Moving Healthcare Upstream: Enhancing Care for Patients with Social Needs

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UNITY Conference
Roadmap

• Healthcare Value & the Social Determinants of Health

• The Upstreamists

• Community Health Workers moving healthcare upstream
Community Health Workers taught me to be an Upstreamist.

Me, age 22
northern India
What does HealthBegins do?

We mobilize and equip healthcare providers to improve health where it begins.
We make Upstreamists*

What if clinics could help patients get healthy and save money by addressing the social & environmental conditions that make them sick?

Learn More

We mobilize, teach and help healthcare professionals to design successful upstream solutions that improve health and lower costs.

*Upstreamists are healthcare professionals and innovators equipped to transform care and the social and environmental conditions that make people sick.
Are our clinics providing the best value to patients?
Veronica had a chronic headache. She sought relief in numerous healthcare encounters.

But Veronica was still sick.
Is that Good Value?

Is that Good Care?
Veronica’s new clinic asked routine questions about housing risks, identified her problem, and developed a plan to address housing risks with a CHW.

Veronica got better. So did her home.
That’s Better Value
That’s Better Care
Treating people without tackling the conditions that make them sick is substandard care and a losing value proposition.
We spend two and half times more than other nations.
But we’re getting less in return

<table>
<thead>
<tr>
<th>Rank</th>
<th>Country</th>
<th>Average Length of Life</th>
<th>Rank</th>
<th>Country</th>
<th>Average Length of Life</th>
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<td>80.53</td>
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It’s called the “US Health Disadvantage”

Compared to 16 peer countries, Americans as a group fare worse in at least nine health areas:

- infant mortality & low birth weight;
- Injuries & homicides;
- adolescent pregnancy & sexually transmitted infections;
- HIV and AIDS;
- drug-related deaths;
- obesity & diabetes;
- heart disease;
- chronic lung disease;
- disability

Why aren’t we getting better value?
Not a great business model
Where the United States health system does MORE than other countries

<table>
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<tr>
<th>Procedure</th>
<th>United States</th>
<th>Rank compared with OECD countries</th>
<th>OECD average</th>
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<tr>
<td>MRI units</td>
<td>31.6 per million population</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>12.5</td>
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<td>MRI exams</td>
<td>97.7 per 1 000 population</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>46.3</td>
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<td>CT scanners</td>
<td>40.7 per million population</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>22.6</td>
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<tr>
<td>CT exams</td>
<td>265.0 per 1 000 population</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>123.8</td>
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<tr>
<td>Tonsillectomy</td>
<td>254.4 per 100 000 population</td>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>130.1</td>
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<tr>
<td>Coronary bypass</td>
<td>79.0 per 100 000 population</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>47.3</td>
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<tr>
<td>Knee replacements</td>
<td>226.0 per 100 000 population</td>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>121.6</td>
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<tr>
<td>Caesarean sections</td>
<td>32.9 per 100 live births</td>
<td>6&lt;sup&gt;th&lt;/sup&gt;</td>
<td>26.1</td>
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</table>

Source: OECD Health Data 2012.
Waste

IN HEALTH CARE...

1/3 of health care expenditures don’t improve health – That’s $750 Billion

Inequity

US has a lopsided health: social services ratio

For Richer and for Poorer

• The US Health Disadvantage cannot be fully explained by health disparities among uninsured or poor.

• Even advantaged Americans experience poorer health compared to peers in other countries.

• Social and Environmental Factors are key.

Social factors contribute to 60% of premature death
Social Determinants of Health (SDOH)

“Circumstances in which people are born, grow up, live, work, and age, as well as the health systems they utilize”

Social factors, like food insecurity, drive health behaviors

One in seven Americans cannot reliably afford food

Food insecurity is associated with increased HIV risk behaviors and susceptibility

In California, risk for hospital admissions for hypoglycemia increased 27 percent in the last week of the month compared to the first week among low-income patients.


Zip code matters more than genetic code

Increased exposure to green space associated with lower death rate from heart disease

**Doctor, where did my social determinants go?**

Social determinants have not been integrated in clinic practice or health care systems. Leads to lower value, substandard care.

Lack of social determinants integration costs clinics a great deal

• Preventable illness & health disparities
• Less effective healthcare interventions
• Decreased efficiency and productivity
• Patient distrust
• Workforce recruitment & retention
• Wasteful spending
• Less competitive?
• Lower payments as payors shift to value instead of volume?
How do we move to the NEW way while getting paid for the OLD way?
Healthcare can be better but care teams and clinics need:

- Redesign
- Training & Tools
- Incentives
- Actionable data
- Networks & support to tackle the social determinants of health
Redesign the healthcare workforce to optimize value.

By 2020,
- Upstreamist: 25,000
- Comprehensivist: 260,000
- Partialist: 450,000

Population Health Impact
“It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change.”

-Institute of Medicine
Let’s rethink what’s “addressable” in healthcare

Diagram:
- Upstreamists
- Comprehensivist
- Partialist
Upstreamists optimize value by systematically improving their clinics’ ability to address upstream problems.

Clinic asks about where patients live, work, eat, and play using EMRs & other tools.

Clinic integrates upstream data & community interventions into workflows.

Clinic addresses upstream problems at patient, clinic, and population levels.
CHWs can put us on ‘Path to Continuously Learning Health Care’ when it comes to social determinants

IOM. 2012. Best Care at Lower Cost. The Path to Continuously Learning Health Care in America
CHWs can equip and train doctors to address social factors

4 out of 5 doctors believe social needs are as important as health problems

Yet 4 out of 5 doctors feel under-equipped to address their patients’ social needs

RWJF “Health Care’s Blind Side” Dec 2011
Clinical opportunities for Upstream Interventions and CHWs

Community-Centered Health Home
- Coordinate with policymakers and community stakeholders to address social and environmental conditions

Medical Neighborhood
- Coordinate care for patients and populations with clinical and community “neighbors”
- Potential role for ACOs

PCMH
- Coordinate care for patients and clinic population, primarily within clinical system

Ambulatory ICU
- Integrate and coordinate care for high-need, +/- high-utilizer patients with clinical and community partners
Vermont’s Community Health Teams are part of the PCMH
PCMH 2014 is a big opportunity for upstream integration of CHWs

1. Health Literacy Assessments
2. Behavioral health conditions
3. High cost/high utilization
4. Poorly controlled or complex conditions
5. Barriers to Self Care
6. Social determinants of health
7. Community Resource lists
8. Referrals by outside organizations, practice staff or patient/family/caregiver
### Social Determinants are coming to EMRs: IOM Phase 1 Recommendations

<table>
<thead>
<tr>
<th>Individual Factors</th>
<th>Psychological</th>
<th>Behavioral</th>
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<tr>
<td>Sociodemographic</td>
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<tr>
<td>Sexual orientation</td>
<td>Health literacy</td>
<td>Dietary patterns</td>
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<tr>
<td>Race/ethnicity</td>
<td>Stress</td>
<td>Physical activity</td>
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<tr>
<td>Country of origin/U.S. born or non-U.S. born</td>
<td>Negative mood and affect: Depression and anxiety</td>
<td>Nicotine use and exposure</td>
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<tr>
<td>Education</td>
<td>Psychological assets: Conscientiousness, patient engagement/activation, optimism, and self efficacy</td>
<td>Alcohol use</td>
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<tr>
<td>Employment</td>
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<td>Financial resource strain: Food and housing insecurity</td>
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<table>
<thead>
<tr>
<th>Individual-Level Social Relationships and Living Conditions</th>
<th>Neighborhoods/Communities</th>
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<tbody>
<tr>
<td>Social connections and social isolation</td>
<td>Geocodable domains: Socioeconomic and race/ethnic characteristics</td>
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<tr>
<td>Exposure to violence</td>
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CHWs can lead transformation through “Community Health Detailing” model developed by HealthBegins

- A participatory curriculum for CHWs/activated community residents
- Combined with community-driven resource mapping
- A “Yelp for Health” web application helps providers find resources
- Community ‘details’ healthcare providers to improve care for patients with social risk factors
Community Health Detailing: Building a “Yelp for Health” in South LA
Over 100 high students engaged. Online tool now at UCLA
Clinic-based CHWs can use an ‘Upstreamist Project Canvas’ to develop solutions

<table>
<thead>
<tr>
<th>POPULATION</th>
<th>PROBLEM</th>
<th>UNIQUE VALUE PROPOSITION</th>
<th>SOLUTION</th>
<th>KEY METRICS</th>
<th>KEY PARTNERS</th>
<th>COST STRUCTURE</th>
<th>BENEFIT/REVENUES</th>
<th>GOOB</th>
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<tbody>
<tr>
<td>List your target population</td>
<td>List the problems facing your target population.</td>
<td>A single clear compelling message that turns an unaware person into an interested stakeholder.</td>
<td>Outline a clinically-integrated solution for an addressable upstream cause</td>
<td>List key numbers that will tell you how well the upstream intervention is working.</td>
<td>List internal &amp; external stakeholders &amp; initiatives</td>
<td>Estimate Total Costs, Fixed Costs (FC), &amp; Variable Costs (VC)</td>
<td>List potential funding. Estimate benefits of SMART objective (Step 3). e.g. individual health, clinic &amp; community benefits (costs avoided; added revenue; value created)</td>
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</table>
To improve social determinants, it is necessary, but not sufficient, to engage and transform health care.

We can't get health care as a right without addressing social determinants.

We can’t get health care right without addressing social determinants of health.
A Better Standard of Care and Better Value is possible

#CHWs can improve healthcare by moving it Upstream #Unity2014 @HealthBegin @RishiManchanda #sdoh
Join the Upstreamists network
HealthBegins.org

1. We Mobilize:
   Over 800 members & growing

2. We Equip:
   Trainings → Coaching
   Workshops for Upstreamists
   Community Health Detailing

3. We Design:
   Partners: Providers, Payers, Clinic Systems, Health Tech
   Evaluation & Analysis
TO LEARN MORE
Thanks!
## Social Screening Tools

<table>
<thead>
<tr>
<th>UPSTREAM TOOLS</th>
<th>Screen</th>
<th>Find Resource</th>
<th>Referral Manage</th>
<th>EMR Integration</th>
<th>Community / Patient Participation</th>
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<td>• Healthify</td>
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<td>• Help Steps</td>
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<td>• Purple Binder</td>
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<td>• Aunt Bertha</td>
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<tr>
<td>• Community Detailing-HB</td>
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<tr>
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*Note: The table above indicates the presence (+) or absence (-) of features for each tool.*