Moving upstream: Challenges & opportunities on the journey to improve care and social determinants of health

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President, HealthBegins

Statewide Summit to address Health-Related Social Needs
New Mexico

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About HealthBegins

A national mission-driven consulting and training firm dedicated to improving care and social determinants of health

We work with partners to:
• Design strategy
• Drive improvement
• Transform systems

Client partners range from health systems and plans to foundations and self-insured employers.
The Problem

- The case for moving health care upstream has never been stronger
  - With the move to value-based care, the case for addressing patients’ health-related social needs by integrating social care into health care delivery has never been stronger.
  - At the same time, pressing concerns about equity are driving health care systems and professionals to articulate their role in improving community-level social determinants of health & structural determinants of health, like structural racism.

- Healthcare systems and community partners lack adequate support to lead this transformation
The Solution: Move upstream with rigor

• To “move upstream” means to continuously improve social drivers of health and equity at all levels –
  • individual social needs & networks,
  • community-level social determinants, and
  • broader structural determinants of health
Helping health care move upstream

Health Begins works with partners to help America’s health care professionals understand and lead upstream transformation

**Activation & Engagement**
- Improve awareness and buy-in for upstream transformation
- *Upstream Communications Toolkit* and materials
- Targeted strategic communications campaigns

**Education & Continuous Learning**
- Support learners to lead upstream health care transformation using our proprietary *Upstream Approach*
- Modular training curriculum via in-person workshops & webinars
- Bespoke learning collaboratives

**Training & Capacity Building**
- Train facilitators to run *Upstream Approach* workshops on their own
- In-person & web-based facilitator trainings
- Institutional *Upstream Training Network* members get ongoing support
Moving upstream is becoming mainstream
**Quadruple aim**

- **Outcomes**
  - Effective interventions
  - Less preventable illness
  - Decreased disparities

- **Costs**
  - Lower per-capita costs
  - Appropriate spending & utilization

- **Equity**
  - Societal opportunity
  - Decision making
  - Structural Fairness

- **Provider Experience**
  - Professionalism
  - Joy at Work
  - Recruitment & Retention

- **Patient Experience**
  - Satisfaction
  - Quality
  - Trust
CMS is testing an approach to identify and address health-related social needs among Medicare and Medicaid beneficiaries.

Goal: Reduce health care utilization and cost.

Disclosure: In 2017, CMS selected HealthBegins, along with Mathematica Policy Research and Center for Health Care Strategies to provide implementation and learning system support for AHC bridge organizations.
Costs Fell by 11% When Payer Addressed Social Determinants of Health

The group reporting that all their social needs were met experienced an 11 percent reduction, or $2601, in total healthcare costs in the year after social service referrals.

…the medically tailored meals program yielded net savings of $220 per patient, while the non-tailored program saw $10 in net savings.

Meal delivery programs reduce cost of healthcare in dually eligible Medicare and Medicaid beneficiaries

About 13 percent of U.S. households report food insecurity.
Does this sound familiar?

“I'm a primary care physician [in a rural county]...meth addiction, high school drop out rate... Many more issues. Understand upstream approach for years.

Try my best but falls by the wayside as I don't have resources – No help, city/county overwhelmed. Patients lost to follow up- I’m seeing over 30 a day. How to manage? Would like to discuss.”

- Physician
• National study of 1298 family physicians
• 27% of family physicians reported burnout
• Physicians with a high perception of their clinic’s ability to meet patients’ social needs were less likely to report burnout

**ORIGINAL RESEARCH**

**Physician Burnout and Higher Clinic Capacity to Address Patients’ Social Needs**

*Emilia De Marchis, MD, Margae Knox, MPH, Danielle Hessler, PhD, Rachel Willard-Grace, MPH, J. Nwando Olayiwola, MD, MPH, Lars E. Peterson, MD, PhD, Kevin Grumbach, MD, and Laura M. Gottlieb, MD, MPH*
Poor Patient Experience
- Lower Satisfaction
- Low Quality
- Low Trust

Poor Provider Experience
- Eroding Professionalism
- Frustration at Work
- Costly Recruitment & Retention

Rising Costs
- Rising per-capita costs for high need
- Wasteful spending & utilization

Worse Outcomes
- Ineffective interventions
- More preventable illness
- Continued disparities

No social needs integration = No quadruple aim

Less Equity
The question is no longer whether to address the upstream needs of patients and populations, but how.
Meet Mrs. M
She’s a 46 year old mother of two who also cares for her frail elderly mother.

Her Type II diabetes is poorly controlled (last HbA1c = 8.4) and she has mild heart failure with preserved ejection fraction. At the end of last month, she nearly fainted at work and was admitted at a local hospital.

The cause of her admission was hypoglycemia (low blood sugar).

Root cause: Food insecurity

Lower-income diabetic adults have a 27% higher rate of hospital admissions at the end of the month due to food insecurity, compared with higher-income diabetics.

# Mapping the glossary of upstream terms

<table>
<thead>
<tr>
<th>Terms</th>
<th>Common Definition</th>
<th>Populations targeted</th>
<th>Level of change</th>
<th>Associated Approaches</th>
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<tbody>
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<td>“The effects of the causes”</td>
<td>Specific individuals or defined populations</td>
<td>Micro +/- Meso</td>
<td>Population Health</td>
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<td>Health-related social needs</td>
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<td>• Population health management</td>
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<td>(HRSNs)</td>
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<td>(SDH)</td>
<td>Underlying community-wide social, economic, and physical conditions</td>
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<td>• Community Health Needs Assessments (CHNAs)</td>
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<td>Structural determinants</td>
<td>“The causes of the causes”</td>
<td>Cities, states, nations, or the world</td>
<td>Macro + Meso</td>
<td>Public Health 3.0</td>
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<td>Human-rights approach</td>
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Source: Upstream Communications Toolkit, HealthBegins. May 2019
Birmingham’s ‘Food Deserts’ Have Been Shaped by its Redlined Past

A map drawn in the 1930s to divide white and Black residents—a practice employed across the nation—foretells today’s most food-insecure communities.
A step-wise approach to charting a course upstream
A step-wise approach to charting a course upstream

Identify our:
1. Priority populations
2. Priority social determinants of health
3. Existing barriers and solutions
4. Early wins
5. Roadmap to achieve early wins
1. Pick a Priority population

For example,

Adult diabetics with high rates of preventable hospitalization within 4 zip codes in defined catchment areas

The more precise the definition, the better.
A step-wise approach to charting a course upstream

Identify our:
1. Priority populations (e.g. Diabetics like Mrs.M)
2. Priority social needs & determinants of health
3. Existing barriers and solutions
4. Early wins
5. Roadmap to achieve early wins
2. Pick a “Root Cause” social determinant of health or health-related social need, based on your priority population.

The more specific, the better.

For example, Food insecurity
A step-wise approach to charting a course upstream

Identify our:

1. Priority populations (e.g. Diabetics like Mrs. M)
2. Priority social determinants of health (e.g. Food Insecurity)
3. Existing barriers and solutions
4. Early wins
5. Roadmap to achieve early wins
3a. Identify goals and, if possible, KPIs for priority populations and related social determinants of health.

- Utilization trends
- Quality measures
- Health status
- Financial outcomes
- Social conditions
- Other institutional and community-level goals
Core health care quality measures*

C-04 Improving or maintaining physical health
C-05 Improving or maintaining mental health
C-15 Diabetes care- blood sugar controlled
C-23 Getting needed care
C-24 Getting appointments and care quickly
C-25 Customer service
C-28 Care coordination
D-10 Medication adherence – diabetes
D-11 Medication adherence – hypertension (RAS)
D-12 Medication adherence - cholesterol

*A key step in moving upstream is defining core quality measures for social services
3b. Bring clinical & community stakeholders together to chart a course for population health with the Upstream Strategy Compass™

<table>
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<th>Upstream Strategy Compass™</th>
<th>Patient Level of Intervention (Micro level of change)</th>
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Upstream Strategy Compass™, Manchanda R. HealthBegins. Adapted from Chokshi and Farley (2012); Gottlieb et al. (2013); Cohen and Swift (1999); and Leavell and Clark (1965). Abbreviations: DM, diabetes mellitus.
3c. Then identify potential solutions to improve care and health-related social needs for priority populations.

(example: diabetes and food insecurity)

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<td>Financial literacy, support, &amp; nutrition programs for low-income families with strong family history of DM</td>
<td>Provide on-site Farmers’ Market, gym, walking trails, or financial counseling for employees and dependents</td>
<td>Support ban on trans fats or a tax on refined grain products with added sugar, with subsidy support for healthier foods</td>
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<td>Secondary Prevention</td>
<td>Screening &amp; assistance for DM patients at-risk of end-of-month hypoglycemia</td>
<td>Subsidize vouchers to a farmer’s market, incorporate the DPP into benefits plan for prediabetic employees</td>
<td>Change timing and content WIC &amp; school food programs to avoid food insecurity among DM</td>
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<td>Tertiary Prevention</td>
<td>Reduce hospital use among high-utilizer diabetics using medically-tailored meals</td>
<td>Coordinate with local banks, collectors, lenders, to reduce debt burden for utilizer diabetics</td>
<td>Support legislation/regulations to provide financial and “hotspotter” services to severe diabetics</td>
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A step-wise approach to charting a course upstream

Let’s identify our:

1. Priority populations (e.g. Diabetics like Mrs.M)
2. Priority social determinants of health (e.g. Food Insecurity)
3. Existing barriers and opportunities
4. Early wins
5. Roadmap to achieve early wins
### 4. Early wins

A growing number of health systems and plans are making the business case to address social needs for high-cost, high-risk patients.

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  - Social movements  
  - Capability approach  
  - Human-rights approach |

**Source:** Upstream Communications Toolkit, HealthBegins. May 2019
4. Choose “early wins” and “major initiatives” to improve outcomes for specific communities and conditions (example: diabetes and food insecurity)

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A step-wise approach to building capacity and capability to go upstream

Let’s identify our:

1. Priority populations (e.g. Diabetics like Mrs. M)
2. Priority social determinants of health (e.g. Food Insecurity)
3. Existing resources and opportunities
4. Early wins
5. Roadmap to achieve early wins
Upstream Quality Improvement to achieve early wins
Go Upstream: Launch an Upstream QI Campaign

Example: A FoodRx program to reduce hospital admissions among food insecure patients

- Improve screening of food insecurity among diabetics by 30% within 6 months
- Improve provider confidence to address food insecurity by 30% within 6 months
- Reduce hospital admissions among food-insecure patients by 30% within 18 months
What #UpstreamQI looks like in practice

- 95% Screening Rate for Food Insecurity
- 300% improvement in clinician & care team confidence
- 15x increase in food-resource referrals
- 92% of uncontrolled diabetics referred to clinical pharmacist
- 2% drop in HbA1c among diabetics who returned for repeat visit

Representative results from an HealthBegins-designed Upstream Quality Improvement Campaign at Alameda Health System – Hayward Wellness Center
What #Upstream QI looks like in practice
Support transformation
“Give a man a fish and you feed him for a day; teach a man to fish and you feed him for a lifetime.”

But…
• What if the pond is polluted?
• What if he is denied access to a fishing rod?
• Why not teach a woman to fish?
Tap community experts to drive upstream change
Tap the power of community to optimize health and healthcare with Community Health Detailing™

1900's – Present

- **Pharmaceutical Detailing**
  - **Goal:** Change prescriber behavior to increase sales of drugs.
  - Sales reps were known as "detailmen" because of role promoting "details" about particular drugs in one-on-one meetings with doctors.

1980's – Present

- **Academic Detailing** - Pioneered by Dr. Jeffrey Avorn, Harvard
  - **Goal:** Change prescribing behavior to be consistent with medical evidence, promote safety and choice of cost-effective medications.

2003 – Present

- **Public Health Detailing** – Adapted by Dr. Tom Frieden, NYC Dept of Health
  - **Goal:** Promote essential preventive and disease management practices in high mortality areas in New York City.

2012 – Present

- **Community Health Detailing** – Adapted by HealthBegins
  - **Goal:** Engage community-based organizations to promote preventive & disease management practices that impact clinical outcomes for patients with health-related social needs (social determinants of health).
Move upstream with rigor to advance the quadruple aim and equity

Outcomes
- Effective interventions
- Less preventable illness
- Decreased disparities

Patient Experience
- Satisfaction
- Quality
- Trust

Provider Experience
- Professionalism
- Joy at Work
- Recruitment & Retention

Costs
- Lower per-capita costs
- Appropriate spending & utilization

Equity
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- Decision making
- Structural Fairness
Let’s move upstream
Thank you!

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