections and how 2017 ended, health care, Medicaid, the ACA, and health centers fared well. No doubt our contribution to the national advocacy and dialogue was instrumental, however, we believe it could have been stronger.

At the statewide level, it does not appear that advocacy is an ingrained part of the health center culture. Only a few health centers regularly engaged multiple levels of staff in advocacy. In fact, at too many health centers almost no advocacy was done at all, at least from what was visible to us. We know that volume can change discourse. The #metoo and #blacklivesmatter movements have changed our country. The driving factor was consistency and volume. Health centers and our issues do not have such a following in the public, but nor do they have a following among our own staff or patients. It is nearly impossible to break through the myriad of important issues and news debates without massive volume and some semblance of coordination. And, at present, we have yet to achieve that goal. But it is the goal, and CPCA, working with our advocacy affiliate CaliforniaHealth+ Advocates, has a goal of reaching every single health center staff and patient in order to create a committed and invested advocacy base.

II. Advocacy Tactics

In order to achieve our goal, we are engaged in many different strategies.

o New Advocacy Software

CaliforniaHealth+ Advocates conducted an advocacy inventory project to assess the advocacy communication tools we currently use and identify areas to improve advocacy engagement with members and the general public. Obtaining user-friendly advocacy tools to align with our c4 mission is a priority and we have definitely experienced an inevitable learning curve with digital advocacy. Since the inception of our c4, we have invested in multiple advocacy platforms, which sometimes created a delayed process for providing advocacy action opportunities to our membership. We are excited to announce our partnership with *CQ Roll Call*, a leading grassroots advocacy firm dedicated to amplifying and streamlining the digital advocacy infrastructure. Beginning in March,

CaliforniaHealth+ Advocates will launch a new advocacy action center and mobile app to amplify advocacy efforts, educate and rally supporters with legislative resources and multiple grassroots calls-to-action, including social media activities. In addition, we will be able to track and report activity to improve our campaigns over time and report back to stakeholders on performance. There is also a potential opportunity for consortia partners to utilize *CQ Roll Call* products and we look forward to reporting back on our partnership progress.

- Increased coordination and communication with RAC

  Introduced in 2017, and continuing into 2018, is new and improved coordination with RAC. Every two weeks CEOs and advocacy staff meet to discuss the latest political updates and coordinate and strategize on advocacy and communications. As a result, RAC and CPCA, and CaliforniaHealth+ Advocates have conducted more coordinated advocacy efforts than in years past.

- Growing the Advocacy Contacts: 10k Campaign

  At CPCA's Annual Conference in October, CaliforniaHealth+ Advocates launched a 10k in 100 days campaign to increase the current statewide grassroots network count from 8,500 to 10,000 by the end of January. As of January 2nd, 585 new California advocates have joined our statewide grassroots network, bringing the total to 9,085. We are very close to meeting our goal and we are asking all members to continue distributing the CHC advocate supporter opt-in link through their communication channels.

- Building local infrastructure: Advocacy Centers of Excellence (ACE) Program

  The ACE program is an opportunity to increase our collective advocacy engagement and involvement with NACHC, and federal policy issues impacting health centers and their patients. By becoming an ACE you ensure that your health center, the patients you serve, and the community at large has a voice in the process. Much the way Health Centers strive to achieve operational excellence to signal quality and effectiveness, engaging in and operationalizing advocacy should receive the same attention and priority.On December 11th, on behalf of CPCA, CaliforniaHealth+ Advocates hosted a webinar to revisit California's participation in NACHC's Advocacy Center's of Excellence (ACE) program. In the past, NACHC's national ACE webinars did not include a California member perspective and CPCA members requested an opportunity to hear from more California ACE participants. . Twenty eight CPCA members participated in the call and one California ACE member provided a presentation on the benefits and progress their organization has seen, since become part of ACE. Increasing our ACE participation is a priority for CPCA and we encourage members to apply. In order to increase California's ACE participation, we would like to host additional ACE webinars. Members are encouraged to contact Jana Castillo at jana@healthplusadvocates.org to participate and provide ACE program feedback.

- Building on Best Practices and Networking: CaliforniaHealth+ Advocates' Public Affairs Peer Network

  In 2017 the Public Affairs Peer Network (PAPN) met 11 times, where PAPN members provided suggestions as to how the Advocates team could engage health centers in increased advocacy at

the patient, board and staff level. In 2016, we had 119 members join the Public Affairs Peer Network and in 2017 we added an additional 31 members to the group. Some of the topics discussed in 2017 where ways in which health centers could partner with local government, the importance of collecting patient stories, social media campaigns, how to make National Health Center Week a success, how to maximize your time when meeting with an elected official and what works and doesn't work in terms of outreach and advocacy. As we revamp our funding cliff advocacy efforts and begin the 2018 state legislative year, the PAPN's monthly calls is a great space for health center and consortia staff who engage in public affairs work (government, community, media, advocacy, etc.) to share best practices and learn from one another. This is also a space to provide feedback to CaliforniaHealth+ Advocates' staff on how to best support health centers in their legislative engagement. If you would like to be included in future PAPN meetings, please contact our Assistant Director of Legislative Affairs, Victor Christy at victor@healthplusadvocates.org.

- Deepening Personal Relationships with Elected Officials: Key Contacts

  Throughout 2017, we engaged and activated health center leaders that were identified as Key Contacts with their elected leaders in Washington and Sacramento to help engage in a higher level of advocacy. This included making personal phone calls, sending emails and scheduling meetings in district and at the Capitol to compliment the broader advocacy effort being undertaken by the health center community. In addition, we saw a higher level of targeted outreach by our key contacts to Republican Members of Congress and Democratic leaders in California. As we saw the need for advocacy to ramp up, especially relating to the funding cliff, CHIP reauthorization and the need to save the ACA, staff engaged each key contact personally to identify the best way to send the message to a particular Member of Congress. For example, we encouraged key contacts to continue to develop their relationships with Members of Congress and the Legislature by inviting them to attend a health center tour, attending a press conference or roundtable that the elected official was holding, and by meeting with them during P and I and DAC.

- Deploying different advocacy tactics: Advocacy Alerts

  XX

- Leveraging relationships with partners

  In 2017 we worked more with partner organizations on advocacy than in many years past. In coordination with the RAC, we hosted an ACA state-wide celebration in March and Funding Cliff day-of-action in November. During both events, Advocates partnered with local health centers and community partners, including Health Access and Children Now, to host press conferences at the state capitol. We also participated in a press conference with Treasurer Chiang, announcing the lifeline grant program.

III. Important Dates / Events

Below are upcoming opportunities to strengthen our federal and statewide advocacy efforts:

- State Advocacy: Preparing for State Advocacy for the 2018 Legislative Cycle
  On January 23, CaliforniaHealth+ Advocates' will host a webinar to address how CPCA members can participate in state advocacy to support our 2018 state legislative engagement. If you would like to register for the webinar, please email Jana Castillo at jana@healthplusadvocates.org.

- NACHCs 2018 Policy and Issues Forum: March 14-18, 2018 in Washington, DC
  The P&I Forum is an opportunity for clinicians, board members, consumers, executives and other community health leaders to bring perspectives to Members of Congress and offer constructive solutions to the issues at hand. Participants will also have the opportunity to hear from government officials, some of the nation's leading health care experts, and their peers. Registration is now open at http://www.nachc.org/conferences/policy-and-issues/.

- Advocates Day at the Capitol: Wednesday April 25, 2018 in Sacramento, CA
  Day at the Capitol is an annual event that welcomes health center executives, clinicians, staff, patients, and advocates to Sacramento to engage with legislators and legislative staff about budget and legislative priorities impacting health centers. With legislative visits, a health center fair, a capitol steps program, and luncheon, we look forward to continuing to expand our successful capitol program with all of you. To allow us to display a strong and unified statewide presence to the capitol community, we will again be calling on health centers to participate in a health center fair. If you are interested in participating in the fair, please email Jana Castillo at jana@healthplusadvocates.org. Registration is now open at www.cpca.org.

- Voter Engagement:
  Health centers have a long history of supporting voter registration activities. During elections years, CPCA alongside the consortia, aim to engage health centers in coordinated voter engagement campaigns. In the summer of 2018, CaliforniaHealth+ Advocates will provide a new resource webpage which will provide updates and resources for your continuous engagement in voter registration. Stay tuned for more information in the upcoming months.

IV. Discussion

As we launch into 2018, our state and federal agenda will only be successful through our continued partnership with the RAC, health centers, and external partners.

- Do you agree with our advocacy goal?
- Do you believe we should be fostering a culture of advocacy?
- How do we achieve the goal of all health center staff being advocates on behalf of health centers and our patients?
- How should we, if at all, change our advocacy approach?
- What is working for you? What is not working for you?

Consortia Policy Group

Thursday – January 18, 2018
3:40 PM –4:40 PM

David Lavine, Facilitator

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		David Lavine	A
II. Approval of Agenda	• Agenda	David Lavine	A
Looking ahead in 2018 - Federal advocacy - State Advocacy - Imprenta		Jana Castillo Angie Melton Andie Patterson	D
III. State Legislation	*Please see materials in Legislative Committee*	Beth Malinowski	D
IV. Getting it done: how we stay engaged		David Lavine	D
V. Save the date: upcoming advocacy opportunities - 2018 P&I Forum: March 14-18 - 2018 Day at the Capitol: April 25	• Day at the Capitol 2018 – Process and Expectations	Jana Castillo Kelley Aldrich	D
VI. Adjourn			A

Click on the link below to access the CPG Dropbox:
https://www.dropbox.com/sh/z92kwh99biqgqaw/AAAVuwlSnhvph3L2iU0_Qo71a?dl=0

California Primary Care ASSOCIATION

INFORMATIONAL

Date: January 3, 2018

To: Consortia Policy Group

From: Jana Castillo, Advocacy Coordinator, Kelley Aldrich, Senior Administrative Coordinator

Re: Day at the Capitol 2018 – Process and Expectations

California Health+ Advocates
Day at the Capitol
Wednesday, April 25

Why You Should Attend

Day at the Capitol is an annual event that welcomes physicians, clinicians, directors, and patients and health center advocates to Sacramento to engage with legislators and legislative staff about budget and legislative priorities impacting community health centers (CHCs). This year's program will maintain valuable legislative visits, which help emphasize the importance of CCHCs in the 2018 budget and legislative session. In addition, there will be a Legislator drop-in welcome and luncheon on the west steps of the capitol grounds, which will allow us to display a strong and unified statewide presence to the capitol community. General question regarding DAC can be directed to Janalynn Castillo at jana@healthplusadvocates.org

Save the Date

A save the date email that includes the reception invite will be sent to every legislator, chief of staff and scheduler in March.

**** Once CaliforniaHealth+ Advocates "Save the Date" goes out, meeting requests can be submitted by members of CPG.**

Meetings with Members of the Legislature

Each consortia will take the lead in scheduling meetings with legislators. *"Taking the lead"* means scheduling the meeting, coordinating with the overlapping consortia on attendees, and passing along your confirmed visits to Kelley Aldrich to be included in the master grid.

CaliforniaHealth+ Advocates maintains a master grid to assist members and legislative offices who contact us with questions. As you confirm your visits please e-mail the following information to Kelley Aldrich at kelley@healthplusadvocates.org

- District #

- Legislator's name
- Name of staff person you are meeting with (*if not the legislator*)
- Date
- Time
- Room number

All legislative meetings should be confirmed and sent to Kelley Aldrich by Friday, April 20 to be added to the master visit grid. **We will need everyone's participation in this process in order to provide members with a successful master grid.** Once finalized the master visit grid will be sent out to all CPG members for review.

Resources

Feel free to contact Kelley Aldrich if you would like any of the materials below to help with your meeting request(s)

- Copy of CaliforniaHealth+ Advocates "Save the Date" e-mail
- Electronic version of the reception invite
- Legislative contact grid
- Sample meeting request
- Sample meeting grid

Materials and Questions

If at any time you have questions or would like any of the following materials, please contact Kelley Aldrich.

- List of DAC registrants
- Copy of the master meeting grid
- State or District profiles
- Meeting materials
- Tips on meeting with your legislators

Executive Committee

Thursday, January 18, 2018
3:40-4:40p
CPCA Conference Room

Scott McFarland, Chair

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Scott McFarland, Chair	A
II. Approval of Agenda		Scott McFarland, Chair	A
III. Approval of Minutes	• Minutes from Oct. 10, 2017	Scott McFarland, Chair	A
IV. CEO Report		Carmela Castellano-Garcia	I/D
V. Epic Partnership Update	• *Memo:* CPCA/Epic Joint Venture – Business Negotiations Update	Carmela Castellano-Garcia	I/D/A
VI. Emeritus Requests (2): John Gressman Steve Schilling		Carmela Castellano-Garcia	I/D/A
VII. Executive (Closed) Session	• CEO Assessment Timeline for 2018 • *Memo:* UHW Ballot Initiative	Scott McFarland, Chair	I/D/A
VIII. Adjourn		Naomi Fuchs, Chair	A

EXECUTIVE COMMITTEE MEETING

October 10, 2017

Meeting Minutes

Members Present :	Scott McFarland (Chair-elect), Kerry Hydash, Kevin Mattson, Louise McCarthy, Danielle Myers, Christine Noguera, Tracy Ream, and David Vliet
Members Absent:	Naomi Fuchs, Sherry Hirota
Guests:	Christy Ward, Britta Guerrero, Cathy Frey, Paulo Soares, Robin Affrime, Christine Velasco, Marty Lynch, Dean Germano, Andy Principe, Anitha Mullangi, Yvonne Magallanes, Linda Costa, Leslie McGowan
Staff:	Carmela Castellano-Garcia, Robert Beaudry, Mike Witte, Heather Barclay

1. Call to Order

Scott McFarland, Chair-elect, called the meeting to order at 3:40p. He noted that Board Chair Naomi Fuchs is staying in her region to deal with the wildfires that are affecting their main Vista clinic.

2. Approval of Agenda

Motion

A motion was made and seconded to approve the agenda as presented. **The motion carried.**

3. Approval of Minutes

Motion

A motion was made and seconded to approve the minutes from the July 13, 2017, meeting as presented. **The motion carried.**

4. CEO Report

Carmela Castellano-Garcia provided a brief report, noting that she and the staff are excited for another Annual Conference event. Everyone's thoughts are with those impacted by the recent wildfires that have directly impacted the personal and professional lives of some of our members. The ACA has been a roller coaster this year and everyone was thanked for their efforts in preventing an overturn of the legislation. Despite uncertainties, she feels we are well positioned for the challenges we'll face in the coming year. Regarding NACHC, David Vliet is the new California representative on the NACHC Board and he's interested in being on the Executive Committee. Carmela has been talking with him, along with Sherry Hirota who's involved in NACHC executive elections. Sherry has also helped develop a diversity caucus - anyone interested in working with them (Carmela, Sherry, David and Naomi) on a long-term workgroup to impact NACHC Board leadership from California, please let her know (Marty Lynch volunteered).

5. Update on Epic Partnership

Carmela provided a brief introduction on the Epic partnership topic, noting the TAG and Board workgroups have been busy since the July meetings and recently had a second in-person visit to Epic headquarters in Madison, WI. Recently, the groups have been delving into the concept and business plan and today, the group is being asked to allow CPCA to move ahead with good faith negotiations with

Epic. If there are any concerns/roadblocks to moving ahead to negotiations, we need to know today. Information including the business plan was included in the meeting packet to guide discussion.

Consultant Andy Principe provided a high level overview including the vision and goals of a CPCA/Epic partnership. Governance, staffing and pricing issues were all discussed. It was noted Epic is eager to begin discussing practice management issues. Fitment strategies and financial pro formas were also reviewed. How to fund the initial $4M upfront investment was discussed, including the potential for Foundation support.

Staff is proposing a single member LLC with a separate/distinct Board (including some CPCA Board members) to oversee day-to-day operations. A handful of Committee's would also report to this Board.

The Board Workgroup provided the following motion for consideration: CPCA begin negotiating with Epic for actual price terms in order to reach an agreement to be brought to the Board for approval.

CPCA would bring back all negotiated terms to the full Board before finalizing the partnership with Epic. The Board will have full review of the negotiations.

Motion
CPCA begin negotiating with Epic for actual price terms in order to reach an agreement to be brought to the Board for approval. **The motion carried**. One abstention was noted.

6. <u>CaliforniaHealth+ Advocates Board Seats</u>
Three (3) CaliforniaHealth+ Advocates Board members' terms expire in October 2017 and another member is retiring. Staff has made the following recommendations to replace these members:

- Replace Tracy Ream (term expires) with Steve Schilling
- Replace Dean Germano (term expires) with Scott McFarland (CPCA's incoming Board Chair)
- Replace Kathy Kneer (retiring) with Lisa Maas of CAPP
- Leslie McGowan (term expires) to be re-elected

Motion
A motion was made and seconded to approve the proposed slate of CaliforniaHealth+ Advocates Board members. **The motion carried.**

8. <u>Adjourn</u>
The meeting was adjourned by the Chair-elect at approximately 4:40p.

California Primary Care Association

Date: January 18, 2017

To: Executive Committee

From: Carmela Castellano-Garcia

Re: CPCA/Epic Joint Venture – Business Negotiations Update

MEMORANDUM

I. BACKGROUND & OVERVIEW

At the Annual Meeting in October, the CPCA Board of Directors voted to approve continued business negotiations between CPCA and Epic around an FQHC-specific instance of Epic for CPCA members. Additionally, should negotiations be successful, the Board approved housing the new HIT services and technical assistance in a separate LLC, owned and operated by CPCA.

The final quarter of 2017 was spent in conversation with the Technical Advisory Group (TAG) identifying functionality concerns and issues that needed to be discussed with Epic, as well as in strategy conversations with Stoel Rives, LLP. Below is a summary of business plan negotiations, legal considerations that need to be addressed within the potential partnership, and next steps.

II. PROGRAM DEVELOPMENT & BUSINESS NEGOTIATION UPDATE

Business Plan/Negotiations

On December 5, 2017, Robert Beaudry, Vice President & COO; Andy Principe, Starling Advisors; Roopak Manchanda, BlueNovo; and Wunna Mine, CIO, Golden Valley Health Center, travelled to Madison, WI to continue business negotiations with Epic. This meeting focused on clarifying contract terms and validating key assumptions in the business plan regarding staffing levels and implementation costs and timeline.

This meeting as well as analysis of the initial contract terms by legal counsel continue to demonstrate that CPCA has a high probability of negotiating reduced pricing terms and will discuss with Epic three specific strategies:

1. Better starting price and additional discounting based on commitment of reaching 3M encounters per year within the first 5 years.
2. Start discount based on total number of encounters committed at initial contract signing, based on the following: Golden Valley, Neighborhood, Western Sierra, CMC, and Mountain Valleys.
3. Delay payment for data center hosting (or grant some technical assistance) to defer $600k in capital requirements.

Legal Considerations

Stoel-Rives has reviewed the template Epic contracts for both licensing and hosting services as well as the various appendices for both contracts. After a detailed review, the items outlined below describe the primary findings that CPCA will need to address/revise in final contract language.

1. Limits of liability for HIPAA violations seems low, and passes risk to the new entity.
2. Indemnity requirements need to have pass-through given relationship between Member, CPCA, and Epic.
3. We would prefer Epic to increase liability limits where they are currently carved out in the contract.
4. Epic needs to assume liability for program errors related to clinical products.
5. There are issues with non-solicit terms that are impacted by California law.
6. Contractual language around minimum staffing could modify business plan, but Epic has validated the business plan to date. Contract language should match the staffing plan Epic agrees to.
7. Contract specifies that option to participate in Epic community is "all or nothing" meaning CPCA could not selectively decide which templates to share. No legal change is necessary, but CPCA and Members will want to careful determine how to proceed.
8. Reference to routine increases in fees are not specific enough for proper planning.
9. Contract must spell out clear definition of down-time processes so that reciprocity can be built into contract with Members.Final contract will need to better clarify effect of term and termination, in the case that a single Health Center were to leave, since they can negatively effect cost for CPCA and others.
10. Final contract will need to clearly specify reporting relationship in event of HIPAA security breach.

It is Stoel-Rives guidance that the terms and conditions currently presented are not consistent with the current market for "cloud-based" or "hosted" clinical information systems. As a result, CPCA will explore options for negotiation of terms and conditions in these areas (issues #1 - 4 above.) Negotiation, combined with exploring options for insurance against these issues, are being explored as we work towards the best possible deal with Epic.

Issue #5 should be curable, as Epic is currently doing business in California. We are exploring remedies.

Issues #6 – 11 are issues that arise out of the unique nature of the relationship CPCA intends to have with Epic. We anticipate each of these is curable through modified contractual language, but must work through these issues during the course of creating a final contract.

III. TECHNICAL ADIVSORY GROUP (TAG) UPDATE

In the final quarter of 2017, the TAG focused on demonstrating member commitment in order to increase negotiating leverage with Epic as well as improve the certainty of the program business modeling. The TAG also further developed a working list of technical issues that will

need to be investigated further as part of implementation planning, and began to collect some of this technical information from individual participants.

For the purposes of demonstrating the intention to implement Epic, the TAG drafted a Memorandum of Understanding. Signing this non-binding MOU indicated the health center's intention of implementing Epic through a CPCA partnership, including the intended timeline for implementation. Signing an MOU granted CPCA the ability to use an organization's name and encounter totals in negotiations with Epic. In addition to a signed MOU, TAG members were asked to submit a modest initial deposit serving as a down payment on the implementation costs. To date, four MOUs have been signed and returned and one MOU is pending.

The TAG also developed a technical working list to inform implementation planning, including issues such a technical connectivity, data segmentation, and the impact of third party services such as billing clearinghouse services, reference labs, and appointment reminder systems. The group will focus on these technical issues in the first quarter of 2018.

IV. NEXT STEPS

Throughout January and February, CPCA will continue negotiations with Epic and the TAG will continue to meet, focusing on working through the technical working list.

1. CPCA staff, with support from consultants, are updating the underlying financial assumptions in the business plan and new cost information is expected from Epic, to be completed in January.
2. Stole-Rives is leading the ongoing process of red-lining the hosting and license agreements. This is an ongoing initiative.
3. The Technical Advisory Group is moving ahead to tackle the next round of implementation challenges in January and February:
    a. Identifying necessary interface and software integrations necessary to support the CPCA community.
    b. Vetting and validating more detailed implementation plans.
    c. Assessing key decisions in architecture, including options for data-segmentation.
    d. Assessing the Epic Community options.
    e. Developing the approach to application governance.
4. CPCA staff and members of the Technical Advisory Group intend to conduct a thorough reference check at the Yakima Valley Farm Workers Clinic (FQHC) in Yakima, WA.

Attachments:

- ***TAG Roster***

CPCA/Epic Partnership Development 2017
Technical Advisory Group Roster

AltaMed
Dr. Michael Eaton, Associate Medical Director
Emmett Jacobs, Director, Application Support and Development

Borrego Health
Dave Baldwin, CIO
Gary Rotto, VP of Govt. Affairs for Borrego Communality Health Foundation

Community Health Association Inland Southern Region
Deanna Stover, CEO

Clinicas de Salud del Pueblo
Yolanda Lantz, HIT Manager

Community Medical Centers, Inc.
David Hyder, HIT Director
Arthur Feagles, CFO

Golden Valley Health Centers
Wunna Mine, CIO
Dr. Ellen Piernot, CMO

Mountain Valley Health Centers
Scott Putnam, CIO
Dr. Shannon Gerig, Associate CMO

Neighborhood Healthcare
Dr. Jim Schultz, CMO

North County Health Services
Dr. Kenneth Morris, Associate Medical Director
Jonathan Smith, VP of IT

North East Medical Services
Dr. Ted Li, Associate Medical Director
Clifton Yuen, Director of Informatics

Omni Family Health
Tony Carbone, CIO

Via Care Health Center
Deborah Villar, CEO
Lourdes Olivares, CCO

San Ysidro Health Centers
Alicia Rodriguez, VP & CIO

Western Sierra Medical Clinic
Dan Happs, CIO

CEO Assessment Timeline - 2018

Assessment Period (3 years due to Contract Year): Sept. 1, 2015 to August 31, 2018

Current Three Year Contract Period: Sept. 1, 2015 – August 31, 2018

New Contract Period will be: Sept. 1, 2018 – August 31, 2021

MONTH	ITEM	MATERIALS	LEADER
January 9, 2018	CEO and Board Chair call to review timeline/assessment tool	Draft timeline & Draft Assessment Tool	Scott McFarland
January 18, 2018	Executive Committee Closed Session to review timeline & procedure; appoint workgroup	Draft timeline	Scott McFarland
April 26, 2018	Exec Committee Closed Session to: approve final tool, CEO job description & review evaluation process. Also, determine which member will lead process.	Final timeline, job description, assessment tool	Scott McFarland
Mid-May 2018	Member lead to send out assessment tool to Board (results due late May/early June)	Assessment tool (provided by **member lead**); CEO's self-assessment/Accomplishment document	**Member lead;** Heather Barclay at CPCA to provide Accomplish. doc
Late May, early June 2018 (*exact due date TBD*)	Assessment survey due from all Board members	Assessment tool; accomplishments document	**Member Lead;** Board members
Late June 2018	Executive Committee call to discuss assessment results.	Assessment results (provided by **Member Lead)**	**Member Lead;** Heather Barclay from CPCA to schedule the call
July 12 & 13, 2018	Executive Committee and Board of Directors meetings to include Closed Session (w/out CEO) for final review of results.	Copies of final assessment for Executive Committee & Board review and for final presentation to CEO (on 7/21)	Scott McFarland
Friday, July 21, 2018	Scott McFarland and Kerry Hydash to present Assessment results and contract to Carmela	Final Assessment & Contract for Carmela to sign.	Scott McFarland & Kerry Hydash

California Primary Care ASSOCIATION

DISCUSSION

Date: December 20, 2017

To: Executive Committee

From: Carmela Castellano Garcia, President and CEO

Re: UHW Ballot Initiative

MEMORANDUM

Overview

On November 14, 2017 UHW filed a ballot proposition for Title and Summary to the Attorney General's office, entitled California Care Act. The proposition directly impacts health centers and is now public. On December 19, 2017 the proposition was slightly amended.

Quick Summary

Title: California Care Act

- 1% tax on anyone in California earning over $1M
    - Context: Similar to Proposition 63 Mental Health, which brings in about $1 billion/ annually.
- Earnings would be collected into a "special fund" that would be allocated as such:
    - 70% to a Safety Net Hospital Fund
    - 25% to a Community Health Clinic and *Qualified Primary Care Providers* Fund
    - 5% to a Healthcare Workforce Training Fund
    - Plus any administrative costs
        - The totals were amended on Dec 19. Originally it was 60% for hospitals, 30% for clinics, and 10% for workforce.
- Safety Net Hospitals Fund
    - Eligible hospitals are those licensed as general acute care, meet the "disproportionate share hospital" definition, located in a MUA or MUP, meet the "eligible hospital" definition, and licensed as a nonprofit or are in a local health care district.
        - Context: According to the CA Hospital Association only about 20 hospitals meet this definition.
- Community Health Clinic and *Qualified Primary Care Providers* Fund
    - Eligible clinics are those that are licensed as 1204a
        - The original version required 330 grant FQHC status. The amended version no longer does.

    - A Qualified Primary Care Provider is an entity not licensed under 1204a but that provides substantially similar services to those entities that are so licensed. DHHS will establish standards for qualifying under this category.
        - The original version did not include "Qualified Primary Care Providers." The Dec 19 version added this element.
    - The distribution of funding in this category would be at the discretion of DHCS
    - The monies once distributed to clinics or qualified providers could be used for anything that improves the health and well-being of their communities and community members and support the clinic ability to deliver quality care and access.
    - The monies are not considered reimbursement and the government can't use them to offset other costs.
- Workforce Fund
    - The workforce training fund would be overseen by a Workforce Training Panel and could be administered by the Governor's office or an appointed Executive Director
    - The workforce money would be for grants or contracts for workforce development or training projects.
    - Training would be for new frontline health care workers new to the field, or wanting to advance or for paid internships.

Ballot Proposition Process

The proposition is in the early stages. It has been written, now filed for title and summary. It must go through internal vetting at Department of Finance. There are some 65 days (could be less or more) for a financial analysis and then the AG's office can give the final Official Summary Date. After this point signatures can begin to be gathered.

Timeline of Events for the UHW Ballot Proposition

- November 14, 2017- Filed with the AG
- December 14 - 30 days allotted for public comment
- December 19 – Submission of amendment to California Care Act (within the five days post the 30 to meet timely amendment standards)
- February 7- as much as fifty days post amendment to allow DOF and LAO to provide the fiscal analysis on the proposition (could potentially be shorter or be extended)
- February 22 - Official title and summary to allow for signature gathering (if full 50 days plus 15 days for AG are used - could be shorter or longer)

*** MUST be certified at least 131 days before the next General election (by June 28th)

Initiative Statute – requires 5% of total votes cast for Gov in last Gubernatorial election (365,880)

Initiative Constitutional Amendment – requires 8% of total votes cast for Gov in last Gubernatorial election (585,407)

Clinicians Committee

Friday, January 19, 2018

8:30 a.m. - 10:00 a.m.

Ellen Piernot, Chair

ORDER OF BUSINESS		RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I.	Call to Order		Ellen Piernot	A
II.	Approval of Agenda		Ellen Piernot	A
III.	Approval of Minutes		Ellen Piernot	A
IV.	CPCA CMO Report	• Memo	Mike Witte	I
V.	Integrated Care/Behavioral Health	• Refer to Government Programs Packet	Allie Budenz	I
VI.	Legislative Update	• Refer to Legislative Committee packet	Beth Malinowski	I
VII.	Workforce Update	• Refer to Workforce Committee packet	Nataly Diaz	I
VIII.	CP3 & Data Report	• Memo	Lucy Moreno	I
IX.	Value Based Care	Guest Speaker	Jay Lee	I/D
X.	Adjourn			A

CALIFORNIA PRIMARY CARE ASSOCIATION
CLINICIANS COMMITTEE
October 11, 2017
8:30am-10:00am

Members: Anitha Mullangi, Chair, Ellen Piernot, Chair-elect, Maria Carriedo-Ceniceros, Susie Foster, Cathy Frey, Dean Germano, Kerry Hydash, David Kadar, David Lavine, Ivonne Magallanes, Danielle Myers, Christina Velasco, Jason Wickham

Guests: Nik Gupta, Paulo Soares, Gary Rotto, Scott McFarland, Doreen Bradshaw, Tim Rine, Christine Noguera, Kevin Mattson, Richard Veloz, Melissa Eidman, Chrisly Bruma, Christy Ward,

Staff: Mike Witte, Val Sheehan, Ginger Smith, Cindy Keltner, Beth Malinowski, Janelle Mollgaard, Sandy Birkman, Andie Patterson, Andrea Chavez, Nenick Vu

I. Call to Order
Anitha Mullangi, Chair, called the meeting to order at 8:33am.

II. Approval of Agenda
A motion was made to approve the agenda as presented. **The motion carried. (Myers/Frey)**

III. Approval of Minutes
A motion was made to approve the minutes of July 14th, 2017. **The motion carried. (Germano/Frey)**

IV. CMO Report
Mike Witte reviewed his CMO report with priorities of focus workforce, outreach, and Emergency Preparedness.

V. CP3 & Data Report
Keltner provided an update on the CP3 pilot site assessments and upcoming programs for TA, Non-Traditional Services, and Managed Care.

VI. Integrated Care/Behavioral Health
Witte reviewed a memo on Emergency Preparedness and updates on fires currently affecting member health centers.

VII. Legislative Update
Malinowski reviewed top bills to watch as October 15th deadline to veto or sign rapidly approaches.

VIII. Workforce
Due to time committee was advised to refer to Workforce packet for updates.

IX. Tele-Dentistry
Dr. Glassman provided a presentation on Tele-Dentistry and its cost effective ability to reach those, especially children, who do not typically receive dental care.

X. Adjourn
The meeting was adjourned at 10:02am.

Respectfully submitted,
Janelle Mollgaard, Meeting Minutes Recorder

CMO Quarterly Report

Date: January 19, 2018

CLINICIANS COMMITTEE

From: Dr. Mike Witte

CMO Guiding Principle:

> Working together, each member organization, each consortium, and CPCA—will be able to strategically manage our opportunities to move our Health Centers to become centers of excellence in this rapidly evolving world of primary healthcare, and community health.

UPDATED PRIORITY AREAS:

- **Workforce:**
  - Pipeline development of our future healthcare teams.
  - Building teams for the future primary care workforce.
- **Provider and Employer of Choice:**
  - Recruiting, Training, and Retaining the best workforce under a value-based care model of work.
  - Build on the concept of resiliency and joy in the workplace, as an antidote to burnout.
- **Increasing Outreach To Safety-Net Clinicians:**
  - Develop meaningful involvement of increased numbers of clinicians in managing change as we work toward health center and health system transformation.

Updated Strategic Directions for 2018:

- **Clinician Peer Network**
  - Continue to expand our **clinician database.**
  - Define our "universe" of clinicians. **How do we define what a clinician is, as we evolve into team care**?
    - MD/DO/RN/PA/NP/CNM/DDS/BH providers, etc.
    - **Identify clinician leaders**: Behavioral, Dental, Medical, Specialty Services
    - Reach out to and meet with Clinical Leaders in the Regional Associations.
    - Enhance networking possibilities: conferences, in-the-field outreach, webinars, etc.

1. Develop trainings and other ways to reach out to clinicians, based on feedback.
2. Expand work in partnership with **State AHEC** to further support the 13 regional AHECs.
3. Research and develop partnership with best available **MA training/certification programs** for CHC's MA role.
4. Identify best practices in **integrating** medical, dental and behavioral health.
5. Develop **new workflows** with providers in CP3 pilots—value-based, team care.
6. Incorporate **Social Determinants of Health** into primary care:
   - Best practices in working with Community Based Organizations.
7. Develop **shared decision-making and patient engagement**.
8. Support Motivational Interviewing Training, for all CHC staff.
9. Develop New Partnerships/relationships in the primary care world:

- Our current and potential partners:
  - State Agencies: DHCS, DMHC, CDPH, MBC, BRN
  - CMA, CAFP
  - AT Still University
  - Sutter Medical Foundation, Dignity, Et Al.
  - Kaiser
  - Academic Centers: UCSF, UC Davis
  - Managed Care Medi-Cal and other Payers.
  - Weitzman Institute

10. Work toward development of a training Academy at CPCA, to make workforce training available to all CPCA member organizations and their staff.

ACTIVITY AREAS DURING THIS PAST QUARTER:

CDPH OFFICE OF HEALTH EQUITY ADVISORY COMMITTEE--Site visits:

- Marin Health and Wellness Free-standing Birth Center.

Workforce Convening (11/6): Third meeting convened by CPCA's Workforce staff, to assess and plan for the future healthcare primary care workforce. Excellent dialog among representatives of FQHC's, RHCs, State Agencies and Health plans.

Center for Connections in Health Policy: Sitting on the Committee for Expansion of Tele-health, in particular eConsult, into primary care—with effective payment model for its use.

CDPH: Working with their Committee on Immunizations to help to effectively make immunizations available to ALL populations, particularly focused on un-insured adults (for Hep A vaccine) and pregnant women (for TDaP).

KPSOM/KGI Claremont:

- Continuing to work with Kaiser's team on the development of their School of Medicine, with commitment from them to their including placement of medical students in CHCs, as an integral facet of their educational model.
- Beginning investigation with the Keck Graduate Institute at the Claremont Colleges on the feasibility of a primary care School of Medicine in their area.

UCD Center for Workforce Diversity and UCSD Hispanic Center of Excellence:

- **Primary Care Workforce project:** Health Careers Community Of Practice developing as a coalition between UCD/UCSD and CPCA.

MAT Training/Opioid Epidemic: Working with our Behavioral Health team on evaluating and spreading best practices in both Substance Abuse and chronic pain care, centered on the Medication Assisted Treatment model.

Hub and Spoke Concept: (UCSF—ECHO+) (UCD-Chronic pain): Many of our sites have become "spokes" for the management of chronic complex medical problems. We continue to work with the resources (academic centers and clinical research centers, such as Weitzman Institute and the ECHO Institute) providing the "hubs" of specialized skill and knowledge to our clinical teams.

IHA/P4P Managed Care MediCal Standardizing QIP's: Continuing participation in the IHA-convened committee on standardization of quality measures among all 23 Managed Care MediCal Health plans.

SMART CARE: Another IHA convening is based on the "Choosing Wisely" national model for removing waste from healthcare. This multi-faceted group has DMHC, DHCS, CDPH, many health plans, and purchasers (CalPERS co-chairs with Covered California), as well as associations, like PCA, CMA, CHA, CAFP, CHCF, CCI, etc. Consumer Reports also attends and has reported on the issues being addressed currently: elective primary C-sections, imaging for acute back pain, and opiate use for chronic non-cancer pain.

Provider Directory Utility (UMC): SB 137 has required Blue Shield, as an undertaking of their becoming a Managed Care MediCal provider, to finance the development of a Provider Directory Utility, with all Health plans responsible for providing valid, updated information to all their eligible providers, with an end goal being improved timely access to care for enrolled patients. It is in development, with a vendor to be selected in February, a pilot to be done in late 2018, and roll-out in 2019. I sit on the Utility Management Committee.

AHEC—Scholars Program—who is eligible? (40 hours/year for 2 years): AHEC has re-invented its Community Health Fellowship, as a Healthcare Scholars program. The details of eligibility for this are still being discussed, since it could be made available to many different members of the clinical team.

NACHC-PCA Meetings (November, Austin TX):

- There was a clear focus on Business Intelligence ("B.I.") in our CHCs with an emphasis on,
- The need for Good Data and tools to collect and communicate it:
    - "Data→Information→knowledge→Wisdom".
    - **Also, from Morgan Honea, CEO of Colorado's RHIO: "Effective Behavioral Health information exchange is what will fix healthcare."**

CMO List Serve: We are developing a comprehensive list of Chief Medical Officers, which I intend to expand to all clinical leaders in our organization. We now reach an "opt-in" list of clinicians that needs expansion to level the playing field of information, bi-directionally, as a kind of blog, among all of our sites.

UPCOMING EVENTS:

- **CPCA QUALITY CARE CONFERENCE:** March 1-2, 2018 (Sacramento Hyatt)
- **REGION 9 CLINICAL EXCELLENCE CONFERENCE**: June 3-5, 2018 at the Sheraton Grand at Wild Horse Pass in Chandler, Arizona.
- **CPCA Annual Conference**: October 4-5 at Sacramento Convention Center

California Primary Care ASSOCIATION

DISCUSSION

Date: January 5, 2017
To: Clinicians
From: Lucy Moreno, Data Informaticist
Re: CP3 Update: Payment Reform Readiness

MEMORANDUM

I. Capitation Payment Preparedness Program

CPCA's Capitation Payment Preparedness Program (CP3) will continue to support health centers in well-positioning themselves for payment reform by strengthening internal and external systems. CPCA will continue to provide technical assistance to CP3 sites through a number of electronic and in-person mediums. This memo provides information on the training and technical assistance CP3 has implemented since the last board memo was presented.

II. Technical Assistance

Non-Traditional Services

From an extensive analysis, CPCA has a complete list of the codes that will be used to track non-traditional services. The list will be used to train health centers on using the codes when doing a non-traditional service. CPCA is also working with the EHR vendors to ensure readiness of their systems to enter the codes in specified fields. In addition, CPCA will work with the health plans so that health centers can ensure success in transmission of the codes to the health plans. CPCA will focus on training health centers, working with health plans and EHR vendors in order to ensure success of accurately coding and transmitting the list of non-traditional services.

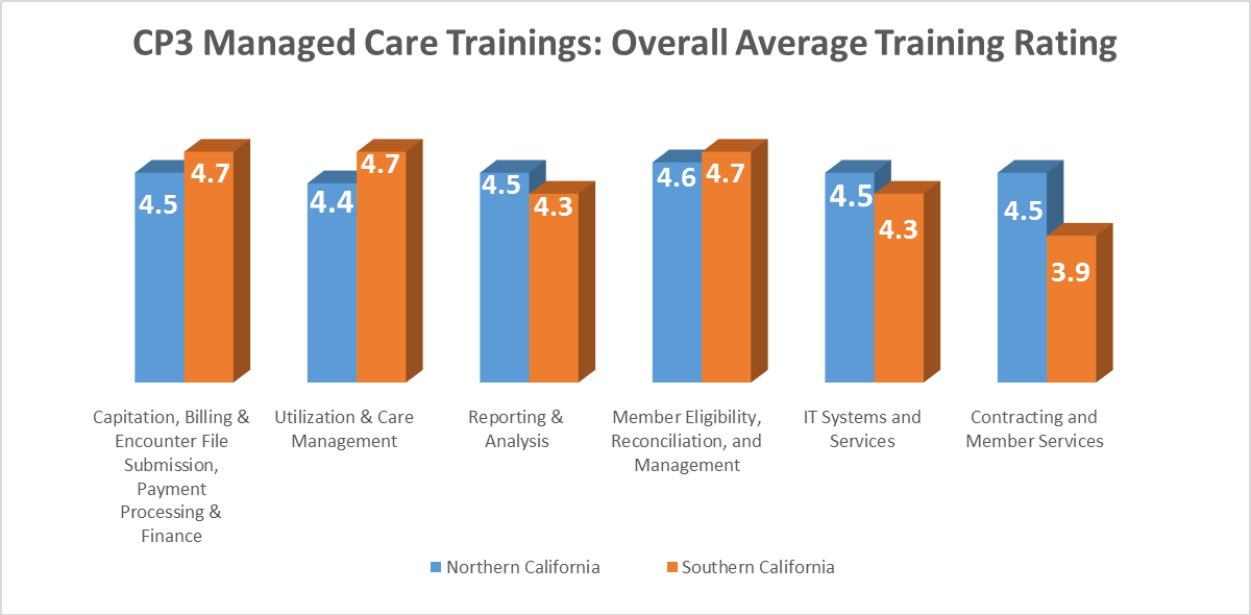
Telehelp:

CP3 offered all participating sites the opportunity for 20 individualized consulting hours with experts from the CP3 managed care trainings. The program is called TeleHELP and 12 health centers are participating. Members had the opportunity to request support for a specific project. Requests varied from support to develop a risk stratification protocol to financial and managed care data analytics.

III. Training*:*

Managed Care:

CPCA's CP3 team launched a series of managed care trainings in June of 2017 and completed the series of twelve trainings in October 2017. These trainings were designed to train health centers in managed care operational and clinical areas to enhance health centers' readiness to be successful in payment reform. These trainings were delivered in a series of sessions (each offered in both Northern and Southern CA) that brought together interdisciplinary clinic teams. The idea is that health centers bring key members of the team and take lessons and action plans back to the site/organization for implementation and to refine processes. The trainings have been very successful with an average rating of 4.47 out of a 5.0 scoring system.



Member Attribution and Management:

To spread solutions to the issue of unseen patients, CP3 hosted the Member Attribution and Management Webinar. CP3 sites, CommuniCare and Neighborhood Healthcare have developed data/IT systems that can import monthly patient assignment lists by health plan/IPA, gap in care reports, and compare them to utilization records. Both clinics presented at the CP3 Managed Care Webinar, Patient Attribution and Management and showcased their processes, dashboards, and workflows to articulate how staff use data to inform and drive member outreach and management.

Social Determinants of Health (SDOH)

CP3 will be working with the preparedness pilot sites and Consortia to launch a learning cohort in early February 2018 on SDOH, specifically working with the PRAPARE tool. The CP3 team is working with partners to develop the curriculum outline including a timeline to share with our members in January as we begin our registration process for sites interested in this work. Our goal with this work is to develop a learning cohort to advance PRAPARE implementation across our members and to inform a possible continuation of the Blue Shield implementation grant work.

CPCA and the CP3 team, in collaboration with NACHC, AAPCHO and regional association consortia's, continue to work on the PRAPARE implementation grant funded by Blue Shield. This project is being finalized with the 8 health center participants. The team is working towards developing a Phase 2 project to continue to spread the work across all CPCA membership.

Payment Reform Podcast:

CPCA released a number of podcasts on our Community HealthCast station about the developments health centers can expect in an alternative payment environment and how CP3 has supported health centers to prepare. Each podcast is about 25 minutes long and pairs a participating CP3 health center with a content expert to dive into the weeds of practice transformation and financial readiness for APM. We have completed 4 of 6 podcasts with an average download rate of 32.

III. Hand Out(s)

- None

Board of Directors

Friday, January 19, 2018
10:15a – 12:15p
CPCA Office

Scott McFarland, Chair

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Scott McFarland, Chair	A
II. Approval of Agenda		Scott McFarland, Chair	A
III. Consent Calendar • Approval of Minutes	• Oct. 11, 2017 Minutes	Scott McFarland, Chair	I/D/A
IV. CEO Report	• *Memo: "*Staff Engagement Survey 2017" • Resume: Buddy Orange, VP, Human & Organizational Development • *Memo*: "CPCA Training Program and TA Update" • *Memo*: "Advocates Grant Report" • Final 2018 Board Calendar	Carmela Castellano-Garcia	I/D
V. Financial Presentation	• Board Financial Presentation • Financial Reports ending November 30, 2017 (*see Finance Committee packet)*	Carmela Castellano-Garcia and Sandy Birkman	I/D/A
VI. Speaker – Brianna Lierman, CEO, Local Health Plans of California	• Bio	Brianna Lierman	I/D
VII. Epic Partnership Update	• *Memo*: "CPCA/Epic Joint Venture – Business Negotiations Update"	Robert Beaudry	I/D/A
VIII. Strategic Plan Update	• PowerPoint slides	Carmela Castellano-Garcia	I/D
IX. Approval of Committee Action Items and Brief Informational Reports	• Audit • Clinicians • Executive • Finance/Ventures Finance • 330 • Governance • Government Programs • Legislative • SPARC • Workforce	• Tony Weber • Ellen Piernot • Scott McFarland • David Vliet • Louise McCarthy • Ben Flores • Robin Affrime • Kevin Mattson • Tim Rine • Paulo Soares	I/D/A

X. NACHC Update (recurring)	• NACHC Report to CPCA Board of Directors	David Vliet, new NACHC Region IX rep	I
XI. RAC Update (recurring)		Henry Tuttle, RAC Chair	I
XII. Closed Session	• *Memo:* UHW Ballot Initiative • 2018 CEO Assessment Timeline	Carmela Castellano-Garcia	I/D
XVI. Adjourn		Scott McFarland, Chair	A
Additional Attachments:	• CPCA Code of Conduct • Board Attendance Policy		

Board of Directors Meeting

October 11, 2017

Meeting Minutes

Board Members Present : *Chair-Elect:* Scott McFarland, Robin Affrime, Isabel Becerra, Doreen Bradshaw, Ben Flores, Cathy Frey, Jane Garcia, Britta Guerrero, Nik Gupta, Kerry Hydash, Deborah Lerner, Marty Lynch, Kevin Mattson, Louise McCarthy, Danielle Myers, Christine Noguera, Tracy Ream, Tim Rine, Ralph Silber, Paulo Soares, Richard Veloz, and David Vliet

Members Absent: Deb Farmer, Naomi Fuchs, Sherry Hirota, Jackie Ritacco, Graciela Soto-Perez, Mary Szecsey, and Paula Wilson

Guests: James Luisi & Joe Gallegos, NACHC: Christy Ward, Joanne Preece, John Price, Tony Weber, Tony Alatorre, Henry Tuttle, Deanna Stover, Christina Velasco, Reymundo Espinoza, Gary Rotto, Dean Germano, Anitha Mullangi, Corinne Sanchez, Leslie McGowan

Staff: Carmela Castellano-Garcia, Robert Beaudry, Heather Barclay, Sandy Birkman, Andie Patterson, Mike Witte, Victor Christy, Ginger Smith, Val Sheehan, Liz Oseguera, Michael Helmick, Cindy Keltner, Emili LaBass, Beth Malinowskiw, Meaghan McCamman

1. Call to Order

Chair-elect Scott McFarland called the meeting to order at 12:15p.

2. Approval of Agenda

Motion

A motion was made and seconded to approve the agenda as presented. **The motion carried.**

3. Consent Calendar

Motion

A motion was made and seconded to approve the Consent Calendar. **The motion carried.**

4. CEO Report

Carmela Castellano-Garcia provided a report, noting how thankful we are that the ACA repeal efforts have failed and appreciated all of the staff, clinic and consortia support in helping defeat the efforts. Everyone is looking forward to the Conference kick-off later this week.

Scott McFarland, Board Chair-Elect, added how great it is to see new attendees at the meeting as developing new leaders is important to CPCA and the Board.

5. Approval of Financial Audit for FY 2016-17

Matt Krehe, CPA and Sr. Manager at Gilbert & Associates, attended the meeting at the Board's request

to present the findings of the fiscal year 2016-17 financial audit. In short, Mr. Krehe noted this is one of the cleanest audits he's completed in a long time and there were no findings or recommendations to report. He noted this is the first year that CaliforniaHealth+ Advocates was included in the audit along with CPCA and CPCA Ventures. There are no control deficiencies, audit adjustments, or findings, which he noted is highly unusual. Additional, no management letter was issued which is also very positive. He noted CPCA isn't spending a disproportional amount to run the organization, and is on the low-end of organizational costs compared to other organizations.

6. Financial Presentation

Sandy Birkman, Director of Finance & Operations, gave a financial presentation by reviewing the balance/loss and profit documents that are provided at each meeting for review and approval. She reviewed key information and there were no questions. The Board requested quarterly updates of this nature.

Motion

A motion was made and seconded to approve the financials as presented. **The motion carried.**

7. Speaker: Mr. James Luisi, NACHC Board Chair

Mr. James Luisi, NACHC Board Chair and CEO of North End Waterfront Health in Boston, MA, attended the meeting to address the Board. He discussed his priorities during his term as Chair and also highlighted a successful 2017 National Health Center Week. He spoke about major threats to community health centers – namely changes to Medicaid and immigration reform, including questions about how healthcare will be delivered in the years to come. Restoring health center funding is a key goal and bipartisan support is essential. He noted the CHIME and CHAMPION Acts and requested members to keep up the pressure on elected officials, as well as general advocacy pressure. He feels our efforts and message is making an impact, but we need a permanent funding fix. He also discussed leadership development and ensuring that PCAs have the tools they need to succeed.

Mr. Luisi answered questions from the Board, including how to keep legislators engaged who are already on our side and protecting 340B, and he also stated the 340B workgroup would be elevated once the fiscal cliff issues have been fixed. There was also discussion about APM-related issues. Joe Gallegos from NACHC was also in attendance and noted that there are 20 or so PCAs who are working on some form of APM development and he suggests closely monitoring 1115 waiver developments including approaches other states will take. Mr. Luisi added that PCAs also need to keep NACHC apprised of state APM/ACO developments. There was also discussion about leadership development at NACHC which Mr. Luisi is very supportive of. He encouraged members who are interested in leadership roles at NACHC to get involved at the Committee level. He looks forward to speaking at the Conference tomorrow and to meeting members during his stay.

8. Epic Partnership Update

Scott McFarland introduced the topic and noted that there is a Technical Advisory Group (TAG) and a Board workgroup looking at Epic-related issues and the TAG group has conducted two (2) in-person visits at Epic's Madison, WI headquarters. There are still unknowns until a good faith negotiation between CPCA and EPIC is entered into, but what is presented today is the "best guess" for now. Today, CPCA leadership wants to ensure the Board is comfortable with what we know now to move forward in the process with Epic. Scott read the motion that is proposed by the Executive Committee for Board approval today: CPCA begin negotiating with Epic for actual price terms in order to reach an agreements to be brought to the Board for approval. It was reiterated that we won't know the answers to some of

the outstanding questions until the negotiation process begins.
Consultant Andy Principe provided an overview of how we got where we're at in the process today, and he noted that an initial financial term sheet was received by Epic, but we need Board approval to negotiate further. In all three (3) of the proposed scenarios, 100% of invested capital would be returned within seven (7) years and the more encounters, the lower the price. Good faith conversations would be a next step and would include approaching Foundations about financial support for upfront costs. Governance models were reviewed and there was discussion about potential reputational harm. CPCA is proposing a structure whereby a wholly owned LLC subsidiary would be managed by a distinct Board (which would be appointed by the CPCA Board). Staffing was also briefly discussed. The Board was reminded that all figures are pre-negotiation and represent a worst case scenarios.

Motion
A motion was made and seconded for the Board to approve CPCA begin negotiating with Epic for actual price terms in order to reach an agreements to be brought to the Board for approval.

Discussion ensued and topics included: are there other avenues for members to acquire the Epic product; if the goal of this partnership is revenue generation, are there other areas to explore; is this model the correct approach; does CPCA have the internal expertise necessary; are there additional risks to CPCA that haven't been considered; could our policy decisions lead us to diminish work with other EHRs; and are there other structures for consideration.

The motion was re-introduced for a vote.

Motion
A motion was made and seconded for the Board to approve CPCA begin negotiating with Epic for actual price terms in order to reach an agreements to be brought to the Board for approval. **The motion carried.** (7 "nays" and 1 abstention was noted).

Discussion ensued regarding the legal structure and there are two (2) recommendations – a limited liability single member corporation (CPCA is suggesting this approach); a multi-member LLC is the second option. The CPCA Board would have oversight, similar to the CaliforniaHealth+ Advocates Board, but the LLC Board would oversee IT operations. The CPCA Board would also have financial oversight (how to reinvest proceeds, reinvestment, etc.) The LLC would manage day-to-day operations (vendor management, etc.) Board composition is recommended to include 4 active CPCA Board members and 3 program participants (non-CPCA Board members). CPCA attorneys recommend he single member LLC option to ensure CPCA retains some oversight. Ideally, we'd have this structure piece finalized in advance of the negotiations with Epic and it was noted that Epic has expressed interest in working with CPCA, not a Health Center Controlled Network (HCCN).

Motion
A motion was made and seconded to accept staff's recommendation (single member LLC) on the structure for the project. **The motion carried.** (5 "nays" and 4 abstentions were noted).

9. Approval of Committee Action Items

AG Worker Health – no report; although it was noted that next year the AG worker and Rural committee's will be combined.

Audit – no report; staff were thanked for support and hard work last year.

Clinicians – no report.

Executive –

Motion

A motion was made and seconded to adopt the following slate of CaliforniaHealth+ Advocates Board members:

- Steve Schilling (replacing Tracy Ream)
- Scott McFarland (replacing Dean Germano)
- Lisa Maas, CEO of CAPP (replaces Kathy Kneer
- Re-elect Leslie McGowan

The motion carried.

Finance/Ventures Finance – Kevin Mattson presented a report, noting three (3) motions from Finance Committee and one (1) motion from Ventures Finance Committee:

Motion

A motion was made and seconded to amend the Investment Security Policy to read that "Summary performance statistics and a policy analysis should be provided to the Board on an annual basis."

The motion carried.

Motion

A motion was made and seconded to amend the Reserve Policy to read, "CPCA shall have a goal of three months cash on hand for long-term organizational and operating stability."

The motion carried.

Motion

A motion was made and seconded to approve the financials ending August 31, 2017.

The motion carried.

Motion

A motion was made and seconded to approve the Ventures financials for the period ending August 31, 2017.

The motion carried.

330 –

Motion

A motion was made and seconded for CPCA staff to work with clinics, health plans and IHA to ensure that all P4P programs around the state implement the best practices outlined in the P4P paper. Once best practices are implemented, the Committee will meet again to consider working with the State to promulgate guidance around FQHC P4P.

The motion carried.

Governance –

Motion
A motion was made and seconded to approve the membership application from Health to Hope clinics in Riverside.
The motion carried.

Motion
A motion was made and seconded to add the following language to the Board Attendance Policy, "…strongly encourage attendance at Committee meetings."
The motion carried.

Government Programs –

Motion
A motion was made and second for CPCA staff to pursue a muti-faceted approach that positions health centers for a future legislative play to exempt health centers from licensing.
The motion carried.

Motion
A motion was made and seconded to oppose the Reforming American Immigration for Strong Economy Act (RAISE Act).
The motion carried.

Motion
A motion was made and seconded to support the Dream Act.
The motion carried.

Motion
A motion was made and seconded to oppose the SUCCEED Act.
The motion carried.

Legislative – The Committee was going to propose the same three (3) motions as made by Government Programs and those three (3) motions have already been carried.

Motion
A motion was made and seconded to approve CPCA's Policy Priorities.
The motion carried.

Rural Health – no report.

Workforce – no report.

(Item 10 was removed from agenda; was handled via Executive Committee report.)

11. NACHC Board Report

David Vliet provided a verbal report and noted a reconnection with Jim Macrae at the Bureau of Primary Health Care (BPHC), who outlined their proprieties and Dr. Padilla addressed HPSA issues. BPHCs priorities include: increasing access to primary health care; health center quality impact and optimizing

BPHC operations. He is committed to ensuring opportunities for people of color and kicked off his commitment with a meeting with 15 black leaders to discuss diversity issues and the group intends to meet again. If there are issues members would like David to bring to NACHC, please let him know. Carmela also added she'd love to see California's role in NACHC leadership to be elevated and David is interested in helping her in these long-term efforts. Sherry Hirota is also interested and participates in the unity caucus. If anyone wants to join Carmela on a small workgroup around NACHC leadership, let her know.

12. RAC Update

Ralph Silber, Alameda Health Consortium, provided a brief updated noting that the partnership between CPCA and the Consortia has been deepening and there is a joint program underway regarding advocacy communications. RAC recently held a Staff Day event to help expand collaboration between Consortia and their staff.

13. Outgoing Chair Report

Outgoing Chair Naomi Fuchs was unable to attend the meeting due to the wildfires, but will have an opportunity for to present an outgoing report in Jan. 2018.

14. Seating of FY 2017-18 Board of Directors

The new Board for FY 2017-18 was seated.

15. Election of FY 2017-18 Executive Committee

A. Chair-Elect – Kerry Hydash is nominated as Chair-elect, accepts, and is approved via consensus.
B. Secretary – Jane Garcia is nominated as Secretary, accepts, and is approved via consensus.
C. Treasurer – David Vliet is nominated as Treasurer, accepts, and is approved via consensus.
D. Speaker – Kevin Mattson is nominated as Speaker, accepts, and is approved via consensus.
E. Vice-Speaker – Britta Guerrero is nominated as Vice-Speaker, accepts, and is approved via consensus.
F. Members-at-Large (3)

- **Danielle Myers is nominated; accepts**
- **Richard Veloz is nominated; accepts**
- **Doreen Bradshaw is nominated; accepts**

The three (3) Members-at-Large are approved via consensus.

16. Adjourn

There being no further business, the Board meeting was adjourned at 2:13p.

California Primary Care Association

INFORMATIONAL

Date: January 18, 2017

To: Executive Committee

From: Carmela Castellano-Garcia

Re: Staff Engagement Survey 2017

MEMORANDUM

I. BACKGROUND & OVERVIEW

CPCA leadership prioritize staff satisfaction, and have committed to periodically assessing staff engagement so that action plans can be developed to address deficits or concerns. In year's past, CPCA has used a homegrown, survey monkey tool to bi-annually assess staff engagement. While this tool helped us see changes in trends from survey to survey, the tool itself was not validated and it could not benchmark the Association against other similar nonprofit organizations.

For those reasons, CPCA conducted research in the summer of 2017 to find an evidenced-based staff engagement tool that could provide us with peer benchmark data. Tools researched included GreatPlacestoWork, Survey Monkey, Workify and the tool that CPCA ultimately chose – Gallup's *Employee Engagement Survey*. Gallup was chosen based on cost effectiveness, tool implementation ease (Gallup only consists of 12 questions and they conduct aggregated analysis within 48 hours of the close of the survey), and the depth of benchmark comparison data (their database currently has over 12 million respondents from different industries).

Below you will find aggregated results of the most recent staff engagement survey, as well as an outline of next steps.

II. EMPLOYEE ENGAGEMENT RESULTS

On September, 12, 2017, CPCA conducted a 12-question, employee engagement survey through a partnership with Gallup. A total of 40 out of 43 employees participated. CPCA's mean overall score was 4.03 on a scale of 5 (with 5 being the highest score), which ranked the Association in the 48th percentile among total participants in the overall Gallup database. When comparing CPCA to only non-profit respondents in the database, CPCA's rank percentile improves to the 54th percentile.

The three highest scored questions when compared to other non-profits are:

- **Q02:** I have the materials and equipment I need to do my work right.
- **Q03:** At work, I have the opportunity to do what I do best every day
- **Q05:** My supervisor, or someone at work, seems to care about me as a person

The three lowest scored questions when compared to other non-profits are:

- **Q04:** In the last seven days, I have received recognition or praise for doing good work.
- **Q10:** I have a best friend at work.
- **Q11:** In the last six months, someone at work has talked to me about my progress.

Engagement Hierarchy

Taken collectively, the 12 survey questions are meant to help an organization identify trends in four specific areas, or what's referred to as the "Engagement Hierarchy" – with the idea that organizations can positively impact the top tiers of the hierarchy by ensuring there are no major issues or gaps within the tiers below. The tiers and CPCA's associated mean scores are noted below (the score is again based on a 5 point scale, with 5 being the highest score):

1. Growth – How Can I Grow? : **3.83**
2. Teamwork – Do I Belong Here?: **3.9**
3. Individual – What Do I Give?: **4.10**
4. Basic Needs – What Do I Get?: **4.33**

CPCA Engagement Hierarchy scores indicate that we are doing well in meeting employee's basic needs and in providing opportunities for individual growth and development. These pieces are foundational to working to improve the ***Teamwork*** and ***Growth*** scores above.

III. NEXT STEPS

Buddy Orange, newly hired Vice President of Human & Organizational Development, will work to moderate staff focus groups to better understand the issues specifically contributing to the lowest scoring questions, and based on feedback, will work with the senior leadership team across the organization to develop a workplan. The survey will be re-administered next fall to check for progress.

David Orange

Bronx, NY ▪ 347-510-5728 ▪ borange1@optonline.net ▪ https://www.linkedin.com/in/david-orange

VICE PRESIDENT OF COMMUNITY SCHOOLS

DRIVING ORGANIZATIONAL TRANSFORMATION, EFFECTIVENESS & COLLABORATION

PROFILE: 20 years of experience revitalizing organizational effectiveness for public and private sector organizations. Empowers peak performance and maximum community and industry impact. Excels at assessing organizational health, identifying opportunities for improvement, and designing and leading implementation of organizational development (OD) strategies and initiatives.

TOP SKILLS: Organizational Development, Design & Implementation | Change Management | Organizational Training & Development | Organizational Assessment | Process Consultation | Strategic Planning | Action Research | Program & Leadership Development | Team Building | Conflict Resolution | Project Management | Diversity Training | Microsoft Office Suite | Adult Learning | Action Learning | Experiential Learning

DISCstyles™ Leadership Report (Style DI): *Confident and independent; a self-starter with a strong competitive edge who can react, adjust and modify behavior in a variety of situations. Excellent at initiating activity and providing direction for the team or organization. Ability to use discipline in an appropriate manner, often effecting win-win situation. Strong presentation skills, bringing a poised, confident, and engaging message to any audience. Juggle many projects and activities simultaneously while maintaining a keen awareness of the status of each. Tend to set high goals, then work hard with people to achieve those goals.*

DISCstyles™ Natural Professional Traits: Assertive. Results-Focused. Rapid Decisions. Seeks Challenges. Wants to Lead. Determined. Persuasive. Embraces New Concepts. Mover and Shaker. Very Outgoing. High Energy. Engaging. Brave.

PROFESSIONAL EXPERIENCE

Vice President of Community Schools ▪ *Partnership with Children* ▪ *New York, NY* 2016 – 2017

Nonprofit providing support for the hardest to reach youth and building safe, effective schools that are conducive to learning.

As member of leadership team reporting to COO, responsible for $5M budget. Provide superior and inspiring management and leadership with 4 program directors managing 40+ staff based in 14 NYC community schools supporting 4K+ students. Initiate, support and maintain relationships with principals and multiple levels of NYC Department of Education and related city and state entities. Lead and co-design professional learning community of direct service staff. Cultivate, retain and develop program staff who bring high levels of knowledge, skill and passion to advancing organization's mission. Incorporate research and ensure programs reflect best practices in field.

- **Reduced absenteeism 5% across 14 schools** by revising attendance work plans and augmenting evidence-based Success Mentoring program.
- **Boosted directors' performance** by addressing conflicts and establishing expectations and performance follow up.
- Redesigned metrics dashboard to increase data accuracy, allowing directors to better design and align initiatives that **enhance academic achievement and social emotional learning.**
- **Synergized teams** by orchestrating communication and collegiality between principals and program directors.

Founder/Chief Executive/Organizational Development Consultant ▪ *Quests and Summits LLC* ▪ *Bronx, NY* 2008 – Present

Organizational development consulting firm serving primarily educational institutions and not-for-profits.

Created and manage 5-person OD consulting group that conducts change management projects in education sector for districts, schools, leadership teams and administrators. Designs customized organizational change initiatives, managing OD processes, training and development as well as client contracting and building and sustaining client relations.

- **Boosted annual survey rating of a client's teacher collaboration efforts to improve instructional practices, raising it from 92% to 96% and yielding 100% retention of effective teachers as staff grew by 25%.** Conceptualized and implemented professional development training program for teachers, incorporating core competencies, observations, self-evaluation, feedback and coaching.
- **Enabled school's first-ever overall effectiveness rating of "proficient" and its removal from New York State's list of "persistently dangerous" schools,** evolving it into a safe community school or hub of community resources. Designed

and facilitated strategic planning process involving cross-section of stakeholders, addressing school culture and climate and creating incident reduction plan.

- **Retained school leaders who previously reported job as "unmanageable and overwhelming." School principal gained promotion and 88% of teachers reported that leaders provided regular, helpful feedback.** Overhauled workflow for administration, aligning roles/responsibilities with skills, talent and capacity.
- **Raised teacher job satisfaction and student achievement** by clarifying organizational structures and job expectations and composing competency standards with measurable outcomes tied to student achievement.
- **Ended ongoing conflict between budget director and school principal** resulting from unfilled expectations from both parties. Coached and guided conflict reduction, using expectation dialogue protocol.

Director of Organizational & Staff Development ▪ *New Settlement Apartments* ▪ *Bronx, NY* 2014 – 2016

Not-for-profit housing/community service organization serving 12,500 people in Bronx area.

Constructed and executed comprehensive plan to improve internal communication and collaboration. Plan encompassed internal/external communications strategy and impacts and feedback channels to promote cross-communication between programs. Introduced senior staff to OD concepts. Conducted experiential learning labs and trainings for direct reports, senior staff and directors. Working with senior leadership, spearheaded creation of print materials.

- **Identified, prioritized and actualized capacity-building initiatives.** Led organization-wide diagnosis and reformed senior management meetings to combine action learning, generative conversation and enhance inquiry.
- **Forged pathway to community wellbeing in southwest Bronx within 5 years** by steering comprehensive strategic planning process that resulted in a strategic blueprint.
- **Propelled community engagement, organizational collaboration and internal/external communication and produced new onboarding program** by spearheading implementation of key organizational change initiatives.
- **Facilitated development of high-impact organizational change projects** by providing inclusive step-by-step visioning and design processes that included budgets, work plans, structures, benchmarks and design features.

Program Manager, Organizational Development ▪ *NYC Outward Bound Schools* ▪ *Queens, NY* 1996 – 2008

Non-profit serving 35K+ students and supporting systemic change in 250+ NYC public schools.

Governed full continuum of OD processes for schools and districts within New York City Department of Education and non-profit organizations. Trained and oversaw OD specialists in shaping learning systems to support organizational change. Conducted trainings in experiential learning technologies. Served as internal OD consultant.

- **Co-created, launched and conducted Outward Bound's first diversity training program for Expeditionary Learning (EL) educators that evolved into a national gateway program** for hundreds of educators on inherent teacher biases/prejudices and their impact on racial achievement gap. Generated positive feedback.
- **Yielded sustained peer learning communities for 150 assistant principals** by designing program to change culture of "knowledge containment," including implementation of year-long leadership development training institute.
- **Boosted DePauw University student retention 10% within 3 years via "Depauw.Year1" program, cited by *US News & World Report* as a "program to watch."** Piloted project for upper class student mentors to support first year students in developing self-awareness, self-esteem and team building skills.
- **Improved internal dynamics within cabinet of former New York City school chancellor Rudy Crew** by co-developing and facilitating 3-day retreat.
- **Played key role in guiding online/print branding and organizational direction** by spearheading identification and articulation of core values implicit in initiatives and common practices, but not previously explicated.

Community Outreach Coordinator ▪ *Children's Defense Fund* ▪ *NY* 1995 – 1996

Child advocacy organization that is an authority on protecting children and strengthening families.

Coordinated community mobilization efforts throughout NYC, driving child vaccination and primary health care.

- **Elevated child immunization rates** by building broad-based constituency of 100+ community-based agencies and health care providers who assisted in citywide mobilization efforts.
- **Raised awareness and provided families with information and access to primary health care** by coordinating outreach events in 13 of New York City's most underserved communities.
- **Registered over 100K families in East and Central Harlem with primary health care facilities** by mobilizing 1,000 volunteers. Coordinated, with regional leaders, NYC component of "Hope for a Million Kids," a national event.

347-510-5728 ▪ borange1@optonline.net ▪ https://www.linkedin.com/in/david-orange

David Orange

Additional: **Educational Program Developer/Consultant** at NYC Outward Bound Schools; **Curriculum Developer** at Project Adventure; **Science Teacher** at Boys and Girls Harbor

EDUCATION

Master of Science, Organization Development ▪ *American University & NTL Institute for Applied Behavioral Sciences* 2005

PROFESSIONAL ASSOCIATIONS

American University Alumni Association
American Express Leadership Academy Alumni Group

VOLUNTEER ACTIVITIES

Co-Founder ▪ *The Sophisticated Gents (A program that supports men of color seeking employment)*
Volunteer ▪ *Hope for Kids*
Former Board Member ▪ *Achieving Leadership's Purpose*

PROFESSIONAL DEVELOPMENT

Community Schools Fundamentals ▪ *CAS National Center for Community Schools* 2016
American Express Leadership Academy Certificate ▪ *American Express* 2015
The Courage to Create: Professional Reinvention & Business Development Intensive 2011
Expeditionary Learning National Conference ▪ *EL Education* 2008
Systems, Social Justice & Quadrant Identities ▪ *Organization Development Network* 2007
Decoding Culture Using Social Networks: Measure What You Manage In Your Organization ▪ *Organization Development Network* 2007
Undoing Racism Community Organizing Workshop ▪ *The People's Institute for Survival and Beyond* 2006
Organization Development Network Annual Conference ▪ *Organization Development Network* 2007; 2004; 2003
Developing an Organization's Workforce Potential, Certification ▪ *Empowerment Institute* 2006
Whole System Transformation: The Real Secrets to Sustainability ▪ *Organization Development Network* 2003
Action Research ▪ *Organization Development Network* 2003
Innovation & Inclusion Conference ▪ *Outward Bound USA* 2003
Human Interaction Laboratory ▪ *NTL Institute for Applied Behavioral Sciences* 2001
Facilitating Reflective Conversations ▪ *Pegasus Communications* 2000
Systems Thinking In Action Conference ▪ *Pegasus Communications* 2000; 1999
Systems Thinking & Complexity Modeling ▪ *Linkage, Inc.* 2000
Facilitation Tools for Building a Learning Organization, Certificate ▪ *Pegasus Communications* 1999
Civil Rights Summit ▪ *Expeditionary Learning* 1996
Wilderness First Aid Certification ▪ *Stonehearth Open Learning Opportunities (SOLO Wilderness Medicine)* 1993
Active Learning for Middle Schools, Conference ▪ *Harvard University & Outward Bound USA* 1991
Introduction to Myers-Briggs ▪ *New York City Outward Bound Schools* 1991
Advanced Adventure Based Counseling Certification ▪ *Project Adventure* 1988
Advanced Skills & Standards Certification ▪ *Project Adventure* 1988

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California Primary Care Association

INFORMATIONAL

Date: January 5, 2018

To: CPCA Board of Directors

From: Erin Perry, Assistant Director of Education and Training

Re: CPCA Training Program

MEMORANDUM

Attached is the training report for the 3nd quarter of the 2017-2018 fiscal year. Below are the highlights of this report:

- FY 2017-2018 Quarter 2
  - **16** learning opportunities
    - CPCA launched the 4 iteration of the FinancialManagement+ program with 34 participants signed up for the full program in October.
  - **Over 2,200 attendees** at in-person and online sessions
  - Average Satisfaction Score of 4.14 on a 5-point scale

- What's Ahead:
  - CPCA's Quality Care Conference is taking place on March 1-2, 2017
  - Cohort 9 of HealthManagement+ begins in March.
  - And much more… take a look at the events calendar at www.cpca.org.

Any questions or inquiries regarding the Training Program can be addressed to eperry@cpca.org.

FY2017-18 Post Training Report

Quarter 3: October 2017 - December 2017
Updated: January 5, 2018

Date	Training Category	Title	Type	Number Attended/Lines**	Number of Additional Webinar Attendees*	Satisfaction Score (1-5)
10/2/2017	Finance	FM+ Online: Contracting	Webinar	45	10	4.08
10/12/2017	Events	CPCA Annual Conference	In-Person	592	-	4.24
10/17/2017	Finance	FM+ Online: Medicare PPS and Cost Reports	Webinar	52	4	4.375
10/24/2017	Health Center Operations	Transforming Care for Formerly Incarcerated Patients	Webinar	25	3	4.6
10/24/2017	Health Center Operations	Enhancing Empathy Within Health Care Teams	Webinar	52	31	3.31
11/1/2017	Finance	FM+ Online: PPS 101	Webinar	56	10	4.75
11/7/2017	Advocacy	Using CHWs/Promotoras to Reduce Fears in Immigrant Patients	Webinar	48	10	4.5
11/8/2017	Human Resources	CPCA Compensation & Benefits Survey: 2017 Results	Webinar	203	7	4.5
11/20/2017	Finance	FM+ Online: UDS 101	Webinar	53	4	4.308
11/29/2017	Finance	FM+ Online: 330 Requirements and Governance	Webinar	47	2	3.9
12/12/2017	Data	Uniform Data Systems (UDS) Training - Sacramento	In-Person	201	-	-
12/13/2017	Health Center Operations	Optometry: A New Vision for Health Centers	Webinar	90	21	3.96
12/14/2017	Data	Uniform Data Systems (UDS) Training - Ontario	In-Person	199	-	-
12/18/2017	Finance	FM+ Online: FQHC Billing	Webinar	75	14	3.389
12/19/2017	Advocacy	SB 323: What's Next?	Webinar	262	45	4.45
12/19/2017	Health Center Operations	Using AIMS Grant to Begin Your Telehealth Journey	Webinar	76	4	3.64
Totals/Average:			**16**	**2076**	**165**	**4.14**

*Includes additional attendees on connection with attendee for webinars as identified in evaluation data

** Not including Sponsors & Exhibitors

- Data not collected or pending

californiahealth+ advocates
ADVANCING THE MISSION OF COMMUNITY HEALTH CENTERS

INFORMATION

Date: January 4, 2018

To: Advocates Board

From: Andie Patterson, Director of Government Affairs

Re: Advocates Grant Report for 2017

MEMORANDUM

I. Summary

The purpose of this grant is to support the following specific charitable project of Grantee: to advocate on behalf of policies that preserve and enhance the ability of community clinics and health centers in California to deliver high-quality clinical care to California's underserved and disenfranchised health care consumers, as defined by the Grantor's and Grantee's public policy platform and legislative agenda.

II. Advocacy Efforts & Media Relations

- Coordinated state-wide activities for National Health Center Week.
- In coordination with RAC, hosted an ACA state-wide celebration in March and Funding Cliff day-of-action in November.
- Coordinated a media blitz following the health center funding cliff deadline to garner media coverage on the impact.
- Coordinated various advocacy activities to "Save the ACA", reinstate $100 million workforce funding, fix the health center funding cliff and stop 1250. Advocacy activities included social media, phone calls, emails, letters, and postcard campaigns.
- Sent regular member communications with summaries on legislation, talking points and social media posts.
- Coordinated media interviews with CEO, Carmela Castellano-Garcia and members.
- California Advocates made 434 calls to Congress regarding the health center funding cliff
- CPCA members participated in 20 federal and state advocacy actions, from letter of support campaigns to thunder claps and call-in days.
- Our statewide advocacy supporter program continues to grow its advocacy base. Approximately 9, 085 individuals signed up to be health center advocates.

III. Advocacy and Policy Webinar Trainings

CaliforniaHealth+ Advocates hosted a series of trainings in 2017.

- 2/28/17 – Lobbying & Advocacy 101: What You can Do (189 attendees)
- 3/04/17 – Advocacy Rules for Foundation Grantees (75 attendees)
- 3/07/17 – Lobbying & Advocacy 102: Rules & Reporting for Nonprofits (133 attendees)
- 3/20/17 – Get the Most Out of National Health Center Week 2017 (98 attendees)
- 3/21/17 – P&I Prep Webinar (55 attendees)
- 3/21/17 – Working together c(3) & c(4) (46 attendees)
- 4/18/17 – DAC Prep Webinar (55 attendees)

- 5/11/17 – Online Meeting to Discuss Potential Amendments to AB 387 (18 attendees)
- 5/30/17 – Advocacy Committee Webinar (23 attendees)
- 7/20/17 – Get the Most Out of National Health Center Week 2017 (98 attendees)
- 12/11/17 - What is the NACHC Advocacy Center of Excellence Program? (28 attendees)

IV. Public Affairs Peer Network (PAPN)

In 2017 the PAPN met 11 times, where PAPN members provided suggestions as to how the Advocates team could engage the health center members in increased advocacy at the patient, board and staff level.

- Some of the topics discussed were ways in which health centers could partner with the Counties, the importance of collecting patient stories, how to make National Health Center Week a success, how to maximize your time when meeting with an elected official and what works and doesn't work in terms of outreach and advocacy.
- The PAPN grew from 62 members in 2016 to 112 in 2017.

V. State Legislation

- In 2017, at CPCA's bequest, CaliforniaHealth+ Advocates sponsored and cosponsored, three bills - SB 323 (Mitchell), SB 456 (Pan) and AB 1003 (Bloom). We are excited to share that SB 323 (Mitchell) was signed into law by the Governor.
- At a time of great uncertainty for California's health care delivery system, the Budget Act of 2017 reflects California's commitment to creating a healthy California. Through successful lobbying and advocacy, and with the tremendous leadership of our health centers and a wide array of advocacy partners, we were successful at reinstating workforce funding ($100 million), securing the Community Clinic Lifeline Grant Program ($20 million), preventing changes to the 340B Drug Discount Program, halting the implementation of the Newly Qualified Immigrant (NQI) Wrap, and greenlighting AB 1863 implementation.
- In addition to these sponsored bill and budget efforts, CaliforniaHealth+ Advocates influenced dozens of bills and participated in robust partnerships to achieve legislative success to forward CPCA's policy priorities.
- Advocates played an active role in supporting an immigration bill package, including SB 54.
- Advocates also had the challenging task of maneuvering difficult political and policy waters as it participated in an oppose campaign (AB 1250) and expressed strong concerns on a number of bills early in session. For both legislative and budget success, partnerships continued to be key to our capitol strategy.
- Advocate's tracked over 200 bills of interest, submitted letters of support on over 50 measures, and provided oral testimony on dozens of bills.
- Health center leaders were also called upon to testify in a variety of legislative hearings and briefings held since November 2016 to defend the ACA and protect California's diverse communities from federal policy threats.

CPCA 2018 BOARD MEETING CALENDAR

** Dates will be based on event space availability, even after Board approval.

Board & Committee Meetings

Thursday - Friday, January 18-19, 2018		Sacramento – CPCA Office

(NACHC Winter Strategy Mtg. – January 25-27, 2018 in Delray Beach, FL)

Day at the Capitol / Board & Committee Meetings

Wednesday, April 25 2018	Day at the Capitol & Reception	Sacramento – CPCA Office
Thursday-Friday, April 26-27, 2018	Committee & Board meetings	Sacramento – CPCA Office

(NACHC P&I – March 14-18, 2018 in Washington, D.C.)
(NACHC Conf. for Agricultural Worker Health – May 1-3, 2018 in San Antonio, TX)

Mar. 31-Apr. 7, 2018	*(Passover Week)*
April 1, 2018	*(Easter Sunday)*

Board & Committee Meetings

Thursday-Friday, July 12-13, 2018	Sacramento – CPCA Office

(NACHC CHI – August 24-28, 2018 in Orlando, FL)

**** Annual Conference / Board & Committee Meetings**

Tuesday-Wednesday, October 2-3, 2018	Board & Committee meetings	Sacramento – CPCA Office
Thursday-Friday, October 4-5, 2018	Annual Conference	Sacramento Conv. Ctr.

(NACHC PCA/HCCN Conference – Nov. 14-16, 2018 in New Orleans, LA)
(NACHC FOM/IT Conference – Oct. 16-18, 2018 in Las Vegas, NV)

Sept. 10, 2018	*(Rosh Hashanah)*
Sept. 19, 2018	*(Yom Kippur)*
Sept. 24-30, 2018	*(Sukkot)*

Financial Presentation 11.30.17

	March 31, 2017				November 30, 2017			
	CPCA	**Ventures**	**Advocates**	**Combined**	**CPCA**	**Ventures**	**Advocates**	**Combined**
Statement of Financial Position								
ASSETS:								
Current Assets								
Cash & Equivalents	$ 3,090,327	$ 4,168,171	$ 1,063	$ 7,259,561	$ 2,527,005	$ 2,567,949	$ 224,278	$ 5,319,232
Grants Receivable	$ 510,692			$ 510,692	$ 272,280		$ -	$ 272,280
Dues and Accounts Receivable	$ 324,242			$ 324,242	$ 561,313		$ -	$ 561,313
Current Portion of Loan Receivable		$ 2,278,200		$ 2,278,200		$ 2,278,220		$ 2,278,220
Prepaid Expenses/Undeposited Funds	$ 186,649		$ 846	$ 187,495	$ 37,484		$ -	$ 37,484
Due from (to) affiliate	$ 99,241	$ (128,849)	$ 29,608	$ -	$ 235,026	$ (238,470)	$ 3,444	$ -
Noncurrent Assets								
Certificates of Deposit	$ 806,713			$ 806,713	$ 873,372		$ -	$ 873,372
Loan Receivable, Net		$ 4,099,373		$ 4,099,373		$ 5,876,092	$ -	$ 5,876,092
Property and Equipment, Net	$ 4,871,647			$ 4,871,647	$ 4,871,647		$ -	$ 4,871,647
TOTAL ASSETS	**$ 9,889,511**	**$ 10,416,895**	**$ 31,517**	**$ 20,337,923**	**$ 9,378,127**	**$ 10,483,791**	**$ 227,722**	**$ 20,089,640**
LIABILITIES & NET ASSETS								
Current Liabilities								
Accounts Payable	$ 215,905			$ 215,905	$ 27,686	$ -	$ 400	$ 28,086
Accrued Expenses	$ 275,029			$ 275,029	$ 598,174	$ -	$ -	$ 598,174
Deferred Revenue	$ 427,794			$ 427,794		$ -	$ -	$ -
Current Portion of Loan Payable	$ 131,925	$ 44,954		$ 176,879				$ -
Loan Payable (net)	$ 3,635,667			$ 3,635,667	$ 3,682,686	$ -	$ -	$ 3,682,686
								$ -
TOTAL LIABILITIES	**$ 4,686,320**	**$ 44,954**		**$ 4,731,274**	**$ 4,308,546**	**$ -**	**$ 400**	$ 4,308,946
								$ -
TOTAL NET ASSETS	**$ 5,203,191**	**$ 10,371,941**	**$ 31,517**	**$ 15,606,649**	**$ 5,069,581**	**$ 10,483,791**	**$ 227,322**	**$ 15,780,694**
Unrestricted	$ 3,062,255	$ 10,371,941	$ 31,517	$ 13,465,713	$ 3,891,838	$ 10,483,791	$ 227,322	$ 14,602,951
Temporarily Restricted	$ 2,140,936			$ 2,140,936	$ 1,177,743	0	0	$ 1,177,743
Cash on Hand - how many days organization could operate with no further cash				*257 days*				*195 days*
Current Ratio - compares current assets to current liabilities to show ability to meet short-term financial obligations				*9.64*				*13.53*
-								
Profit and Loss								
Total Income	$ 9,693,951	$ 200,582	$ 703,017	$ 10,597,550	$ 7,028,901	$ 116,792	$ 795,552	$ 7,941,245
Total Expenses	$10,128,130	$ 151,986	$ 703,017	$ 10,983,133	$ 7,151,519	$ 4,963	$ 599,747	$ 7,756,229
Net Income	**$ (434,179)**	**$ 48,596**	**$ -**	**$ (385,583)**	**$ (122,618)**	**$ 111,830**	**$ 195,805**	**$ 185,017**

Profile

Brianna Lierman

Chief Executive Officer

Ms. Lierman comes to LHPC with over a decade and a tremendous breadth of experience in health care. She was most recently Vice President of Government Affairs & Compliance for California Health & Wellness Plan, where she was responsible for county and State government affairs and advocacy with executive and legislative branch, served as legal counsel in health plan operations and new business initiatives, and was the health plan's Compliance Officer. Ms. Lierman was a founding executive and the lead licensing counsel in the start-up of California Heath & Wellness Plan.

Prior to her role at California Health & Wellness Plan, she was an attorney and lobbyist for the law firms Nossaman LLP and Nielsen Merksamer Parrinello Gross & Leoni where she represented a variety of health care clients – such as health plans, hospitals, specialized plans, medical groups and licensed medical professionals – on legal and strategic issues. Ms. Lierman also served as Director of Legal & Regulatory Affairs for the California Association of Health Plans. Ms. Lierman began her career with the State of California.

Ms. Lierman earned her undergraduate degree from UC Davis and Juris Doctor, with distinction, from McGeorge School of Law. Ms. Lierman is a member of the State Bar of California.

California Primary Care Association

Date: January 18, 2017

To: Executive Committee

From: Carmela Castellano-Garcia

Re: CPCA/Epic Joint Venture – Business Negotiations Update

MEMORANDUM

I. BACKGROUND & OVERVIEW

At the Annual Meeting in October, the CPCA Board of Directors voted to approve continued business negotiations between CPCA and Epic around an FQHC-specific instance of Epic for CPCA members. Additionally, should negotiations be successful, the Board approved housing the new HIT services and technical assistance in a separate LLC, owned and operated by CPCA.

The final quarter of 2017 was spent in conversation with the Technical Advisory Group (TAG) identifying functionality concerns and issues that needed to be discussed with Epic, as well as in strategy conversations with Stoel Rives, LLP. Below is a summary of business plan negotiations, legal considerations that need to be addressed within the potential partnership, and next steps.

II. PROGRAM DEVELOPMENT & BUSINESS NEGOTIATION UPDATE

Business Plan/Negotiations

On December 5, 2017, Robert Beaudry, Vice President & COO; Andy Principe, Starling Advisors; Roopak Manchanda, BlueNovo; and Wunna Mine, CIO, Golden Valley Health Center, travelled to Madison, WI to continue business negotiations with Epic. This meeting focused on clarifying contract terms and validating key assumptions in the business plan regarding staffing levels and implementation costs and timeline.

This meeting as well as analysis of the initial contract terms by legal counsel continue to demonstrate that CPCA has a high probability of negotiating reduced pricing terms and will discuss with Epic three specific strategies:

1. Better starting price and additional discounting based on commitment of reaching 3M encounters per year within the first 5 years.
2. Start discount based on total number of encounters committed at initial contract signing, based on the following: Golden Valley, Neighborhood, Western Sierra, CMC, and Mountain Valleys.
3. Delay payment for data center hosting (or grant some technical assistance) to defer $600k in capital requirements.

Legal Considerations

Stoel-Rives has reviewed the template Epic contracts for both licensing and hosting services as well as the various appendices for both contracts. After a detailed review, the items outlined below describe the primary findings that CPCA will need to address/revise in final contract language.

1. Limits of liability for HIPAA violations seems low, and passes risk to the new entity.
2. Indemnity requirements need to have pass-through given relationship between Member, CPCA, and Epic.
3. We would prefer Epic to increase liability limits where they are currently carved out in the contract.
4. Epic needs to assume liability for program errors related to clinical products.
5. There are issues with non-solicit terms that are impacted by California law.
6. Contractual language around minimum staffing could modify business plan, but Epic has validated the business plan to date. Contract language should match the staffing plan Epic agrees to.
7. Contract specifies that option to participate in Epic community is "all or nothing" meaning CPCA could not selectively decide which templates to share. No legal change is necessary, but CPCA and Members will want to careful determine how to proceed.
8. Reference to routine increases in fees are not specific enough for proper planning.
9. Contract must spell out clear definition of down-time processes so that reciprocity can be built into contract with Members.Final contract will need to better clarify effect of term and termination, in the case that a single Health Center were to leave, since they can negatively effect cost for CPCA and others.
10. Final contract will need to clearly specify reporting relationship in event of HIPAA security breach.

It is Stoel-Rives guidance that the terms and conditions currently presented are not consistent with the current market for "cloud-based" or "hosted" clinical information systems. As a result, CPCA will explore options for negotiation of terms and conditions in these areas (issues #1 - 4 above.) Negotiation, combined with exploring options for insurance against these issues, are being explored as we work towards the best possible deal with Epic.

Issue #5 should be curable, as Epic is currently doing business in California. We are exploring remedies.

Issues #6 – 11 are issues that arise out of the unique nature of the relationship CPCA intends to have with Epic. We anticipate each of these is curable through modified contractual language, but must work through these issues during the course of creating a final contract.

III. TECHNICAL ADIVSORY GROUP (TAG) UPDATE

In the final quarter of 2017, the TAG focused on demonstrating member commitment in order to increase negotiating leverage with Epic as well as improve the certainty of the program business modeling. The TAG also further developed a working list of technical issues that will

need to be investigated further as part of implementation planning, and began to collect some of this technical information from individual participants.

For the purposes of demonstrating the intention to implement Epic, the TAG drafted a Memorandum of Understanding. Signing this non-binding MOU indicated the health center's intention of implementing Epic through a CPCA partnership, including the intended timeline for implementation. Signing an MOU granted CPCA the ability to use an organization's name and encounter totals in negotiations with Epic. In addition to a signed MOU, TAG members were asked to submit a modest initial deposit serving as a down payment on the implementation costs. To date, four MOUs have been signed and returned and one MOU is pending.

The TAG also developed a technical working list to inform implementation planning, including issues such a technical connectivity, data segmentation, and the impact of third party services such as billing clearinghouse services, reference labs, and appointment reminder systems. The group will focus on these technical issues in the first quarter of 2018.

IV. NEXT STEPS

Throughout January and February, CPCA will continue negotiations with Epic and the TAG will continue to meet, focusing on working through the technical working list.

1. CPCA staff, with support from consultants, are updating the underlying financial assumptions in the business plan and new cost information is expected from Epic, to be completed in January.
2. Stole-Rives is leading the ongoing process of red-lining the hosting and license agreements. This is an ongoing initiative.
3. The Technical Advisory Group is moving ahead to tackle the next round of implementation challenges in January and February:
    a. Identifying necessary interface and software integrations necessary to support the CPCA community.
    b. Vetting and validating more detailed implementation plans.
    c. Assessing key decisions in architecture, including options for data-segmentation.
    d. Assessing the Epic Community options.
    e. Developing the approach to application governance.
4. CPCA staff and members of the Technical Advisory Group intend to conduct a thorough reference check at the Yakima Valley Farm Workers Clinic (FQHC) in Yakima, WA.

Attachments:

- ***TAG Roster***

CPCA/Epic Partnership Development 2017
Technical Advisory Group Roster

AltaMed
Dr. Michael Eaton, Associate Medical Director
Emmett Jacobs, Director, Application Support and Development

Borrego Health
Dave Baldwin, CIO
Gary Rotto, VP of Govt. Affairs for Borrego Communality Health Foundation

Community Health Association Inland Southern Region
Deanna Stover, CEO

Clinicas de Salud del Pueblo
Yolanda Lantz, HIT Manager

Community Medical Centers, Inc.
David Hyder, HIT Director
Arthur Feagles, CFO

Golden Valley Health Centers
Wunna Mine, CIO
Dr. Ellen Piernot, CMO

Mountain Valley Health Centers
Scott Putnam, CIO
Dr. Shannon Gerig, Associate CMO

Neighborhood Healthcare
Dr. Jim Schultz, CMO

North County Health Services
Dr. Kenneth Morris, Associate Medical Director
Jonathan Smith, VP of IT

North East Medical Services
Dr. Ted Li, Associate Medical Director
Clifton Yuen, Director of Informatics

Omni Family Health
Tony Carbone, CIO

Via Care Health Center
Deborah Villar, CEO
Lourdes Olivares, CCO

San Ysidro Health Centers
Alicia Rodriguez, VP & CIO

Western Sierra Medical Clinic
Dan Happs, CIO

California Primary Care Association

Strategic Plan 2017 - 2020

Bi-Annual Update

May – December 2017

January 2018

Strategic Plan Bold Steps

- Lead a statewide advocacy agenda that supports a robust system of health for the communities health centers serve.

- Advance health system transformation at the national, state, and local levels to promote health equity for all.

- Identify and articulate a shared vision promoting the value of community health centers to California communities and the health system as a whole.

Support the development of a strong healthcare workforce that is responsive to and reflective of California's diverse communities.

Advocating for Access & Coverage
Progress to Date

Clear & Effective Advocacy Messaging

- Developed a protocol for communicating with members when new legislation or issues arise that are of critical importance to CHCs or their patients.

Leveraging Partnerships to Advance the CHC Mission

- 340B – Working with hospitals and other covered entities, CPCA fought back a Governor's proposal to eliminate the 340B program in Medi-Cal managed care.
- Mental Health – Worked with multiple stakeholders to ensure health center representation on the California Mental Health Planning Council (CMHPC); that primary care was included in No Place Like Home Program, AB 1315 (Mullin), and the revised PEI program in MHSOAC.

Supporting Advocates' Efforts Towards Healthy Communities

- Began strategically building relationships with statewide partners that focus on SDOH issues. Staff have met with food, housing and transportation organizations.
- CPCA staff participated in a food and health policy summit to explore how to further integrate the two fields.

Advocating for Access & Coverage
Progress to Date

Internal CHC Cultures of Advocacy

- Strengthened a "Key Contacts" program where health center leaders grow and leverage high value personal relationships with policymakers to advance the center agenda.
- During annual conference, over 30 members committed to more deeply supporting three areas of CPCA's advocacy infrastructure: 1) increasing our statewide grassroots supporter network, 2) state advocacy strategy, and 3) California's participation in NACHC's ACE program.

Outreach, Enrollment and Eligibility

- Have begun the work to develop a vision/principles for a transformed health system (e.g. universal health care or single payer) that will help to guide CPCA and Advocates in advocating and creating a future that maintains and strengthens the mission of community health centers.

Advocating for Access & Coverage
Challenges

- With ongoing duplicate discount concerns related to the 340B program, the federal and state policy environment continues to become more oppositional to the program in its current form.
- The uncertain federal landscape has made advocacy reactive, which undermines the desire and goal to proactively build a strong advocacy foundation and culture.
- There have been unanticipated challenges around CPCA's efforts to coordinate a statewide communications campaign(Wellness Grant). While there has been agreement to focus further into Medicaid, ACA, and health center value – the next steps are to clearly identify an execution strategy.

Advocating for Access & Coverage
Opportunities

- Continue to refine and improve advocacy communications, including utilizing a new digital advocacy software.
- Health care partners are reaching out to sponsor legislation with CPCA's advocacy affiliate CA Health+ Advocates as they are realizing the important role health centers play in the health care system, in particularly primary care and behavioral health integration.
- Continue to work with DHCS and 340B Partners to address duplicate billing discounts while maintaining a critical program.
- Leverage the deeper commitment to advocacy than has existed in years past. CHCs are increasingly being invited to advocacy conversations, and more and more CHCs are employing advocacy/political/external affairs staff to support efforts.
- The Attorney General's Office will be holding stakeholder meetings in January to decide which immigrant policies and procedures they will share with Californians. CPCA sees this as a great opportunity to have our policies mirrored by the state.
- Increasingly leverage social media to push unified messaging.
- The federal landscape will eventually stabilize, and once it does, the immense amount of current planning and agreed upon strategy will help us prioritize next steps.

Transform the Health System
Progress to Date

Innovative & Highly Effective Care Strategies

- Completed the final draft of the behavioral health toolkit, "Leveraging FQHC's in California's Behavioral Health Care Continuum"; presented the toolkit at DHCS' SUD Conference.
- Provided continued training, technical assistance and support around MAT expansion efforts.
- As a leading member in the California Oral Health Network, worked to successfully reinstated full adult Denti-Cal benefits

SDOH Advocacy

- In partnership with NACHC, CPCA is leveraging Phase 1 of the "PRAPARE" pilot to eventually help inform future advocacy efforts.
- An SDOH learning cohort is being developed within the CP3 TA program. Registration will be available by February; cohort meetings will begin in March.

Transform the Health System
Progress to Date

Integrated Delivery Networks and Bridging Gaps within Siloed System

- Inspired by the new federal administration and direction for health care, participated regularly in stakeholder meetings (providers, plans, foundations, academics, and CBOs) to explore how to expand coverage, protect Medicaid, improve system efficiencies, and ultimately grow and improve CA's delivery system.
- Conducted a statewide behavioral health survey to identify successful CHC/county/hospital/MCO partnerships; conducted all-member webinar to share findings.
- Continue to support members in their efforts to standardize data collection and reporting capacity through Azara Healthcare (DRVS) partnership.
- Continue to explore a partnership with Epic to develop a cloud-hosted, FQHC-specific instance of the Epic EHR tool, that would be customized to meet the needs of California CHCs.

Transform the Health System
Progress to Date

Integrated Delivery Networks and Bridging Gaps within Siloed System
(continued)

- Developed 340B FAQ to help CHCs better understand covered entities obligations; conducted legal research around the use of contract pharmacies for 340B in Medi-Cal managed care, and developed an FAQ to help CHCs better understand the current state of affairs. .
- In partnership with IHA, conducted encounter data submission research for the purposes of furthering a statewide directory project funded under the Centene/Health Net and Blue Shield/Care1st mergers.
- Developed “unseen patients” workgroup; proactively partnering with members of CAHP and LHPs to align utilization and provider assignment.

Transform the Health System
Challenges & Opportunities

CHALLENGES

- To continue to find ways to bring together system partners based on common goals and efforts.

OPPORTUNITIES

- Increasing the number of CHCs using tools like PRAPARE to begin standardizing the collection of SDOH data and to help aggregate and report out regional and statewide findings.

Workforce
Progress to Date

Pipeline: Increase Primary Care Workforce Visibility

- In partnership with UCSF's Healthforce Center, published the second of three reports about primary care workforce gaps and opportunities.
- Worked closely with the UCD Center for a Diverse Healthcare Workforce to both develop a Community Health Center Workforce Evaluation and Statewide Health Center Community of Practice, as well as to develop a HRSA grant to develop an executive fellowship in Health Policy for CHC physicians.
- Investigated K-12 pipeline opportunities for early introduction of Health Careers possibilities: visit to Arthur A. Benjamin Health Professions High School.
- Provided public comment to inform the California Community College System's new strategic plan; continued to work with the community college system to identify opportunities for health career development.
- Worked with a consultant to interview community health centers across the state about the challenges and successes they experience with physician residency training via their accredited residency programs or continuity sites. This research project will conclude in the first quarter of 2018.

Workforce
Progress to Date

Primary Care Provider/Staff Training

- Continued to facilitate academic partnerships that are necessary to helping increase primary care provider training/resources for training, such as:
  - KP School of Medicine: CPCA's CMO participated on the Liaison Committee on Medical Education Executive Taskforce
  - Leveraged CSU partnership to develop a care coordinator training
  - Discussion with Keck Graduate Institute around a new medical school
- CPCA worked alongside the American Association of Teaching Health Centers to inform and advocate for the federal Teaching Health Center Program.
- The Song-Brown Healthcare Workforce Training Program received a $33M installment of new funds this year due to a strong coalition effort led by CaliforniaHealth+ Advocates. All member CHC applicants received an award.
- CPCA successfully advocated for the addition of two new commissioners with health center affiliations to join the Song Brown Commission, including the first ever teaching health center affiliated commissioner.

Workforce
Progress to Date

Incentivizing Primary Care

- CPCA commissioned a research project to understand the current loan forgiveness programs and explore future models for public/private loan forgiveness programs.
- Successful budget advocacy that restored the State's commitment to primary care workforce funding, included $333,000 for the State Loan Repayment Program
- Continued participation on the Steven M. Thompson Physician Corps Loan Repayment Program's (STLRP) advisory committee.

Reduce Provider Recruitment Barriers

- Developed strong relationships with the California Board of Registered Nursing (BRN) and the California Medical Board.
- CPCA developed an informational document regarding the different programs that a health center can utilize when hiring providers through a J-1 and H1-B visa.

Workforce
Progress to Date

Retention & Advancing Team Based Care

- In partnership with HRSA and ACU, CPCA hosted the Region 9 PCA meeting and developed a regional action plan to 1) increase staff engagement and satisfaction; 2) improve health center understanding of successful practices; 3) assist health centers with developing workforce strategic plans; and 4) increase the number of qualified candidates who seek and accept jobs at health centers.
- In continued partnership with UCSF's Healthforce Center, published the second report in a three-report series that projected the need for primary care providers in the next decade.
- Provide trainings in partnership with Western Clinicians Network on: provider health, improved access to complex care, team-based care, and SDOH.

Workforce
Progress to Date

Diversify the Health Professions / Address Workforce Disparities

- Through primary care residency budget advocacy, CPCA has continued to bring together a diverse set of statewide associations (CMA, CHA, CAFP) to address disparities in our primary care physician workforce
- CPCA continues to participate in Community College's HWI Statewide Advisory Committee, where industry and community college educators and administration meet to address the role of CCs in addressing health workforce disparities

Workforce Policy Coalition

- CPCA continued to coordinate a statewide Workforce Policy Coalition consisting of members across multiple sectors to discuss potential policy solutions around the primary care workforce gap. CPCA facilitated additional meetings in both June and November of 2017, which culminated in an agreement around three priority issue areas for 2018: residency redesign, equity in education (focused on college pipeline programs), and researching primary care specific tax incentive programs.

Workforce
Challenges

- No database about specific health center activities in health professions training.
- No expedited licensing process for nurses practicing in underserved settings within the Board of Registered Nursing.
- Autonomy amongst academic institutions limits standardization for health professions training (i.e. standard training requirements for community health, SDOH, etc.).
- Continued need for Song Brown advocacy for fair resource dissemination.
- Continued federal funding instability will plague the NHSC and THCGME program
- The impact of Federal Tax Reform and other policy shifts will likely impact the California State Budget, including future funding commitments to workforce
- PPS FFS care (volume based), provides perverse incentives for care, and is an important cause of provider burn-out and a retention problem.
- No dedicated resources to support Workforce Policy Coalition efforts.

Workforce
Opportunities

- Potential policy solutions around the three content areas agreed to by the Primary Care Workforce Policy Coalition; developing new partners for capitol/programming work.
- Robust new relationships with the Medical Board of California and Board of Registered Nursing.
- Increased engagement with the California Future Health Workforce Commission and subject matter experts.
- Commissioner transitions at the Song-Brown Commission, as well as greater attention on the Commission by the legislature, could create the environment for needed administrative reforms.
- The issue of “billable providers” provides a forced opportunity for investigating new models for care and payment for care with “alternative encounters” including care provided by non-traditional (billable) providers.

Value of CHCs
Progress to Date

Supporting CHC Internal Cultures of Quality

- Completed a statewide environmental scan to inform a continuous quality improvement infrastructure .
- In partnership with NACHC, CPCA is finalizing Phase 1 of an “PRAPARE” pilot with 4 RAC and 8 clinic sites.
- Trained over 500 CHC staff around multiple managed care topics (curriculum created through CP3 program)
- Produced four podcasts on what CHCs can expect in an APM environment; and in particular, on practice transformation and financial readiness.
- Provided individual consulting hours to 12 CP3 sites through TeleHELP, on topics such as developing a risk stratification protocol to working with financial and managed care data analytics.

Value of CHCs
Progress to Date

Promoting a Shared "Value Vision"

- In October, CPCA released the newly designed californiahealthplus.com website to support open enrollment activities.
- With support from Cal Wellness, CPCA and RAC continued to work on an advocacy communication project (expected roll-out May 2018) that will connect share advocacy efforts through social media.

Enhancing CHC Capacity Toward Community Partnership

- Over the past few months, CPCA staff have met with several SDOH-related local, statewide, and national groups to explore potential partnerships. Groups include California Food Policy Advocates, the WIC Association, California Transit Association, Sacramento Housing Alliance, JSI, and Futures Without Violence.

Value of CHCs
Challenges & Opportunities

Challenges

CPCA and the consortia have run into some challenges working with the communications firm secured to work on the advocacy communications project. Steps are being taken to identify what the specific issues are so that they can be addressed.

Opportunities

A new Communications Team has been establish to better coordinate all communications work for both CPCA and CaliforniaHealth+ Advocates. The goal will be to ensure that while each organization has its own communications vehicles and strategies, all efforts align to support and promote community health centers.

NACHC Board Report to the CPCA Board

David B. Vliet, CPCA Representative, Region IX

January 18, 2018

The National Association of Community Health Centers (NACHC) Board of Directors convened in Austin, Texas, November 13, 2017, in conjunction with PCA/HCCN meeting that occurs each year serving as one of the three annual meetings held by the Board. Here are some highlights:

General Updates

Three new regional representatives were formally seated at the Board meeting, including myself to serve over the next two years. The new NACHC Board Chair, Jim Luisi was also formally seated for his two year term at that time. Mr. Luisi is the CEO for North End Waterfront Health, in Boston, MA.

Hurricane and Wildfire Impact

Jason Patnosh, NACHC Staff, briefed the Board on the impact of the hurricanes and wildfires on health centers in quite a few areas of the county, including Northern California, Puerto Rico, and Houston. Some 36 health centers were directly affected and were in the process of recovery at the time of the meeting in November.

Special mention was made regarding the efforts to assist our colleagues in Northern California, specifically, the extensive damage suffered by our colleague health center in Santa Rosa, under the leadership of our former Board Chair Naomi Fuchs. Mr. Patnosh highlighted the outpouring of support for the Santa Rosa Health Center and for the other health centers impacted, many of these efforts were covered in the media.

Puerto Rico remained in serious condition at the time of the board meeting with NACHC Board Secretary Paloma Hernandez who is from the island, there seeking relief and raising awareness as to the fate of health centers and the acute desperation of impacted communities. Her report from the island was that folks were very much still in crisis with progress slowly being made. Access to power and clean water remained an ongoing issue.

NACHC announced it had posted a donation page that allowed for financial support for affected health center.

BPHC Leadership Report

Transitions

As is the NACHC Board custom, Jim Macrae, Associate Administrator and Tonya Bower, Deputy Associate Administrator, senior leaders from the Bureau Primary Health Care (BPHC) attended the board meeting and provided a report on several key areas, with an emphasis on the transition(s) the Bureau

has faced with the change of administration in Washington DC, and with the recent appointment of HHS Secretary nominee Alex Azar, former President of Eli Lily pharmaceutical company. Mr. Azar's nomination was announced the day of the Board meeting, November 13, 2017. Mr. Macrae advised the Board that recent meetings with the HRSA (Health Resources Administration) Secretary, George Sigounas, PhD, have been positive and that Dr. Sigounas has articulated his support for the work of Federally Qualified Health Centers and suggested that we continue to demonstrate the "value" and the "return on investment" that health centers provide.

Mr. Macrae and Ms. Bowers covered key areas related to the hurricane relief efforts and suggested that health centers focus further on emergency preparedness to ensure we don't lose our "muscles" in this area and that we remain proactively prepared for any future crises.

At the time of the Board meeting, Mr. Mcrae advised that 330 grant awards would be made based on the continuing resolution (CR) funding. He also stated at that time that there was "no plan B" related to the potential gap in funding and asked that we continue to the document community impact the funding concerns as we get "closer to the edge". This meeting preceded the end-of-year Children's Health Insurance Plan (CHIP) funding issues "scramble" that remains of serious concern as of this writing.

Mr. Macrae suggested that we continue close adherence to program requirements through program audits and stated this was vital. He also suggested, at the behest of Dr. Sigounas, that the Bureau develop a type of "certification system" for meeting the rigorous twenty program requirements of the Operational Site Visit (OSV) and suggested it would raise the brand profile of HRSA and the health centers and that adherence to such high standards could and should culminate in a certification that would represent a "seal" of approval and a high standard of quality that health centers meet, maintain and provide. In general, Mr. Macrae advised that Dr. Sigounas suggested a concerted effort and focus on Quality Improvement would further benefit and should be an area of overall focus for health centers.

Mr. Macrae outlined some possible upcoming changes to the Medicaid program which could include work requirements, an effort that the current head of Centers for Medicare & Medicaid Services (CMS), Seema Verna, has lead in her previous role in Indiana.

The greater scrutiny of the 340 B program was discussed by Mr. Macrae and board member Mike Holmes outlined the "difficult" audit his health center was subject to related the 340 savings program by the Office of Inspector General (OIG). There was consternation among board members that there was an apparent lack of understanding related to the importance of the 340 B program to the sustainability for health centers, a program some feel has been misused by hospitals and other non-health center entities. Mr. Macrae indicated that Dr. Sigounas understood the value of this program and speculated that Mr. Azar, the HHS Secretary nominee, would as well given his pharma background.

Board Chair and NACHC CEO Comments

Jim Luisi, NACHC Board Chair

Jim Luisi spoke briefly about the current funding predicament health centers face and advised folks not to become "advocacy weary" requesting that we continue to "raise the urgency" of needed funding for health centers with our public officials and congressional delegates. He stated that health centers should "turn it on hard in January" to ensure that we maintain high levels of advocacy.

He advised that we would be evaluating the NACHC membership dues structure during his tenure and he outlined some key areas of focus for the upcoming Winter Strategy Meeting in Florida at the end of January: messaging alignment, building capacity at the state level, and driving innovation.

Tom Van Coverden, NACHC CEO

Mr. Van Coverden echoed many of the same concerns around funding, some of which are considered sensitive. He also indicated NACHC staff has met with Dr. Sigounas and the meeting was cordial, with a reassured sense that the Secretary understands and appreciates our work. He also reported that Mike Holmes, Treasurer of NACHC and Manny Lopes, CEO of East Boston Health center and had good dialogue/meeting with Seema Verna, head of CMS and reported that the conversation was robust and often quite direct on the part of Ms. Verna.

Conclusion

This concludes my brief written summary and I will provide additional comments and observations in my oral report at the upcoming January CPCA Board meeting.

I appreciate the opportunity to represent our health centers and primary care association on the NACHC Board and welcome any questions or feedback.

Respectfully submitted,

David B. Vliet, MBA, Board Member, Tiburcio Vasquez Health Center, Hayward/Union City, CA

California Primary Care ASSOCIATION

DISCUSSION

Date: December 20, 2017

To: Executive Committee and Board of Directors

From: Carmela Castellano Garcia, President and CEO

Re: UHW Ballot Initiative

MEMORANDUM

Overview

On November 14, 2017 UHW filed a ballot proposition for Title and Summary to the Attorney General's office, entitled California Care Act. The proposition directly impacts health centers and is now public. On December 19, 2017 the proposition was slightly amended.

Quick Summary

Title: California Care Act

- 1% tax on anyone in California earning over $1M
    - Context: Similar to Proposition 63 Mental Health, which brings in about $1 billion/ annually.
- Earnings would be collected into a "special fund" that would be allocated as such:
    - 70% to a Safety Net Hospital Fund
    - 25% to a Community Health Clinic and *Qualified Primary Care Providers* Fund
    - 5% to a Healthcare Workforce Training Fund
    - Plus any administrative costs
        - The totals were amended on Dec 19. Originally it was 60% for hospitals, 30% for clinics, and 10% for workforce.
- Safety Net Hospitals Fund
    - Eligible hospitals are those licensed as general acute care, meet the "disproportionate share hospital" definition, located in a MUA or MUP, meet the "eligible hospital" definition, and licensed as a nonprofit or are in a local health care district.
        - Context: According to the CA Hospital Association only about 20 hospitals meet this definition.
- Community Health Clinic and *Qualified Primary Care Providers* Fund
    - Eligible clinics are those that are licensed as 1204a
        - The original version required 330 grant FQHC status. The amended version no longer does.

    - A Qualified Primary Care Provider is an entity not licensed under 1204a but that provides substantially similar services to those entities that are so licensed. DHHS will establish standards for qualifying under this category.
        - The original version did not include "Qualified Primary Care Providers." The Dec 19 version added this element.
    - The distribution of funding in this category would be at the discretion of DHCS
    - The monies once distributed to clinics or qualified providers could be used for anything that improves the health and well-being of their communities and community members and support the clinic ability to deliver quality care and access.
    - The monies are not considered reimbursement and the government can't use them to offset other costs.
- Workforce Fund
    - The workforce training fund would be overseen by a Workforce Training Panel and could be administered by the Governor's office or an appointed Executive Director
    - The workforce money would be for grants or contracts for workforce development or training projects.
    - Training would be for new frontline health care workers new to the field, or wanting to advance or for paid internships.

Ballot Proposition Process

The proposition is in the early stages. It has been written, now filed for title and summary. It must go through internal vetting at Department of Finance. There are some 65 days (could be less or more) for a financial analysis and then the AG's office can give the final Official Summary Date. After this point signatures can begin to be gathered.

Timeline of Events for the UHW Ballot Proposition

- November 14, 2017- Filed with the AG
- December 14 - 30 days allotted for public comment
- December 19 – Submission of amendment to California Care Act (within the five days post the 30 to meet timely amendment standards)
- February 7- as much as fifty days post amendment to allow DOF and LAO to provide the fiscal analysis on the proposition (could potentially be shorter or be extended)
- February 22 - Official title and summary to allow for signature gathering (if full 50 days plus 15 days for AG are used - could be shorter or longer)

*** MUST be certified at least 131 days before the next General election (by June 28th)

Initiative Statute – requires 5% of total votes cast for Gov in last Gubernatorial election (365,880)

Initiative Constitutional Amendment – requires 8% of total votes cast for Gov in last Gubernatorial election (585,407)

CEO Assessment Timeline - 2018

Assessment Period (3 years due to Contract Year): Sept. 1, 2015 to August 31, 2018

Current Three Year Contract Period: Sept. 1, 2015 – August 31, 2018

New Contract Period will be: Sept. 1, 2018 – August 31, 2021

MONTH	ITEM	MATERIALS	LEADER
January 9, 2018	CEO and Board Chair call to review timeline/assessment tool	Draft timeline & Draft Assessment Tool	Scott McFarland
January 18, 2018	Executive Committee Closed Session to review timeline & procedure; appoint workgroup	Draft timeline	Scott McFarland
April 26, 2018	Exec Committee Closed Session to: approve final tool, CEO job description & review evaluation process. Also, determine which member will lead process.	Final timeline, job description, assessment tool	Scott McFarland
Mid-May 2018	Member lead to send out assessment tool to Board (results due late May/early June)	Assessment tool (provided by **member lead**); CEO's self-assessment/Accomplishment document	**Member lead;** Heather Barclay at CPCA to provide Accomplish. doc
Late May, early June 2018 (*exact due date TBD*)	Assessment survey due from all Board members	Assessment tool; accomplishments document	**Member Lead;** Board members
Late June 2018	Executive Committee call to discuss assessment results.	Assessment results (provided by **Member Lead)**	**Member Lead;** Heather Barclay from CPCA to schedule the call
July 12 & 13, 2018	Executive Committee and Board of Directors meetings to include Closed Session (w/out CEO) for final review of results.	Copies of final assessment for Executive Committee & Board review and for final presentation to CEO (on 7/21)	Scott McFarland
Friday, July 21, 2018	Scott McFarland and Kerry Hydash to present Assessment results and contract to Carmela	Final Assessment & Contract for Carmela to sign.	Scott McFarland & Kerry Hydash

California Primary Care ASSOCIATION

THE CODE OF CONDUCT

- Mutual respect and courtesy shall prevail at all times between all participants.
- Listen fully to others.
- Encourage diverse perspectives.
- Disagree openly and courteously.
- Share all relevant information. Confidentiality shall be strictly adhered to.
- Strive for consensus.
- Ask, rather than assume.
- Discuss interests, not positions.
- Be a good team player.
- Treat the staff with dignity and respect.
- Maintain appropriate communication boundaries with staff concerning internal operational and personnel issues.

Attendance at Board of Directors Meetings Policy

Members of the Board of Directors of the California Primary Care Association (CPCA) have a responsibility to the members who elected them to oversee the management and affairs of the Association and to set policies which guide CPCA in all of its activities.

1. All members of the CPCA Board of Directors have a duty to be present at all official meetings of the Board. The current practice is to have four Board meetings each year, however special Board Meetings may be called as necessary for items that are time sensitive.
2. All members of the CPCA Board of Directors are strongly encouraged to attend Committee meetings.
3. Per Bylaws, "Directors shall participate in at least 50% of regularly scheduled Board of Directors meetings in a given Board year. Directors who do not participate as so described shall be subject to removal from office by a majority of the Board." A Board year will be considered October through September 30th. The Board of Directors Job Description outlines a desire for a higher attendance rate at 75% in order for a Director to act in the best interest of CPCA as a whole and to exercise the legal and financial duties of the organization.
4. All minutes will reflect not only those Directors present, but those absent.
5. The Board Chair at his/her sole discretion, may (a) excuse (i.e., not count as a missed meeting) one (1) absence per Director per year and/or (b) grant a leave of absence for a Director without forfeiture of the Director's Board seat.
6. After one absence by a Director, a letter will be sent by staff to remind them of this policy.
7. After two absences, a call will be made by the Chair of the Board.
8. On the third absence in any given year, continued participation of any board member who has been unable to be present will be put to vote of the Board for removal.
9. Attendance will be tracked and reviewed regularly and a report made to the Governance Committee and Chair. All candidates running for reelection will have their attendance records in the prior year noted in election materials. Directors not meeting the 50% criteria for each year of their prior term will not be eligible to run for re-election.

Ventures Board

Friday, January 19, 2018
10:15 – 12:15p
Scott McFarland, Chair

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Scott McFarland, Chair	A
II. Approval of Agenda		Scott McFarland, Chair	A
III. Consent Calendar • Approval of Minutes • Approval of Financials	• Minutes of October 11, 2017 • *See Ventures Finance packet*	Scott McFarland, Chair	I/D/A
IV. CEO Report		Carmela Castellano-Garcia	I/D
V. Adjourn Ventures Board		Scott McFarland, Chair	A

Ventures Board of Directors Meeting

October 11, 2017

Meeting Minutes

Board Members Present : *Chair-Elect:* Scott McFarland, Robin Affrime, Isabel Becerra, Doreen Bradshaw, Ben Flores, Cathy Frey, Jane Garcia, Britta Guerrero, Nik Gupta, Kerry Hydash, Deborah Lerner, Marty Lynch, Kevin Mattson, Louise McCarthy, Danielle Myers, Christine Noguera, Tracy Ream, Tim Rine, Ralph Silber, Paulo Soares, Richard Veloz, and David Vliet

Members Absent: Deb Farmer, Naomi Fuchs, Sherry Hirota, Jackie Ritacco, Graciela Soto-Perez, Mary Szecsey, and Paula Wilson

Guests: James Luisi & Joe Gallegos, NACHC: Christy Ward, Joanne Preece, John Price, Tony Weber, Tony Alatorre, Henry Tuttle, Deanna Stover, Christina Velasco, Reymundo Espinoza, Gary Rotto, Dean Germano, Anitha Mullangi, Corinne Sanchez, Leslie McGowan

Staff: Carmela Castellano-Garcia, Robert Beaudry, Heather Barclay, Sandy Birkman

1. Call to Order

Chair-elect Scott McFarland called the meeting to order at 2:15p.

2. Approval of Agenda

Motion

A motion was made and seconded to approve the agenda as presented (Gupta/McCarthy). **The motion carried.**

3. Consent Calendar

Motion

A motion was made and seconded to approve the Consent Calendar as presented. (Frey/Lynch). **The motion carried.**

4. Approval of Financial Audit for FY 2016-17

Motion

A motion was made and seconded to approve Financial Audit for FY 2016-17 as presented. (Lynch/Frey). **The motion carried.**

5. CEO Report

No report.

6. Seating of FY 2017-18 Ventures Board

The Board was seated by consensus.

7. Election of FY 2017-18 Ventures Board Officers

The slate elected at the Board meeting was approved by Consensus for the Ventures Board.

8. Adjourn

The meeting was adjourned by consensus at 2:18p.

californiahealth+ advocates

ADVANCING THE MISSION OF COMMUNITY HEALTH CENTERS

Board of Directors

Friday, January 19, 2018
12:45 – 1:45p
Leslie McGowan, Chair

Agenda

ORDER OF BUSINESS		RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I.	Call to Order		Leslie McGowan, Chair	A
II.	Approval of Agenda		Leslie McGowan	A
III.	Consent Calendar • Approval of Minutes • Grant report 2017	• Minutes from October 2017 • Grant Report CY 2017	Leslie McGowan	A
IV.	Financial Report	• Financial Report as of November 30, 2017	Sandy Birkman	A
V.	Policies for the c4	• Travel	Sandy Birkman	A
VI.	Policy Priorities 2018	• CPCA Policy Priorities 2018 • Action grid	Andie Patterson	A
VII.	Fundraising	• Memo: Fundraising Report	Andie Patterson Victor Christy	D
VIII.	Political Action Committee Process	• Memo: Endorsement Process Progress and PAC Recommendation	Andie Patterson	A
IX.	Political endorsements Process	• General endorsement framework • Endorsement interview process • Sample Interview Questions for Candidates • Questionnaire- Open Seats • Questionnaire- Incumbents • Worksheet for Candidates	Andie Patterson Victor Christy	D
X.	Public Affairs Peer Network Update	• Memo: Staff Update	Victor Christy	D
XI.	Adjourn		Leslie McGowan	A

californiahealth+ advocates

ADVANCING THE MISSION OF COMMUNITY HEALTH CENTERS

BOARD OF DIRECTORS MEETING

October 11, 2017

Meeting Minutes

Board Members:	Leslie McGowan (Vice-Chair), Reymundo Espinoza, and Carmela Castellano-Garcia, Dean Germano, Tracy Ream, Corinne Sanchez, Richard Veloz
Members Absent:	Naomi Fuchs, Kathy Kneer
Guests:	Cathy Frey, Ralph Silber, Gary Rotto, Marie Torres, Marty Lynch, David Vliet, Scott McFarland, Christine Noguera, Louise McCarthy, Henry Tuttle
Staff:	Andie Patterson, Heather Barclay, Andrea Chavez, Sandy Birkman, Liz Oseguera, Mike Witte, Jodi Samuels, Val Sheehan, Victor Christy, Meaghan McCamman, Jana Castillo, Ginger Smith, Cindy Keltner

1. Call to Order

Chair Tracy Ream called the meeting to order at 2:30p.

2. Approval of Agenda

Motion

A motion was made and seconded to approve the agenda as presented (Germano/Ream). **The motion carried.**

3. Consent Calendar

Motion

A motion was made and seconded to approve the Consent Calendar as presented (Sanchez/Veloz).

4. Financial Report

Sandy Birkman, Director of Finance and Operations, provided a brief report and noted the financial report in the meeting packet.

5. Board Seats

In 2018, three (3) Board terms expire and one member is retiring and requested to be replaced. Staff made the following recommendations and the members would be seated in January 2018:

- Replace Tracy Ream with Steve Schilling
- Replace Dean Germano with Scott McFarland (incoming CPCA Board Chair)
- Replace Kathy Kneer (retiring) with Lisa Maas, CAAP
- Re-elect Leslie McGowan (who is currently Vice Chair and would serve as Chair in 2018)

Motion
A motion was made and seconded to approve staff's recommendation for filling the four (4) Board seats. (Germano/Veloz). **The motion carried**.

6. Staff Report
Andie Patterson, Director of Government Affairs, provided a brief report. A staff report memo was also included in the meeting packet. She presented information about a proposal to advance the c4 (there was also a related memo in the packet) including the necessary Secretary of State filing and opening of a 527 bank account, all for the purpose of beginning candidate endorsement activities. While this is recommended for now, the recommendation could change down the road. Forming a PAC would require non c3 funds (a c4 can endorse but can't use c3 funds to do so). Advocates currently has $1k available for non c3-related activities. Forming the PAC would give Advocates additional tools, adds credibility to the organization (and CPCA) and more face time with potential candidates. It was noted that new Board member Lisa Maas has a lot of ideas she'll share.

Andie also noted that we should be thinking about political giving as well, and no matter what we do or use funds for, we do need to start fundraising now and estimated we'd need $20k for the proposed efforts with the goal of starting endorsements in Feb.-April 2018. If more funds are raised, we can determine how to spend those. Members will check with their organizations' legal counsel about using c3 time vs. vacation/volunteering time since c3 time or funds can't be spent on c4 activities (including no endorsements/discussions). Currently, Advocates is not in the financial position to get involved in local races. It was noted that the Advocacy Committee, chaired by Marie Torres, VP of Government Affairs at AltaMed, is also supportive of the plan.

Motion
A motion was made and seconded to approve the c4 Advancement Plan as presented (Sanchez/Veloz). **The motion carried.**

7. Public Affairs Peer Network Update
A memo was provided in the meeting packet.

8. Adjournment
The meeting was adjourned by Vice Chair Leslie McGowan at 3:00p.

californiahealth+ advocates
ADVANCING THE MISSION OF COMMUNITY HEALTH CENTERS

INFORMATION

Date: January 4, 2018

To: Advocates Board

From: Andie Patterson, Director of Government Affairs

Re: Advocates Grant Report for 2017

MEMORANDUM

I. Summary

The purpose of this grant is to support the following specific charitable project of Grantee: to advocate on behalf of policies that preserve and enhance the ability of community clinics and health centers in California to deliver high-quality clinical care to California's underserved and disenfranchised health care consumers, as defined by the Grantor's and Grantee's public policy platform and legislative agenda.

II. Advocacy Efforts & Media Relations

- Coordinated state-wide activities for National Health Center Week.
- In coordination with RAC, hosted an ACA state-wide celebration in March and Funding Cliff day-of-action in November.
- Coordinated a media blitz following the health center funding cliff deadline to garner media coverage on the impact.
- Coordinated various advocacy activities to "Save the ACA", reinstate $100 million workforce funding, fix the health center funding cliff and stop 1250. Advocacy activities included social media, phone calls, emails, letters, and postcard campaigns.
- Sent regular member communications with summaries on legislation, talking points and social media posts.
- Coordinated media interviews with CEO, Carmela Castellano-Garcia and members.
- California Advocates made 434 calls to Congress regarding the health center funding cliff
- CPCA members participated in 20 federal and state advocacy actions, from letter of support campaigns to thunder claps and call-in days.
- Our statewide advocacy supporter program continues to grow its advocacy base. Approximately 9, 085 individuals signed up to be health center advocates.

III. Advocacy and Policy Webinar Trainings

CaliforniaHealth+ Advocates hosted a series of trainings in 2017.

- 2/28/17 – Lobbying & Advocacy 101: What You can Do (189 attendees)
- 3/04/17 – Advocacy Rules for Foundation Grantees (75 attendees)
- 3/07/17 – Lobbying & Advocacy 102: Rules & Reporting for Nonprofits (133 attendees)
- 3/20/17 – Get the Most Out of National Health Center Week 2017 (98 attendees)
- 3/21/17 – P&I Prep Webinar (55 attendees)
- 3/21/17 – Working together c(3) & c(4) (46 attendees)
- 4/18/17 – DAC Prep Webinar (55 attendees)

- 5/11/17 – Online Meeting to Discuss Potential Amendments to AB 387 (18 attendees)
- 5/30/17 – Advocacy Committee Webinar (23 attendees)
- 7/20/17 – Get the Most Out of National Health Center Week 2017 (98 attendees)
- 12/11/17 - What is the NACHC Advocacy Center of Excellence Program? (28 attendees)

IV. Public Affairs Peer Network (PAPN)

In 2017 the PAPN met 11 times, where PAPN members provided suggestions as to how the Advocates team could engage the health center members in increased advocacy at the patient, board and staff level.

- Some of the topics discussed were ways in which health centers could partner with the Counties, the importance of collecting patient stories, how to make National Health Center Week a success, how to maximize your time when meeting with an elected official and what works and doesn't work in terms of outreach and advocacy.
- The PAPN grew from 62 members in 2016 to 112 in 2017.

V. State Legislation

- In 2017, at CPCA's bequest, CaliforniaHealth+ Advocates sponsored and cosponsored, three bills - SB 323 (Mitchell), SB 456 (Pan) and AB 1003 (Bloom). We are excited to share that SB 323 (Mitchell) was signed into law by the Governor.
- At a time of great uncertainty for California's health care delivery system, the Budget Act of 2017 reflects California's commitment to creating a healthy California. Through successful lobbying and advocacy, and with the tremendous leadership of our health centers and a wide array of advocacy partners, we were successful at reinstating workforce funding ($100 million), securing the Community Clinic Lifeline Grant Program ($20 million), preventing changes to the 340B Drug Discount Program, halting the implementation of the Newly Qualified Immigrant (NQI) Wrap, and greenlighting AB 1863 implementation.
- In addition to these sponsored bill and budget efforts, CaliforniaHealth+ Advocates influenced dozens of bills and participated in robust partnerships to achieve legislative success to forward CPCA's policy priorities.
- Advocates played an active role in supporting an immigration bill package, including SB 54.
- Advocates also had the challenging task of maneuvering difficult political and policy waters as it participated in an oppose campaign (AB 1250) and expressed strong concerns on a number of bills early in session. For both legislative and budget success, partnerships continued to be key to our capitol strategy.
- Advocate's tracked over 200 bills of interest, submitted letters of support on over 50 measures, and provided oral testimony on dozens of bills.
- Health center leaders were also called upon to testify in a variety of legislative hearings and briefings held since November 2016 to defend the ACA and protect California's diverse communities from federal policy threats.

CaliforniaHealth Plus Advocates
Balance Sheet
As of November 30, 2017

	Nov 30, 17
ASSETS	
Current Assets	
Checking/Savings	
1000.00 · Cash	224,277.67
Total Checking/Savings	224,277.67
Accounts Receivable	
1320.00 · Due from CPCA	3,444.46
Total Accounts Receivable	3,444.46
Total Current Assets	227,722.13
TOTAL ASSETS	**227,722.13**
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
2000.00 · Accounts Payable	400.00
Total Accounts Payable	400.00
Total Current Liabilities	400.00
Total Liabilities	400.00
Equity	
3900 · Retained Earnings	31,516.79
Net Income	195,805.34
Total Equity	227,322.13
TOTAL LIABILITIES & EQUITY	**227,722.13**

CaliforniaHealth Plus Advocates
Profit & Loss Budget vs. Actual
April through November 2017

	Apr - Nov 17	Budget	$ Over Budget	% of Budget
Income				
4600.00 · Grants	300,000.00	200,000.00	100,000.00	150.0%
4700.00 · Donations	3,500.00			
4800.00 · Membership Dues Donations	492,052.24	391,666.64	100,385.60	125.6%
Total Income	795,552.24	591,666.64	203,885.60	134.5%
Expense				
6100.00 · Salaries	131,911.75	141,436.00	-9,524.25	93.3%
6300.00 · Employee Benefits	29,507.68	36,773.32	-7,265.64	80.2%
6500.00 · Occupancy	12,332.85	10,000.00	2,332.85	123.3%
6505.10 · Building Repairs	38.98			
6510.10 · Communications	1,499.84	716.00	783.84	209.5%
6520.10 · Postage & Delivery	144.79	0.00	144.79	100.0%
6530.10 · Supplies	1,464.64	2,800.00	-1,335.36	52.3%
6540.10 · Printing	2,277.00	5,000.00	-2,723.00	45.5%
6552.10 · Equipment Lease/Maintenance	709.42	680.00	29.42	104.3%
6554.10 · Equipment/Furniture Purchase	696.20			
6560.10 · Insurance	818.28	666.64	151.64	122.7%
6565.10 · Dues & Licenses	420.00	2,666.64	-2,246.64	15.8%
6570.10 · Subscriptions/Publications	334.79	11,000.00	-10,665.21	3.0%
6580.10 · Marketing and Outreach	162,146.75	100,000.00	62,146.75	162.1%
7010.10 · Audit/Accounting	3,800.00	1,500.00	2,300.00	253.3%
7020.10 · Legal Services	18,732.00	1,666.64	17,065.36	1,123.9%
7110.10 · Board of Directors	0.00	3,333.32	-3,333.32	0.0%
7200.10 · Travel & Registration Fees	1,718.24	1,000.00	718.24	171.8%
7200.20 · Travel - Non Staff	5,226.16			
7300.00 · Meetings	1,581.97	13,333.32	-11,751.35	11.9%
7350.00 · Training	50.00	6,666.64	-6,616.64	0.8%
7350.14 · PayPal Service Fees	18.30			
7500.00 · Consultants	224,317.26	252,428.00	-28,110.74	88.9%
8000.00 · Overhead	0.00			
9999.99 · In-Out	0.00			
Total Expense	599,746.90	591,666.52	8,080.38	101.4%
Net Income	**195,805.34**	**0.12**	**195,805.22**	**163,171,116.7%**

CPCA Board Member Travel Reimbursement Policy
July 10, 2008 Approved

Board members in good standing needing travel assistance for board related meeting attendance must submit a letter from their clinic requesting assistance. Receipts must accompany the request.

California Primary Care Association
Public Policy Platform 2018

To promote healthy people and healthy communities, CPCA is committed to strengthening California's community clinics and health centers.

Coverage and Access for All

- Protect Californians' right to comprehensive health care **coverage**.
- Ensure Californians' in rural and urban areas have **access** to vital health care services that meet the comprehensive healthcare needs of individual patients and communities.

Delivery of Culturally Competent Whole Person Health Care, Preventive Care, and Support Services

- Continue to refine and develop an **innovative financial model** for health center reimbursement that leverages the unique strengths of health centers and positions them to meet patients where the patient is at.
- Empower patients to access and utilize healthcare services appropriately by advancing policy which allows and incentivizes the seamless **integration of primary, oral, and behavioral health care** services.
- Help rural and urban communities strengthen the **behavioral health delivery system** through coordination of mental health and substance use disorder service in the primary care setting.
- Support patients by strengthening **culturally competent care**, **case management**, **preventative care**, and **coordination of care with social services and community resources**.
- Improve the quality and delivery of care to patients by promoting healthcare innovation and quality improvement through systemic **Pay-for-Performance** and **shared savings** programs.

Strong Workforce and Core Business Infrastructure

- Counter the nation's shortage of healthcare providers, especially in underserved communities, by maintaining funding for innovative **residency programs**, improving **loan repayment programs**, reforming **provider licensing**, and championing novel workforce development strategies.
- Advocate for **equitable and transparent reimbursement policies** and the application of those policies in a standardized and timely fashion.

Building Healthy Communities

- Address the **social determinants of health** that affect families we serve. By looking at "upstream" non-clinical factors, we aim to disrupt the trajectory of poor health and instead, help people build a core foundation of health in their communities.

California Primary Care Association - Policy Platform 2018

To promote healthy people and healthy communities, CPCA is committed to strengthening California's community clinics and health centers.

Objective	ACTION - IMPLEMENTATION		
	Legislative	**Administrative**	**Educational**
Coverage and Access for All			
Protect Californians' right to comprehensive health care coverage.	-Working with NACHC, continue aggressive federal advocacy for solutions that promote long-term 330 program funding stability. - Advocate for federal and state protections to the ACA and Medicaid to ensure as broad and inclusive a benefit package as possible, including primary/behavioral/oral health care. - Engage in the universal coverage/single payer efforts in a robust and thoughtful manner using member-informed, board approved principles. - Continue to fight for an inclusive country that welcomes and protects all persons regardless of immigration status.		
Ensure Californians' in rural and urban areas have access to vital health care services that meet the comprehensive healthcare needs of individual patients and communities.	- Continue to advocate for a robust and comprehensive health care delivery system where patients have choice of providers, including Planned Parenthood. - Continue to fight for an inclusive country that welcomes and protects all persons regardless of immigration status. - Continue to lay the necessary ground work that will lead to the elimination of unncessary barriers to care, including licensing and building code rules that prevent the creation and operation of safe new health centers. - Add the necessary provisions to AB 2053 - the consolidated licensing bill- to allow an intermittent site that moves to full time to continue to use the parent site's PPS rate	- Work with DHCS to develop educational tools for dental providers to help ensure that when audits are done the rules and expectations are understood well in advance. - Build strong working relationships with OSHPD and DPH to further our licensing and building code interests. - Engage with OSHPD to build a better process for flex requests and reform OSHPD 3 regulations.	-Educate policy makers on the challenges with OSHPD3 -Provide training opportunities related to licensing and OSHPD 3 standards.
Delivery of Culturally Competent Whole Person Health Care, Preventive Care, and Support Services			
Continue to refine and develop an innovative financial model for health center reimbursement that leverages the unique strengths of health centers and positions them to meet patients where the patient is at.		- Work to ensure a value based APM is implemented in CA in a manner that is supportive of FQHCs	- Continue to position health centers for the APM through the CP3 (Capitation Payment Preparedness Program) - Disseminate best practices to non APM sites - Work towards risk stratification for SDOH. Build data gathering into APM pilot and work with NACHC on a national strategy.
Empower patients to access and utilize healthcare services appropriately by advancing policy which allows and incentivizes the seamless integration of primary, oral, and behavioral health care services.	- Determine whether or not there are legislative approaches to enahance health center capacity to meet the behavioral health need of patients. Could include same day billing legislation.	- Implement AB1863 MFT to ensure billing for MFTs is as easy as doing a scope change - Ensure that CCHCs are recognized for the important role that they play in the BH delivery system, and ensure that MHSA funding is available to support their BH work.	- Engage with county BH directors and others to showcase the ways in which CCHCs can partner with county-based BH delivery systems - Support clinic and health center participation in the Dental Transformation Initiative.

California Primary Care Association - Policy Platform 2018

To promote healthy people and healthy communities, CPCA is committed to strengthening California's community clinics and health centers.

	ACTION - IMPLEMENTATION		
Objective	**Legislative**	**Administrative**	**Educational**
Help rural and urban communities strengthen the behavioral health delivery system through coordination of mental health and substance use disorder service in the primary care setting.		Implement SB 323- Drug Medi-Cal and Specialty Mental Health contract services and FQHCs	- Provide technical assistance on behavioral health contracting and billing processes to ensure that CCHCs are fully able to participate in the BH delivery system.
Support patients by strengthening culturally competent care, case management, preventative care, and coordination of care with social services and community resources.	- Ensure that "services that follow the patient" are left out of reconciliation	- Work with the state to develop robust and appropriate 340B claims processes to ensure health centers are protecting the state from duplicate discounts.	- Help health centers better understand the rules of 340B and how to best track the savings to ensure program integrity. - Working with the health plans, facilitate a coordinated implementation of the Health Home Program with the goal of ensuring the plans and providers implementing the benefit save the state money and the benefit remains in perpetuity
Improve the quality and delivery of care to patients by promoting healthcare innovation and quality improvement through systemic Pay-for-Performance and shared savings programs.	- explore opportunities to mitigate the challenges posed by assigned but unseen Medi-Cal beneficiaries		- Rebrand and enhance the CP3 program to focus and tailor to the P4P programs and to be for all health centers regardless of APM interest
<u>Strong Workforce and Core Business Infrastructure</u>			
Counter the nation's shortage of healthcare providers, especially in underserved communities, by maintaining funding for innovative residency programs, improving loan repayment programs, reforming provider licensing, and championing novel workforce development strategies.	- At the Federal Level, work with NACHC, AATHC, and Clinicians for the Underserved to stabilize Federal funding solutions and HRSA policies that strengthen investments in Teaching Health Centers and National Health Service Corp. - At the state level, work to develop a comprehensive workforce policy platform through a policy convening to centralize our work into one coalition, to create and foster the ability to influence graduate medical education reform, expansion of the primary care team, and continue to support policy that grows the workforce pipeline. - State advocacy to ensure the the Brown Administration remains committed to the $100 M workforce investment.	- Working with NACHC and OSHPD inform conversations on HPSA rescoring and methodology -- Participate in stakeholder groups at multiple state agencies, aim to inform and influence a statewide health workforce agenda that centers on the needs of health center patients. Included, but not limited to, expanded funding of loan repayment, reintroduction of state GME funding, and supporting pipeline and educational programs/partnerships that diversify our provider workforce - Work with OSHPD, on implementation of provisionf of AB 2048 (Gray) - State Loan Repayment Program. - Work with OSHPD and partners on implementation of $100 million investment in primary care residency and loan repayment. - Develop stronger relationships with Kaiser, ACU, AHEC, and other organizations to influence provider recruitment and retention. -Work with academic and foundation partners (including UCSF, Kasier, CHCF) to advance research that will support our workforce strategy. - Strengthen relationships with licensing boards to guarantee timely licesnure for providers in rural and underserved communities	- Work with health centers to maximize their utilization of state and federal opportunities related to healthcare workforce (this includes increasing use of OSHPD programs like SLRP). - Provide statewide learning opportunities around innovative workforce models, and partner with higher learning institutions to influence positive change in primary care degree/certificate programs. - Support teaching health center and hosptial/health center residency partnerships by connecting health center to training and experts on residency development. -Educate health centers on how to expedite processsing of provider licenses.

California Primary Care Association - Policy Platform 2018

To promote healthy people and healthy communities, CPCA is committed to strengthening California's community clinics and health centers.

Objective	ACTION - IMPLEMENTATION		
	Legislative	**Administrative**	**Educational**
Advocate for equitable and transparent reimbursement policies and the application of those policies in a standardized and timely fashion.		- Work with A&I to ensure that auditors are working with health centers in a transparent and fair manner and that rules are understood and agreed upon by both health centers and state auditors - Continue working with A&I and health centers on an FQHC SPA that protects and strengthens FQHC interests and ensures clear, transparent, and standardized rules.	

California Primary Care Association - Policy Platform 2018

To promote healthy people and healthy communities, CPCA is committed to strengthening California's community clinics and health centers.

Objective	ACTION - IMPLEMENTATION		
	Legislative	**Administrative**	**Educational**
Building Healthy Communities			
Address the social determinants of health that affect families we serve. By looking at "upstream" non-clinical factors, we aim to disrupt the trajectory of poor health and instead, help people build a core foundation of health in their communities.	- Continue to support legislative solutions to address healthy communities (for example, Sugar Sweetened Beverage Tax, Housing, Medi-Cal rates for electric breast pumps). - Support critical partners in the social safety net like WIC, CalFresh		- Help spread use of a tool to capture SDOH

californiahealth+ advocates
ADVANCING THE MISSION OF COMMUNITY HEALTH CENTERS

DISCUSSION

Date: January 4, 2018
To: Board of Directors
From: Andie Patterson, Director of Government Affairs
Re: Fundraising Update

MEMORANDUM

I. Overview

Beginning October of 2017, CaliforniaHealth+ Advocates began fundraising in order to move forward with endorsements, and potentially a PAC.

Advocates staff have reached out to:

- Board of CaliforniaHealth+ Advocates,
- Board of the California Primary Care Association,
- Regional Association of California,
- CaliforniaHealth+ Advocates Advocacy Committee, and
- Nearly all Health Center CEO's.

A total of 90 individuals have been contacted and 37 individuals have made commitments to contribute. Seven have actively declined, with the remainder ignoring the communications.

Additionally, we intend to, though have not begun, to solicit corporate donations to support Day at the Capitol. The package to solicit donations is under development.

II. 2017/2018 List

Below is a list of individuals who have contributed one time or monthly to the c4:

<u>Champion - $1,000 and More</u>

- Deb Farmer
- Ralph Silber
- Richard Veloz*
- David Vliet*
- Jim Mangia
- Steve Schilling
- Corinne Sanchez
- CAPP – Californians Allied for Patient Protection
- Sherry Hirota

<u>Advocate - $500 and More</u>

- Marty Lynch

- Marie Torres
- Leslie McGowan
- Scott McFarland
- Carole Press

Supporter - $250 and More

- Yvonne Bell* ($100/month)
- Henry Tuttle
- Jason Vega
- Luisa Buada
- Anonymous
- Christine Noguera

Friend - $100 and More

- Isabel Becerra
- Dolores Alvarado
- Doreen Bradshaw
- Alvaro Fuentes
- Steve Heath
- Greg Stone* ($100/month)
- Robin Affrime
- Graciela Soto
- Mary Michal Rawling
- Val Sheehan
- Debbie Howell

Partner – Up to $100

- Sabra Matovsky
- Deena Lahn
- Joanne Preece
- Saaliha Kahn
- Sandy Birkman
- Kelley Aldrich
- Kearsten Shepherd
- Courtney Rodseth
- Lauren Kahn
- Beth Malinowski*
- Andie Patterson* ($50/month)

* *indicates monthly donators or donations in incremental amounts*

Fundraising Totals

- In the Bank: $8,725

- Additional Committed
    - For 2018: $9,600 (total of $18,325)
    - Through March: $7,200 (total of $15,925)
- Gap: approximately $4,000 shy of the $20,000 budgeted for endorsements

III. Resources spent to date

All of the fundraising work as well as the development of the endorsement materials and process must be paid for with the new c4 monies. As of December 31 we have spent approximately $4,000.

IV. Discussion

We need to raise additional resources and about 2/3 of members contacted are not responsive to the communication.

If we cannot reach the full $20,000 we anticipate having to scale back the endorsements we can do. Considering the thousands of staff at community health centers in California (see Appendix) we are hard pressed to believe we cannot raise this amount, and in fact had hypothesized being able to raise $50,000.

In order to achieve these goals we need to change the approach, the ask, the level of intensity or any other number of factors.

1. What else can staff do?
2. Is there anything the Board can do to help?
3. How do we engage or reach out to health center staff?
4. Are there other partners we can bring in to our efforts?

Appendix
Contribution Scenarios

Dream Scenario	Everyone	Position	Contributors	Monthly	Annual	Total Monthly	Total Annual
		CEO	176	50	600	8800	105600
		CFO	160	30	360	4800	57600
		CMO	176	35	420	6160	73920
		clinician	5000	25	300	125000	1500000
		other staff	20000	5	60	100000	1200000
						$244,760	$2,937,120
80% participation	Amazing	Position	Contributors	Monthly	Annual	Total Monthly	Total Annual
		CEO	140.8	40	480	5632	67584
		CFO	128	24	288	3072	36864
		CMO	140.8	28	336	3942.4	47308.8
		clinician	4000	20	240	80000	960000
		other staff	16000	4	48	64000	768000
						$156,646	$1,879,757
50% participation	Good	Position	Contributors	Monthly	Annual	Total Monthly	Total Annual
		CEO	88	25	300	2200	26400
		CFO	80	15	180	1200	14400
		CMO	88	17.5	210	1540	18480
10%		Clinician	500	12.5	150	6250	75000
		other staff	20000	0	0	0	0
						$11,190	$134,280
25% participation	Realistic	Position	Contributors	Monthly	Annual	Total Monthly	Total Annual
		CEO	44	12.5	150	550	6600
		CFO	40	7.5	90	300	3600
		CMO	44	8.75	105	385	4620
10%		clinician	500	6.25	75	3125	37500
		other staff	20000	0	0	0	0
						$4,360	$52,320

californiahealth+ advocates
ADVANCING THE MISSION OF COMMUNITY HEALTH CENTERS

DISCUSSION

Date: January 4, 2018
To: Board of Directors
From: Andie Patterson, Director of Government Affairs
Re: Endorsement Process Progress and PAC Recommendation

MEMORANDUM

I. Review

In October the Board approved Advocates staff to move forward on the following recommendation:

> Staff recommend that the California Health+ Advocates board create a new bank account (known as a 527 bank account) and file with the Secretary of State as a general purpose recipient committee also known as a Political Action Committee (PAC), in order that the organization can begin to engage in overtly political work. This account and affiliated PAC will keep monies fundraised from non-c3 organizations and individual persons, and pay for the work that currently is not allowed in the c4.
>
> Staff further recommend that the PAC engage in state level endorsements, and should there be sufficient monies raised, also directly contribute to state elected officials.
>
> *Note we do not recommend forming a state ballot PAC as there are no ballot propositions we believe we need to engage with at this time. We further do not recommend engaging in federal elections as the rules are more complicated and it is harder to influence congressional races with limited resources.*

II. Discussion

Since the board approval staff have commenced fundraising and development of the political endorsement process and materials. As can be seen in the fundraising report we have raised over $8,000 from members, with an additional $9,500 committed for 2018. All of the resources raised are committed to covering the costs of the fundraising and endorsement work, both of which are permissible in a c4 organization and do not expressly require creating or opening a Political Action Committee.

We also have had lawyers draft amendments to the bylaws to allow the creation of a PAC and we have explored names for the PA,C as well as interviewed professional treasurers who would help with the reporting of the PAC contributions and activities.

As we have not yet achieved the fundraising goal of $20,000 however we are not convinced that we should open a PAC just yet.

Creating a Political Action Committee is in essence creating a new organization that must be cared to financially and that we will need to monitor and maintain. As we have not even been able to fundraise the necessary amount just to do political endorsements, we are far from being able to raise sufficient funds to justify the creation of a PAC.

III. Recommendation

Advocates staff recommend we continue fundraising and investing resources in developing a strong endorsement program, as well as educating health centers about this new area of work, and that the Board wait on approving amended bylaws, and creating a PAC until there are sufficient resources to cover the endorsement work, there is a demonstrated commitment from health centers to contribute to a PAC, and there is greater statewide buy-in to move in a more concertedly political direction from health center members of CPCA.

The Advocacy Committee concurs with staff's recommendation as well.

CaliforniaHealth+ Advocates
Endorsement Framework for 2018
Updated 01.03.2018

Overview

- For the 2018 election cycle (primary and general), CaliforniaHealth+ Advocates intends to focus on State Assembly and State Senate races.
    - In 2018, Advocates does not intend to engage in federal races.
- As a general rule, Advocates will not recommend endorsing two or more candidates in one race.
    - There may be special situations where a dual endorsement is done. Deviances from the general rule will be approved by the CaliforniaHealth+ Advocates Board of Directors.

Process: Questionnaires & Interviews

- In open races, to be considered for endorsement by CaliforniaHealth+ Advocates both a completed questionnaire and interview is required.
- For incumbent legislators, to be considered for endorsement by CaliforniaHealth+ Advocates a completed questionnaire is preferred. No interviews will be conducted for incumbents, unless there are cases where an incumbent has a credible opponent and the Board Agrees to make that exception.
- Completed questionnaires will be saved by CaliforniaHealth+ Advocates and available to health center members of CPCA upon request. Completed questionnaires will be shared with the participants of the interviews.
- As a general rule, interviews of candidates in open races will take place in a non-c3 tax exempt facility.
    - There may be special situations where a phone or virtual interview is conducted. Deviances from the general rule will be approved by the CaliforniaHealth+ Advocates Board Chair.
- To the extent possible, interviews will be scheduled in or around the district where the election is taking place. Interviews will be scheduled for 30 minutes.
- The CaliforniaHealth+ Advocates Board and health centers and consortia in the respective district will be alerted of the interviews in advance and invited to participate.
- Health center and consortia staff participating in an interview are advised to use non-work time to participate.

Endorsement

(916) 503-9130
healthplusadvocates.org
1231 I Street, Suite 400, Sacramento, CA 95814

- Once the CaliforniaHealth+ Advocates Board of Directors approves an endorsement, incumbents and candidates in open races will receive a formal letter informing them of the endorsement and how it may be used.
- Members of CPCA will also be informed through a formal communication as to which candidates received the Advocates endorsement.
    - Incumbent legislators and candidates who have been endorsed will be listed on the Advocate's website.

*** All CaliforniaHealth+ Advocates staff time and administrative costs for endorsements will be paid for by non-C3 monies.*

CaliforniaHealth+ Advocates
Endorsement Interview Process
Updated 01.03.18

- All candidates in a given district that complete a questionnaire will be invited to interview.
- Members in the district and the CaliforniaHealth+ Advocates Board will be invited to the endorsement interview via email as soon as the interview is set.
- To the extent possible, interviews will take place in the district or close to the district under contention. Occasionally meetings will be held in Sacramento.
- A pre-meeting will take place in advance to every interview. The meeting may be in-person directly in advance of the interview or via conference call. The meeting will review the format, how questions will be asked, a brief overview of the candidates, hot topics to consider, location and time details.
- Participants in the interview process will receive
    a. A page fact sheet about the candidate
    b. A copy of the completed questionnaire
    c. A list of sample questions to ask during the interview
    d. A scoring rubric to assist in vetting the candidate
- Each interview shall last 30 minutes and will be scheduled consecutively as to maximize all participants time.
- The interview format will begin with a roundtable of introductions, allowing the candidate space to discuss their race and candidacy, then followed by question and answer. Candidates will have the opportunity to provide a closing statement.
- At the end of each interview, there will be a closed discussion about the candidate with the group present and completed scoring rubrics will be provided to CaliforniaHealth+ Advocates' staff.

californiahealth+ advocates
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- At the conclusion of all interviews in a given race, Advocates' staff will use the candidate's questionnaire, feedback during the interviews and completed individual scoring rubrics under consideration to develop a recommendation for the BOD.

CaliforniaHealth+ Advocates
Sample Interview Questions for Candidates
Updated 01.03.2018

1. Why are you running for public office?

2. What are your top legislative priorities?

3. What is your familiarity and connection to community health centers?

4. In your opinion, what are the top healthcare issues facing our state?

5. How would you address these challenges once in office?

6. There is a health care workforce shortage across the delivery system in California, especially in primary care. Do you have ideas on how to address this specific issue?

7. Health centers operate in underserved communities that are challenged by a multitude of inequities. Health care access and the support we provide is essential but there are numerous other challenges that must be addressed to achieve health and prosperity across the spectrum. What are the issues in your district? Do you have ideas on how to address them?

8. Will you be an advocate and champion for coverage and access once elected?

9. Will you be an advocate and champion for those in underserved and economically disadvantaged communities once elected?

10. No debate was hotter in healthcare in 2017, then the federal debate on the repeal of the Affordable Care Act. Health centers were at the core of the Affordable Care Acts success, and its future will have an incredible impact on California's health care delivery system, health centers and the patients they serve. If elected, what do you see as your role as it relates to the Affordable Care Act in California?

11. Health center are not just different because of who they care for, but they are different because of how they are paid. The prospective payment system (PPS) is a per visit payment methodology that is tied to a physical encounter between a set list of providers at designated locations for designated services. In recent years, much debate has surrounded movement to an alternative payment methodology and payment reform that puts value first. If elected, what do you as your role in supporting payment models that better reflect the care needs of our communities?

12. Health center leaders are the first to tell you that coverage does not translate to access. Without a diverse workforce we will never achieve the access our communities deserve. While projections range, it is estimated that between 8,000 and 10,000 primary care providers, will be needed by 2030. If elected, what will you do to address the primary care workforce challenges facing our state?

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13. California has led the nation in expanding Medicaid, including the expansion of Medicaid to immigrant communities. At the same time, the federal policy environment that can be seen by some as hostile to immigrant communities and, separately, hostile to the continued expansion of Medicaid. If elected, what do you see as your role as it relates to keeping all California's healthy?

14. In recent years, we have seen state budgets with limited new general fund investments in health and human services. If elected, what will be your budget priorities?

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CaliforniaHealth+ Advocates Incumbent Questionnaire

PERSONAL BACKGROUND

1. Name:
2. Offices held prior to current office:
3. What is your background?

CANDIDACY

4. Elected position being sought?
5. Why do you want the CaliforniaHealth+ Advocates endorsement?
6. Who are your consultants and fundraiser?
7. What organizations and individuals have endorsed you?
8. What has compelled you to run?

HEALTHCARE ISSUES

9. What have you done in the area of healthcare?
10. No debate was hotter in healthcare in 2017, then the federal debate on the repeal of the Affordable Care Act. Health centers were at the core of the Affordable Care Acts success, and its future will have an incredible impact on California's health care delivery system, health centers and the patients they serve. If elected, what do you see as your role as it relates to the Affordable Care Act in California?
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14. In recent years, we have seen state budgets with limited new general fund investments in health and human services. If elected, what will be your budget priorities?

COMMUNITY HEALTH CENTERS

15. What have you done locally on behalf of Community Health Centers?
16. What is your familiarity with and connection to community clinics and health centers?
17. How do community clinics and health centers factor into your healthcare platform?

LEGISLATIVE PLATFORM

18. What have you authored or co-authored relating to healthcare?
19. What are your legislative priorities in the upcoming year?
20. What more do you seek to achieve during your tenure in office?

Your responses will not be shared with members of the public or the media.

If you have questions about this questionnaire, please feel free to contact Victor Christy at victor@healthplusadvocates.org or (916) 503-9130.

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CaliforniaHealth+ Advocates Candidate Questionnaire

PERSONAL BACKGROUND

1. Name:
2. What is your background and current position?

CANDIDACY

3. Elected position being sought?
4. Who are your consultants and fundraiser?
5. Any polling you would like to share?
6. How much money have you raised?
7. What organizations and individuals have endorsed you?
8. Why do you want the CaliforniaHealth+ Advocates endorsement?
9. What has compelled you to run?

HEALTHCARE ISSUES

10. What is your familiarity with and connection to community clinics and health centers?
11. No debate was hotter in healthcare in 2017, then the federal debate on the repeal of the Affordable Care Act. Health centers were at the core of the Affordable Care Acts success, and its future will have an incredible impact on California's health care delivery system, health centers and the patients they serve. If elected, what do you see as your role as it relates to the Affordable Care Act in California?
12. Health center are not just different because of who they care for, but they are different because of how they are paid. The prospective payment system (PPS) is a per visit payment methodology that is tied to a physical encounter between a set list of providers at designated locations for designated services. In recent years, much debate has surrounded movement to an alternative payment methodology and payment reform that puts value first. If elected, what do you as your role in supporting payment models that better reflect the care needs of our communities?
13. Health center leaders are the first to tell you that coverage does not translate to access. Without a diverse workforce we will never achieve the access our communities deserve. While projections range, it is estimated that between 8,000 and 10,000 primary care providers, will be needed by 2030. If elected, what will you do to address the primary care workforce challenges facing our state?
14. California has led the nation in expanding Medicaid, including the expansion of Medicaid to immigrant communities. At the same time, the federal policy environment that can be seen by some as hostile to immigrant communities and, separately, hostile to the continued expansion of Medicaid. If elected, what do you see as your role as it relates to keeping all California's healthy?
15. In recent years, we have seen state budgets with limited new general fund investments in health and human services. If elected, what will be your budget priorities?

COMMUNITY HEALTH CENTERS

16. What have you done locally on behalf of Community Health Centers?
17. What is your familiarity with and connection to community clinics and health centers?

18. How do community clinics and health centers factor into your healthcare platform?

LEGISLATIVE PLATFORM

19. What are your legislative priorities?
20. What do you seek to achieve during your potential tenure?
21. Please provide Candidate Statement if you have one

Your responses will not be shared with members of the public or the media.

If you have questions about this questionnaire, please feel free to contact Victor Christy at victor@healthplusadvocates.org or (916) 503-9130.

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Worksheet for Incumbent Legislators for Re-Election

Health Center Participant: _____

Candidate: _____

District: _____

Please Note: *In each section feel free to elaborate on why you chose either one of the 1 – 5 options*

1) **Healthcare Issues:** *5 – Strongly Agree, 4 – Agree, 3 –Neutral, 2 – Disagree, 1 – Strongly Disagree*

   a. Do you agree that they have they shown a commitment to healthcare in their district or career?
      i. _____
      _____
      _____
      _____

   b. Do you agree that their views on healthcare align with those of Advocates?
      i. _____
      _____
      _____
      _____

   c. Do you agree they have been helpful with Advocates' sponsored or supportive/oppose bills?
      i. _____
      _____
      _____
      _____

2) **Community Health Centers:** *5 – Strongly Agree, 4 – Agree, 3 –Neutral, 2 – Disagree, 1 – Strongly Disagree*

   a. Do you agree that the candidate demonstrates knowledge of issues pertaining to Community Health Centers and a commitment to the mission and purpose of health centers?
      i. _____
      _____
      _____
      _____

b. Do you agree that the candidate has a relationship with their local health centers?
   i. _____
   _____
   _____
   _____

3) Candidacy: *5 – Strongly Agree, 4 – Agree, 3 –Neutral, 2 – Disagree, 1 – Strongly Disagree*

a. Do you agree that their past leadership and elected experiences demonstrates an ability to succeed?
   i. _____
   _____
   _____
   _____

b. Do you agree that they remain a formidable legislator and candidate?
   i. _____
   _____
   _____
   _____

4) Other Political Considerations: *5 – Strongly Agree, 4 – Agree, 3 –Neutral, 2 – Disagree, 1 – Strongly Disagree*

a. Have you found there to be any controversies surrounding their candidacy?
   i. _____
   _____
   _____
   _____

b. Have they been endorsed by the previous legislator and/or neighboring legislators?
   i. _____
   _____
   _____
   _____

c. Are they in a priority race for leadership?
   i. _____
   _____

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Worksheet for Candidates in Open Races

Health Center Participant: _____

Candidate: _____

District: _____

Please Note: *In each section feel free to elaborate on why you chose either one of the 1 – 5 options*

1) **Healthcare Issues:** *5 – Strongly Agree, 4 – Agree, 3 –Neutral, 2 – Disagree, 1 – Strongly Disagree*

   a. Do you agree that they have they shown a commitment to healthcare in their district or career?
      i. _____
      _____
      _____
      _____

   b. Do you agree that their views on healthcare align with those of Advocates?
      i. _____
      _____
      _____
      _____

   c. Do you agree they have been helpful with Advocates sponsored or supportive/oppose bills?
      i. _____
      _____
      _____
      _____

   d. Do you agree that their views on addressing the issues facing underserved populations align with those of Advocates?
      i. _____
      _____
      _____
      _____

2) **Community Health Centers:** *5 – Strongly Agree, 4 – Agree, 3 –Neutral, 2 – Disagree, 1 – Strongly Disagree*

a. Do you agree that the candidate demonstrates knowledge of issues pertaining to Community Health Centers and a commitment to the mission and purpose of health centers?
    i. _____
    _____
    _____
    _____

b. Do you agree that the candidate has a relationship with their local health centers?
    i. _____
    _____
    _____
    _____

3) Candidacy: *5 – Strongly Agree, 4 – Agree, 3 –Neutral, 2 – Disagree, 1 – Strongly Disagree*

a. Do you agree their qualifications position them well for election?
    i. _____
    _____
    _____
    _____

b. Do you agree their past leadership experiences demonstrates an ability to succeed in Sacramento?
    i. _____
    _____
    _____
    _____

c. Do you agree they are viable for this office? Consider Money Raised, Endorsements, Volunteer Base and Campaign Outreach
    i. _____
    _____
    _____
    _____

4) Other Political Considerations: *5 – Strongly Agree, 4 – Agree, 3 –Neutral, 2 – Disagree, 1 – Strongly Disagree*

a. Have you found there to be any controversies surrounding their candidacy?

i. _____
_____
_____
_____

b. Have they been endorsed by the previous legislator and/or neighboring legislators?
   i. _____
   _____
   _____
   _____

c. Are they in a priority race for leadership?
   i. _____
   _____
   _____
   _____

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INFORMATIONAL

Date: January 19, 2018

To: Board of Directors

From: Victor Christy, Assistant Director of Legislative Affairs

Re: Public Affairs Peer Network Update

MEMORANDUM

I. Overview

The Public Affairs Peer Network (PAPN), which meets once a month, provides a forum for health center and consortia staff who engage in public affairs work (government, community, media, advocacy, etc.) to share best practices and learn from one another.

II. Work to Date

The PAPN, chaired by Gary Rotto from the Borrego Community Health Foundation, met two times during the fourth quarter of the year.

October's meeting focused on the findings of a survey sent out in advance to the PAPN members to identify which topics discussed earlier in the year that individuals felt that they needed more information on. Some of those items included developing media relations, working with veterans, NACHC's ACE and HACE program, immigration, use of social media, developing key contacts, CEO and Board involvement in advocacy, Advocates website and resources, and making the most out of P and I and Day at the Capitol.

November's PAPN call focused on discussing the advocacy requests being sent out by CaliforniaHealth+ Advocates and in identifying other ways in holding Members of Congress accountable on community health center funding and CHIP reauthorization.

In 2018, the PAPN will be chaired by Ana Melgoza from San Ysidro Health and will continue to meet the Fourth Tuesday of each month at 2:00 p.m.

III. Next Steps

The PAPN continues to focus on finding innovative ways to strengthen advocacy and to provide feedback to CaliforniaHealth+ Advocates' staff on how to best support health centers with elected official engagement.

If you would like to be included in future PAPN meetings, please contact Victor Christy at victor@healthplusadvocates.org.