Memorandum

Date: July 22, 2019
To: WellSpace Health, All Employees
From: A. Jonathan Porteus, Ph.D., CEO
Re: Mid-Month CEO Message - July 2019 - A Decade Later

Colleagues,

With so many references to the 1969 moon landing I can't help but recall what we called our organizational 'moonshot' – embracing a unified and relentless focus on building an appropriate health and social service delivery platform for low income people in the region and unleashing our mission of achieving regional health through high quality comprehensive care.

We did not put a person on the moon, but our organization has been radically transformed in the ten years since we became an FQHC and a tremendous number of persons have engaged in our expanding and accessible array of services. Since we have been seeing how so many individuals made the original 'moonshot' a success, please know that I feel deep gratitude for the vital role each of you have played and continue to play in ours.

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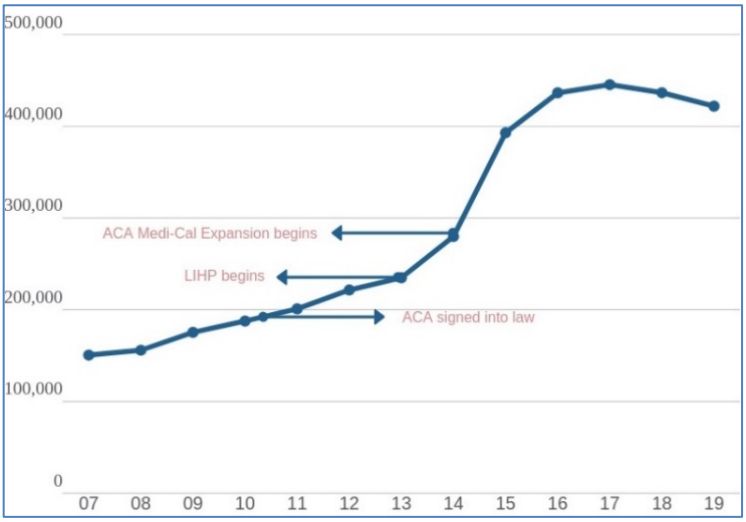
From January 2009-16, more than 260,000 residents of Sacramento county became Medi-Cal beneficiaries, 86% of which were added after 2014 when the Affordable Care Act (ACA) drove a radical expansion of coverage for people who were previously uninsured.

In January 2015, Medi-Cal enrollment in Sacramento County was already up to 393,000 and by January 2016 it reached 436,494 beneficiaries. Enrollment peaked in 2017 at 445,425 and has remained relatively stable to the present.



Medi-Cal Managed Care Enrollment Sacramento County (Beneficiaries by Year)
Department of Health Care Services, Medi-Cal Managed Care Enrollment Report 2007-Present

In 2009, Sacramento County's Department of Health and Human Services (DHHS) closed and reduced hours at all but one of their primary care clinics in the face of a steep economic downturn. The network of 6 county-run primary care clinics, which previously served approximately 50,000 patients, was reduced to 3 part time and one full time clinic serving 15,000. Moreover, DHHS cancelled its contract with U.C. Davis Health

System for specialty and hospital services resulting in catastrophic cost overruns for area Emergency Departments as a medically indigent people sought access to primary care services.

In 2013, DHHS transitioned the care of 15,000 remaining clinic patients to non-profit community health centers. This transition, facilitated by a Medi-Cal expansion bridge program called the Low-Income Health Program (LIHP), represented the greatest regional collaboration of all elements of the low income delivery system to date. Unfortunately, more than 100,000 medically indigent residents continued to lack primary care services due to a lack of coverage and scaled back DHHS clinics.

Today, non-profit community health centers are the largest providers of primary care, oral health, behavioral health, and supportive services to Medi-Cal beneficiaries and those who remain uninsured in Sacramento County.

Add to this, for us, the 12,000 people who are uninsured for whom we also provide a health home. This is the environment we have 'grown up' in. We have embraced our moonshot to serve the region.

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Sacramento County has always had a lack of primary care access for poor (MediCal) and uninsured persons and has never had an adequate health delivery structure for its least fortunate residents. This lack of primary care preceded the introduction of a Geographic Managed Care (GMC) model in 1994 and was most evident in the almost non-existence of clinics and Community Health Centers, the heavy utilization of area Emergency Departments for primary care, and the lack of ever having a county hospital. With the economic downturn in the late 000s, the small county-run clinics were decimated, Western Health Advantage pulled out of MediCal, and what little structure may have existed for a system of care for low income persons was gutted. Consequently, the large population of persons already using the Emergency Departments for primary care got larger, and the county's MediCal beneficiaries were largely disconnected from primary care.

So, unlike many communities around the state, the embrace of the low income population into care during the implementation of the ACA did not build upon an existing structure of care delivery – rather it demanded that one be built, that we go from almost nothing to something. During the ACA expansion, Kaiser more than doubled its MediCal roster in the county and the remaining MediCal population has slowly been brought in to care through the expansion of a few private MediCal providers and a burgeoning network of Federally Qualified Health Centers (FQHCs). And again in Sacramento's unique context compared to other communities around the state, the local FQHCs are all 'new' and rapidly-expanding FQHCs except for the one original small FQHC (Health For All) that closed its doors in 2015.

One of the consequences of a large population of persons coming in to routine care for the first time is that individuals typically have a high rate of comorbid medical and behavioral health conditions. As persons acclimate to having primary care, precious medical appointments are filled to the brim with major issue after major issue. As one of the last of 58 counties in California to adopt a real structure of health delivery for its low income populations (and certainly the last large county) it's not a surprise that *the baseline level of physical, behavioral, and oral health is still extremely poor* despite ballooning new access to care, and the social determinants of health in communities that were health access deserts bear out the fact that a person's zip code is more predictive of their health outcomes than their genetic code. For these novice patients health conditions are more often uncontrolled than controlled, patients have multiple 'gaps in care' (due to missed routine assessments, vaccinations, etc), the demand for specialty services is relatively high, and the supply of associated mental health and substance use disorders treatment is far smaller than the demand. This is the tragic state of where we are, but anything else would seem like a miracle with our region's history.

Despite the challenges, and as noted in the papers appended to this narrative,[1] the Sacramento region has made major strides in developing health access and an adequate care continuum. A scalable practice means we have rapidly become not just a provider of a broad continuum of services, but a large employer (over 200 employees in Sacramento is considered 'large' and we are almost 900 strong) and purchaser of services. Moreover, having a larger population of persons served with increased access to care means we can bring the right type or services in to play at the right time, for example: referring to more urgent levels of

[1] Porteus (2012) Casting a Wide Blanket: Moving Beyond Safety Nets for Sacramento's Underserved. Sierra Sacramento Valley Medical Society; Porteus (2016) Eliminating the Safety Net. Comstocks.

care at the appropriate time; bringing more people into care in an ambulatory primary health setting; providing women's health services; providing pediatric oral health; having complimentary co-occurring mental health and substance use disorders treatment; managing care transitions; linking our suicide prevention services to our Health Centers and local EDs; developing innovative services for patients who are just getting to know how to be patients; and welcoming those who have a non-urgent need for a quick walk-in visit (e.g. our 4 Immediate Care Centers offering extended hours 7 days per week). This represents unprecedented health access for the Sacramento region, but while the markers for the health and wellbeing of the region's least fortunate are finally on the rise they continue to be unacceptably bad compared to much of the state. Let's remember our moonshot though and remember that people are increasingly in care which means we have the opportunity to engage them in comprehensive care and bend the health curve in their favour and in the region's favour.

We have been building towards this moment as an organization for quite some time now, focusing on our mission and gathering momentum. Our 'moonshot' predicted expansion, and we have grown by 30X over 10 years since becoming an FQHC in 2009 when we set out to replace the ragged 'safety net' in our region with a 'blanket of care.' Furthermore, anticipating the creation of a 'blanket of care' we knew that a 'blanket' is only as strong as the fibers making up its fabrics o we chose *quality initiatives* as our essential 'fibers' in our fabric of care and have criss-crossed our organization with Ambulatory Care and Behavioral Health Accreditations from The Joint Commission and strengthened this fabric with our practices – namely our Patient Centered Health Home and Behavioral Health Home practices (both also Certified by The Joint Commission). We knew a 'blanket' demanded a *regional* network of local Community Health Centers and behavioral health access with linkage to other parts of the health care continuum so that persons can access primary care in their home communities. We knew a 'blanket' needed integrated behavioural health in our Health Centers and crosswalks to our specialty behavioral health services. We knew a 'blanket' needed care transition models to ensure engagement of clients and continuity of care, additional women's health and behavioral health services to complement our expanding primary health population, and brainging of all of our additional programs and services complimenting the relatively simple scope of a primary care practice.

We have all come from another place to be a part of this team together. We have chosen to work in behind a shared mission and that resolution binds us. We do this because we envision a future where all people have access to high quality comprehensive care realized through the rapid rise of sufficient access to care allowing us to come from almost nothing to something – despite the effort this requires. We do this because we believe that everyone deserves to be seen - no matter who they are, where they come from, where they work or what place they call home.

Be well,

Jonathan

**The "Mid-Month Message" is intended as a place to share pieces of our organizational culture and/or history. As our tagline says, WellSpace Health has been providing care in our community since 1953. Over the decades we have developed quite an organizational culture. We have had many accomplishments, created histories, have profoundly affected so many, and have been profoundly affected by so many. Sometimes it's hard to keep up with it all. And often, one part of the organization may not know about something affecting another part of the organization.*

Casting a Wide Blanket

Moving Beyond Safety Nets for Sacramento's Underserved

By A. Jonathan Porteus, PhD, CEO of The Effort, Inc.

DIEGO INCHED OUT ONTO THE LEDGE. The heat was unbearable: he had to jump. Below him a voice, maybe two voices, called up from the dark. "Jump. Jump. It's your only chance. We are holding a net!" The flames appeared from nowhere and he'd watched them grow, helpless. Panicked reflection, a wish to blink and have it all go away. Now his only chance was to fall into the unknown hoping the safety net would hold him. He jumped.

For those of us in the caring professions, each day brings examples of health issues that have spun out of control. Often these issues are graver than they were to begin with, and our treatment options become more assertive and costly. A casual peek on any given night in a local emergency department shows us the abundance of undocumented, uninsured, poor, and working poor, who — like Diego above — walk the ledge until it is time to jump for help. And often they are not sure how much to trust the net below. The time has come for us to move beyond these "safety nets."

According to a March 2012 Sutter-commissioned Valley Vision study, Sacramento County alone has a treatment capacity shortfall of primary care services leaving 82,000 persons with Medi-Cal without access to health care.

Our current safety net consists of multiple organizations, most with a clinical specialty or cultural niche focus, that have traditionally functioned in relative isolation. In recent months, the Sierra Health Foundation has convened a "Healthy Sacramento Coalition" bringing this diverse group together. This is timely as a January market analysis by their team of consultants predicts a tsunami of 220,000 persons in the Sacramento region who will convert from uninsured to Medi-Cal with the advent of health care reform. We must act quickly to secure facilities and ensure a workforce to provide medical homes in a relatively short time. I am encouraged by the community-wide conversation, as well as programs like the county's Low Income Health Program that will increase coverage for up to 8,000 currently medically indigent people.

Here at The Effort, we are stepping up our role in the community. The Effort is the largest local Federally Qualified Health Center (FQHC) with four full-scope Health Centers serving core medically underserved areas in Sacramento on a North-South axis from North Highlands to Midtown, to Oak Park, and South Sacramento. Using recent Geographic Information Systems (GIS) data to map each nexus of need for health access, a fifth Health Center opened in Roseville in March and will be followed in short order by Health Centers in Folsom, Rancho Cordova, downtown Sacramento, and Citrus Heights. A detailed map of The Effort's current locations can be found at *http://www.theeffort.org/loc_map_and_service_guide.htm*.

Dental Clinics None Too Soon

Our Health Centers provide pediatric and adult primary care, women's health services, and prenatal services (most notably our "centering pregnancy" model and Comprehensive Perinatal Services Program). In addition, the third of four First 5-funded state-of-the-art children's dental clinics will be completed this July, and the fourth should start serving the eastern part of Sacramento County by mid-2013. The dental clinics came not a moment too soon, given the miserable state of the local MediCal-funded children's dental network.[1] Assemblyman Dr. Richard Pan and State Senator Darrell Steinberg

Comments or letters, which may be published in a future issue, should be sent to the author's email or to *e.LetterSSV Medicine@gmail.com.*

have been very supportive of our cause.

The Effort is also a well-known regional behavioral health provider. Poor access to mental health services is a major driver of health care costs and ED visits. Our Health Centers use an Integrated Behavioral Health model to extend the capacity of a generalist practice. The model also addresses the fact that the average life expectancy for a person with a mental illness is 25 years shorter than for a person without one, largely due to silos of care.

Many of our Health Center locations offer synergistic access to other services, including: County-contracted child, adolescent, and family counseling services; behavioral health counseling and psychiatry; evidence-based home visitation and family resource center services through our role as a founding partner in the Birth and Beyond network; [2] and Youth Development programs including street outreach and gang prevention.[3]

Innovation is at the core of many Effort programs. For example, The Effort's partnership with Sutter Health led to the acclaimed T3 model (Triage — Transport — Treat), successfully supporting frequent non-urgent ED visitors into "whole person" coordinated care in a Health Center medical home and providing assertive case management to meet other needs (*e.g.* benefits acquisition, housing for the homeless, etc). The result: a 65 percent reduction in ED utilization.

Targeting coordinated care to these daily ED patrons makes sense on all levels from giving humanistic care to saving health care dollars and promoting sustainable preventive and primary care services. Our results are comparable to ED reductions seen in a recently-published study of a North Carolina program where high risk, uninsured patients were assigned to a primary care interdisciplinary team.[4] Their study also references many other studies showing how proactive outreach can curtail costs and utilization. Dr. Aytul Gawande drives home the point in his *New Yorker* article, "The Hot-Spotters."[5]

Our service to homeless members of this cohort led us to build satellite FQHC clinics within affordable housing settings (providing immediate and preventive care). We figured that medical homes work best when coupled with real homes. A full scope Health Center is built into the new multi-story affordable housing complex going up in downtown Sacramento at 7th and H Streets.

Another partnership program of ours, the Interim Care Program (ICP), serves all four regional health systems by providing safe hospital discharge for persons who are homeless. Patients are discharged to The Effort's FQHC satellite within the Salvation Army where they receive health access and assertive case management. Over 800 ICP discharges have yielded over 20,000 bed days in this successful and cost-effective program, and copies of it have sprung up elsewhere. We have a YouTube video explaining the process to discharge planners.[6]

The Name Says It All

All of these services emerge from our "Health Access and Case Management" division. The name says it all. Kaiser CEO, George Halvorson, describes the need for "connectors" in his 2009 book, *"Health Care Will Not Reform Itself,"* and these programs exemplify his vision. So in another program, we have partnered with Sutter to create a Navigator program serving Sutter General and Memorial EDs. Seven days a week, we approach all users of the ED (not just the non-urgent, frequent users targeted in the T3 model) to ensure that they have access to health care, benefits, and any other ancillary services in the community.[7]

The growth of The Effort has been nurtured by partnership, the generosity and support of the health systems, and programs such as SPIRIT through the Sierra Sacramento Valley Medical Society. As our Health Center network expands, there are also increased opportunities for volunteerism and pedagogical relationships. Providing a community-level opportunity to serve, as well as to learn, is vital for our next generation of physicians. The Effort's collaboratives with UC Davis exemplify this pedagogical synergy and workforce development, be it through the Pediatric

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Residency partnership, community fellowship, or the two student-run clinics hosted in our facilities on Saturdays (Clinica Tepati and Imani Clinic). An expansion of these partnerships provides crucial settings for training, the groundwork for a Teaching Health Center, and exposure to this very meaningful workplace for an emerging primary care workforce. Of note, The Effort is a National Health Service Corps provider and therefore able to accelerate loan repayment while paying a competitive salary.

An exciting future looms, one promising to relieve some of the burden of health access for low-income patients, with critical inter-relationships between systems of care, with opportunities for enhancing quality, and opportunities for workforce incubation. Feel free to contact me if you would like to participate in our mission, or learn more about us at *www.theeffort.org*.

Through our shared hard work and investment, I envision that our proverbial "safety net" will morph into something more substantial — perhaps a "safety blanket." Who wouldn't want a blanket?

Diego smelled burning. Flames had appeared from nowhere. He quickly threw a fire blanket over them, thinking "good thing everyone has one of these." He called maintenance and then set to work cleaning up and figuring out what had caused the fire and how to prevent another one.

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1 *The Sacramento Bee* 2/14/12 (Editorial: Dental plan for poor kids is a mess, *http://www.sacbee.com/2012/02/14/4261500/dental-plan-for-poor-kids-is-a.html#storylink=misearch)*
2 *The Sacramento Bee* 2/28/12. Science-based parenting classes helps moms and dads deal with discipline, *http://www.sacbee.com/2012/02/28/4295448/science-based-parenting-classes.html#storylink=misearch*
3 *The Sacramento Bee* 7/17/11 and Capital Public Radio 4/4/12. East Bay gunshot victim a success story for Sacramento intervention program, *http://www.sacbee.com/2011/07/17/3774589/east-bay-gunshot-victim-a-success.html#storylink=misearch*, ER becomes turning point for young victims *http://www.capradio.org/articles/2012/04/04/er-becomes-turning-point-for-young-victims*.
4 Crane S et al. Reducing utilization by uninsured frequent users of the emergency department. J Am Board Fam Med. 2012;25(2):184-191.
5 *http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande*.
6 Type "ICP Referral" in YouTube and you can see The Effort team explaining the program to discharge planners.
7 See the 3/23/12 feature in *The Sacramento Bee* for a deeper description. Sutter "navigators" steer routine patients out of emergency rooms. *http://www.sacbee.com/2012/03/23/4359992/sutter-navigators-steer-routine.html#storylink=misearch*.

Remember When?

ELIMINATING THE SAFETY NET

by Jonathan Porteus

The concept of a safety net sets off alarm bells for many administrators and public health professionals. It connotes duplication, inefficiency, incoherence and a 2-tiered health delivery system. It misses the very real business opportunities and positive health impacts that have emerged for the entire population.

A safety net is a last resort, often dangerous to jump into, but perhaps not as dangerous as not jumping. It's also a rather small patch of safety, moved around with the hope of catching people and implying there may be another net here and there, or wide open areas without any net at all. And how do people transition from one net to another? This seems like an awful way to describe a health delivery system that, just in 2014, saw the conversion of 122,000 people into MediCal in Sacramento County alone, bringing the overall number of those enrolled to well over 400,000.

Without health coverage, many in our region's low-income population have historically used costly urgent or emergency care settings to get treatment, often waiting until conditions have become dangerous. The stellar episodic care afforded in those settings is then often squandered when people return to the community but have to manage their own care and can only access a patchwork of primary care and prevention services. It's for this reason that in my organization, we have historically referred to leaving the safety of treatment in a hospital system as "walking the plank."

The last few years have seen the landscape of safety nets in the Sacramento region transform into what I like to call a "blanket of care" — a true integrated health care continuum. Coordinating care services requires, and breeds, health and fiscal efficiency. This efficiency has engendered a cascade of business opportunities in construction, the health professions and the service sector. Furthermore, a healthier population means a more engaged population of adults in the workforce, children more readily able to focus on their academics, and families focused on wellness instead of illness.

A blanket of care means that the full health care continuum (spanning from prevention and primary care to specialty care and acute/inpatient care) is well-defined. Care is driven down to its least restrictive, least expensive and most preventive level. Transition mechanisms ensure seamless continuity from one level of care to another. This new treatment system re-engineers investments in and around the care continuum and its ancillary businesses, moving the population towards increasingly better health. Higher costs at one level of care are managed, and the returns yielded enable new and smaller investments in lower levels of care — to stop the higher costs from re-occurring. Improved health for the population, particularly those previously without access to health care, leads to less resource burden on the overall system, as well as potential economies of scale for providers who may not have worked with the MediCal population in the past.

In Sacramento County, about 7 to 8 cents of every MediCal dollar is spent on primary care services, while the remainder is spent on specialty and acute/inpatient care. This makes a lot of sense as much of the MediCal population is relatively sick, new to health coverage and has traditionally received sporadic, episodic or no treatment. Now, a greater proportion of persons have coverage (since 2014, our uninsured rate has dropped from around 28 percent to 20 percent of all primary care visits) and are enrolled through health plans such as Anthem, HealthNet, Molina, Kaiser, and California Health and Wellness — who either directly contract for primary care services or contract with a third-party independent physician association. Primary care is delivered through federally qualified health centers, clinics and some of the treatment affiliates of the plans themselves (e.g. Molina and Kaiser). Individuals and medical groups provide specialist

care, and acute care is offered through contracts with the region's health systems.

Obviously, some of the initial efforts have focused on increasing primary care accessibility. This includes both a brick-and-mortar approach (building new exam rooms) as well as care management efficiency (using existing exam rooms more efficiently). Other outreach and enrollment initiatives have supported access to insurance and entitlements, getting people enrolled in the coverage that drives this new economy. The adoption of electronic health records helps providers coordinate between one another to reduce the cost and relative inaccessibility of some specialty care — so that treating MediCal patients becomes a value option. Still other efforts have focused on providing people with the right care in the right place, exemplified by programs like T3 (triage, transport, treat). This program engages people who have been using emergency departments for non-urgent care, brings them out to local community health centers and establishes them as long-term recipients of preventive and primary care.

The Sacramento region is in the midst of a major transition, with the abandonment of safety nets and the adoption of a far more integrated care delivery system that demands and pays for services for the MediCal population. This new system will rely on innovation, and will ultimately be driven by quality and care delivery at the right level in the continuum. The creation of a basic foundation of preventive and primary care access has been the weakest link, but it is strengthening. Interestingly, this was the case with the adoption of RomneyCare in Massachusetts, which caused a temporary run on higher levels of care as people became covered by insurance, but drove statewide emergency department utilization down permanently below pre-RomneyCare levels once community-level access had been strengthened.

Dr. Porteus *is Chief Executive Officer of WellSpace Health, a Federally Qualified Health Center providing extensive health, dental, and behavioral health services.*