Senate Budget and Fiscal Review—Nancy Skinner, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Susan Talamantes Eggman, Ph.D., Chair
Senator Melissa Melendez
Senator Richard Pan, M.D.

Wednesday, May 4, 2022
9:30 am
Room 1200, 1021 O Street

Consultant: Scott Ogus

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4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: IT, Data Science, and Informatics – Framework for a 21st Century Public Health System

Budget Change Proposal – April Finance Letter. DPH requests 33 positions and General Fund expenditure authority of $20.1 million in 2022-23 and $18.1 million annually thereafter. If approved, these positions and resources would support foundational enterprise and strategic planning activities to modernize public health information technology infrastructure and systems, consistent with initiatives recommended by the Future of Public Health Workgroup. In addition, DPH requests provisional budget bill language to authorize augmentation of the requested General Fund expenditure authority by $15.9 million upon approval of enterprise planning and strategy documents by CalHHS and the California Department of Technology.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0001 – General Fund	$20,109,000	$18,146,000
Total Funding Request:	**$20,109,000**	**$18,146,000**
Total Requested Positions:	**33.0**	**33.0**

* Positions and resources ongoing after 2023-24.

The Future of Public Health Work Group. In 2021, the Administration convened stakeholders, including representatives of state departments and agencies, local health jurisdictions, tribal health officials, and community advocacy organizations to develop a memo, titled "Future of Public Health Work Group: Investments and Capabilities Needed for the Future Public Health System", which was published in September 2021. The work group memo identified the need for investments in the following foundational public health services: 1) workforce; 2) emergency preparedness and response; 3) information technology (IT), data science, and informatics; 4) community partnerships; 5) communications and public education; and 6) community health improvement.

2022 Spending Plan for Public Health Infrastructure Investment. Based on the work of the Future of Public Health Work Group and the memo published in September 2021, the Administration released its Spending Plan for Public Health Infrastructure Investment along with the Governor's January budget. In the spending plan, DPH requests 404 positions and General Fund expenditure authority of $300 million annually to modernize California's public health system with the goal of protecting and improving the health of all Californians. Of these resources, $200.4 million would support California's 61 local health jurisdictions and $99.6 million would support statewide public health priorities at DPH.

Disease Surveillance Readiness, Response, Recovery, Maintenance of IT Operations. In addition to the Public Health Infrastructure Investment proposal, the Governor's January budget included a significant investment in maintaining several IT systems. In that proposal, DPH requests 130 positions and General Fund expenditure authority of $235.2 million in 2022-23, ten additional positions and General Fund expenditure authority of $156.1 million in 2023-24, and $61.8 million annually thereafter to maintain and operate the technology platforms and applications necessary to support both COVID-19 response activities and other potential disease outbreaks. These systems included: 1) CA Notify, 2) California Immunization Registry 2 (CAIR2) Message Broker, 3) California Confidential Network for Contact

Tracing (CalCONNECT), 4) California Reportable Disease Information Exchange (CalREDIE), 5) CDPH Employee Redirection Tracker (CERT), 6) California COVID-19 Reporting System (CCRS), 7) various enterprise infrastructure and security, 8) Laboratory Information Management System (LIMS), 9) Lab Testing Metrics (LTM) application, 10) Vaccine Management (including MyTurn and myCAvax), 11) Research Electronic Data Capture (REDCap), and 12) IT operations center management.

Future of Public Health Workgroup - Information Technology (IT), Data Science, and Informatics. Among the Future of Public Health Workgroup recommendations that were not addressed by proposals in the Governor's January budget were those related to information technology (IT), data science, and informatics. The projects supported by the January budget proposal for Disease Surveillance Readiness, Response, Recovery, and Maintenance of IT Operations primarily focus on systems established and utilized for the state's COVID-19 pandemic response. The Future of Public Health Workgroup made several recommendations related to the need for IT resources dedicated to state and local public health departments' broader public health mission and goals. Specifically, the workgroup suggested the following initiatives:

1) *Dynamic Public Health Structure.* Build a flexible and scalable backbone for dynamic public health activities using cloud-based, secure, and scalable platforms needed for data sharing and management.
2) *Surveillance and Licensing Systems*. Streamline data in disease surveillance and licensing systems to create one-stop shops for disease and environmental surveillance information.
3) *Rapid Public Health Data Services.* Enable more efficient public health business processes and reduce manual burden to facilitate more efficient tracking and impact assessments.
4) *Public Health Data Integration.* Integrate and access new data streams to enable public health analyses including electronic health records, social determinants of health, and environmental data.
5) *Public Health Information Asset Management*. Enhance system-wide data governance and standards.
6) *Analytics Workspaces.* Build analytics workspaces to query data, run, iterate, and share models on key public health use cases.
7) *Information Sharing and Interoperability.* Enable access to accurate and timely data for city and county health jurisdictions and stakeholders.
8) *Public Health Strategy and Innovation.* Build IT, data, and informatics capacity, skillsets, and knowledge sharing to improve decision making.
9) *Enhancing the Public Health IT Operating Model.* Establish an enterprise-wide IT, data science, and informatics project office to ensure successful delivery of these initiatives.

Staffing and Resource Request. DPH requests 33 positions and General Fund expenditure authority of $20.1 million in 2022-23 and $18.1 million annually thereafter to support foundational enterprise and strategic planning activities to modernize public health information technology infrastructure and systems, consistent with initiatives recommended by the Future of Public Health Workgroup. This request is comprised of three primary components:

1) One-time planning resources of $18.5 million for foundational enterprise and strategic planning to modernize public health IT infrastructure and systems, and implement the ecosystem of data sharing. $9.3 million of these resources are contingent on approval of enterprise planning and strategy documents.

2) One-time implementation resources of $6.6 million, contingent on approval of enterprise planning and strategy documents, to begin implementation of a flexible and scalable information technology backbone, focusing on cloud migration and technology, and public health data systems integration.
3) Ongoing staffing, training, and expanded workforce pipeline resources of $10.8 million in 2022-23 and $18.1 million annually thereafter, including 33 positions, staff training and upskilling, and implementation of an internship program in 2023-24.

To implement these efforts, DPH requests the following positions and resources for each of these initiatives:

Enterprise Planning and Strategy (Initiative 0). DPH expects the enterprise planning and strategy phase to establish roadmaps for implementation of several of the initiatives identified in the workgroup memo. 22 positions and $20.9 million in 2022-23 would support these efforts, including establishment of an Office of Data Strategy and Innovation (ODSI) with a Chief Data Officer (CDO), and an Office of Technology Innovation and Strategy and the following positions:

Office of Technology Innovation and Strategy

- **One Chief Technology Innovation Officer (CTIO)** would oversee and direct the operation of the Office of Technology Innovation and Strategy to identify strategies, business opportunities, and new technologies to deliver new capabilities to better meet business and programmatic needs. The CTIO would also oversee the Enterprise Architecture Services Section, Planning and Project Management, and Enterprise Platform Services Branch.
- **One Enterprise Platform Services Branch Chief** would administer, oversee, and lead development of an enterprise platform strategic plan and define platform standards, strategies for retiring systems and reducing costs, and develop an enterprise intake process to assess and prioritize requests.
- **One Information Technology Specialist (ITS) III** position would assist the CTIO to strategize, devise, and execute on the plan to meet the department's goals to digitally transform its operating model to deliver new capabilities to better meet business and programmatic needs.
- **One Information Technology Specialist (ITS) III** position would serve as Enterprise Cloud Architect and would develop the framework, methods, and models for cloud readiness assessment.
- **One Information Technology Specialist (ITS) III** position would serve as Enterprise Business Architect and would implement enterprise business strategy, principles, and roadmaps to address interoperability, portability, scalability, accessibility, and availability across DPH business programs, applications and systems.
- **One Information Technology Specialist (ITS) III** position would serve as Enterprise Platform Services Architect and would help lay the foundational framework necessary to launch the migration of systems into platform service-based solutions.

Enterprise Data and Analytics Section

- **One Information Technology Manager (ITM) I** position would manage the Enterprise Data and Analytics Section, set the direction for the section and organize the work of the data and analytics staff.
- **One Information Technology Supervisor (IT Sup) II** position would plan, organize and direct the work of the ITS II and ITS I staff in the section

- **One ITS II** position would work across vertical program domains.
- **Three ITS I** positions would serve as Data and Software Analyst, Data and Software Developer, and Data Security Administrator.

Enterprise Architecture Services Section (EASS)

- **Two ITS II** positions would serve as Enterprise Architects to develop and maintain the overall department architecture strategy for alignment with the CDPH Technology Management Plan.

CalHHS Office of the Agency Information Officer

- **One ITS II** position would serve in the CalHHS Office of the Agency Information Officer (OAIO) for integrated IT Capital planning, prioritization, and IT enterprise portfolio management.

Enterprise Platform Services Branch

- **One IT Sup II** position would assist the Enterprise Services Section Chief in the overall management and oversight of enterprise intake and delivery.
- **One ITS II** position would serve as Cloud Specialist, responsible for defining, maintaining, and maturing the cloud-based infrastructure and environments to support DevOps; maintain visibility over on premise and hybrid cloud migrations, manage cloud connections and relationships, analyze weaknesses, and recommend system improvements.
- **One ITS II** position would serve as DevOps Security Engineer, responsible for managing the overall security of the DevOps environment and working closely with the development teams to preserve data integrity and security at every stage of the product lifecycle.

Fiscal and Business Operations Section (FBOS)

- **One Staff Services Manager I** position would act as manager over the Recruitment and Resource Unit.
- **Three Associate Governmental Program Analysts (AGPA)** would provide IT personnel resources for recruiting, filling vacancies, maintaining and updating organizational charts, and assisting with contracts.

Consulting Costs

- Initiative 1 Planning Contracts: Dynamic Public Health Infrastructure – DPH requests General Fund expenditure authority of $1.6 million in 2022-23 for Cloud Assessment and Application Migration Strategies. According to DPH, fourteen candidate applications have been identified for migration. The requested resources would support contract staff for seven to eight months to develop a unified cloud environment to support current and future public health operations, including prioritizing applications for migration and developing migration plans.
- Initiative 2 Planning Contracts: Surveillance and Licensing System Consolidation Strategy – DPH requests General Fund expenditure authority of $3.3 million in 2022-23 for strategy development related to planning for consolidation of licensing and surveillance systems. According to DPH, there

are 31 separate disease surveillance systems and 32 separate licensing systems. One out of twenty of these systems report 20 or fewer active users. As a result, twelve surveillance and licensing systems have been identified as candidates for consolidation. The requested resources would support contract staff for eight months to perform an architectural analysis of these systems that prioritizes consolidation and develops consolidation strategies and development plans.

- Initiative 2 Planning Contracts: Syndromic Surveillance Architecture Integration, Case Management, and Reporting Strategy – DPH requests General Fund expenditure authority of $2.6 million in 2022-23, contingent on approval of enterprise planning and strategy documents, for development related to implementation of the Centers for Disease Control and Prevention (CDC) BioSense platform and enhancement of syndromic surveillance data. These resources would support contract staff for five to eight months and management staff for twelve months.
- Initiative 3 Planning Contract: Rapid Public Health Data Services Platform Consolidation Strategies – DPH requests General Fund expenditure authority of $2.2 million in 2022-23 for Platform Consolidation planning, including evaluation of low code platforms and recommendations for platform consolidation.
- Initiative 3 Planning Contract: Rapid Public Health Data Services Licensing Application Migration Strategies – DPH requests General Fund expenditure authority of 2.2 million in 2022-23 for Licensing Application Migration Strategies, including consolidating on-premise systems and migrating services on those systems to the cloud. According to DPH, six applications have been identified as candidates for migration.
- Initiative 4 Planning Contracts: Public Health Data Integration Strategy – DPH requests General Fund expenditure authority of $1.7 million in 2022-23, contingent on approval of enterprise planning and strategy documents, for development of governance, charter, roadmap, engagement model, and plans for data integration and distribution of informed public health decision making. These resources would support contract staff for six to seven months for establishing a data intelligence hub.
- Initiative 5 Planning Contracts: Public Health Data Governance Strategy – DPH requests General Fund expenditure authority of $756,000 in 2022-23, contingent on approval of enterprise planning and strategy documents, for development of a multi-year, enterprise-wide data strategy and roadmap.
- Initiative 5 Planning Contracts: Public Health Information Portfolio Strategy – DPH requests General Fund expenditure authority of $1.3 million in 2022-23, contingent on approval of enterprise planning and strategy documents, to assess the department's information portfolio and business objectives; evaluate costs, risk, and benefits of potential information portfolio assets; prioritize and select assets that best align with business objectives; set schedules and balance resource requirements; and measure and manage the value of the portfolio over time.
- Initiative 6 Planning Contracts: Public Health Data Integration Strategy – DPH requests General Fund expenditure authority of $1.5 million in 2022-23, contingent on approval of enterprise planning and strategy documents, for expansion of analytics workspaces to query data, iterate, and share models around public health use cases.
- Initiative 7 Planning Contracts: Information Sharing and Interoperability – DPH requests General Fund expenditure authority of $1.5 million in 2022-23, contingent on approval of enterprise planning and strategy documents, for contract staff to research interoperability opportunities within and across programs and with external stakeholders; research current public facing dashboards and understanding gaps; and making recommendation for specific helpdesk support capabilities.

Initiative 1 – Dynamic Public Health Structure. This initiative would establish a foundational infrastructure that expands the department's cloud operations, replacing legacy infrastructure with more than 70 percent of components on physical premises. According to DPH, legacy on-premises infrastructure is inflexible, less adaptable, and limits scaling, self-service, and effective partnerships with internal stakeholders, external departments, and oversight agencies. Implementation of this initiative would require the following contract resources:

- Cloud Application Migration Implementation – DPH requests General Fund expenditure authority of $4 million in 2022-23, contingent on approval of enterprise planning and strategy documents, to initiate cloud application migrations of legacy systems. According to DPH, fourteen candidate applications have been identified for cloud migration.
- Capacity Expenses for Cloud Operations – DPH requests General Fund expenditure authority of $1.3 million in 2022-23, contingent on approval of enterprise planning and strategy documents, to support the capacity expenses for cloud and platform operations related to Azure, Databricks, and Snowflake platforms for the fourteen applications.

Initiative 2 – Surveillance and Licensing Systems. This initiative would: 1) consolidate surveillance and licensing systems to reduce number of systems, consolidate data sources, and enable data to be used in public health informatics; and 2) implementation of the CDC BioSense Platform, explore integration with DPH systems, and expand available syndromic surveillance data by onboarding facilities and local health jurisdictions. Proposed expenditures related to this initiative are included in the Enterprise Planning and Strategy (Initiative 0) efforts.

Initiative 3 – Rapid Public Health Data Services. This initiative would implement a low-code application platform to support rapid and responsive development of business services built using a rich suite of deploy-ready technical capabilities like workflow, digital signature, financial transactions, and forms management. Proposed expenditures related to this initiative are included in the Enterprise Planning and Strategy (Initiative 0) efforts.

Initiative 4 – Public Health Data Integration. This initiative would focus on integrating multiple diverse data sets and public health information into DPH systems, including streamlining current data teams and vital statistics products and acquiring a multitude of new data sources to be used enterprise-wide. This effort would include combining the Informatics Branch and the Vital Statistics Branch into the Office of Data Strategies and Innovation (ODSI), redirecting 10 vacant positions and adding one new position. Implementation of this initiative would require the following positions and contract resources:

<u>Office of Data Strategy and Innovation</u>

- **Three Research Data Specialist I** positions (redirected) would act as subject matter experts for the inter-jurisdictional exchange of vital events; perform data linkage for special contractual projects, engage with stakeholders that use these systems; extract, analyze data, validate and peer review final tabulated products; actively participate in the Data Review Committee to review data prior to release from the unit to verify compliance with data de-identification guidelines; and participate in the design and development of vital records projects, web-based applications, and analytical tools.
- **One Research Data Analyst** (redirected) would participate in the data acquisition process; participate in development of surveillance and licensing system consolidation; participate in public health data

integration and public health information asset management strategy; provide advanced data acquisition and data quality support; support procurement of data sets; extract, clean, and prepare necessary data sets; conduct quality control evaluations on final data products; provide programs with requested data products; confirm successful migration of data between systems; identify and develop mathematical models and analytics services to optimize use of public health data; prepare custom data; and extract and report at the request of center leadership.

- **One Research Data Specialist II** position (redirected) would perform operational analysis functions and support data end users.
- **One Research Data Supervisor I** position (redirected) would lead development and implementation of demographics in external reports by planning, organizing, and conducting data analysis of statewide and county health data.
- **One Staff Services Manager III** position (redirected) would oversee and collaborate with all interested parties within DPH, state, and federal agencies, and other jurisdictions and health departments to improve data accuracy and analytics capacity.
- **One Research Scientist Supervisor I** position (redirected) would lead department-wide efforts and implementation of data visualization software, quality metrics, and predictive analytics techniques.
- **One Staff Services Manager I** position (redirected) would establish policies for data exchange with internal and external customers that comply with vital statistics data release laws.
- **One Office Technician** (redirected) would provide administrative support to the Informatics Branch.
- **One Research Scientist Supervisor I** position (new) would oversee and provide guidance and direction the CalIVRS team, work across programs to get input on CalIVRS, and develop policy recommendations for leadership regarding functionality.

Contract Resources

- Public Health Data Integration – DPH requests General Fund expenditure authority of $780,000 in 2022-23, contingent on approval of enterprise planning and strategy documents, for data and information integration.
- Capacity Expense for Health Data Integration – DPH requests General Fund expenditure authority of $610,000 in 2022-23, contingent on approval of enterprise planning and strategy documents, for costs of Cloud and Platform Operations related to Azure, Databricks, and Snowflake platforms.

Initiative 5 – Public Health Information Asset Management. This initiative would focus on enhancing system-wide data governance and standards to improve data quality, build shared data definitions, maintain appropriate access while meeting or exceeding security standards, prioritize data acquisition efforts and raise the level of data literacy across state and local governmental public health systems. Implementation of this initiative would require the following positions:

- **One Health Program Specialist (HPS) II** position would serve as Lead Community Engagement Data Specialist, responsible for engagement with both local health jurisdictions and individual partners to tighten information flow, personalize interaction, and develop frequent touch points with community partners.
- **One HPS II** position would serve as Lead Health Care Data Specialist, leading the coordination of cross-cutting program activities in partnership with the centers and offices at DPH.

- **One HPS II** position would serve as Lead Health Equity Data Specialist, championing health equity in data, and identifying and implementing transformation of public health data to be equity focused data.
- **One HPS II** position would serve as Lead Population Health Data Specialist, leading the Data Governance Steering Committee, implementing the high-level vision and goals from a department-wide perspective, and creating a clear understanding of program roles and responsibilities within the committee to govern public health data.

Initiative 6 – Analytics Workspaces. This initiative would expand upon the analytics workspaces developed for the COVID-19 pandemic response related congregate care dashboard, to query data, iterate, share models, and develop dashboards around public health use cases. Proposed expenditures related to this initiative are included in the Enterprise Planning and Strategy (Initiative 0) efforts.

Initiative 7 – Information Sharing and Interoperability. This initiative would focus on building bidirectional, collaborative systems for access to data sets such as disease registries, immunization registries, vital statistics registries and others. Proposed expenditures related to this initiative are included in the Enterprise Planning and Strategy (Initiative 0) efforts.

Initiative 8 – Public Health Strategy and Innovation. This initiative would focus on addressing the following gaps and challenges: 1) lack of committed data and informatics workforce pipeline and access to relevant training throughout DPH to support a workforce equipped with appropriate knowledge; 2) siloed roles and lack of cross-functional engagement; 3) lack of appropriate positions in the center and corresponding staff and funding that could provide centralized support to programs for data and analytics; 4) opportunities to upskill and cross-skill DPH's workforce to prepare for the future of public health. Implementation of this initiative would require the following contract resources, beginning in 2023-24:

- Upskilling Trainings – DPH requests General Fund expenditure authority of $4.9 million in 2023-24 and annually thereafter to support upskilling training to develop subject matter-specific training and practical frameworks for public health staff, including: 1) self-guided or asynchronous general overview online training; 2) small cohort hybrid training using real time data; 3) large lectures for general content and specific skills; 4) training for different levels of staff; 5) subject matter-specific training and practical frameworks on decision intelligence for public health staff; and 6) training in behavioral economics, health economics, return on investment, multi-criteria decision theory, and developing interventions based on these models.
- Partnerships for Workforce Pipelines – DPH requests General Fund expenditure authority of $2.4 million in 2023-24 and annually thereafter to support educational partnerships to foster a robust student internship, fellowship, and apprenticeship program to provide opportunities to recruit and hire new talent, with necessary IT, data, and informatics capacity, skillsets, and knowledge, while also building partnerships with educational institutions.

Initiative 9 – Enhancing the Public Health IT Operating Model. This initiative would focus on project management resources needed for the success of the other initiatives. Implementation of this initiative would require the following positions:

<u>Planning and Project Management Branch (PPMB)</u>

- **Three IT Sup II** positions would plan, organize, and direct work of IT staff; provide IT project planning, approvals, and initiation; IT project management, oversight, governance, and reporting services; and guidance to less experienced project managers.
- **One IT Specialist II** position would support low to medium complexity, department-wide projects, track project risks, schedule, budget, and quality through close coordination with team members and department partners.
- **One IT Associate** would serve as the first level project analyst and technical specialist in providing project management support, monitoring, and problem resolution of all DPH IT projects.

CalHHS - OAIO

- **One IT Specialist I** position would serve in the CalHHS Office of the Agency Information Officer (OAIO) for integrated IT Capital planning, prioritization, and IT enterprise portfolio management.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 2: April Finance Letter – Technical Adjustment

Technical Adjustment – April Finance Letter. DPH requests the following technical adjustment to its budget:

Children and Youth Behavioral Health Initiative. DPH requests budget bill language to extend until June 30, 2024, the encumbrance and expenditure authority of $50 million General Fund approved in the 2021 Budget Act for the Children and Youth Behavioral Health Initiative. The 2021 Budget Act augmentation was approved to support a comprehensive and linguistically proficient public education and change campaign to raise behavioral health literacy to normalize and support the prevention and early intervention of mental health and substance use challenges.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this technical adjustment.

4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

Issue 1: Health Workforce Programs and Central Services Resources

Budget Change Proposal – April Finance Letter. HCAI requests 32 positions, funded with existing expenditure authority. If approved, these positions would support administration of health and behavioral health workforce development programs approved by the Legislature in previous fiscal years, as well as programs proposed in the Governor's January budget.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0001 – General Fund	$-	$-
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**32.0**	**32.0**

* Positions ongoing after 2023-24.

Background. According to HCAI, funding for the department's workforce programs funding has grown more than four-fold, from approximately $170 million in 2020-21 to over $800 million annually beginning in 2021-22. Expansions in funding for workforce development programs, such as Song-Brown, or the Health Professions Career Opportunity Program have led to increased workload for the department. In addition to increased funding, recent budgets have increased the type of workforce programs HCAI is administering, including for certified nursing assistants, substance use disorder counselors, a new behavioral health coach classification. HCAI also is expanding its work in behavioral health fields, implementing initiatives to develop a new community health workforce, and accelerate training of social workers and support the broader care workforce beyond the health arena. The Governor's January budget included proposals to train 25,000 community health workers, increase the number of nursing professionals, increase the number of trained social workers, increase behavioral health providers, increase linguistic and cultural competencies in the health care workforce, and research health workforce shortages and support research on best practices and strategies to build a diverse, culturally competent health workforce. The January budget proposal included funding for state operations costs for administration of the programs, but did not include position authority.

Staffing Request. HCAI requests 32 positions, funded with existing expenditure authority, to support administration of health and behavioral health workforce development programs approved by the Legislature in previous fiscal years, as well as programs proposed in the Governor's January budget. Specifically, HCAI requests the following positions:

Workforce for a Healthy California for All Program – 12 positions

- **One Health Program Specialist I** would serve as a policy specialist to assist with ongoing policy and program support, including social work and community health worker professions.
- **One Health Program Specialist I** would provide health workforce policy support to the Health Workforce Education and Training Council.

- **One Research Data Specialist I** would provide data analysis and data management support to the Health Workforce Education and Training Council.
- **One Associate Governmental Program Analyst (AGPA)** and **one Staff Services Analyst (SSA)** would implement and administer community health worker, nursing, social work, multilingual grant, scholarship, and stipend programs.
- **One SSA** would implement and administer social work grant, scholarship, and stipend programs.
- **Two Program Technician II** positions would process grant agreements, scholarship agreements, and loan repayment agreements associated with these programs.
- **One Staff Services Manager I (Specialist)** would serve as the Health Equity coordinator ensuring program goals are realized, specifically to recruit, train, hire, and advance an ethnically and culturally inclusive health and human services workforce, with improved diversity, compensation, and health-equity outcomes.
- **Two AGPAs** would serve as Contract Analysts to perform all contract support activities.
- **One Budget Analyst** would perform all budget support activities including but not limited to budget development and maintenance functions.

Children and Youth Behavioral Health Initiative – Four positions

- **One Health Program Specialist II** would serve as HCAI's behavioral health specialist, supporting implementation of new behavioral health workforce programs.
- **Three SSAs** would support administration of loan repayment, scholarship, stipend, and grant programs for behavioral health professions.

Health Professions Careers Opportunity Program (HPCOP) – One position

- **One Staff Services Analyst** would support successful implementation and long-term sustainability of the HPCOP pipeline programs.

Small Rural Hospital Improvement Program (SHIP) – One position

- **One Staff Services Manager I** position to supervise the SHIP program.

Song-Brown Program – Two positions

- **Two AGPAs** would support program administration and monitoring of awarded organizations in the Song-Brown Program.

Loan Repayment and Scholarship Programs – Five positions

- **Three AGPAs** would support ongoing administration of scholarship and loan repayment programs, such as the Steven M. Thompson Physician Corps Loan Repayment Program and Allied Healthcare Loan Repayment and Scholarship Programs.

- **Two SSAs** would support the ongoing administration of scholarship and loan repayment programs, such as Bachelor of Science Nursing Loan Repayment Program, Associate Degree Nursing Scholarship Program, and Vocational Nurse Scholarship Program.

Workforce Development Division Operations – Four positions

- **One Staff Services Manager I** would manage the operational support needs in the division.
- **Two AGPAs** would support communications and outreach efforts to generate awareness for prospective applicants of HCAI's workforce programs; and support budget, accounting, invoicing, and contracting workflows across health workforce programs.
- **One Staff Services Manager I** would provide long-term internal project management services to HCAI's new and growing workforce programs.

Central Services Support – Three positions

- **One Staff Services Manager III** would serve as Human Resource Relations Officer, to provide administrative support to the growing HCAI workforce.
- **One Staff Services Manager II** would serve as Budget Officer, to support the growing budgetary needs of HCAI.
- **One Accounting Officer** would support the growing grant program of HCAI.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 2: Office of Health Care Affordability

Budget Change Proposal – April Finance Letter. HCAI requests 59 positions in 2022-23, 117 positions and General Fund expenditure authority of $13 million in 2023-24, and 142 positions and General Fund expenditure authority of $31.6 million annually thereafter. If approved, these positions and resources would support implementation of the Office of Health Care Affordability, which would establish and enforce statewide and sectoral health care cost targets. The position authority in 2022-23 would be supported by the Administration's proposed reappropriation of $30 million for the Office adopted in the 2021 Budget Act, the subject of a separate request with accompanying trailer bill language included in the Governor's January budget.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0001 – General Fund	$-	$13,021,000
Total Funding Request:	**$-**	**$13,021,000**
Total Requested Positions:	**59.0**	**117.0**

* Additional fiscal year resources requested: 2024-25: 142 positions and $31,630,000; 2025-26 and ongoing: $31,580,000.

Office of Health Care Affordability and Health Care Payments Data Program. The Governor, in his 2020 January budget, proposed the establishment of an Office of Health Care Affordability to increase price and quality transparency, develop specific strategies and cost targets for different sectors of the health care industry, and financial consequences for entities that fail to meet these targets. The proposal included expansion and recasting of existing health care cost data efforts as the Health Care Payments Data Program at HCAI, and expected this program to become an integrated part of the data collection efforts to support the efforts of the new Office of Health Care Affordability. Due to the pandemic, the Administration withdrew its proposal to implement the Office of Health Care Affordability, but continued with its proposal to move forward to the next stage of development of the Health Care Payments Data Program.

The 2021 January budget reintroduced the proposal for the Office of Health Care Affordability, with updated statutory language. According to the Administration, the proposed Office of Health Care Affordability would have done the following:

- **Set Health Care Cost Targets by Sector.** The Office would establish a statewide health care cost target with the authority to set specific targets by sector, including by payer, provider, insurance market or line of business.
- **Increase Cost Transparency.** The Office would collect and analyze data from existing and emerging public and private data sources to publicly report total health care spending and factors contributing to health care cost growth. The Office would publish an Annual Report and conduct public hearings about performance against the health care cost targets, trends in health care costs, and recommendations for mitigating cost growth.
- **Enforce Compliance with Cost Targets.** The Office would oversee the state's progress towards meeting health care cost targets by providing technical assistance, requiring public testimony, requiring submission of corrective action plans, monitoring progress of corrective action plans, and assessing escalating civil penalties for noncompliance.

- **Promote and Measure Quality and Health Equity.** The Office would utilize HCAI and other departmental data to standardize quality measures for evaluating spending of health care service plans, insurers, hospitals, and physician organizations, with consideration for minimizing administrative burden and duplication.
- **Advance and Monitor Adoption of Alternative Payment Models.** The Office would promote a shift from payments based on fee-for-service to payments that reward high quality and cost-efficient care. The Office would measure progress towards the goal and adopt standards for alternative payment models that may be used by providers and payers during contracting.
- **Advance Standards for Health Care Workforce Stability and Training Needs.** The Office would monitor the effects of health care cost targets on workforce stability, high-quality jobs, and training needs of health care workers. The Office would develop standards to assist health care entities in implementing cost-reduction strategies that advance the stability of the health care workforce and avoid exacerbating existing health care workforce shortages.
- **Address Consolidation and Market Power.** The Office would monitor cost trends in the health care market including the impact of consolidation and market power on competition, prices, access, and quality. The Office would partner with the Attorney General, Department of Managed Health Care, and Department of Insurance to examine mergers, acquisitions, or corporate affiliations in the health care sector to promote competitive health care markets.

No Resources Expended or Positions Filled Pending Approval of Trailer Bill Language. The 2021 Budget Act included 58 positions and expenditure authority from the California Health Data and Planning Fund of $11.2 million in 2021-22, 106 positions and $24.5 million in 2022-23, 123 positions and $27.3 million in 2023-24, and 123 positions and $27.3 million annually thereafter to establish the Office of Health Care Affordability. According to HCAI, despite the approval of state operations resources in the 2021 Budget Act, it has not moved forward with hiring, contracting or other implementation activities for the Office of Health Care Affordability. HCAI indicates it will wait for approval of the trailer bill language authorizing implementation of the office before moving forward with hiring staff or other implementation activities. As a result, HCAI is requesting reappropriation of General Fund expenditure authority approved in the 2021 Budget Act for initial implementation of the Office.

Staffing and Resource Request. HCAI requests 59 positions in 2022-23, 117 positions and General Fund expenditure authority of $13 million in 2023-24, and 142 positions and General Fund expenditure authority of $31.6 million annually thereafter to support implementation of the Office of Health Care Affordability, which would establish and enforce statewide and sectoral health care cost targets. This request is accompanied by a separate trailer bill language proposal that would implement the Office. Specifically, HCAI requests the following positions and resources:

- **One Deputy Director (CEA B)**
- **One Chief Medical Officer**
- **One Pharmaceutical Consultant II (Specialist)**
- **Two Branch Chiefs (CEA A)**
- **One Deputy Chief Counsel (CEA B)**
- **One Assistant Chief Counsel**
- **Seven Manager Positions**
- **45 Staff Level Positions**

According to HCAI, in 2023-24 positions would grow to 116 staff positions and in 2024-25 and ongoing, positions would grow to 141 staff positions.

Contract Resources. The 2021 Budget Act also included expenditure authority from the California Health Data and Planning Fund for the following contract resources:

- $1.3 million in 2022-23, $750,000 in 2023-24, and $500,000 annually thereafter for information technology (IT) consulting for systems development and continuous operation.
- $400,000 annually for IT software, services, and infrastructure.
- $1.3 million in 2022-23, $550,000 in 2023-24, and $50,000 annually thereafter for program planning and management consulting.
- $2.8 million annually, beginning in 2023-24, for enforcement consulting contracts.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 3: Reducing the Cost of Insulin: CalRx Biosimilar Insulin Initiative

Budget Change Proposal and Trailer Bill Language – April Finance Letter. HCAI requests General Fund expenditure authority of $100 million, available for encumbrance or expenditure until 2025-26. If approved, these resources would support the CalRx Biosimilar Initiative, which would invest $50 million in development of low-cost, interchangeable biosimilar insulin products and $50 million towards a California-based insulin manufacturing facility, pursuant to the requirements of SB 852 (Pan), Chapter 207, Statutes of 2020. HCAI also requests trailer bill language to exempt the program from contract requirements until December 31, 2032, and delay delivery of its feasibility report until December 31, 2023.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0001 – General Fund	$100,700,000	$700,000
Total Funding Request:	**$100,700,000**	**$700,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2023-24.

Background. SB 852 (Pan), Chapter 207, Statutes of 2020, the California Affordable Drug Manufacturing Act of 2020, requires CalHHS to enter into partnerships or contracts resulting in the production or distribution of generic prescription drugs, with the intent that these drugs be made widely available to public and private purchasers, providers, suppliers, and pharmacies. SB 852 targets failures in the market for generic drugs resulting from supplier concentration and other anti-competitive practices that lead to higher prices for consumers and health care service providers. CalHHS is required to prioritize production and distribution of drugs that would have the greatest impact on lowering patient drug costs, increasing competition, addressing shortages, and improving public health. In making these determinations, CalHHS must consider the drug expenditure reporting from the Department of Managed Health Care and the Department of Insurance pursuant to SB 17 (Hernandez), Chapter 603, Statutes of 2017, as well as prioritize the production of at least one form of insulin, drugs for chronic and high-cost conditions, and those that can be delivered through mail order. SB 852 also requires CalHHS to report its progress on implementation to the Legislature by July 1, 2022, and report to the Legislature by July 1, 2023, on the feasibility of the state directly manufacturing and selling prescription drugs at a fair price. The requirement to conduct the feasibility report is subject to appropriation of funding in the budget for that purpose.

CalRx Implementation. The 2021 Budget Act included one position to serve as Project Manager, and General Fund expenditure authority of $2.2 million in 2021-22, and $184,000 annually thereafter to establish CalRx, consistent with the requirements of SB 852. According to HCAI and CalHHS, CalRx enables California to manufacture generic drugs in highly concentrated, low competition drug markets. CalRx has the potential to become a "producer of last resort," remedying drug shortages and addressing what researchers have described as oligopolistic market structures and other market failures that plague the pharmaceutical industry. Under this proposal, CalRx would identify a partner to bring to market low-cost interchangeable biosimilar insulins with the goal of providing Californians with access to insulin products that are a fraction of the $300 per vial prices charged by insulin manufacturers in the United States. Injecting such steep price competition in the market would ease the financial burden for millions of diabetics in the State.

Resource Request. HCAI requests General Fund expenditure authority of $100 million, available for encumbrance or expenditure until 2025-26, to support the CalRx Biosimilar Initiative, which would invest $50 million in development of low-cost, interchangeable biosimilar insulin products, and $50 million towards a California-based insulin manufacturing facility, pursuant to the requirements of SB 852 (Pan), Chapter 207, Statutes of 2020. Specifically, HCAI's proposal consists of the following components:

Partnership for Biosimilar Insulin Products - $50 million

HCAI requests General Fund expenditure authority of $50 million to enter into a partnership with a contract manufacturer to develop and bring to market interchangeable biosimilar insulin products in both vial and pen form. According to HCAI, the potential market for these biosimilar insulin products will be substantial for consumers and would likely be widely available through a variety of major outlets, generating significant system wide savings. Many Californians, such as the uninsured, underinsured, and those with high deductible plans, are exposed to high list prices, and would benefit enormously from broadly available low-cost insulin. In the long run, all consumers would also benefit if the branded insulin manufacturers lower their prices in response to the entry of a low-cost option.

According to HCAI, the state would also seek the following benefits as part of a biosimilar insulin partnership:

- *Priority Access.* California would have priority of supply, so that the state's volume needs are met, but with no minimum volume commitment from the state.
- *Branding.* CalRx insulin products sold within California would be labeled with California-related branding, such as the logo with a California Golden Bear, or verbiage such as "CalRx Insulin" or "CalRx Insulin – Brought to you by the State of California".
- *Low Cost Implementation.* Compared to direct manufacturing, HCAI and CalHHS believe a partnership in contract manufacturing would be the lowest cost and most feasible option for the state to bring biosimilar insulin products to market.

Insulin Manufacturing Facility - $50 million

HCAI requests General Fund expenditure authority of $50 million for the construction of an insulin manufacturing facility based in California. CalHHS intends to partner with the Governor's Office of Business and Economic Development (GO-Biz), leveraging its expertise in business investment services such as site review, permit assistance, and other related activities. According to HCAI and CalHHS, development of this facility may spur economic development and create highly technical positions for Californians, thus expanding skilled employment in the state. Construction of the facility would also support and strengthen insulin supply chains within the state. The location of the California-based insulin manufacturing facility would be jointly determined by the state and the contract manufacturer.

State Operations - $700,000

HCAI requests General Fund expenditure authority of $700,000 to support state operations for administration of CalRx. Specifically, HCAI requests the following positions and resources:

- **One Staff Services Manager I (Specialist)** would perform all contract support activities including drafting the contract, contract negotiation functions, and compliance with contract deliverables.
- **One Attorney IV** would serve as the legal expert and monitor corporate governance, advise on contractual compliance, and review and advise on contract amendments.
- **One Pharmacy Program Consultant** would serve as the subject matter expert to advise the CalRx program; assess and analyze pharmaceutical data and information necessary for oversight of contract deliverables; research, analyze, and prepare various reports to inform ongoing program priorities and feasibility of prescription drug development considerations.

In addition to these resources, HCAI requests trailer bill language to provide contract exemption authority until December 31, 2032. According to HCAI, this exemption would allow CalRx to quickly enter into an agreement with the contract manufacturer.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

2. When would CalRx expect to be able to provide California-branded biosimilar insulin products to Californians, under this proposal?

3. How much would CalRx expect consumers to pay per vial of biosimilar insulin under this proposal?

Issue 4: Small Rural Hospital Improvement Program Increase in Expenditure Authority

Budget Change Proposal – April Finance Letter. HCAI requests federal fund expenditure authority of $56,000 annually. If approved, these resources would continue support for the department's Small Rural Hospital Improvement Program.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0890 – Federal Trust Fund	$56,000	$56,000
Total Funding Request:	**$56,000**	**$56,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2023-24.

Background. The 2021 Budget Act recast the former Office of Statewide Health Planning and Development as HCAI. This recast included consolidation and transfer of the State Office of Rural Health (SORH) and its associated federal grants from DHCS to HCAI's Primary Care Office (PCO).

HCAI currently receives federal grant funds from the Health Resources and Services Administration (HRSA) to serve as the state PCO and SORH. Within the SORH program, HCAI received HRSA grants for the Small Rural Hospital Improvement Program (SHIP), which allows HCAI to provide federal funds to California's 49 qualifying small rural hospitals. The SHIP grant provides awards of up to $12,000 annually to support hospitals in meeting value-based payment and care goals, becoming accountable care organizations, participating in shared savings programs, purchasing health information technology, and training to comply with quality improvement activities.

Resource Request. HCAI requests federal fund expenditure authority of $56,000 annually to continue support for the department's Small Rural Hospital Improvement Program (SHIP). In the current and ongoing federal SHIP grant project period, HRSA increased funding to the SORHs to account for additional small rural hospitals and allow states to maximize award amounts to the hospitals. As a result, HCAI is requesting an increase in expenditure authority that corresponds with the increase in federal funding available for SHIP.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 5: April Finance Letter – Technical Adjustment

Technical Adjustment – April Finance Letter. HCAI requests extension of encumbrance and expenditure authority until June 30, 2028, for $6.3 million General Fund approved in the 2021 Budget Act to administer workforce programs as part of the Children and Youth Behavioral Health Initiative.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested HCAI to respond to the following:

1. Please provide a brief overview of this technical adjustment.

Issue 6: Panel Discussion - Health and Behavioral Health Workforce Development

Informational Issue. The Governor's January budget included several workforce development proposals related to the health care workforce, including training community health workers, nursing professionals, social workers, psychiatric residents, and multilingual professionals. In prior years, the Legislature approved budget augmentations for several additional workforce development programs for primary care and behavioral health professionals. These proposals and augmentations were made in response to shortages in various health or behavioral health provider types, particularly in underserved areas. As the Legislature considers how to address these shortages, the subcommittee will convene a panel discussion with HCAI, and with various stakeholders to evaluate options for addressing the state's health and behavioral health workforce development needs.

Background. As California continues to make progress providing affordable health coverage to all its residents, current and projected shortages of providers of health care services make it difficult for many Californians, particularly those enrolled in Medi-Cal or with complex health care needs, to easily access necessary medical care. According to the California Future Health Workforce Commission, a diverse body of public, private, and non-profit stakeholders convened to study the state's health workforce needs, California is facing statewide and regional shortages of many essential providers of primary care, behavioral health, public health interventions, and care for older adults. In addition, California lacks an adequate supply of frontline health care workers, such as community health workers (CHWs), home care workers, medical assistants (MAs), and peer support specialists, as well as an adequate supply of all providers with the necessary cultural and linguistic competency to effectively serve the health care needs of an increasingly diverse state.[1]

Primary Care Workforce Shortages. According to the Healthforce Center at the University of California, San Francisco (UCSF), California will likely face a statewide shortfall of clinicians by 2030, with some regions facing greater shortages than others as providers are not evenly distributed across regions of the state. Based on their forecast of provider supply, the Healthforce Center estimates the supply of primary care physicians (MDs) will decrease between 8 and 25 percent because an insufficient numbers of new primary care MDs are completing residency programs to replace physicians who are projected to retire. The Healthforce Center also estimates that, by 2030, the supply of primary care nurse practitioners (NPs) is projected to increase between 82 and 157 percent and the supply of primary care physician assistants (PAs) is projected to increase between 64 and 127 percent. By 2030, nearly half of California's primary care workforce will consist of NPs and PAs, delivering up to 75 percent of all primary care services.[2]

Shortages in the supply of primary care physicians is largely a regional phenomenon, particularly in the San Joaquin Valley, Northern and Sierra Region, and the Inland Empire. The statewide availability of primary care physicians has improved between 2015 and 2020, but these three regions continue to lag behind the rest of the state.

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[1] California Future Health Workforce Commission. *Meeting the Demand for Health: Final Report of the California Future Health Workforce Commission.* February 2019.

[2] Joanne Spetz, Janet Coffman, and Igor Geyn (Healthforce Center at UCSF). *California's Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030*. August 2017.

Supply of Primary Care Physicians per 100,000 Population, by Region, 2015 to 2020 [3,4] (Recommended Supply: 60 to 80 per 100,000)[5]			
Region	PCPs per 100,000 2015	PCPs per 100,000 2020	Difference (%) 2015 to 2020
Northern and Sierra	47	48	+1 (2.1%)
Greater Bay Area	64	80	+16 (18.8%)
Sacramento Area	54	66	+12 (22.2%)
San Joaquin Valley	39	47	+8 (20.5%)
Central Coast	50	58	+8 (16.0%)
Los Angeles County	48	58	+10 (20.8%)
Orange County	52	61	+9 (17.3%)
San Diego Area	50	61	+11 (22.0%)
Inland Empire	35	41	+6 (17.1%)
STATEWIDE	**50**	**60**	**+10 (20.0%)**

(Highlighted rows indicate regions below recommended supply as of 2020)

Behavioral Health Workforce Shortages. Similar to primary care, providers of behavioral health services suffer from geographic maldistribution. For example, the San Joaquin Valley and Inland Empire regions have the lowest provider-to-population ratios in the state for almost every category of behavioral health provider, compared to the Bay Area which has more than three times as many psychiatrists by population as those two regions. In addition, most behavioral health occupations do not reflect the racial, ethnic, or gender diversity of the state. African Americans and Latinos are underrepresented among psychiatrists and psychologists, while Latinos are also underrepresented among counselors and clinical social workers. Men constitute the majority of psychiatrists, while women constitute the majority of psychologists, counselors, and social workers.

Training opportunities are similarly maldistributed. For example, there are no residency programs for psychiatrists and no educational programs for mental health nurse practitioners or psychologists north of Sacramento. There are also no doctoral programs in psychology in the Central Coast or San Joaquin Valley regions. While Latino representation among graduates of social work and psychiatric technician programs has improved, Latinos remain underrepresented among graduates of psychiatric residency programs and clinical or counseling psychology programs.

According to Healthforce researchers, based on current supply of providers and demand for service utilization, by 2028 California will have 50 percent fewer psychiatrists than needed to meet the state's mental health needs, and 28 percent fewer psychologists, licensed marriage and family therapists

[3] California Health Care Foundation. *California Physicians: Quick Reference Guide*. 2017. www.chcf.org/wp-content/uploads/2017/12/PDF-CaliforniaPhysiciansQRG2017.pdf

[4] California Health Care Foundation. *California Physicians: Quick Reference Guide.* 2021. www.chcf.org/wp-content/uploads/2021/03/PhysiciansAlmanac2021QRG.pdf

[5] Council on Graduate Medical Education (COGME). United States Health Resources and Services Administration.

(LMFTs), licensed professional clinical counselors (LPCCs), and licensed clinical social workers (LCSWs) than needed.[6]

Public Health Workforce Shortages. The COVID-19 pandemic has laid bare the decades-long underinvestment in public health in California, the nation, and the world. Two years into the pandemic, many public health officers identify additional staff resources as the most important resource they would have wanted to be available before the pandemic began. According to the California Future Health Workforce Commission, 61 percent of managers and supervisors, and 44 percent of non-supervisory staff at the California Department of Public Health are eligible for retirement, and the department estimates two-thirds of its workforce will retire in the next five years. At the local level, county and city health departments report challenges in recruiting and retaining well-qualified workers, citing a lack of tools for recruiting, limited options for advancement, and instability of funded positions.[7] The instability of funding is a particular problem the Legislature attempted to address in its public health infrastructure package in last year's joint Senate-Assembly budget proposal, but delayed for a year in the final agreement. Most local public health funding is categorical, tied to specific programs or activities, with no flexibility to support comprehensive public health strategies. The Legislature also attempted to appropriate ongoing funding to develop public health workforce development programs at the Department of Health Care Access and Information (HCAI, formerly OSHPD). There are currently few workforce development programs to recruit, train, or retain qualified public health professionals. In particular, local health departments have identified the need for public health nurses, laboratory staff, epidemiologists, health equity staff, and data analysts.

Shortages in Providers of Care for Older Adults. California's aging population will continue to stretch the capacity of the health care system to provide for the needs of the state's older adults. By 2030, 20 percent of Californians will be over age 65 and will be more likely to be single or childless, live alone, and live in poverty. In addition, most older adults would prefer to age in a home- or community-based setting, rather than institutional care. However, Healthforce researchers estimate a shortfall of 600,000 home care workers to care for this population by 2030.[8] In addition, the American Geriatrics Society estimates the nation will need nearly an additional 27,000 geriatricians by 2025 to meet demand.[9]

Recent State Investments in Healthcare Workforce Development. The shortages of various types of healthcare workers in California have led to several recent investments in workforce development. These investments are as follows:

Primary Care Workforce

- *Medi-Cal Physician and Dentist Loan Repayment Program.* The 2018 Budget Act included one-time expenditure authority of Proposition 56 tobacco tax revenue of $220 million for loan repayments to

[6] Janet Coffman, Timothy Bates, Igor Geyn, and Joanna Spetz (Healthforce Center at UCSF). *California's Current and Future Behavioral Health Workforce.* February 2018. https://healthforce.ucsf.edu/publications/california-s-current-and-future-behavioral-health-workforce

[7] California Future Health Workforce Commission. *Meeting the Demand for Health.*

[8] Janet Coffman, et al. *California's Current and Future Behavioral Health Workforce.*

[9] American Geriatrics Society. *State of the Geriatrician Workforce.* https://www.americangeriatrics.org/geriatrics-profession/about-geriatrics/geriatrics-workforce-numbers

physicians and dentists who serve Medi-Cal beneficiaries. The 2019 Budget Act included an additional $120 million of Proposition 56 funding for the program, which provides loan repayment awards up to $300,000 to physicians and dentists in exchange for a five-year service obligation and providing at least 30 percent of services to Medi-Cal beneficiaries.

- *Song-Brown Healthcare Workforce Training Programs.* The 2016 Budget Act included General Fund expenditure authority of $33 million a year for three years to support primary care residencies in the Song-Brown Healthcare Workforce Training Program. The 2019 Budget Act approved this funding on an ongoing basis. The 2021 Budget Act included a one-time augmentation of $50 million for 2021-22 for the Song-Brown program.

- *Nursing Pre-Licensure Programs.* The 2021 Budget Act included General Fund expenditure authority of $10 million in 2021-22 to support Board of Registered Nursing-approved pre-licensure programs, with priority to public programs.

- *Pediatric Residency Program Augmentation.* The 2019 Budget Act included General Fund expenditure authority of $2 million to support pediatric primary care residency slots at children's hospitals.

- *California Medicine Scholars Program.* The 2021 Budget Act included General Fund expenditure authority of $10.5 million in 2021-22 to support the California Medicine Scholars Program, a pilot project to enable a statewide pathway to medicine to prepare community college students for careers as primary care physicians in underserved communities.

- *Health Professions Career Opportunity Program.* The 2021 Budget Act included General Fund expenditure authority of $16 million in 2021-22 to support the Health Professions Career Opportunity Program to implement pipeline programs and post-baccalaureate opportunities at colleges and universities for students from underrepresented regions and backgrounds to pursue health careers.

Behavioral Health Workforce

- *Children and Youth Behavioral Health Initiative – Workforce Programs.* The 2021 Budget Act included General Fund expenditure authority of $600 million in 2021-22, $125 million in 2022-23, and $75 million in 2023-24 to support programs to improve the capacity of the behavioral health workforce, particularly for children and youth. These investments will support the following workforce development efforts at the Department of Health Care Access and Information (HCAI):

    - Behavioral Health Counselors and Coaches – $352 million over three years will be used to create and develop workforce programs for behavioral health counselors and coaches. Counselors provide in-person or virtual, individual or group, supports. Coaches are a class of providers that includes support counselors, behavior specialists, intervention specialists, peer personnel, or community health workers who work side by side with licensed clinical staff.

    - Youth Substance Use Disorder (SUD) Counselor/Specialist – HCAI will develop a new certificate or credentialing program for youth SUD counselor/specialist.

- Psychiatric Nurse Practitioners – HCAI will work with nursing and other health professional schools to develop enhanced online stimulated training and provide free tuition and stipends for 5,000 to 7,500 registered nurses (RNs) or other professionals to become Psychiatric Nurse Practitioners to serve in California for at least five years.

- "Earn and Learn" Apprenticeship Models – HCAI will develop programs to provide tuition support and on-the-job training at a behavioral health provider organization while attending post-secondary school. The employer will provide a position for the graduate with a period of service obligation. These models would support training of SUD counselors, community health workers, and psychosocial rehabilitation specialists.

- Training to Support Justice- and System-Involved Youth – HCAI will develop specialized training programs for child welfare, education, and probation staff on effective behavioral health strategies for justice- and system-involved youth, including preventing involvement among high-risk, vulnerable youth and their families.

- Peer Support Specialists – HCAI will develop programs to train, recruit, and provide stipends for youth peer support specialists and family and caregiver support specialists.

- Social Workers – HCAI will expand certificate programs at higher education institutions that train child and adolescent social workers and child welfare workers.

HCAI will also augment existing loan repayment, scholarship, and stipend programs to support training and development for behavioral health disciplines.

- *Workforce Education and Training (WET) Five-Year Plan.* The 2019 Budget Act included expenditure authority of $60 million ($35 million General Fund and $25 million Mental Health Services Fund) to implement the 2020-25 WET Five-Year Plan which addresses workforce shortages in the state's public mental health system.

- *Mental Health Workforce Development.* The 2019 Budget Act included General Fund expenditure authority of $47.4 million in 2019-20 to fund scholarships and loan repayment awards for mental health workforce programs.

- *Psychiatric Fellowship Augmentation.* The 2019 Budget Act included General Fund expenditure authority of $2.7 million in 2019-20 to fund scholarships for primary care and emergency providers receiving Primary Care Clinician Psychiatry Fellowships.

Public Health Workforce

- *Public Health Infrastructure.* The 2021 Budget Act included a commitment from the Administration to allocate $300 million annually, beginning in 2022-23, to support public health infrastructure. While the Administration's proposed allocation of these funds is pending release of the 2022-23 Governor's January Budget, the Legislature's joint proposed public health infrastructure package included $35 million annually devoted to developing the public health workforce. It is unclear whether the Administration will propose similar workforce investments.

Older Adults Care Workforce

- *Certified Nursing Assistant Workforce Programs.* The 2021 Budget Act included General Fund expenditure authority of $45.5 million in 2021-22 to support certified nursing assistant training programs.

- *Alzheimer's Workforce Programs.* The 2021 Budget Act included General Fund expenditure authority of $8 million in 2021-22 to support Alzheimer's and geriatric care providers through HCAI's existing health care workforce development programs.

Workforce for a Healthy California for All. In the Governor's January budget, HCAI is requesting expenditure authority of $296.5 million ($270.5 million General Fund and $26 million Opioid Settlement Fund) in 2022-23, and General Fund expenditure authority of $370.5 million in 2023-24 and 2024-25 to support loan repayment, scholarship, stipend, and organizational grant awards for health workforce initiatives in the Workforce for a Healthy California for All Program. Specifically, these resources would support the following workforce initiatives:

- *Community Health Workers.* HCAI is requesting resources to support a new program to recruit, train, and certify 25,000 new community health workers by 2025, with specialized training to work with certain populations including the justice-involved, the unhoused, older adults, or persons with disabilities. According to HCAI, the training requirements would align with Medi-Cal requirements for reimbursement for providing its new community health worker services benefit.
- *Comprehensive Nursing Initiative.* HCAI is requesting resources to increase the numbers of registered nurses, licensed vocational nurses, certified nursing assistants, certified nurse midwives, certified medical assistants, family nurse practitioners, and other health professions. These resources would expand existing workforce programs at HCAI for these professionals. According to HCAI, these resources would annually support 4,509 loan repayments, 1,666 scholarships, and 20 training program grants for nurses and other professionals covered by this program expansion.
- *Social Workers.* HCAI is requesting resources to increase the number of social workers trained in California by supporting social work training programs and providing stipends and scholarships for working people to create a new pipeline for diverse social workers. According to HCAI, these resources would annually support 250 loan repayments, 620 stipends, and 5 training program grants for social workers' training.
- *Psychiatric Residents.* HCAI is requesting resources to increase the number of behavioral health providers such as psychiatrists, psychiatric nurse practitioners, and psychologists. Utilizing its existing workforce programs, HCAI expects these resources to result in eight additional residency slots in 2022-23, 10 in 2023-24, and 12 in 2024-25.
- *Multilingual Health Initiatives.* HCAI is requesting resources to increase the linguistic and cultural competencies in the health workforce by expanding scholarship and loan repayment opportunities for multilingual applicants. According to HCAI, additional slots will be created and set aside in existing health workforce programs for multilingual applicants, including annual support for 389 loan repayments and 459 scholarships.

In addition to support for workforce programs, HCAI request resources to support the existing Health Workforce Education and Training Council to research healthcare shortages and best practices and strategies to build a diverse, culturally competent health workforce.

California Future Health Workforce Commission – Final Report and Recommendations. The California Future Health Workforce Commission, comprised of 24 commissioners from the fields of health, policy, workforce development, and education, was created in 2017 to create a comprehensive action plan for building the health workforce California will need by 2030.[10] In February 2019, the Commission published "Meeting the Demand for Health: Final Report of the California Future Health Workforce Commission" with 27 recommendations to implement three workforce strategies. The recommendations are as follows:

Strategy 1: Increase opportunity for all Californians to advance in the health professions

- 1.1 – Expand and scale pipeline programs to recruit and prepare students from underrepresented backgrounds for health careers.
  Timeframe: 10 years; Total Cost: $62.0 million

- 1.2 – Recruit and support college students, including community college students, from underrepresented regions and backgrounds to pursue health careers.
  Timeframe: 10 years; Total Cost: $159.0 million

- 1.3 – Support scholarships for qualified students who pursue priority health professions and serve in underserved communities.
  Timeframe: 10 years; Total Cost: $479.8 million

- 1.4 – Increase postbaccalaureate program slots for students reapplying to medical school from underserved communities.
  Timeframe: 10 years; Total Cost: $26.0 million

- 1.5 – Expand funding for educational capacity, stipends, and scholarships to strengthen the size, distribution, and diversity of the behavioral health workforce.
  Timeframe: 10 years; Total Cost: $341.5 million

- 1.6 – Expand and strengthen loan-repayment programs for primary care clinicians practicing in safety-net settings and underserved communities.
  Timeframe: 10 years; Total Cost: $353.8 million

- 1.7 – Create a California Health Corps to engage students, health workers, and retirees in addressing health workforce gaps.
  Timeframe: 3 years; Total Cost: $4 million

- 1.8 – Assess, treat, and improve college student mental health and promote behavioral health careers.
  Timeframe: 3 years; Total Cost: $8.6 million

[10] California Future Health Workforce Commission. *Meeting the Demand for Health.*

- 1.9 – Implement a statewide prevention and early intervention mental health and workforce development model for K-12 students.
  Timeframe: 5 years; Total Cost: $2.5 million

Strategy 2: Align and expand education and training to prepare health workers to meet California's health needs.

- 2.1 – Sustain and expand the PRIME program across UC campuses.
  Timeframe: 10 years; Total Cost: $93.5 million

- 2.2 – Expand the number of primary care physician and psychiatry residency positions.
  Timeframe: 10 years; Total Cost: $1,562.0 million

- 2.3 – Recruit and train students from rural areas and other underresourced communities to practice in community health centers in their home region.
  Timeframe: 10 years; Total Cost: $64.4 million

- 2.4 – Expand medical school enrollment at public institutions for the benefit of medically underserved areas.
  Timeframe: 10 years; Total Cost: $755.3 million

- 2.5 – Develop a four-year medical education program at Charles R. Drew University of Medicine and Science.
  Timeframe: 3 years; Total Cost: $1.0 million

- 2.6 – Bring together schools and programs of public health and local health departments to train the next generation of public health professionals and advance health equity.
  Timeframe: 7 years; Total Cost: $15.5 million

- 2.7 – Integrate training on social determinants into all health professions training programs.
  Timeframe: 4 years; Total Cost: $21.8 million

- 2.8 – Expand the role of the California Community Colleges system and its new online college in training the future health workforce.
  Timeframe: TBD ; Total Cost: $0.1 million

Strategy 3: Strengthen the capacity, effectiveness, well-being, and retention of the health workforce.

- 3.1 – Maximize the role of nurse practitioners as part of the care team to help fill gaps in primary care.
  Timeframe: 10 years; Total Cost: $462.2 million

- 3.2 – Establish and scale a universal home care worker family of jobs with career ladders and associated training.
  Timeframe: 4 years; Total Cost: $7.0 million

- 3.3 – Develop a psychiatric nurse practitioner program that recruits from and trains providers to serve in underserved rural and urban communities.
  Timeframe: 5 years; Total Cost: $24.6 million

- 3.4 – Scale the engagement of community health workers, promotores, and peer providers through certification, training, and reimbursement.
  Timeframe: 3 years; Total Cost: $68.0 million

- 3.5 – Strengthen training for primary care providers on behavioral health and wellness using train-the-trainer modalities.
  Timeframe: 10 years; Total Cost: $44.0 million

- 3.6 – Establish a California Health Workforce Technology and Data Center to support the adoption of technologies that increase access to quality care.
  Timeframe: 2 years; Total Cost: $2.0 million

- 3.7 – Assess the well-being of health professions students and providers, and develop a statewide action plan to proactively address burnout.
  Timeframe: 1 years; Total Cost: $0.9 million

- 3.8 – Establish primary care spending targets and requirements for public and private payers.
  Timeframe: 4 years; Total Cost: $1.1 million

- 3.9 – Build capacity of local public health agencies to support collaborative community health improvement through state-hospital matching funds.
  Timeframe: 3 years; Total Cost: $33.5 million

- 3.10 – Engage health plans in regional workforce partnerships and initiatives.
  Timeframe: 10 years; Total Cost: $1,401.0 million

Panel Discussion – Behavioral Health Workforce Needs. The subcommittee has requested the following panelists to discuss options for the state to address gaps in its behavioral health workforce:

- **Amer Rashid -** Legislative Advocate, County Behavioral Health Directors Association
- **Tyler Rinde -** Executive Director, California Association of Alcohol and Drug Program Executives
- **Colin Sueyres -** Director of Government Affairs, California Psychological Association
- **Rebecca Gonzales -** Director of Government Relations and Political Affairs, NASW-CA

Panel Discussion – Health Care Workforce Needs. The subcommittee has also requested the following panelists to discuss options for the state to address gaps in its health care workforce:

- **Michelle Gibbons -** Executive Director, County Health Executives Association of California
- **Beth Malinowski -** Government Affairs Advocate, SEIU California
- **Claire Enright -** Executive Director, Quality Care Health Foundation

- **Kathryn Scott -** Senior Vice President-State Relations and Advocacy, California Hospital Association
- **Dennis Cuevas-Romero -** Legislative Advocate, California Medical Association
- **Nataly Diaz -** Deputy Director of Workforce Development, California Primary Care Association

Subcommittee Staff Comment—This is an informational issue.

Questions. The subcommittee has requested HCAI to respond to the following:

1. Please describe the health and behavioral health workforce augmentations adopted in the 2021 Budget Act and proposed in the Governor's January budget.

2. How do the previous augmentations and current proposed augmentations address the recommendations of the California Future Health Workforce Commission?

The subcommittee has also requested the invited behavioral health panelists to respond to the following questions:

CBHDA

1. What is CBHDA's evaluation of the state's needs for behavioral health workers to ensure adequate access to behavioral health care for Californians?

2. What does CBHDA believe is the most effective way to address shortages and geographic maldistribution of behavioral health providers?

CAADPE

3. What is CAADPE's evaluation of the state's needs for behavioral health workers, particularly providers of substance use disorder (SUD) services?

4. What types of workforce programs currently exist for SUD services providers? What types of programs would be most effective in improving access?

California Psychological Association

5. What is CPA's evaluation of the state's need for behavioral health workers?

6. What would be the most effective way to address shortages and geographic maldistribution of behavioral health providers?

NASW-CA

7. Please describe the need in California for additional social workers, particularly the types of services that would benefit from an adequate supply of providers.

8. What would be the most effective workforce development interventions to improve the pipeline of social workers in California?

CHEAC

9. Please describe the current challenges in recruiting and retaining public health workers.

10. Please describe any current workforce development programs that exist for the public health workforce.

11. What would be the most effective investments in workforce development to improve the pipeline of public health workers available to support state and local public health departments?

SEIU

12. What are the most significant barriers faced by individuals hoping to join the health or behavioral health workforce? How might the state work to overcome those barriers?

13. What are the most effective strategies for the state to recruit, train, and retain health and behavioral health workers?

Quality Care Health Foundation/CAHF

14. The California Future Health Workforce Commission identified shortages in providers of care for older adults. What are the primary types of providers that skilled nursing facilities have a difficult time recruiting and/or retaining?

15. How might the state make investments to improve the pipeline for this workforce?

California Hospital Association

16. What are the most common workforce challenges faced by hospitals in California?

17. What would be the most effective state investment that could help address those challenges?

California Medical Association

18. What is CMA's view of the challenges in ensuring a sufficient supply of physicians to underserved areas?

19. How might the state make investments to address these challenges?

California Primary Care Association

20. What are the most common workforce challenges faced by community clinics in California?

21. What might the state do to help ensure an adequate supply of providers that could serve in community clinics?