Moving Upstream to Improve Care and the Social Determinants of Health

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PRESIDENT, HEALTHBEGINS
Y OF THE USA COMMUNITY INTEGRATED HEALTH
About HealthBegins

We improve care and the social determinants of health by making clinical-community partnerships more effective and efficient.

Our client-partners include Medicaid health plans, large hospitals and healthcare delivery systems, local and national hospital associations, community health centers and self-insured employers. In 2017, HealthBegins was selected to provide technical assistance to CMS Accountable Health Communities model grantees.
YMCA as a community partner in improving health outcomes

The nation’s 2700 Ys serve more than 22 million people each year in 10,000 communities. 80% of U.S. households live within five miles of a Y.

COURTESY OF Y OF THE USA
COMMUNITY INTEGRATED HEALTH

THE YMCA’S MODEL OF COMMUNITY INTEGRATED HEALTH

**Evidence-based Interventions**
Ys are discovering, developing, and disseminating research-tested, high-fidelity health interventions to improve health.

**Capacity Building**
Y-USA is engaging Ys from the earliest stages to ensure they have the staff, competencies, and relationships necessary to implement evidence-based programs.

**Compliance**
Y-USA is helping YMCAs and other community-based organizations comply with privacy laws and health care regulations.

**Shared Physical Spaces**
Ys are exploring the value of shared spaces with health practices, rehab and cancer centers, primary care within Y facilities, retail programming space with health care systems, clinical facilities at camps, and other health services.

**Health Equity**
Y-USA infuses principles of equity into services to ensure everyone has the opportunity to live their healthiest lives, and that underserved populations have access to health-promoting resources.

**Healthier Communities Initiative**
Across 247 communities, Ys have used a collective impact model to implement policy, systems, and environmental changes so that healthy choices are the easy choices for all. Building on this knowledge, Y-USA’s Talent and Knowledge Management department is testing new and advanced models of collaboration over the next three years.

**Community Health Navigation**
Ys help individuals develop the relationships necessary to manage health by conducting home visits, spreading awareness of recommended preventive services, and helping connect people to health care exchanges and marketplaces.
Exercise: Your clinical-community partnerships

1. Who's your target population and/or community?
2. What are your top three measures of success for this CIH effort in the next 2 years?
3. What are the biggest risks or challenges to achieving these measures of success for your clinical-community partnership?

A) Pair up and share
B) Share answers to question with tablemates
Addressing patient’s health related social needs (HRSNs) is not only necessary, it’s possible.

More rigor is necessary for healthcare systems, public health and community partners to address HRSNs and, more broadly, SDOH, at scale

As we look ahead, there are critical challenges and questions we must confront on the journey upstream.
First, what do each of us mean when we say “SDoH”?

- Social determinants of health care
- Social determinants of health
- Social determinants of health equity
Social Determinants of Health (SDoH) manifest as Health-Related Social Needs (HRSNs)
Addressing patient’s health-related social needs (HRSNs) is not only necessary, it’s possible.
**Quadruple aim**

**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**
- Societal opportunity
- Decision making
- Structural Fairness
Worse Outcomes
- Ineffective interventions
- More preventable illness
- Continued disparities

Poor Patient Experience
- Lower Satisfaction
- Low Quality
- Low Trust

No social determinants integration = No quadruple aim

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

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

Less Equity
More rigor (strategic, financial, operational) is necessary for healthcare systems and their community partners to address HRSNs and, more broadly, SDOH, at scale.
Meet Mrs. M
She’s a 46 year old mother of two who also cares for her frail elderly mother.

She has hypertension, mild heart failure with preserved ejection fraction and Type II Diabetes (last A1c=8.2). 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.

We want to reduce and prevent hospital admissions for patients like Mrs. M while advancing the Quadruple Aim.

How do we do this?
We recognize that stakeholder priorities often differ by level of prevention.

<table>
<thead>
<tr>
<th>Primary Prevention</th>
<th>Secondary Prevention</th>
<th>Tertiary Prevention</th>
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**Primary prevention** is concerned with preventing the onset of disease; it aims to reduce the incidence of disease.

**Secondary prevention** is concerned with detecting a disease in its earliest stages, before symptoms appear, and intervening to slow or stop its progression: "catch it early." 

**Tertiary prevention** refers to interventions designed to arrest the progress of an established disease and to control its negative consequences.

Source: University of Ottawa. https://www.med.uottawa.ca/sim/data/Prevention_e.htm
Examples of SDOH-related barriers and solutions

<table>
<thead>
<tr>
<th>Primary Prevention</th>
<th>Barriers</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overconsumption of trans fats, refined grain products and high-salt foods, especially among lower-income families</td>
<td>Support ban on trans fats, a tax on refined grain products with added salt and sugar, with subsidy support for healthier foods</td>
<td></td>
</tr>
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<tr>
<th>Secondary Prevention</th>
<th>Poor access to healthy affordable food for employees with CVD and other comorbidities</th>
<th>Subsidize vouchers to a farmer’s market, incorporate the DPP into benefits plan for at-risk employees</th>
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<tr>
<th>Tertiary Prevention</th>
<th>No tailored food or income support for high-utilizer, high-need diabetics</th>
<th>Reduce hospital use among high-utilizer diabetics using medically-tailored meals</th>
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Source: University of Ottawa. [https://www.med.uottawa.ca/sim/data/Prevention_e.htm](https://www.med.uottawa.ca/sim/data/Prevention_e.htm)
Stakeholder priorities also differ by level of intervention

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<td>Interventions directed toward individual beneficiaries (e.g. patients, clients)</td>
<td>Interventions directed toward organizations and their stakeholders (e.g. employees, vendors, partners, investors)</td>
<td>Interventions directed toward entire communities or broad populations (e.g. zip codes, cities, states)</td>
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### Examples of SDOH-related barriers and solutions

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<td>Limited screening for food insecurity among patients with CVD</td>
<td>Physical spaces and organizational policies not conducive for healthy activity or eating for all employees</td>
<td>Policy barriers limit access to WIC &amp; school food to avoid food insecurity among families of CVD patients</td>
</tr>
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<td>Poverty screening &amp; financial assistance for patients at-risk of end-of-month hypoglycemia</td>
<td>Provide on-site Farmers’ Market, gym, walking trails, or financial counseling for employees and dependents</td>
<td>Change timing and content WIC &amp; school food programs to avoid food insecurity among families with CVD</td>
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### Upstream Strategy Compass™

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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.
Identify potential solutions to improve care and health-related social needs for priority populations.

(example: diabetes and food insecurity)

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<td><strong>Primary Prevention</strong></td>
<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><strong>Secondary Prevention</strong></td>
<td>Poverty screening &amp; financial 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><strong>Tertiary Prevention</strong></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 utilization diabetics</td>
<td>Support legislation/regulations to provide financial and “hotspotter” services to severe diabetics</td>
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Choose “early win” solutions to

a) improve outcomes for specific populations & social needs, and
b) improve cross-sector capability

(Example: diabetes and food insecurity)

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<td><strong>Primary Prevention</strong></td>
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<td>Advocate for local increase in supports for low-income families, particularly those at risk of DM</td>
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<td>Subsidize vouchers to local Farmer’s Market or hire a financial counselor for low-income DM patients</td>
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<td>Reduce hospital use among high-utilizer severe diabetics using food and income support</td>
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*Upstream Strategy Matrix™, 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.*
A path to achieving early wins in clinical-community partnerships

1. Get Ready
Once early wins are identified, assess the organizational capability of current or potential health care partners to help address target social determinants of health.

2. Get Set
Based on level of readiness, our experts & coaches help identify or optimize on a priority population, an upstream problem, relevant partners and data to move upstream.

3. Go Upstream with QI
Using the Upstream Quality Improvement toolkit, launch rigorous, targeted campaigns to redesign systems and workflows to dramatically improve health and social outcome measures.
Upstream Quality Improvement

Upstream factors
Social factors such as food security, social support, housing stability are associated with better health outcomes.

Quality Improvement
High performing healthcare systems routinely identify opportunities for quality improvement to improve value and outcomes.
We need to get clinical and community partners on the same page to chart a course for population health.

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As we look ahead, there are critical challenges and questions we must confront on the journey upstream.
What prevents cross-sector collaboration from working as we had hoped?
"Despite growing interest in understanding how social factors drive poor health outcomes, many academics, policy makers, scientists, elected officials, journalists, and others responsible for defining and responding to the public discourse remain reluctant to identify racism as a root cause of racial health inequities." [Bailey et al, 2017]
Structural Racism

“The totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources.” [Bailey et al, 2017]

- **Institutional racism** refers specifically to discriminatory policies and practices carried out...[within and between individual] state or non-state institutions on the basis of racialized group membership. [Krieger, 2014]

- **Individual and interpersonal racism** = Prejudgment, bias, or discrimination based on race by an individual
Ways to advance a racial equity framework

1. Take institutional steps to align SDH & DI work
   - Adopt a racial equity framework
     (see Government Alliance on Race & Equity (GARE)
   - “Liberation in the Exam Room” model from Southern Jamaica Plain Health Center
   - Join your QI Committee
   - Increase training in structural racism

3. Contract for equity & inclusion
   - Equity-based Contracting (GARE/Haas Institute) & Local Procurement (Democracy Collaborative)
   - HealthBegins Inclusion Rider
How can we engage CBOs and residents with lived experience to make clinical-community partnerships more effective?
Detailing

A proven method to disseminate evidence-based interventions and change knowledge and behaviors of frontline professionals and caregivers.

- First developed by the pharmaceutical industry.

- The approach uses brief, semi-structured, and repeated face-to-face visits that tailor and deliver key messages to fit the learners’ needs.
Example: NYC Dept of Health Used Detailing to Lower High-Dose Opioid Prescribing

Target community → 12.4% decrease.

Control community → 7.3% decrease.

Significantly different, using difference-in-difference analysis.
We adapted detailing to tap into the power of community organizations to optimize health.

We call it 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).
Community Health Detailing™
Original demo: High school students in LA

Over 100 high students from south LA learned how to detail UCLA doctors about SDOH

Results

• Clinicians reported nearly 3x increase in confidence to address patients’ housing and other social needs

• Students reported 3x increase in knowledge and confidence to address health-related social needs
Case study: Community Health Detailing™ fueled this Upstream QI Campaign at a large community clinic.
HOW CAN WE TAP THE POWER OF COMMUNITY TO LEVERAGE AND SCALE EVIDENCE-BASED PROGRAMS?

**Diabetes Prevention – YMCA’s Diabetes Prevention Program**

**Falls Prevention – Enhance®Fitness, Moving For Better Balance**

**Arthritis Self-Management – Enhance®Fitness**

**Cancer Survivorship - LIVESTRONG at the YMCA**

**Hypertension control – Blood Pressure Self-Monitoring**

**Childhood Obesity Intervention**

**Brain Health**

**Parkinson’s**

**Tobacco Cessation**
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
- Societal opportunity
- Decision making
- Structural Fairness
Group Q&A: What can you share? What do you need?

1. How has the presentation helped contribute to your understanding of your clinical-community partnership? Your measures of success?
2. Are there promising practices or resources that you can share to address a challenge you heard? *(What can you share?)*
3. What ideas, practices, or resources do you want to borrow to try in your own clinical-community partnership? *(What can you borrow?)*
Thank you!

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