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STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

MEDICAL BOARD OF CALIFORNIA – Executive Office
1434 Howe Avenue, Suite 92, Sacramento, CA 95825
(916) 263-2389 Fax (916) 263-2387 www.mbc.ca.gov

MEMBERS OF THE COMMITTEE

Steve Alexander, Co-Chair
Gary Gitnick, M.D., Co-Chair
Hedy Chang
Shelton Duruisseau, Ph.D.
Richard Fantozzi, M.D.
Laurie C. Gregg, M.D.
Barbara Yaroslavsky
Frank Zerunyan

ACCESS TO CARE COMMITTEE

July 26, 2007

Embassy Suites
Union Square/Ghirardelli Rooms
250 Gateway Boulevard
South San Francisco, CA 94080
(650) 589-3400

Action may be taken on any item listed on the agenda.

AGENDA

1:00 pm – 2:00 pm
(or until conclusion of business)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE
If a quorum of the Board is present, members of the Board who are not members of the Committee may attend only as observers.

1. Call to Order
2. Approval of Minutes of April 26, 2007 meeting
3. Presentation by Rebecca Hafner-Fogarty, MD, MBA, Medical Director, Minute Clinic
4. Proposed Mission Statement – Mr. Alexander/Dr. Gitnick
5. Diabetes Prevention and Management Initial Workgroup Draft Plan – Dr. Fantozzi
6. California Physician Workforce Roundtable: Meeting Summary – Dr. Gitnick
7. Report on meeting regarding Best Practices Model – Dr. Fantozzi
8. Telemedicine, Volunteer Physician Program, AB 329 – Dr. Fantozzi and Ms. Whitney
9. Public Comment on Items not on the Agenda
10. Adjournment

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Public Meetings Act. The audience will be given appropriate opportunities to comment on any issue before the Board, but the Chair may apportion available time among those who wish to speak. For additional information call (916) 263-2389.

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Access to Care Committee

Sacramento Convention Center
1400 "J" Street, Room 306
Sacramento, CA 95814

April 26, 2007

MINUTES

Members Present:

Steve Alexander
Gary Gitnick, M.D.
Hedy Chang
Shelton Duruisseau, Ph.D.
Richard Fantozzi, M.D.
Laurie Gregg, M.D.
Barbara Yaroslavsky
Frank Zerunyan

Agenda Item 1 Call to Order

The Access to Care Committee of the Medical Board of California was called to order by Co-Chair, Gary Gitnick, M.D., at 10:00 a.m. All members were present. Notice had been sent to interested parties.

Agenda Item 2 Proposed Mission Statement – Mr. Alexander/Dr. Gitnick

Discussion ensued on the wording of the mission statement.

M/S/C (Alexander/Fantozzi) that the mission of the Access to Care Committee shall be to make healthcare accessible to Californians, regardless of the ability to pay, through the licensing and regulatory programs and policies of the Board and consistent with the Board's consumer protection mission.

Dr. Gitnick then began discussion on the next bullet, acknowledging health care rights of patents.

Dr. Gregg suggested that it is easiest for a mission statement to have only one sentence, and that the sentence passed in the previous motion was a good and comprehensive statement.

Ms. Whitney clarified that the various bullet points were included as possible ideas or elements

of a mission statement, none of which the Committee must include.

With that understanding, Mr. Alexander suggested that since a primary sentence had been approved, members should mention any bulleted items that they would like deleted from review.

Dr. Fantozzi asked that "timely healthcare" be deleted, as well as the reference to "acknowledge health rights or needs of patients," since it is implied to be the mission of the Committee.

Agenda Item 3 Legislation – Ms. Whitney

A. Bills Referred by Executive Committee: AB 1154, AB 1224, SB 478, SB 801

Ms. Whitney said that the Executive Committee met and had referred a number of bills to the Committee, so that the Committee could bring a recommendation forward to the Board.

AB 1154/Leno; Diabetes Pilot Program. This bill as amended would require the Department of Health Services to consult with the California Health Alliance to develop a diabetes risk reduction pilot program within 24 counties. The Governor's Diabetes Prevention and Management Workgroup, on which Dr. Fantozzi serves, is actually working on a pilot project for Medi-Cal fee for service. Ms. Whitney stated the Executive Committee previously voted to watch the bill and offer advice and assistance as appropriate to the author as this program is developed, but offered an alternative if the Committee could support the concept of a diabetes pilot program, but not necessarily this one.

Dr. Fantozzi expressed concern the Board not appear to encourage duplicative efforts. Further, he said that the Board should encourage that monies and resources available be kept where they can best be used and not to support this specific bill, which could hurt other efforts.

M/S/P to recommend a watch position on AB 1154.

AB 1224/Hernandez; Telemedicine: Optometrists. Minor amendments have been made to put the optometrists into the definition of a licentiate under the peer review process, since this license category will be added into the telemedicine arena. This bill was referred to the Access to Care Committee because of the focus on telemedicine. Optometrists have been very involved in eye examinations and are very much a part of diabetes healthcare. Ms. Whitney concluded by stating she had previously recommended a support position and was recommending the same from the Access to Care Committee.

M/S/P to recommend a support position on AB 1554.

SB 478/Hollingsworth; Physicians and Surgeons: Loan Repayment. The author is very interested in access to healthcare, but, at this point, has not fully developed what he wanted to do in this arena. When the bill was introduced, the author was not aware of the existing physician loan repayment program. This is a two-year bill, and the recommendation is for this committee and

Board to watch this bill.

In response to a question posed by Ms. Yaroslavsky about funding for a loan repayment program, Ms. Whitney indicated that the Board will work with the Senator to identify funding sources.

M/S/P to recommend a watch position on SB 478.

SB 801/Ridley-Thomas; Chiropractors. Ms. Whitney explained that this bill, as introduced, would have appropriated $3.4 million from the Medical Board to the Health Profession Education Foundation to fund another round of loan repayments for physicians. However, the bill was fully amended to discuss chiropractors. In summary, Ms. Whitney said that with the amendments to the bill, it is no longer related to the Medical Board.

Dr. Gitnick expressed his desire to have legislators and staff attend our meetings. Ms. Whitney explained that the Senator's staff was invited; however, because of items pending on the legislative calendar, they could not attend the Board's meetings this week.

B. Other Legislation

Ms. Whitney said that she had included this agenda item to discuss other bills that have to do with expanded scope of practice, but they have been put over as two-year bills. Ms. Whitney indicated that she would be asking legislative staff to attend board meetings and speak to the development of the issue of expanded scope of practice for nurse practitioners and physician assistants.

Agenda Item 4 Diabetes Prevention and Management Initiative Workgroup – Dr. Fantozzi

Dr. Fantozzi reported that he serves as the Board's representative to the Governor's Task Force on Diabetes Prevention and Management. Other participants include the Department of Health Services, Kaiser, Department of Managed Health Care, various physician groups, safety net clinics, educators in diabetes, nutritionists, CMA, and others. The goal is to come up with a California chronic care model for diabetes; the plan will be completed by June 4, 2007 and delivered to the Governor the same week. It is anticipated that this will be a model for the fee-for-service population in Medi-Cal.

Agenda Item 5 California Physician Workforce Roundtable and SB 764 – Drs. Gitnick and Fantozzi

Dr. Fantozzi reported that Dr. Gitnick and he were part of a group that assembled to look at the health care workforce in California. The physician population is continuing to grow in the state of California, consistent with the population, but nothing is being done to reduce the per capita

need. By the year 2015, it is anticipated that California will start to experience a significant deficit, and there will be a physician workforce issue. One item that came up is the concept of "Can California change the model of delivery?"

If health care experts start to extract chronic care from acute care and come up with other models and data, and data driven outcomes are shown, then California may well find that our workforce is appropriate for where we are. But if California continues business the way they have done over the last 30 years, they will have a significant deficit.

Dr. Gitnick added that if the model is not changed, if the status quo is the model of the future, then many people believe that there would be a significant potential shortage of physicians, especially if the Governor's health care proposal does, in fact, become law and if California brings another six to eight million people into the system.

Dr. Duruisseau agreed with Drs. Fantozzi's and Gitnick's assessment, and stated if the state did not do something about the nursing crisis, the laboratory crisis, the technician crisis, the physicians are going to have an equal problem, and they may not be able to deliver the kind of care to that which California aspires.

Ms. Whitney stated SB 764 (Migden) would require OSHPD to report on physician data regarding the numbers of physicians in primary care areas and the amount of time those physicians are working. The author has agreed to use the survey questions that the Medical Board asks on the license renewal form.

Agenda Item 6 Report on Meeting with DMHC regarding Best Practices Model – Ms. Whitney

Ms. Whitney reported that through the involvement of Dr. Fantozzi in the diabetes area, the Department of Managed Health Care (DMHC) asked the Board to get involved in the development of a best practices model. Specifically, they wanted to explore how the Board might look at a specific medical group to give some direction to DMHC in setting up their contracts with HMOs.

Dr. Fantozzi asked Blue Cross if they would be interested in undertaking a pilot program. The outline for a pilot program would include a larger, multi-specialty group, a hundred plus doctors, that is not doing a chronic care management plan, give them a plan which has been developed, ask them to participate, and see if the Board can promote that, with the goal being to start developing chronic care models for other disease entities. Blue Cross has indicated their interest in participating. Dr. Fantozzi offered the Board's volunteer workforce to be an education component with the chronic model.

Dr. Gitnick suggested that Dr. Fantozzi invite the California Medical Association (CMA) to assist. Sandra Bressler (CMA) supported the idea, since the CMA has a committee looking at

primary care and access to primary care, recognizing that the supply of primary care providers is shrinking.

M/S/P to endorse the concept that the Board work with strategic partners to develop chronic care models.

Agenda Item 7 Telemedicine, Volunteer Physician Program, and AB 329 – Dr. Fantozzi

Dr. Fantozzi reported that the Board has met and agreed with representatives of UC Davis to create a diabetes chronic care model, using their telemedicine equipment. Since UC Davis is hardwired into 80 community clinics throughout the state, he has asked them to select clinics that would be culturally and linguistically sensitive.

Ms. Whitney spoke to address AB 329, a bill introduced by Asm. Nakanishi after a discussion with the president and vice-president of the Board. This bill now has been amended, more fully developed into direction for the Medical Board, to establish a pilot program to expand the practice of telemedicine. It provides the Medical Board clear direction to be involved in the telemedicine arena and provides a requirement to report back. Asm. Nakanishi has asked the Board to co-sponsor the bill with him.

M/S/P to sponsor and support AB 329.

Agenda Item 8 Public Comment on Items Not on the Agenda

There was no public comment

Agenda Item 9 Adjournment

There being no further business the meeting adjourned at 11:00 a.m.

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Retail Clinics Prompt National Media Exposure

Over 1,200 articles and news segments featuring the "disruptive innovation" of MinuteClinic have run in the last 24 months on all national networks and in the leading national print media.

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Mission

To integrate simple, high-quality healthcare solutions into consumers' lifestyles

- We are dedicated to providing high-quality, professional and affordable care for common family illnesses.
- We align ourselves around schedules that are "lifestyle conscious" in convenient locations, where customers live, work and play.
- We provide patients, employers and payers a cost-effective complement to traditional health care services.
- As a result, MinuteClinic is the leader in delivering accessible health care into our consumers' daily lives.

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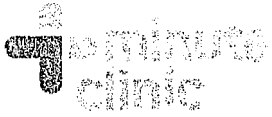
"Right-Sized" Engineered



- Focused range of services
- One practitioner per exam room
- Most services take 15 minutes
- Prices clearly posted
- First come, first served
- No capital-intensive equipment; only diagnostic supplies

ERs, Urgent Care and Medical Offices

- Broad services
- Specialists
- Varied service times
- Complex pricing
- Congested schedule
- Over engineered for simple services with capital-intensive diagnostic equipment

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Retail Clinic Scope of Services

Treatments and Services

(Most services $59 or an insurance copay)

Bladder Infections	Athlete's Foot
Bronchitis	Cold Sores
Ear Infections	Deer Tick Bites
Pink Eye & Styes	Impetigo
Sinus Infections	Minor Burns & Rashes
Strep Throat	Minor Skin Infections
Flu Diagnosis	Minor Sunburn
Mononucleosis	Poison Ivy
Pregnancy Testing	Swimmer's Ear
Wart Removal	Suture Removal

Vaccines

(Price range from $25 - $110)

Flu (seasonal)

Hepatitis A & B

Polio - (IPV)

Meningitis

MMR - (Measles, Mumps & Rubella)

Pneumonia - (Pneumovax)

Tetanus, Diphtheria, Pertussis – (Td, DTap & TDaP)

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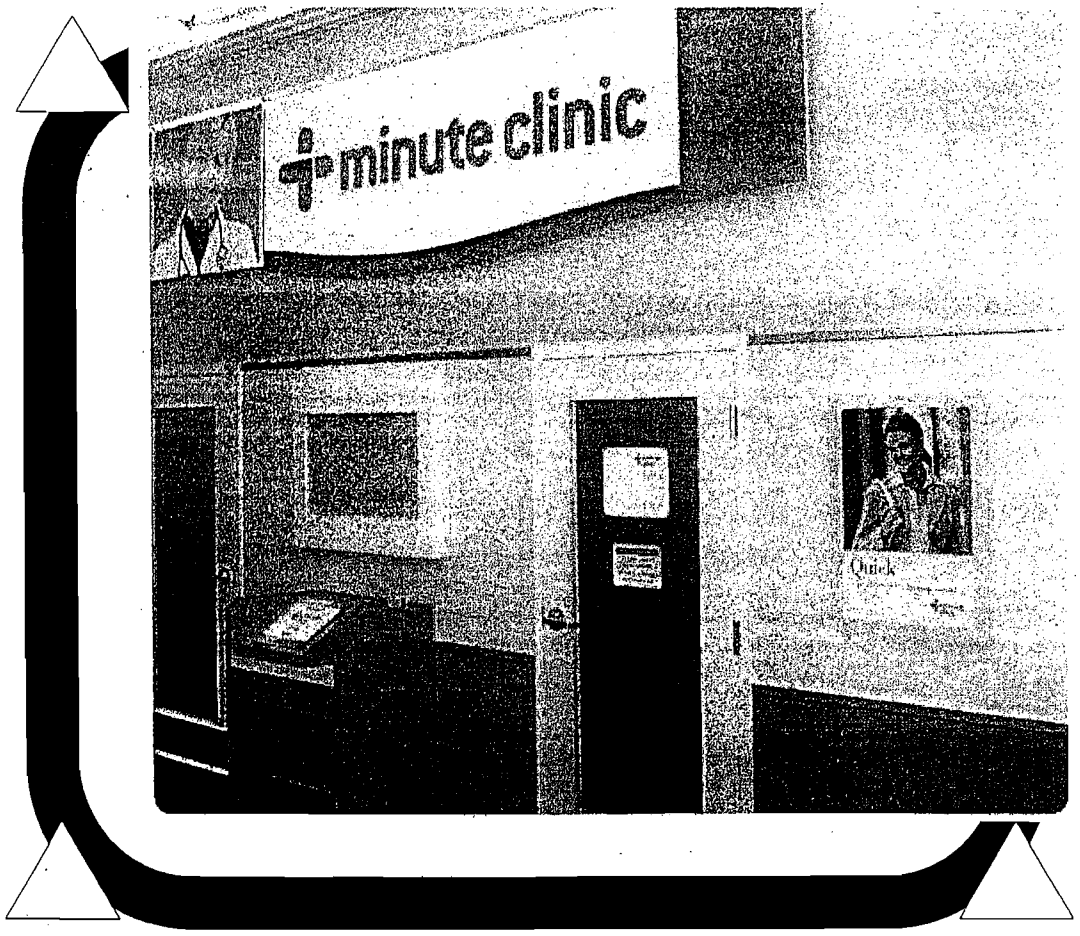
What Does a Typical Clinic Look Like?



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Customer Satisfaction Remarkably High

How would you rate the quality of care you received at MinuteClinic?

Excellent	93%
Good	7%
Average	0%
Less than satisfactory	0%
Unsatisfactory	0%

Would you use this service again?

Yes	99.6%

Do you plan to recommend this service to a family member or friend?

Yes	98.6%

Source: November 2005 survey; 26,273 respondents

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Essential Components

The following six components comprise the health care model

Focused on a narrow range of common family illnesses

Electronic billing to insurers

Staffed by board-certified Family Nurse Practitioners or Physician Assistants

Proprietary software guides evidence-based diagnosis and treatment

Local board-certified Physicians serve as medical directors in every market

Patient record sent to primary care provider

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Studies Confirm Savings

Various studies prove the cost-effective nature of the model

- In a study conducted by Mercer on behalf of Black & Decker using 2005 data:
  - MinuteClinic visits show a **30% to greater than 50% savings** over the same type of office visit at a primary care clinic.
- Blue Cross Blue Shield of Minnesota analyzed visits to MinuteClinic from June 2004 to June 2005 and found:
  - MinuteClinic visits **cost about half** of an office visit.
- A Minnesota-specific Reden and Anders Study from January 2005 to March 2006 indicates:
  - Episodic **savings of 30% or greater**.

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Studies Confirm – No Utilization Concern

Studies prove there is little to no impact on utilization

2005 study conducted by Mercer using Black & Decker data:

- Only 8 per 1,000 patients recorded a visit to their primary care provider within 10 days of a MC visit

2005 HealthPartners study looking at utilization before and after adding MinuteClinic to network:

- 336 members per month episodes (strep, sinus, ear, eye, urinary) prior to MinuteClinic added
- 313 members per month episodes after MinuteClinic added

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High Quality Care – Highly Trained Practitioners

Every MinuteClinic practitioner is licensed and board-certified

- Credentialing – NCQA Guidelines
- Extensive internal training
  - Two-week training prior to working within a clinic
  - Curriculum is divided into the following components:
    - Professional skills
    - Operations skills
    - Clinical skills
- Practitioner competency is verified at the conclusion of each training session
- Each practitioner completes re-certification of each module annually

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High Quality Care – Proprietary Software

Electronic Medical Record (EMR) system results in improved effectiveness and efficiency

- Offers improved results and communication
- Prepares us for new national standard for electronic transmission of basic patient history – Continuity of Care Record (CCR)
- Designed to provide national best practices and clinical guidelines
- Formulary management
  - Generic drug default
- "Circuit Breakers" built in to assure proper triage and referrals
- Records are accessible from any MinuteClinic location, providing
  - Diagnostic record
  - Educational material
  - Patient bill
  - Prescription at end of visit (when clinically appropriate)
  - Reduced patient errors
- No paper charts are maintained – everything is electronic
- Privacy assured through centralized storage

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High Quality Care – Guidelines and Accreditation

MinuteClinic adheres to national standards of practice, as established by:

- Institute for Clinical Systems Improvement (ICSI) regional guidelines
- American Academy of Pediatrics (AAP) Red Book
- American Academy of Family Physicians (AAFP)

MinuteClinic also adheres to:

- AAFP and AMA Desired Attributes for Retail Health Clinics
- NCQA Guidelines for Credentialing

In addition, MinuteClinic is the first and only retail health care provider to be **JCAHO accredited** (as of August, 2006)

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Medical Community Relations

In each market MinuteClinic enters, we establish relationships with the local medical communities

- Local physicians serve as collaborating physicians (medical directors), supporting our delivery of care
- MinuteClinic establishes key relationships with local physicians, clinics and urgent care organizations
- 'Introductory Letter' is sent to local providers two to three weeks before a market opening
- Practitioner sends medical record to primary care physician (as determined by patient)
- If the patient has no primary care physician, a MinuteClinic practitioner will:
  - Discuss with patient and recommend patient develop primary physician relationship
  - Provide the patient with list of local physicians accepting new patients

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The NEW ENGLAND JOURNAL of MEDICINE

Perspective

FEBRUARY 22, 2007

The Rise of In-Store Clinics — Threat or Opportunity?

Richard Bohmer, M.B., Ch.B., M.P.H.

The recent acquisition by the pharmacy chain CVS of MinuteClinic, a chain of in-store clinics founded in Minnesota, has put this model of primary care delivery back in the spotlight. Although still not widespread, the model is increasing in prevalence (see table) and appeals to several stakeholders: payers note that primary care is less expensive when delivered at in-store clinics than when provided in a doctor's office or emergency room, patients value the convenience and low price, entrepreneurs see a profitable business model, and proponents of consumer-driven health care see services that can be paid for out of health savings accounts. Physicians, however, express concern about the quality of care and the potential impact on their businesses.

The typical in-store clinic is a kiosk — a small, thin-walled structure located inside a store — staffed by a nurse practitioner. The clinics differ from the old "doc-in-the-box" model in that they are neither routinely staffed by a physician nor intended to provide all primary care services. Indeed, the range of services — posted as a "menu" on the company's Web site or on the kiosk — is strikingly small, including common adult vaccinations, screening tests, and treatment for simple conditions (see box).

But for these circumscribed services, the clinics provide a compelling value proposition. Care is intended to be quick, inexpensive, and convenient: visits and waiting times are short, the charge is usually less than $50, and extended hours are offered along with ample parking. It's not surprising, then, that patients and investors have taken notice. Although only 7% of respondents in a 2005 poll said they had ever used such a service, 41% said they would be likely to do so.[2] And since 2000, when the concept was developed by QuickMedx (which later became MinuteClinic), at least 10 other companies have entered the market and several hundred clinics have been opened or are being planned. The California HealthCare Foundation expects thousands to open in the near future.[1]

At the heart of the appeal are well-thought-out business and operational models, both dependent on the limited services menu. Overhead is low because staffing, real estate, and financing costs are low, and some of these overhead costs are shared with the

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In-Store Clinic Companies.*

Clinic Operator and Headquarters	Locations and Expansion Plans	Affiliated Retailers	Slogan
Aurora Quick Care			
Milwaukee	17 Locations in Wisconsin	Aurora Pharmacy, Piggly Wiggly, Wal-Mart	No appointment. No waiting. No hassle.
Curaquick			
Sioux City, Iowa	11 Locations in Iowa, Nebraska, and Ohio	Hy-Vee, Pharm Discount Drug	The nurse is in.
HealthRite			
Atlantic City	1 Location in New Jersey	ShopRite grocery stores	Health care right when you need it!
MediMin			
Phoenix	3 Locations in Arizona	Bashas', Food City	Time, sensitive care.
Medpoint Express			
South Bend, Indiana	3 Locations in Indiana	Wal-Mart	Get well sooner.
MinuteClinic			
Minneapolis	156 Locations in Arizona, Connecticut, Florida, Georgia, Indiana, Kansas, Maryland, Michigan, Minnesota, Missouri, Nevada, North Carolina, New Jersey, New York, Ohio, Rhode Island, Tennessee, Texas, and Washington	CVS, Target, Supervalu's Cub Foods, Bartell Drugs, QTC	You're sick. We're quick!
QuickClinic			
Akron, Ohio	3 Locations in Ohio	ACME Fresh Market, Ritzman's Pharmacy	On the spot relief.
QuickHealth			
San Francisco	7 Locations in California and Iowa	Farmacia Remedios, Longs Drugs, Wal-Mart	We make quality medical care affordable and convenient.
RediClinic			
Houston	29 Locations in Arizona, Georgia, New York, Oklahoma, and Texas	HEB, Wal-Mart, Duane Reade	Get well. Stay well. . . . Fast!
SmartCare			
Greenwood Village, Colorado	12 Locations in Colorado, North Carolina, and South Carolina	Kerr Drug, Wal-Mart	Convenient healthcare for everyday needs.
Take Care Health Systems			
Conshohocken, Pennsylvania	36 Locations in Kansas, Missouri, and Oregon	Brooks–Eckerd Pharmacy, Rite Aid, Osco, Sav-On Drugs, and Walgreens	Professional care. Always there.
The Little Clinic			
Louisville, Kentucky	14 Locations in Florida, Indiana, and Kentucky	Kroger, Publix	Convenient neighborhood medical care.

* Information is updated from Scott.[1]

store. Clinics are located in states that allow prescribing by nurse practitioners, and physician involvement is limited. In addition, their focus on out-of-pocket payment limits accounts-receivable costs. Affiliations with drugstores benefit both partners: patients appreciate the convenience of being able to fill prescriptions on the spot, and the clinic draws customers to the store.

The operational model is equally well constructed. The originators based their design on the McDonald's hamburger chain, in which customers select items from a limited menu. The services listed are highly standardized interventions and require no physician evaluation. Diagnoses are made

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A Typical Menu for Care at an In-Store Clinic

Conditions Treated, Tests Offered

Allergies	Minor burns and rashes
Athlete's foot	Minor skin infections
Bladder infections	Minor sunburn
Bronchitis	Mononucleosis
Chlamydia	Nausea and vomiting
Cholesterol screening	Pinkeye and sties
Cold sores	Poison ivy
Diabetes screening	Pregnancy testing
Diarrhea	Ringworm
Ear infections	Sinus infections
Flu	Strep throat
Impetigo	Swimmer's ear
Insect bites	Swimmer's itch
Laryngitis	Wart removal
Lice	

Vaccines

Diphtheria, tetanus, and pertussis
Flu
Hepatitis A
Hepatitis B
Measles, mumps, and rubella
Meningitis
Pneumonia
Polio
Tetanus and diphtheria

by using a simple binary test (such as for a streptococcal throat infection) or by applying a rigid, protocol-based decision rule. In some cases, no diagnosis is required (such as for a hepatitis vaccination). In addition, the conditions treated and therapies offered require no or minimal follow-up (for instance, clinics offer diabetes screening but not treatment), and decisions can be guided by highly specified protocols. More important, the conditions can be diagnosed and treated quickly.

Some concerns have been raised, however, about quality of care. Critics worry that important, albeit rare, diagnoses and opportunities to address other concomitant health issues may easily be missed by nurse practitioners following rigid protocols. Questions have also been raised about the potential lack of continuity of care: when care is fragmented, with different clinics or clinicians providing care at different times, trends suggestive of serious underlying conditions may be missed, and if clinics have no explicit after-hours arrangements, complications arising from daytime care may go unaddressed. In addition, past experience suggests that for-profit clinics might be motivated to overservice patients.

These drawbacks have thus far remained theoretical. Clinics have worked to maintain good relationships with local primary care practitioners,[3] some have software that searches for patterns of repeated presentations, and the strict reliance on evidence-based protocols should prevent overservicing. Both the American Medical Association and the American Academy of Family Physicians support the concept of pluralism in primary care services.[3] Moreover, these clinics raise important issues regarding the future design of primary care delivery.

First, in-store clinics reflect a well-designed operating system in which all the elements — location, physical structure, information systems, staffing, clinical and business processes, and range of services — are aligned to meet a particular population's needs efficiently and effectively. Health care services tend to be loosely stratified, typically by patient age, by body system, or by disease. Although these variables are often rough proxies for the complexity of medical problems, complexity itself is not usually an organizational rubric. In-store clinics, by contrast, stratify the primary care market into more and less complex care and are carefully configured to serve the needs of the less sick. Focus on a small segment of the market facilitates such operating system alignment.

The effect of this specialized care delivery model on traditional primary care practices may be to remove some patients and services from the doctor's office, leaving a sicker population behind. Some practitioners will see this as "cream skimming" and a threat to their revenue, particularly if they rely on income from short appointments for simple cases to subsidize the cost of more time-consuming appointments for more complex cases. But others may see in-store clinics as a way to improve their patients' access to care, decompress their busy waiting rooms, free them up to spend more time with patients, and serve the uninsured, a group of patients whom they may wish to avoid.

Second, in-store clinics place patients in a new role, as they become responsible for sorting their medical problems according to their complexity. Because some menu items are diagnoses, there is an implicit assumption that patients can make their own clinical judgments, relying on clinics only to confirm the diagnosis and deliver the treatment. The clinics' highly engineered business and operational models are very sensitive to misclassification. Attracting patients for whom the clinic is not configured — for instance, someone with an acute, life-threatening disease — would cause a serious delay for others in the queue and weaken the customer value proposition of speed and convenience. Clinics, however, say that such occurrences are less common than one might fear; Michael Howe, the chief executive officer of MinuteClinic, notes that less than 10% of patients are turned away at his company's clinics, which have never had a

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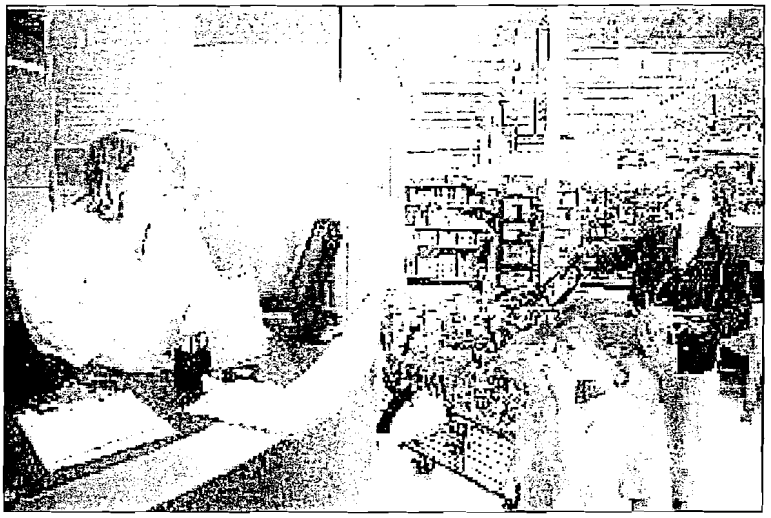

patient present with chest pain, for instance. With regard to the circumscribed set of conditions on the menu, patients have turned out to be capable diagnosticians. Moreover, some patients — and not just those in higher socioeconomic groups — seem to be happy with this role and comfortable arranging their own care.

Third, prognosticators see an impending crisis caused by the convergence of a reduced supply of physicians and nurses and an increased demand for health care as baby boomers age and develop chronic conditions.[4] Service models such as in-store clinics may efficiently provide services to a small slice of the population, freeing up primary care practitioners and emergency rooms to deal with more complex cases, for which they are more appropriately configured. In fact, primary care practices and emergency departments could themselves use such a model, both to improve access to care and to create spare capacity. Indeed, several provider organizations have already opened their own in-store clinics, using their powerful local brand to attract consumers.

Finally, some wonder whether this model is a "disruptive innovation" — that is, a service or technology that enters a market at the low end, initially not performing as well as higher-end incumbents, then improves until it captures the whole market.[5] In-store clinics are certainly entering the market at the low end of medical complexity. However, they have, by design, limited ability to move "up" into coverage of more complex conditions or problems. The menu of services consistent with their operating model is short, and taking on others would undermine their operations and their customer value proposition. Consequently, it is unlikely that in their current form they will usurp the core business of primary care practitioners.

Whether or not this model becomes a permanent feature of the health care landscape, the thinking behind it — in terms of operating-system alignment, alternative approaches to stratification and capacity creation, and the patient's role — may well influence the design of future delivery systems. If these clinics are to complement existing services, they will have to ensure continuity of care by building effective relationships with local primary care physicians and by developing systems to track patients who have multiple appointments in order to identify patterns suggestive of underlying illnesses. However, concern about the quality of care is not a reason to reject such models out of hand. Given the stresses expected to bear upon delivery of services in the future, such models deserve consideration as one potential mechanism for managing a particular class of medical problems, serving a particular patient need, and maximizing patient benefit with limited resources.

An interview with Dr. Bohmer can be heard at www.nejm.org.

Dr. Bohmer is a senior lecturer in business administration at Harvard Business School, Boston.

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CORRECTION

The Rise of In-Store Clinics — Threat or Opportunity?

The Rise of In-Store Clinics — Threat or Opportunity? . The third sentence of the seventh paragraph (page 767) should have read "Both the American Medical Association and the American Academy of Family Physicians support the concept of pluralism in primary care services," rather than "the American Association of Family Practice." The text has been corrected on the *Journal's* Web site at www.nejm.org.

N Engl J Med 2007;356:2437

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The Boston Globe

May 2, 2007 Wednesday
THIRD EDITION

SECTION: METRO; Pg. A1

LENGTH: 990 words

HEADLINE: CVS seeks to open clinics in its stores - Would be first in state; health officials cautious

BYLINE: Liz Kowalczyk GLOBE STAFF

BODY:

CVS Corp. has asked Massachusetts health officials for approval to open the first of 20 to 30 planned "MinuteClinics" in Boston-area stores that executives said will offer patients fast, inexpensive care in a region struggling with packed emergency rooms and closed doctors' practices.

Retail medical clinics are taking off nationally, with about 400 in drugstores, discount chains, and supermarkets in other states. If Massachusetts officials approve the plan, the CVS medical clinics would be the first store-based clinics in the state.

Company executives said they would open the first clinic in a CVS at 474 Washington St. in Weymouth; they would not disclose the other planned locations.

At MinuteClinics in other states, nurse practitioners and physician assistants typically spend about 15 minutes with a patient. They are trained to treat 20 or so common conditions, such as bladder infections, strep throat, and poison ivy, give pregnancy tests and vaccines, remove stitches, and write prescriptions. The clinics would usually charge $59 a visit, and CVS officials said they are negotiating with Blue Cross and Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan to cover their members' visits.

Michael Howe, chief executive of MinuteClinic, which CVS bought last year, said the clinics "are one piece of the solution for improving access in the state" and are not intended to replace primary care doctors. "But it can give consumers back something they're looking for - time," he said. MinuteClinic's slogan is, "You're sick. We're quick!"

The average wait is 20 minutes, Howe said, and MinuteClinics don't require appointments and have evening and weekend hours.

Massachusetts public health officials, who license clinics and must determine if they can operate safely, said they are moving cautiously on the proposal. There has been no organized opposition, but some Massachusetts doctors are concerned about the possible negative impact on patient care. They worry that serious problems will be missed when patients are treated outside their regular physicians' offices, or when they are treated by nurse practitioners and physician assistants without onsite supervision from a doctor.

Dr. Allan Goroll, an internist at Massachusetts General Hospital, said the opening of clinics in CVS stores and in Walmarts in other states reflects "the sorry state of primary care in America." He said insurers underpay primary care doctors, leading to a physician shortage. One answer, he said, is more investment by payers in primary care practices.

"We don't need another doc- or nurse-in-the-box practicing in isolated, uncoordinated fashion and burdening practices with requests for information" about patients they are not familiar with, he said in an e-mail.

MinuteClinic now has 145 locations in CVS pharmacies, Targets, and other stores in 18 states. He said the company analyzed demographics and access to care in the Boston market before developing its plan. The region has a large number of families with two working parents, which may indicate a strong need for quick care, Howe said. The retail clinics also can provide extra business for CVS when patients fill prescriptions in the stores and buy other merchandise.

Sacramento Business Journal - May 14, 2007
http://sacramento.bizjournals.com/sacramento/stories/2007/05/14/story11.html

SACRAMENTO BUSINESS JOURNAL

BUSINESS PULSE SURVEY: Allstate: Leave door open or slam it shut?

Retail health clinics working for Sutter; more locations planned

Health system pilot program picking up where doctors' offices leave off

Sacramento Business Journal - May 11, 2007 by Kathy Robertson Staff writer

Five months after Sutter Health's foray into the retail health business kicked off in a Natomas **Rite Aid** drugstore, almost 3,300 patients have been treated at the medical system's six clinics in the region.

Seventeen healthcare providers now staff that clinic and those in Gold River, Elk Grove, Greenhaven, Folsom and, as of April 26, Roseville.

Dennis McCoy | Sacramento Business Journal
Lynn Denham Martin works as a nurse practitioner at the Sutter Express Care clinic in Natomas.
View Larger

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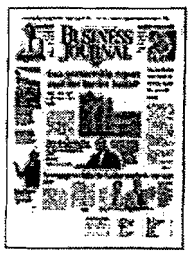

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PROFESSIONAL ISSUES

Physicians pushing state lawmakers to regulate burgeoning retail clinics

Alarmed by the rapid growth of retail health clinics, some physician organizations are beginning to move past voluntary guidelines toward strict regulation.

By Kevin B. O'Reilly, *AMNews* staff. June 4, 2007.

With the number of store-based health clinics expanding quickly, physicians and lawmakers in at least seven states have explored legislation aimed at ensuring that these new sources of primary care do not worsen quality, patient safety and continuity of care. In some cases, doctors' legislative fights are against industry-supported measures that would loosen existing regulations that could be applied to retail clinics.

Industry watchers say these legislative and regulatory challenges are the next hurdles for retail clinics.

"A year ago, this industry was an interesting experiment, and a year later, it is a viable model. Now, regulators have a tremendous opportunity to either encourage or impede the advance of retail clinics," said Mary Kate Scott, a health care technology consultant. Scott prepared a July 2006 report on retail clinics for the California Healthcare Foundation, a nonprofit organization that aims to expand access for the underserved.

The country's leading pharmacy chains, retail outlets and health systems will have an estimated 1,500 convenient care clinic locations up and running by the end of next year, compared with about 400 today. There could be consumer demand for as many as 5,000, Scott said.

States regulate the extent to which nurse practitioners and physician assistants can operate independently of physicians, along with safety issues such as the proper handling of biohazards. Also, the AMA and national family physician, pediatric and internist organizations have set out standards for how retail clinics should interact with physicians to ensure quality, safety and continuity of care. Clinics say the recommendations reflect what they already are doing, and the Convenient Care Assn. adopted its own set of standards in March.

Access to Care Committee
Medical Board of California

Mission: To make healthcare accessible to Californians through the licensing and regulatory programs and policies of the board and consistent with the board's consumer protection mission.

Role / Responsibility: To provide ongoing advice to the Board, and working in cooperation with strategic partners, to facilitate the development of health care for demographically diverse populations, consistent with the mission of the Board.

Means to Facilitate the Role / Responsibility: To evaluate topics of importance related to an accessible, efficient, and affordable health care system in order to make recommendations to and advise the Board.

>>>>>>>>>>>>>>>>>

At the last Board meeting, staff was asked to research and provide information on mission and vision statements of other State agencies.

Dept of Health Services: the mission is "to protect and improve the health of all Californians."

Dept of Managed Health Care: the mission is "to work toward an affordable, accountable and robust managed care delivery system that promotes healthier Californians."

Health and Human Services Agency: 1) the mission is "to promote the health and well-being of a growing and increasingly diverse California and to work with our many partners in individual and collective efforts on behalf of the people of California." 2) The vision is: "All Californians, especially those most at risk or in need, shall have the opportunity to enjoy a high quality of life as measured by the sound physical, mental and financial health of children, adolescents and adults; strong and well-functioning families; safe and sustainable communities; and dignity for all."

Governor's vision for health care reform: "an accessible, efficient, and affordable health care system that promotes a healthier California through prevention, wellness and universality of coverage for all Californians."

Recent speech by Governor Schwarzenegger: " . . . . we can do this by guaranteeing health coverage for all Californians."

The Diabetes Prevention and Management Initiative Workgroup is tasked with working collaboratively with the Medi-Cal Program and the California Diabetes Program in the development and design of a five-year diabetes initiative for Medi-Cal fee-for-service beneficiaries which will decrease the number of individuals who develop Type II diabetes and reduce the severity of the disease in those who have been diagnosed.

To effectively meet this task, the goal of the workgroup is to provide expert advice and consultation to department program staff on the following design elements of the diabetes initiative:

- Screening criteria for pre-diabetes and diabetes
- Targeted population for the initiative
- Proven interventions to improve the health status of individuals diagnosed with pre-diabetes and diabetes which will reduce or prevent complications including the use of incentives for beneficiaries and providers
- Methods to estimate short and long-term cost savings and/or cost avoidance based on risk stratification of screened individuals
- Evaluation criteria

I. There are many different models of care that can be used as a foundation in the development of a delivery system in managing chronic diseases. The Chronic Care Model (CCM) identifies essential elements of a health care system that encourages high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. The use of evidence-based change concepts under each element in the model works synergistically to foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. The foundational elements of the CCM model will be used as the basis on which the components of this initiative are developed.

FRAMEWORK FOR CALIFORNIA'S DIABETES INITIATIVE

ADA SCREENING GUIDELINES:

The following is the most current American Diabetes Association (ADA) criteria for testing diabetes in adult individuals[1]:

1. Testing for diabetes will be considered for those who are:
   - Age ≥45 Years **and**
   - Overweight (Body Mass Index [BMI] ≥25 kg/m^2)
2. Testing for diabetes should be considered for those at a younger age or carried out more frequently in individuals with a BMI ≥ 25 kg/m^2 [2] **AND** have additional risk factors:
   - Habitually physically inactive
   - First degree relative with diabetes
   - Members of a high risk ethnic population: e.g. African American, Latino, Native American, Asian American, Pacific Islander
   - Previously identified impaired fasting glucose or glucose tolerance test
   - History of gestational diabetes or delivery of baby weighing >9lbs
   - Hypertension ≥ 140/90 mm Hg
   - High Density Lipoprotein cholesterol (<35 mg/dl or triglyceride level >250 mg/dl[3])
   - Have other clinical conditions associated with insulin resistance e.g. polycystic ovary syndrome or acanthosis nigricans[4]
   - On previous testing, had impaired glucose tolerance test (IGT) or impaired fasting glucose (IFG)
   - History of vascular disease

[1] American Diabetes Association, Standards of Medical Care Diabetes-2007: Diabetes Care;30(1), 2007
[2] BMI cutoffs for overweight may be adjusted as follows: Non ***AAPI*** ≥ 25, Asian American ≥ 23, Pacific Islander ≥26 kg/m^2)

FRAMEWORK FOR CALIFORNIA'S DIABETES INITIATIVE

Target Population

- Must be a full-scope, Medi-Cal-Only[5] fee-for-service beneficiary, between the ages of 18-64, who meet the ADA screening criteria for testing for diabetes in adults; and
- Diagnosed with pre-diabetes, Type 1 diabetes[6] or Type 2 diabetes

Screening Services

The following laboratory tests will be used for screening eligible adult individuals for pre-diabetes or diabetes:
- Fasting plasma glucose (FPG)
- Oral glucose tolerance test (OGTT)
- Hemoglobin A1C (A1C)

To be eligible for services ***the appropriate lab tests must have been completed within the last 3 months or less.***

Interventions

Risk Category	○ Individuals who are diagnosed with pre-diabetes or diabetes will be placed in the appropriate risk category and will be eligible for a core set of services as outlined in this matrix. ○ Core services will include an initial assessment; case management; enhanced nutrition, health education and psychosocial services; and periodic reassessments.
PRE-DIABETES	
Risk Category: Pre-diabetes ○ ***A1C 6.1-6.9% - for discussion*** ○ IFG (FPG 100-125 mg/dl) ○ IGT (2-hr plasma glucose 140-199 mg/dl)	○ Up to 8 hours of group classes: 2 hours can be administered by a registered dietitian (RD) and 6 hours by a health educator or certified comprehensive diabetes health care worker. Classes will address lifestyle modifications such as nutrition, physical activity, and weight loss. ○ In subsequent years, beneficiaries will be eligible for an additional ***2 or 4 or more? hours of group classes per 12-month consecutive period – for discussion.***

[3] ADA 2007 Clinical Practice Recommendations
[4] Acanthosis nigricans is a disorder that may begin at any age, causing velvety, light-brown-to-black, markings usually on the neck, under the arms or in the groin; most often associated with obesity; can also be congenital or linked to an endocrine disorder.
[5] A full-scope, Medi-Cal Only eligible is an individual who has Medi-Cal as the only source of health insurance and is entitled to the full range of medically necessary services under the Medi-Cal program without any limitations.
[6] There is no specific pre-screening for Type 1 diabetes

FRAMEWORK FOR CALIFORNIA'S DIABETES INITIATIVE	
DIABETES	
Risk Category 1: Low ○ Type 2 diabetes, A1C < 8% **and** ○ LDL Cholesterol< 100 mg/dl **and** ○ Blood Pressure < 130/80 mmHg	○ Up to 10 hours of a diabetes self-management class within a continuous 12-month period ○ One of the training hours may be given on a 1:1 basis and the rest of the classes in a group format ○ For individuals who are blind, deaf or if group classes are not available within a two-month period, individual classes may be provided ○ In the subsequent years, beneficiaries will be eligible for a 2-hour self management class, during a 12-month consecutive period ○ The diabetes self-management class will include the following content areas as per the National Standards for Diabetes Self Management Education and shall include a written curriculum, with criteria for successful learning outcomes. Assessed needs of the individual will determine which of the content areas below are delivered: ▪ Describing the diabetes disease process and treatment options ▪ Incorporating appropriate nutritional management ▪ Incorporating physical activity into lifestyle ▪ Utilizing medications (if applicable) for therapeutic effectiveness ▪ Monitoring blood glucose, and using the results to improve control ▪ Preventing, detecting, and treating acute complications ▪ Preventive (through risk reduction behavior), detecting and treating chronic complications ▪ Goal setting to promote health, and problem solving for daily living ▪ Integrating psychosocial adjustment to daily life ▪ Promoting preconception care, management during pregnancy, and gestational diabetes management (if applicable)
Risk Category 2: Moderate ○ Type 2 diabetes **and any of the following:** ○ A1C ≥ 8% ○ LDL Cholesterol ≥ 100 mg/dl ○ Systolic blood pressure ≥ 130 mmHg or diastolic pressure ≥ 80 mm Hg.	○ Diabetes self-management classes as defined above (if not already taken) ○ Enhanced services for Risk Category 2: Moderate: ▪ 4 Certified Diabetes Educator visits (NP, PA, RN, ***CDE?*** or RD[7]) – ***what is the frequency?*** ▪ 4 enhanced nutrition services per ***each?*** 12-month consecutive periods with primary provider/practitioners ▪ Enhanced psychosocial visits (for clinical depression or adjustment disorder related to the diagnosis of a chronic medical condition) - 4 maximum within a 12-month consecutive period with the appropriate primary provider/practitioners[8]. ***Individuals presenting with major depression, bipolar disorder, or schizophrenia must be referred to County Mental Health since these conditions would be beyond the scope of these visits.***
Risk Category 3: High ○ Type 1 diabetes ○ Type 2 diabetes **with one or more** of the following:	Eligible for all Risk Category 2: Moderate interventions plus the following: ○ Comprehensive diabetes management protocol (***to be developed***). ○ Up to 10 face-to-face Certified Diabetes Educator (NP,PA, RN, CDE, or RD) visits per 12-month period ○ Up to 10 Certified Diabetes Educator phone consultations per each 12-month consecutive period

[7] NP=Nurse Practitioner; PA=Physician Assistant; RN=Registered Nurse; CDE, RN, CDE or RD
[8] If the individuals needs more than 4 visits within a 12 month consecutive period, they should be referred to County Mental Health services for more intensive treatment

FRAMEWORK FOR CALIFORNIA'S DIABETES INITIATIVE	
▪ Taking insulin ▪ Renal Disease[9] ▪ Congestive Heart Failure ▪ ***Hospitalization for preventable diabetes conditions such as hyperglycemia, hypoglycemia, and certain infections e.g. foot ulcers, cellulitis and abcesses. ? ER visits for discussion – for discussion.***	○ In subsequent years, additional visits may be authorized per 12-month consecutive periods
Service Delivery	
Primary Provider	Must have an active, unrestricted Medi-Cal Provider number and be in one of the following categories: ○ Physician - general practice, family practice, internal medicine, obstetrics/gynecology, pediatrics ▪ Relevant specialists will able to see the clients as referrals (e.g. endocrinology, nephrology, cardiology, ophthalmology, podiatry, dental; and appropriate mental health services for clinical depression or adjustment disorder). ○ Group medical practice, if at least one member is one of the physician types noted above. ○ Preferred Provider Organization ○ Clinic (hospital, community, or county) ○ Comprehensive diabetes management protocols (***to be developed***) and technical assistance will be developed by the California Diabetes Program and the Medi-Cal Program and provided to eligible participating Medi-Cal providers.
Practitioner	The primary provider may employ or contract with any of the following practitioners listed below to render comprehensive diabetes services appropriate to their credentials/skill level and the risk category of the beneficiary: ○ Nurse Practitioners ○ Physician Assistants ○ Registered Nurses ○ Certified Diabetes Educators ○ Licensed Vocational Nurses ○ Registered Dieticians ○ Pharmacists ○ Licensed Clinical Social Workers ○ Psychologists ○ Marriage, Family, and Child Counselors ○ Health Educators (***CDE certification? For discussion)*** ○ Comprehensive Diabetes Health Care Worker – individual must be diabetes certified and can be trained medical assistants and/or promotores

[9] Renal disease defined as serum creatinine ≥ 2.0 mg/dl.

FRAMEWORK FOR CALIFORNIA'S DIABETES INITIATIVE	
Designated Care Coordinator	○ Responsibility of the primary provider. ○ May delegate to an appropriate practitioner (see above), as specified in the comprehensive diabetes management protocols (***to be developed***) to oversee and organize the provision of care as per the Individualized Care Plan and as determined by the Risk Category of the individual.
Service Delivery Location	○ The diabetes initiative will be coordinated by the California Department of Public Health (CDPH), California Diabetes Program in collaboration with the Department of Health Care Services (DHCS), Medi-Cal Program and local health agencies. ○ As part of the $150 million allocated for this initiative under the Governor's health care reform proposal, it is proposed that funding be allocated for the development of regional networks to support the management of pre-diabetes and diabetes. ○ The regional network will include diabetes care centers which will be centers of excellence for the program. CDPH, DHCS, and local health agencies will work collaboratively with existing California diabetes care centers of excellence, to determine the number of regional networks and to provide technical assistance to the identified regional networks. ○ The California Diabetes Program will serve as the coordinating office for the regional networks. ○ Services under this initiative will be delivered in the following ***accredited? settings***: ▪ Diabetes Care Centers ▪ Private Medical Practice/Office ▪ Group Medical Practice/Office ▪ Clinics (hospital, community, or county) ▪ Hospital/Medical Centers
Program Benefit Structure/Program Incentives	
Benefits	All eligible participants must meet the targeted population criteria. The Medi-Cal benefit package will be modified to add the following new services for the diabetes initiative: ○ S9140: Diabetic management program, follow-up visit to non-MD provider ○ S9141: Diabetic management program, group session ○ S9455: Diabetic management program, nurse visit ○ S9465: Diabetic management program, dietician visit In addition, ***the following existing Comprehensive Perinatal Services Program (CPSP) Z codes will be modified for the diabetes initiative***: ○ Z1032: Initial comprehensive visit ○ Z1-32-ZL and Z1036: Bonuses for early entry and 10th office visit respectively ○ Z6300, Z 6302, Z6304, and Z 6306: Psychosocial services which include initial psychosocial assessment and development of a care plan, first 30 minutes; initial psychosocial assessment and development of care plan, each subsequent 15 minutes; reassessment/treatment/intervention; and group psychosocial treatment/assessment/intervention, respectively. ○ As warranted, adopt CPSP coding for nutrition and health education services, if above S codes inadequate.

FRAMEWORK FOR CALIFORNIA'S DIABETES INITIATIVE	
Provider Incentives	○ Financial incentives will be provided to participating providers who screen at risk individuals for pre-diabetes or diabetes and follow all specified program requirements including enrollment and management of individuals, data reporting, and making referrals for self-management classes. ○ Emphasis will be on promoting quality improvement activities, improvements in the following: blood glucose levels, blood pressure, weight and physical activity levels in eligible beneficiaries. ○ ***Further discussion will be necessary to develop and refine both incentives and quality improvement methodology.***
Beneficiary Incentives	○ Incentives will be provided to participating beneficiaries who adhere to their individualized care plans and follow through with recommended referrals for screening services, group classes, self-management classes or to specialists. Incentives could include glucose meters; strips and medications (not covered by Medi-Cal) and provided through donations or pharmacy assistance programs or occasional gift cards for classes.
Data Collection	
Data Elements to be Reported	○ Basic demographic information ○ Co-morbid medical conditions ○ Clinical data – A1C, blood pressure, BMI, high/low density lipoproteins, cholesterol, creatinine, serum creatinine ○ Completion of self management classes – group or individual ○ Specialty care received from the following: endocrinology, nephrology, cardiology, ophthalmology, podiatry and appropriate mental health services for clinical depression or adjustment disorder ○ ***Diabetes related hospitalizations- for further discussion***
Evaluation	
Evidence of effectiveness of comprehensive care – some clinical models for consideration: ○ Evaluation results from CPSP: The cost for providing enhanced care was 5 percent higher than average cost of care under existing Medi-Cal program. For every dollar spent on Obstetrical Access model of services, two to three dollars were saved compared to the Medi-Cal obstetric services alone. Impressed by the results California State legislature enacted AB 2821, Bates, requiring publicly subsidized prenatal care to include nutrition, health education, and psychosocial services in addition to obstetrical care. Further legislation AB 3021 implemented a Medi-Cal reimbursement mechanism for enhanced prenatal care. ○ Evaluation results from Project Dulce: Significant improvements in clinical indicators of diabetes control; adherence to standards of care; and self-care activities. Short-term cost study indicates savings in hospital costs and increased pharmacy costs; Simulation model demonstrated cost effective improvements in QALY and decreased incidence of diabetes related complications. ○ Diabetic Prevention Program (DPP)	

FRAMEWORK FOR CALIFORNIA'S DIABETES INITIATIVE	
Evaluation method	***The following is the suggested evaluation methodology for the diabetes initiative:*** ○ Insert Ken Babamoto's and Gary He's edits. ○ Disease registry/regional network info
Outcomes	
Clinical Outcomes	Proposed target optimum values based on ADA guidelines: ○ Hemoglobin A1C < 7% ○ ***Weight loss goal of 7% NEED TO DISCUSS*** ○ ***BMI < 30 kg/m²*** ○ ***HOW DO WE WANT TO APPROACH PHYSICAL ACTIVITY?*** ○ Low Density Lipoprotein < 100 mg/dl ○ High Density Lipoprotein > 45 mg/dl for men; and > 55 mg/dl for women
Economic Outcomes	***To be determined based on clinical outcomes and evaluation methodology***

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AGENDA ITEM 6

June 19, 2007

Richard Fantozzi, MD
Vice President
Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236

Dear Dr. Fantozzi:

Thank you again for your participation in the Physician Workforce Workgroup held on April 11, 2007. On behalf of CHHS Secretary Kim Belshé, attached is a summary document that provides an overview of the meeting discussion, your recommendations for short- and long-term strategies that may be implemented to address California's physician workforce challenges and a description of our next steps. We regret the delay in circulating the document. Again, thank you for your participation and valuable input. If you have any questions please direct them to Deputy Director Angela Minniefield at (916) 654-3019 or aminnief@oshpd.ca.gov.

Sincerely,

David M. Carlisle, M.D., Ph.D
Director

Physician Workforce Workgroup – April 11, 2007
Summary Document

Overview

In January 2007, Governor Schwarzenegger announced his reform proposal to fix California's broken health care system. The Governor is committed to ensuring California has an adequate supply of healthcare providers so that high quality health care is accessible to all Californians. To that end, the California Health and Human Services Agency (CHHS) convened a workgroup on April 11, 2007 to examine California's physician workforce needs related to supply and demand through the 21st century and identify short- and long-term strategies that both the public and private sector should consider for addressing California's physician workforce needs. Attendees consisted of representatives from the education and training, research, policy and advocacy, health facilities, and provider sectors.

There is uncertainty about the magnitude of the physician workforce shortage that California will experience by 2015 due to unpredictable changes in demand for physicians (e.g. aging population, economic growth, insured services, specialty services) and changes in the delivery of health care services (e.g. value-driven health care, HIT, chronic care models). However, there is little dispute regarding the urgency of addressing current physician shortages related to distribution and diversity, as well as long-term planning to ensure a sufficient physician workforce for the growing population.

Experts at the workgroup overwhelmingly agreed that physician workforce must be a priority in the context of health care reform. Discussion focused on defining the problem and identifying short-term and long-term solutions around five major themes that emerged: (1) Capacity; (2) Distribution; (3) Primary Care Physicians and Specialists; (4) Participation in the Medi-Cal Program; and (5) Data. A comprehensive strategy is needed to address current disparities in physician specialty and distribution, as well as to support California's long-term ability to educate, train and retain physicians.

1. **Capacity**

   California must be able to increase physician workforce capacity to meet the needs of the State's growing and increasingly diverse population. California is expected to experience a significant physician shortage in the next ten years, a problem that will be exacerbated in the context of universal coverage. The group was unable to definitively quantify the shortage, but projected California's physician shortage to be in the range of 5,000 to 17,000 physicians by the year 2015. The projected shortage figures are uncertain because the factors impacting physician supply and demand fluctuate: economic growth, incidences of chronic disease, barriers to access, health promotion, prevention, and aging of the population. In addition, some experts believe that changes in service delivery and increased physician productivity will reduce the supply of physicians needed. Although researchers hesitate to assert a solid projection figure, the group recognized the policy value of quantifying the problem and pointing to a credible data source.

Significant factors influencing the projected shortage include: inadequate medical educational capacity; the aging of the population; and overall population growth. California ranks at the bottom of states in medical school and resident training capacity. In fact, UC schools have seen no growth in state-funded enrollment in more than 30 years. Only recently have UC medical schools increased enrollment modestly by expanding their Program(s) In Medical Education (PRIME).

Increasing medical school capacity in California alone will not meet the state's physician workforce needs. California must find ways to recruit and retain physicians from outside the state and to promote chronic care management and innovative models of care to advance high quality health care, while using physician resources efficiently.

- **Recommendations:**

Public Short-Term Strategies

- Allow physician extenders to provide an expanded scope of services while ensuring sufficient oversight to protect patient safety;
- Examine different reimbursement structures for non-physicians (medical assistants and other physician extenders) who are practicing chronic care models and/or providing education and teaching; and
- Remove the barriers for International Medical Graduates (IMGs) to become licensed physicians.

Private Short-Term Strategy

- Develop regional accreditation bodies that can perform functions similar to the Liaison Committee on Medical Education (LCME) to grant accreditation to proprietary institutions that recruit U.S. students.

Public and Private Short-Term Strategies

- Develop incentives to retain doctors in California;
- Examine programs that keep people out of hospitals – support access to more appropriate health care facilities; and
- Identify strategies to transition medically-trained Veterans into physician roles.

Public Long-Term Strategy to Increase Physician Supply

- Restore California as a "Land of Opportunity in Education" in the medical field by sustaining long-term investment in strategic medical school expansion as recommended by the UC Advisory Council on Future Growth in the Health Professions Final Report, January 2007.

Public and Private Long-Term Strategies to Reduce Physician Demand

- Invest in Health Information Technology (HIT) and expand chronic care models (e.g. Project Dulce and Sweet Success Program) to maximize the efficient allocation of physician services; and
- Develop pay for performance measures that discourage unnecessary or marginally beneficial services and thereby decrease physician demand.

2. Distribution

California's current physician shortage is marked by issues of maldistribution and inadequate diversity. The issues of physician distribution related to geography and specialty were among the problems identified, especially as they impact healthcare delivery to medically vulnerable and underserved populations. For example, the Inland Empire and South Valley regions of California have the lowest ratio of physicians per capita, while the Bay Area region has the highest number of physicians per capita. Underserved populations in all three regions face access issues to non-generalist specialty care; thus, merely increasing the supply of physicians will not address issues of maldistribution nor increase the number of providers accepting Medi-Cal or other public insurance programs.

Inadequate diversity in California's physician workforce related to race/ethnicity is also a major challenge for California. Specifically, African Americans, Latinos, Native Americans and some Asian groups are severely underrepresented among physicians. In addition, many rural areas lack a health professions education infrastructure to recruit and retain needed healthcare personnel. These trends compromise access to health care and widen the gaps in health outcomes for California's various ethnic groups, problems that will continue without effective intervention.

- **Recommendations:**

Public Short-Term Strategies

- Modify scope of practice to support the use of nurse practitioners and physician assistants to provide routine care and free physicians for more complex needs;
- Increase medical school and residency enrollments through programs that prepare physicians to meet the need of underserved populations and communities (e.g. Song-Brown Program); and
- Increase reimbursement or make cost of living adjustments for those who provide care to the medically underserved.

Public and Private Short-Term Strategies

- Increase educational loan repayment programs and expand the public-private contribution model;
- Increase the responsibility of doctors to contribute to loan repayment programs (e.g. mandate physician support of the Steven M. Thompson Physician Corps Loan Repayment Program);
- Create scholarship programs for cultural and linguistic competence;
- Support the expansion of the UC Program(s) In Medical Education (PRIME);
- Focus on recruitment and support for programs at the undergraduate level to increase physician diversity;
- Invest in the pre-med pipeline—K-12, undergraduate and post-baccalaureate — to enhance disadvantaged and underrepresented minority youth's ability to be prepared for and accepted to medical school; and
- Utilize advanced technology to increase physician availability, such as telemedicine.

Public Long-Term Strategy

- Examine policies that potentially impede recruitment and retention of underrepresented minorities in the health professions (e.g. Proposition 209).

Public and Private Long-Term Strategy

- Build health academies in rural/underserved areas to recruit from the community and provide hands-on training (more likely to retain physicians in these areas).

3. **Primary Care Physicians and Specialists**
California is experiencing a crisis in the primary care physician workforce, especially in medically underserved communities. The high cost of medical school coupled with lower compensation for primary care services have made specialization an appealing choice and have caused medical school graduates to increasingly enter specialty and sub-specialty fields as opposed to practicing family or general internal medicine. The erosion of key federal programs supporting primary care training and workforce diversity has also contributed to this problem.

- **Recommendations:**
A number of the recommendations proposed above to address distributional issues can similarly be implemented to encourage and support physicians to serve as primary care physicians (e.g. loan repayment, scope of practice, reimbursement policies). The strategies below were explicitly identified in the context of primary care physicians and specialists.

Public Short-Term Strategy

- Reexamine the Medi-Cal reimbursement system for primary care services to incentivize provider participation.

Public and Private Short-Term Strategy

- Increase medical scholarship opportunities for students from underrepresented groups.

Public and Private Long-Term Strategies

- Support the infrastructure for innovative models of primary care (Chronic Care Model, e-health, team-based care, etc);
- Emphasize pediatrics and family medicine in medical school – train doctors to manage the health of a family system; and
- Modernize the primary care medical home to advance patient-centered, prevention oriented, cost effective delivery of care.

4. **Participation in the Medi-Cal Program**
Inadequate Medi-Cal reimbursement rates were identified as a contributing factor to geographic and primary care distributional issues. In addition, the lack of reimbursement for technological enhancements, such as Electronic Medical

Records (EMRs) or e-prescribing, discourages small group or solo practice physicians from upgrading their equipment.

- **Recommendations:**
  Public Short-Term Strategies
  - Consider Medi-Cal reimbursement for RNs and other physician extenders.
  - Increase Medi-Cal reimbursement rates; and
  - Develop pay for performance measures to incentivize and reward technological advancements.

5. **Data**
   A barrier to addressing distributional issues is the absence of a comprehensive database that adequately tracks physician supply and practice location. In order to conduct statewide physician workforce planning, sufficient data is required to inform the State's efforts. In addition, the absence of a comprehensive database to track outcomes for care delivered through chronic care models was identified as a barrier to evaluating the quality and cost-effectiveness of care.

- **Recommendations:**
  Public Long-Term Strategies
  - Develop and implement a centralized data collection and reporting system within state government so that physician workforce trends can be analyzed and reported;
  - Expand funding for data collection in a way that supports the collection of quality data through periodic surveys that include demographic information as well as indicators of supply and demand for physicians (Note: SB 139 (Scott) would create a healthcare workforce data clearinghouse within OSHPD); and
  - Measure, report and publish outcomes data and expand the value-driven health care model.

Public-Private Partnership Opportunities
Several opportunities for public-private collaboration emerged from the presentations and discussion including: Scholarships/loan repayments; Increased adoption and use of Health Information Technology; Pre-Medicine Pipeline Support; and Medical training and education opportunities in underserved areas.

Next Steps
After the Physician Workforce Workgroup meeting on April 11, 2007, the California Health and Human Services Agency identified a number of actions from the workgroup's recommendations that the Administration will pursue in the near term.

Governor Schwarzenegger, in the framework of his health care reform proposal announced in January 2007, is committed to advancing a number of the workgroup's recommendations. Specifically, the Governor's plan will:

- Increase Medi-Cal reimbursement rates to adequate levels;

- Tie future Medi-Cal reimbursement rate increases to pay for performance metrics and quality and efficiency improvements;
- Accelerate the adoption of health information technology (HIT); and
- Expand broadband capabilities to facilitate the use of telemedicine and tele-health, particularly in underserved areas throughout the state.

The Governor is also committed to working with the legislature, health education and industry leadership, health professions associations, private foundations and others to assure California has an adequate supply of diverse, well-trained and accessible cadre of health professionals to meet the healthcare needs of Californians. To this end, the Administration will:

- Convene a Healthcare Workforce Diversity Advisory Council to examine barriers to entry to health profession education programs for underrepresented groups;
- Host regional hearings with health leadership professionals to discuss recommendations to increase the pipeline of students eligible to enter and pursue health professions education programs[i];
- Closely monitor and analyze legislation[ii] that may help the state alleviate health personnel shortages including physicians, nurses, dentists and allied health providers;
- Seek additional funding opportunities for the Song Brown Training Program and the Steven M. Thompson Physician Corps Loan Repayment Program to support the education and training of physicians working in underserved areas; and
- Work with the California Medical Board to discuss scope of practice issues that might result from expanded use of physician assistants and nurse practitioners.

Thank you again for your participation in the physician workforce workgroup discussion. We appreciate your input to date and going forward as we work to identify and implement short- and long-term strategies that address physician workforce challenges.

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[i] The Healthcare Workforce Diversity Advisory Council and regional hearings are funded by a one-year, $125,000 grant awarded to the Office of Statewide Health Planning and Development (OSHPD) by The California Wellness Foundation. The grant will enable OSHPD to develop policy recommendations to address the state's healthcare workforce shortages related to health professions diversity.

[ii] Pending legislation includes:

- AB 611 (Nakanishi), which would establish the California Physician Assistant Scholarship and Loan Repayment Program within the California Health Professions Education Foundation;
- SB 139 (Scott), which would make changes to the terms of loan assumption agreements made under the State Nursing Assumption Program of Loans for Education-State Facilities program and establish the Health Care Workforce Clearinghouse within the OSHPD to serve as the central source of health care workforce and educational data in the state;
- SB 478 (Hollingsworth), which would establish a loan repayment program for educational expenses incurred by a physician and surgeon who practices in an area in the state that is deficient in physician services or who treats patients who are without health care coverage; and
- SB 764 (Migden), which would require OSHPD to research and report to the Legislature projections of the supply of primary care physicians.

AMENDED IN SENATE JUNE 19, 2007

AMENDED IN ASSEMBLY MARCH 29, 2007

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL No. 329

Introduced by Assembly Member Nakanishi
(Coauthors: Assembly Members Arambula, Fuller, and Maze)
(Coauthors: Senators Cogdill and Ridley-Thomas)

February 13, 2007

An act to add Section 2028.5 to the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 329, as amended, Nakanishi. Chronic diseases: telemedicine.

Existing law, the Medical Practice Act, creates the Medical Board of California that is responsible for issuing a ~~physician~~ *physician's* and surgeon's certificate to practice medicine and for regulating the practice of physicians and surgeons. The act also regulates the practice of telemedicine, defined as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

This bill would ~~require~~ *authorize* the board to establish a pilot program to expand the practice of telemedicine and would authorize the board to implement the program by convening a working group ~~to discuss the means~~. *The bill would specify that the purpose of the pilot program shall be to develop methods, using a telemedicine model,* of delivering health care to those with chronic diseases ~~using~~ *and delivering other* health information ~~technologies~~. The bill would require the board to make recommendations regarding its findings to the Legislature ~~on or~~

~~before January 1, 2009~~ *within one calendar year of the commencement date of the pilot program.*

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 2028.5 is added to the Business and
2 Professions Code, to read:
3 2028.5. (a) The board ~~shall~~ *may* establish a pilot program to
4 expand the practice of telemedicine in this state.
5 ~~(b) The board may implement this pilot program by convening~~
6 *(b) To implement this pilot program, the board may convene* a
7 working group of interested parties from the public and private
8 sectors, including, but not limited to, state health-related agencies,
9 health care providers, health plan administrators, information
10 technology groups, and groups representing health care consumers.
11 ~~(c) The members of the working group shall discuss the means~~
12 ~~of delivering health care to those with chronic diseases, and assist~~
13 ~~in developing a plan for offering the best practices in a telemedicine~~
14 ~~model in order to reach all Californians, using innovative health~~
15 ~~information technologies as a means by which to share nationally~~
16 ~~accepted chronic disease management techniques throughout the~~
17 ~~state.~~
18 *(c) The purpose of the pilot program shall be to develop*
19 *methods, using a telemedicine model, to deliver throughout the*
20 *state health care to persons with chronic diseases as well as*
21 *information on the best practices for chronic disease management*
22 *services and techniques and other health care information as*
23 *deemed appropriate.*
24 (d) The board shall make a report with its recommendations
25 regarding its findings to the Legislature ~~on or before January 1,~~
26 ~~2009~~ *within one calendar year of the commencement date of the*
27 *pilot program.* The report shall include an evaluation of the
28 improvement and affordability of health care services and the
29 reduction in the number of complications achieved by the pilot
30 program.

O