PROMOTING ACCESSIBILITY AND SUSTAINABILITY OF MEDI-CAL IN LOCAL COMMUNITIES

Medi-Cal Task Force Report

Organized by Hospital Council of Northern And Central California And Hospital Association Of Southern California

OCTOBER 2016

ACKNOWLEDGMENTS

This task force is an example of the power to achieve change that starts with a common table where individuals who share in a mission, goal, or activity but work in separate sectors of endeavor come together. At the common table, the perspectives, experience, and knowledge of the participants combine to create comprehensive solutions with greater potential for successful implementation.

This effort required many people working together including coordinating significant activity behind the scenes. We offer special thanks to the following individuals.

Task Force Members

Project Facilitator, Guide, and Mentor
Bobbie Wunsch
Founder and Partner
Pacific Health Group
bwunsch@pachealth.org/www.pachealth.org
415.459.7813

Project Managers
Martin Gallegos
Sr. Vice President, Policy Development and Communications
Hospital Association of Southern California
Mark Gamble
Sr. Vice President/COO
Hospital Association of Southern California
Art Sponseller
President/CEO
Hospital Council of Northern and Central California

Project Coordinators
Jeanne McAuliffe
Executive Office Coordinator
Hospital Council of Northern and Central California
Margaret O'Donnell
Executive Assistant
Hospital Association of Southern California

Project Advisors
Lynn Baskett
Special Projects Officer
Rebecca Rozen
Regional Vice President
Hospital Council of Northern and Central California
Amber Kemp
Vice President, Health Care Coverage
California Hospital Association

TABLE OF CONTENTS

PROMOTING ACCESSIBILITY AND SUSTAINABILITY OF MEDI-CAL IN LOCAL COMMUNITIES

Medi-Cal Task Force Executive Summary

Purpose and Background:

The Medi-Cal program in California provides insurance for more than 13.5 million Californians – one in every three people. The current period of great change within health care is an opportunity to forge a future that brings diverse organizations together, acknowledges the strengths of all, and builds on those strengths.* Given a history of convening stakeholders on a variety of issues broader than those affecting just hospitals, the Hospital Association of Southern California (HASC) and the Hospital Council of Northern and Central California (Hospital Council) convened a broad stakeholder task force to strengthen ties among the participating stakeholders and deepen support for effective population health management models in the Medi-Cal program.

The *Medi-Cal Task Force: Promoting Accessibility and Sustainability of Medi-Cal in Local Communities* is comprised of local Medi-Cal managed care health plans (Local Initiatives and County Organized Health Systems - COHS), community health centers represented by their consortia, medical groups, county health systems and hospitals.

**Discussion and recommended actions in this report concluded in October 2016 before the election.*

Task Force Structure and Topics:

The Task Force was organized as two simultaneous efforts: 1) a Southern California Task Force hosted by Hospital Association of Southern California, and 2) a Northern and Central California Task Force hosted by Hospital Council of Northern and Central California. After each Task Force meeting, the state associations represented by local Task Force Members received summaries and met to stay informed of the proceedings.

Both task forces identified the same topics for discussion at their first meeting. All subsequent meetings were organized around these issues.

Discussion Topics

- Population health and social determinants of health
- Access and Workforce
- Behavioral health
- Patient education, navigation and coordination

Cross-cutting topics:

- Data and metrics
- Health information exchanges (HIE)
- Financial incentives and new payment models.

Next Steps and Proposals for Moving Forward

There was strong consensus about the need for both local and state action in follow up to this series of meetings. There is work that each community can undertake with their local public Medi-Cal managed care health plan(s), their local hospitals, county health systems, community clinics and consortia as well as physician groups serving large numbers of Medi-Cal beneficiaries. Some solutions discussed by the Task Force rely on state level collaboration and policy action.

Recommendation #1 - Local Coalitions:

The task force agreed that local collaboration is an essential tool to improve the efficiency and effectiveness of systems of care. Locally, hospitals, community clinics, physician groups, county health systems and health plans can identify collaborative opportunities to improve local Medi-Cal systems and health outcomes. Building on existing local coalitions or convening a new local coalition to meet and act together is essential to strengthen coordination and address challenges identified.

Recommendation #2 - Data Sharing, Analysis and Exchange and Expanded Use of Technology:

The next frontier of technology improvement is to link and share information across health care organizations to improve care delivery. Local or regional data systems to collect, share and jointly analyze data are needed in every community to improve health care access and outcomes. Training for health care workforce is also essential to use technology tools effectively within their workflow. Beyond health care, technology-based tools and systems to identify, assess, and share information on beneficiaries' social determinants of health, health status, and current access to social services are needed.

Recommendation #3 - Population Health Management, Social Determinants of Health and Care Coordination:

Health care systems are developing new approaches to assess social determinants of health, connect clinical and community services and implement non-traditional partnerships such as health and housing to improve outcomes. Partners can collaborate to create a local road map among hospitals, county health systems, community clinics, physician groups and health plans to move to a population health management agenda. The DHCS Coordinated Care Initiative, Health Homes program and Whole Person Care pilots are important near-term opportunities to gain experience.

Recommendation #4 - Workforce Development:

Local coalitions can address the region's most pressing workforce needs by creating a local workforce priorities action plan and collaborating on its implementation. Workforce challenges will benefit significantly from state leadership as well as federal and state investment in the health career pipeline in schools. In addition, expanded intern and residency programs for physicians and mid-level providers, and expansion of the National Health Service Corps and loan repayment programs will help overcome workforce shortages. An ambitious yet significant opportunity rests in state level collaboration to change policy related to the scope of practice for certain members of the care team. There is also an opportunity to identify strategies to expand training and career tracks to increase the impact of the current workforce.

Recommendation #5 - Behavioral Health:

The high prevalence of behavioral health conditions and the fragmentation of physical health, mental health and substance use disorders services results in high costs and poor health. Local partners can identify promising practices for adoption across systems to clarify roles and responsibilities of counties, health plans, hospitals, and community clinics, and to coordinate, provide and pay for mental health and substance use disorders services. State leadership is essential to clarify behavioral health regulations and definitions and accelerate local integration of behavioral health services into primary care and primary care into behavioral health settings to improve outcomes.

Conclusion

The time for action is now. The next steps proposed by the Medi-Cal Task Force represent a road map of practical steps for change that are feasible and important. Even in this time of heightened uncertainty, the recommendations serve as an important guide to health system improvements. The work begins with the convening of local community partners to identify areas of collaboration and joint action. Partners can address and improve local health systems through coalition-building with social service agencies to address social determinants of health, participating in health information exchange, streamlining care coordination locally, improving behavioral health integration and supporting workforce pathways into health care. There is no better group to meet the challenge of this urgent work than the local providers and local health plans in our diverse communities around the state.

NOTE: Discussion and recommended actions in this report concluded in October 2016 before the election.

PROMOTING ACCESSIBILITY AND SUSTAINABILITY OF MEDI-CAL IN LOCAL COMMUNITIES

Medi-Cal Task Force Report

Purpose and Background:

The Medi-Cal program in California provides insurance for more than 13.5 million Californians – one in every three people. Nearly 80 percent of the Medi-Cal beneficiaries are in managed care plans and most of those in are in local public plans. Safety net providers and traditional Medi-Cal providers provide most of the care to the beneficiaries; and their role is growing. Over the coming years, payment reform will move reimbursement from visit-based payments to a focus on value. The ability of the partners in the health care system locally to succeed in effectively managing care for this population is critical to creating a sustainable and comprehensive delivery system that is coordinated, integrated and promotes health and wellness across the care continuum.

The current period of great change within health care is an opportunity to forge a future that brings diverse organizations together, acknowledges the strengths of all, and builds on those strengths.* With this in mind, and given a history of convening stakeholders on a variety of issues broader than those affecting just hospitals, the Hospital Association of Southern California (HASC) and the Hospital Council of Northern and Central California (Hospital Council) convened a broad stakeholder task force to strengthen ties among the participating stakeholders and deepen support for effective population health management models in the Medi-Cal program.

The *Medi-Cal Task Force: Promoting Accessibility and Sustainability of Medi-Cal in Local Communities* is comprised of local Medi-Cal managed care health plans (Local Initiatives and County Organized Health Systems - COHS), community health centers represented by their consortia, medical groups, county health systems and hospitals. The Task Force convened to identify best practices and highlight areas for continuing focus at local and state levels to improve the delivery of coordinated, high quality, appropriate and efficient health care.

**Discussion and recommended actions in this report concluded in October 2016 before the election.*

Task Force Structure and Membership:

The Task Force was organized as two simultaneous efforts: 1) a Southern California Task Force hosted by Hospital Association of Southern California (HASC), and 2) a Northern and Central California Task Force hosted by the Hospital Council of Northern and Central California (Hospital Council). The two efforts operated consistently in terms of meeting planning, meeting agendas, and topics. The Task Force met four times between June and October 2016. Organizations were generally represented by their CEO. A list of the Task Force members is included as Attachment A. The Task Force report is issued jointly to represent the work of both groups.

After each Task Force meeting, the state associations represented by local Task Force Members received summaries and met to stay informed of the proceedings. This group included California Primary Care Association (CPCA), California Children's Hospital Association (CCHA), California Association of Physician Groups (CAPG), Local Health Plans of California (LHPC), Private Essential Access Community Hospitals (PEACH), California Association of Health Plans (CAHP), California Medical Association (CMA), California Association of Public Hospitals and Health Systems (CAPH), California State Association of Counties (CSAC), California Association of Health Facilities (CAHF), District Hospital Leadership Forum (DHLF) and California Hospital Association (CHA).

Topics and Discussion Questions

Members of the Task Force held an initial meeting to identify shared challenges and opportunities for collaboration. Many consistent issues surfaced through small group discussions across sectors, including:

- Complex care management
- Data sharing
- Provider availability
- Social determinants of health
- Health literacy/patient education
- Behavioral health integration
- Financial models
- Payment reform and value-based outcomes
- Population health best practices
- Skilled nursing facility arrangements
- Disease management and care coordination
- Care transitions
- Technology to look at managing patients across systems of care
- Emergency Department navigation and discharge planning
- Work with counties on Substance Use Disorder Services Waiver

The issues were grouped into four topics for in-depth discussion through a series of Task Force meetings. In addition, three cross-cutting issues were discussed as part of each topic. Task Force meeting discussions were informed by best practice presentations identified by Task Force members and advance reading materials. The following section outlines highlights of these discussions.

Discussion Topics

- Population health and social determinants of health
- Access and Workforce
- Behavioral health
- Patient education, navigation and coordination

Cross-cutting topics:

- Data and metrics
- Health information exchanges (HIE)
- Financial incentives and new payment models.

Task Force Discussion Summary

Topic 1: Population Health and Social Determinants of Health

Discussion Questions:

- How do population health and social determinants of health impact the health status of our Medi-Cal members and patients from your perspective?
- What are the key issues we should focus on in this area?
- In what ways, can our sectors work together to improve population health for our Medi-Cal members and patients?

Discussion Highlights: Social and environmental factors are significant determinants of health and lead to potentially preventable morbidity and premature mortality. Access to services is essential, however, to be effective, we need to be strongly committed to population health and social determinants of health. This means moving from an episodic approach to a continuous model of care. New payment methodologies and payment reform are needed to address social determinants of health. Comments included:

- Local leadership is necessary to bring stakeholders together to move from the way health care is delivered today to a population health management approach.
- Shared understanding and clear definitions of population health are needed.
- Broad screening tools to assess needs are critical.
- Payment reform pilots offer an opportunity to learn about financing to support population health.
- Sharing information and data across systems, HIE, is critical.
- Role of case managers and care coordinators needs to be clarified. The health plan is accountable but many members/patients have multiple care managers and fragmented, overly complicated care coordination resulting in less effective care.
- Patient navigation in the emergency department is needed.
- The Whole Person Care pilots, Health Homes program (ACA 2703) and the Coordinated Care Initiative (CCI) are key to starting this work together.
- Local EMS agencies (LEMSA) need to be incorporated into the discussion.

Topic 2: Access and Workforce

Discussion Questions:

- How do issues of workforce supply impact access to care?
- What key issues in workforce and access are most important for us to focus on together?

Discussion Highlights: Workforce shortages are impacting every level of health care. There is a shortage of primary care providers, specialists and care team workforce. The resulting barriers to

primary care access leads to patient frustration, delays in treatment, inappropriate ED visits, provider burn-out and competition for existing workforce. Comments included:

- Regular collaborative meetings are needed to develop a local plan of action on workforce.
- Collective advocacy for an increase in National Health Service Corps and loan repayment programs should be considered.
- Health plan subsidies to recruit providers may work.
- Current financing methodologies do not support team-based care.
- Specialty care access is a challenge and telehealth/e-consult expansion is needed.
- Workforce shortages in key specialties, such as cardiology, pulmonary medicine, vascular surgery and neurology are growing and will further limit access to prompt outpatient care. These shortages exacerbate efforts to intervene early. Poor access to care can lead to disease progression, higher morbidity and increased hospitalization.
- Explore the scope of practice for members of care teams; more clearly define appropriate functions within care management teams; utilize local training for medical assistants to create career tracks.
- Work with educational partners to increase capacity to train health care workers at all levels including physicians, nurses and other staff.
- Work with schools to increase the number of students in the pipeline for health careers.
- Engage community leaders to work with and support recruitment and retention of provider candidates including, but not limited to, Chambers of Commerce, Rotary and other service organizations, law enforcement, and banks who may provide discounted home mortgages.

Topic 3: Patient Navigation, Care Coordination, and Patient Education

Discussion Questions:

- How can improved patient education, navigation and coordination improve appropriate access to care?
- What key issues in the area are most important for us to focus on together?
- In what ways, can our sectors work collaboratively to improve access to care through changes in how we implement patient education, navigation and coordination programs?

Discussion Highlights: It is important to focus on high utilizers through data driven identification and we need high touch care coordination for high need patients. Hospitals have begun to document the need for patient education and navigation as well as identify solutions. Hospitals report that a small number of patients (3-5%) can represent high levels of ED visits and costs. Presenting conditions are hypertension, anxiety, diabetes, abdominal pain, chest pain, asthma, smoking-related diseases and drug and alcohol abuse, and 70 percent of the patients in the report were Medi-Cal. Comments included:

- Identify and implement tools to connect providers, navigators and care coordinators/managers.
- Focus on specific populations and identify the high need utilizers.
- Think about new ways to engage and educate the patients to navigate the system, e.g. promotoras or care navigators.
- Develop standard protocols to work with the high utilization patients.
- Notify primary care providers and health home of patients upon hospital admittance and discharge.

- Use data to drive changes and where case managers/care coordinators focus their work.
- Hold case conferences between sectors monthly to talk about common patients and systems problems sectors and re-emphasize the cross-sector sharing of information as it goes beyond health services to keep the patients stable.
- Share data between hospitals, clinics, health plans and others using HIPAA compliant systems.
- Coordinate across health and social support services.
- Offer adult care through school based health centers.
- Ensure individuals discharged from jail are released with sufficient medication to last until they can see a provider.

Topic 4: Behavioral Health

Discussion Questions:

- How do behavioral health conditions impact the health status of our Medi-Cal members, patients and our institutions from your perspective?
- What are the key issues we should focus on in this area?
- In what ways, can our sectors work together to improve access to behavioral health services for our Medi-Cal members and patients?

Discussion Highlights: The prevalence of mental health needs is staggering - about 20% of adults face mental health issues and 1 in 7 over age 12 have drug issues. These are complex conditions and diseases to treat. Siloed funding and access to care are challenges. Comments included:

- Stigma exists for both patients with behavioral health conditions and providers.
- Look at co-location whether it is primary care or behavioral health and where patients can be treated.
- Needs include psychiatric consultations to support the PCP, expanding the role of tele-psych and tele-health, data sharing, and incentivizing training for PCPs.
- Many isolated efforts were described. There is a need to cross barriers, and find ways to overcome data exchange barriers. There is also need to address the stigmas in the mental health arena and workforce issues. How can the health plans leverage their role in all of this? How can we leverage resources to better address these issues?
- FQHC payment limitations that prohibit reimbursement for behavioral health and primary care services on the same day are a barrier to continuity of care and effective, timely delivery of behavioral health services.
- Payment structures and other regulatory differences between counties increase the difficulty and complexity in coordinating care.

Next Steps and Proposals for Moving Forward

Many common themes and proposals for moving ahead emerged across the northern and southern California task force meetings stimulated by the discussion topics.

There was strong consensus about the need for both local and state action in follow up to this series of meetings. Members voiced a sense of urgency that the momentum, collaboration across the health care systems and open exchange of best practices evident in this series of meetings should continue locally.

There is work that each community can undertake with their local public Medi-Cal managed care health plan(s), their local hospitals, county health systems, community clinics and consortia as well as physician groups serving large numbers of Medi-Cal beneficiaries.

Some of the potential solutions discussed by the Task Force rely on state level collaboration and policy action. Particularly in the areas of workforce, health information exchange and behavioral health, state policy and leadership are required. Regular communication from local partners to state associations, especially about local successes and challenges, is important to connect state policy to local efforts.

These recommendations represent the work of the entire task force. The recommendations are not binding on any individual participating or on any association to which they may belong. To the extent that recommendations may either directly or indirectly require governmental advocacy at the local, regional, state, or federal level, each organization represented on the task force and its respective associations must independently decide whether to pursue such changes in governmental policy.

Recommendation #1 - Local Coalitions:

- The task force agreed that local collaboration is an essential tool to improve the efficiency and effectiveness of systems of care. Locally, hospitals, county health systems, community clinics, physician groups, county public hospital and health systems and health plans can identify collaborative opportunities to improve local Medi-Cal systems and health outcomes for Medi-Cal beneficiaries.
- Building on existing local coalitions or convening a new local coalition to meet and act together is essential to strengthen coordination and address the challenges identified. These coalitions can be co-convened to signify the coming together of the sectors represented on the task force and different coalitions might be necessary to bring different voices to the table. Whenever possible, existing groups can be used or expanded for this purpose.

Recommendation #2 - Data Sharing, Analysis and Exchange and Expanded Use of Technology:

- Technology has greatly advanced health care delivery within organizations. The next frontier is to link and share information across health care organizations to improve care delivery. To accomplish this, local or regional data systems to collect, share and jointly analyze data are needed in every community to improve health care access and outcomes. Moreover, training the health care workforce to use technology tools effectively within their workflow is essential. For example, the ability to provide beneficiary information routinely to contracted providers that includes emergency department utilization data, encounter data relative to primary care services, notice of pending care transitions, opportunities for case conferences, and similar notices and data sharing to support care coordination will improve outcomes. Beyond health care, implementing technology-based tools and systems to identify, assess, and share information on beneficiaries' social determinants of health, current health status, and current access to needed social services is needed.
- Full participation of all Medi-Cal contracted hospitals, health plans, provider organizations and clinics in data sharing and exchange is an essential step to ensure that efforts to collect, share and jointly analyze data to improve health care access and outcomes are robust. A specific focus on reducing the barriers to data sharing of behavioral health information also is needed to realize effective service integration.

- Both state and local attention is required to implement widespread telehealth strategies to expand access to timely patient care through telemedicine, more efficient workforce development and distance learning, and physician-to-physician consultation to improve care. The local health plans are key leaders in assuring that telehealth strategies can be successful.

Recommendation #3 - Population Health Management, Social Determinants of Health and Care Coordination:

- There is intense interest in improving population health and developing new strategies to address social determinants of health. Partners can collaborate to create a local road map among hospitals, county health systems, community clinics, physician groups and health plans to move to a population health management agenda. Health care systems are learning together and developing new approaches to assess social determinants of health, connect clinical and community services and implement non-traditional partnerships such as health and housing to improve outcomes. The DHCS Coordinated Care Initiative, Health Homes program and Whole Person Care pilots are important near-term opportunities to gain experience and spread best practices locally on population health management. Active exchange about the successes and challenges locally and statewide will improve population health across the state.
- This effort may include adopting models of "high touch" care and coordination for high utilizers that are data-driven, address underlying causes of poor health, expand local patient navigation programs and activate patients in their own health improvement. Collaborative investment in technology-based systems that identify, assess and share information on social determinants of health and population health across health and social services are essential for success.
- A streamlined and more efficient approach to care for high need populations also requires that case managers, discharge planners and care coordinators across the health system continuum of care meet regularly and decrease the siloed focus and overlapping responsibilities of multiple case managers. For care coordination to be effective, there is urgent need to address temporary shelter, permanent housing, safe places to discharge and provide follow up care for high need patients that include co-located supportive services, behavioral health and addiction medicine.
- Special emphasis should be placed on timely communication among health plans, hospitals, clinics, physicians, Emergency Medical Services (LEMSA) Agency (ies) and, where appropriate, law enforcement at the points of transition and warm handoffs. For example, local partners could work with local EMS agency (ies) to identify opportunities to implement alternative destinations and treatment models for beneficiaries entering the 911 system without true emergencies, such as referral to local nurse advice line. Timely communication and alternative destinations for EMS will require state legislation and leadership from the respective state associations of task force members will be needed if this approach is to be successful.

Recommendation #4 - Workforce Development, Training and Education:

- Local coalitions can help address the region's most pressing workforce needs by creating a local workforce priorities action plan and collaborating on its implementation. Strategies could include increasing the health career pipeline at local schools, health plan incentives for recruitment of new providers to local areas, discounted home mortgages in collaboration with local banks, and engagement of community leaders and civic organizations to attract local health care workforce.

- Workforce challenges will benefit significantly from state leadership as well as federal and state investment in the health career pipeline in schools. In addition, expanded intern and residency programs for physicians and mid-level providers, expansion of the National Health Service Corps and loan repayment programs will also help overcome workforce shortages. Identifying statewide and regional workforce needs by professional category and connecting this information to the State Master Educational Plan will benefit all.
- Conducting workforce education and training across sectors on social determinants of health, and population health management strategies as well as beneficiaries' mental health and substance use conditions to reduce stigma with providers is an important local strategy. The Substance Use Disorders Services (SUDS) waiver is an opportunity to connect systems of care previously fragmented and very limited to achieve significant gains in overall health; however, workforce challenges and service gaps were identified that require both local and state attention in the immediate future. For example, many communities report a paucity of substance use disorders service options for youth; others do not have residential programs or detox options; still others lack sufficient provider capacity to meet local needs.
- An ambitious yet significant opportunity to address workforce challenges rests in state collaboration to change policy related to the scope of practice for certain members of the care team. There is also an opportunity to identify strategies to expand training and career tracks to increase the impact of the current workforce.

Recommendation #5 - Behavioral Health:

- The high prevalence of behavioral health conditions and the fragmentation of physical health, mental health and substance use disorders services results in high costs and poor health. There is a role for both local and state attention to these challenges.
- Local partners can identify promising practices for adoption across systems to clarify roles and responsibilities of counties, health plans, hospitals, and community clinics, and to coordinate, provide and pay for mental health and substance use disorders services.
- State leadership is essential to clarify behavioral health regulations and definitions and accelerate local integration of behavioral health services into primary care and primary care into behavioral health settings to improve outcomes.

Conclusion

Bringing together at the local level Medi-Cal managed care health plans, community clinics, county health systems and hospitals and physician groups was long overdue, evidenced by the strong interest and enthusiasm in this Medi-Cal Task Force. Over the course of meetings, participants engaged in ever-deepening interaction and growing inspiration about the significant impact to be achieved through more coordinated, efficient local health systems, local alignment of county and state initiatives (such as homeless efforts) and consumer-centered care. With one in three Californians enrolled in the Medi-Cal program, there is a clear imperative for action.

The time for action is now. The next steps proposed by the Medi-Cal Task Force represent a road map of practical steps for change that are feasible and important. Even in this time of heightened uncertainty, the recommendations can serve as an important guide to health system improvements. The work begins with the convening of local community partners to identify areas of collaboration and joint action.

Partners can address and improve local health systems by building coalitions with social service agencies to address social determinants of health, participate in health information exchange, streamline care coordination locally, improve behavioral health integration and support workforce pathways into health care. There is no better group to meet the challenge of this urgent work than the local providers and local health plans in our diverse communities around the state.

NOTE: Discussion and recommended actions in this report concluded in October 2016 before the election.

ATTACHMENT A

2016 MEDI-CAL TASK FORCE MEMBERS

Southern California

- John Baackes, LA Care Health Plan
- Ron Boatman, Arrowhead Regional Medical Center
- Patrick Brilliant, Riverside Community Hospital
- June Collison, Community Hospital of San Bernardino and IEHP
- Steve Foster, Barstow Community Hospital
- Bob Freeman, CenCal
- Brad Gilbert, MD, Inland Empire Health Plan
- Deneen Hadley, Dignity Health
- Rodney Hanners, Keck Hospital USC
- Yair Katz, Long Beach Memorial Medical Center
- Mayla Krebsbach, Aurora Vista Del Mar Hospital
- Alex Li, MD, Los Angeles County Department of Health Services
- Darren Lee, St. John's Regional Medical Center/St John's Pleasant Valley Hospital
- Tom Loats, St. Joseph Hospital, Orange
- Tarek Mahdi, Inland Empire Health Plan
- Louise McCarthy, Community Clinic Association of Los Angeles County
- John McNamara, MD, Torrance Memorial Medical Center
- Taryn O'Connell, Cottage Health System
- Mark Refowitz, Orange County Healthcare Agency & CalOptima Chairman of the Board
- Suzanne Richards, KPC Health/Orange County Global Medical Center
- Sandra Reilly, Pomona Valley Hospital Medical Center
- Michael Rembis, Avanti Hospitals
- Joe Ruggio, MD, CalOptima Physician Network
- Zareh Sarrafian, Riverside University Health System - Medical Center
- Michael Schrader, CalOptima
- Martin Serota, MD, Alta Med Corporation
- Deanna Stover, Community Clinic Association – San Bernardino
- Doug Sturnick, Cedars-Sinai Medical Center
- LuAnn Talley, Providence Health & Services – Southern California
- Henry Tuttle, Health Center Partners of Southern California
- Gus Valdespino, Valley Presbyterian Hospital
- Dale Villani, Gold Coast Health Plan
- Beth Zachary, Adventist Health, Southern California Region/AH/Southern California Network

Northern and Central California

- Hakeem Adeniyi, Jr., MD, La Clinica Great Beginnings, North Vallejo - Vallejo Medical
- Maya Altman, Health Plan of San Mateo
- Dolores Alvarado, Community Health Partnership (Santa Clara)
- Lynne Ashbeck, Community Medical Centers
- Doreen Bradshaw, Health Alliance of Northern California
- Scott Coffin, Alameda Alliance for Health
- Cathy Frey, Central Valley Health Network
- Elizabeth Gibboney, Partnership Health Plan of California
- John Gressman, San Francisco Community Clinic Consortium
- John F. Grgurina, San Francisco Health Plan
- Doug Hayward, Kern Family Health Care
- Gregory Hund, CalViva Health
- Mary Jo Jacobson, San Joaquin Valley Rehab Hospital
- Daryn Kumar, Memorial Medical Center
- Bert Lubin, MD, UCSF Benioff Children's Hospital Oakland
- Alan McKay, Central California Alliance for Health
- Robert Minkin, Saint Louise Regional Hospital
- David O'Brien, MD, St. Joseph Health
- Lex Reddy, St. Rose Hospital
- Rene G. Santiago, Santa Clara Valley Health & Hospital System
- Shelly Schlenker, Dignity Health
- Sandy Sharon, Kaiser Permanente
- Amy Shin, Health Plan of San Joaquin
- Suzie Shupe, Redwood Community Health Coalition
- Ralph Silber, Alameda Health Consortium
- Todd Suntrapak, Valley Children's Hospital
- Patricia Tanquary, Contra Costa Health Plan
- Christine Tomcala, Santa Clara Family Health Plan
- Melanie Tubberville, Bakersfield Memorial Hospital
- Bill Walker, MD, Contra Costa Health Services
- Louis Ward, Mayers Memorial Hospital
- Daniel Wolcott, Lodi Memorial Hospital