Moving Upstream to Improve Care and the Social Determinants of Health

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Y OF THE USA COMMUNITY INTEGRATED HEALTH

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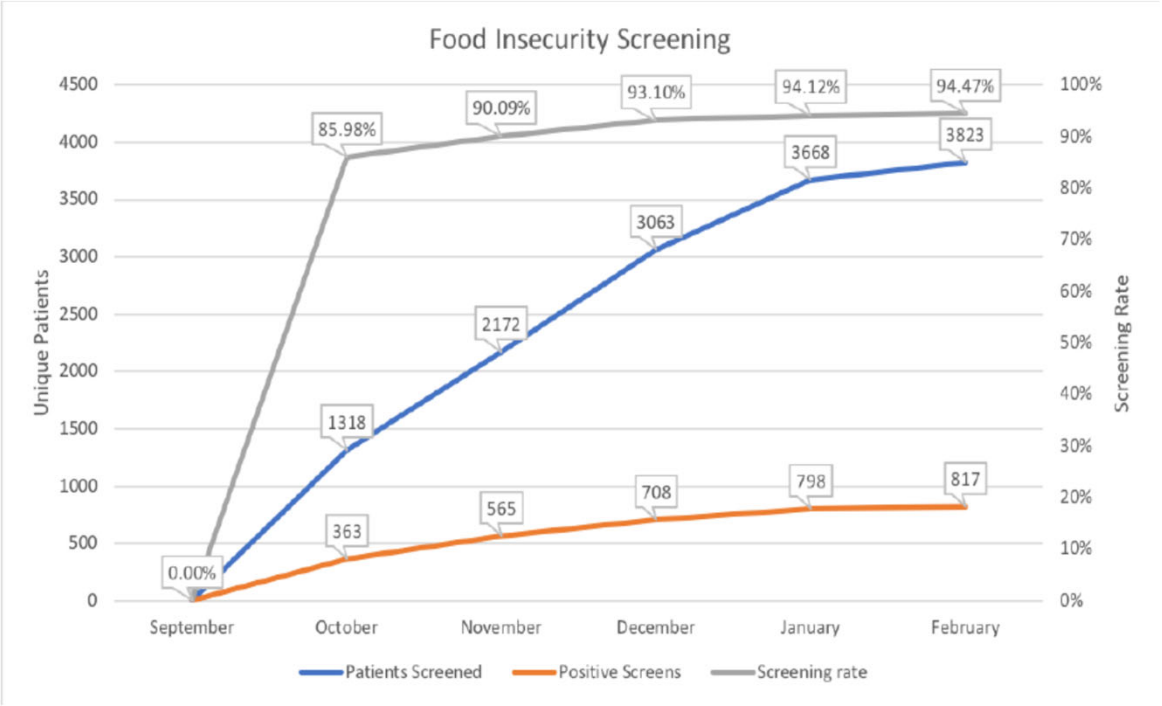
About HealthBegins

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.

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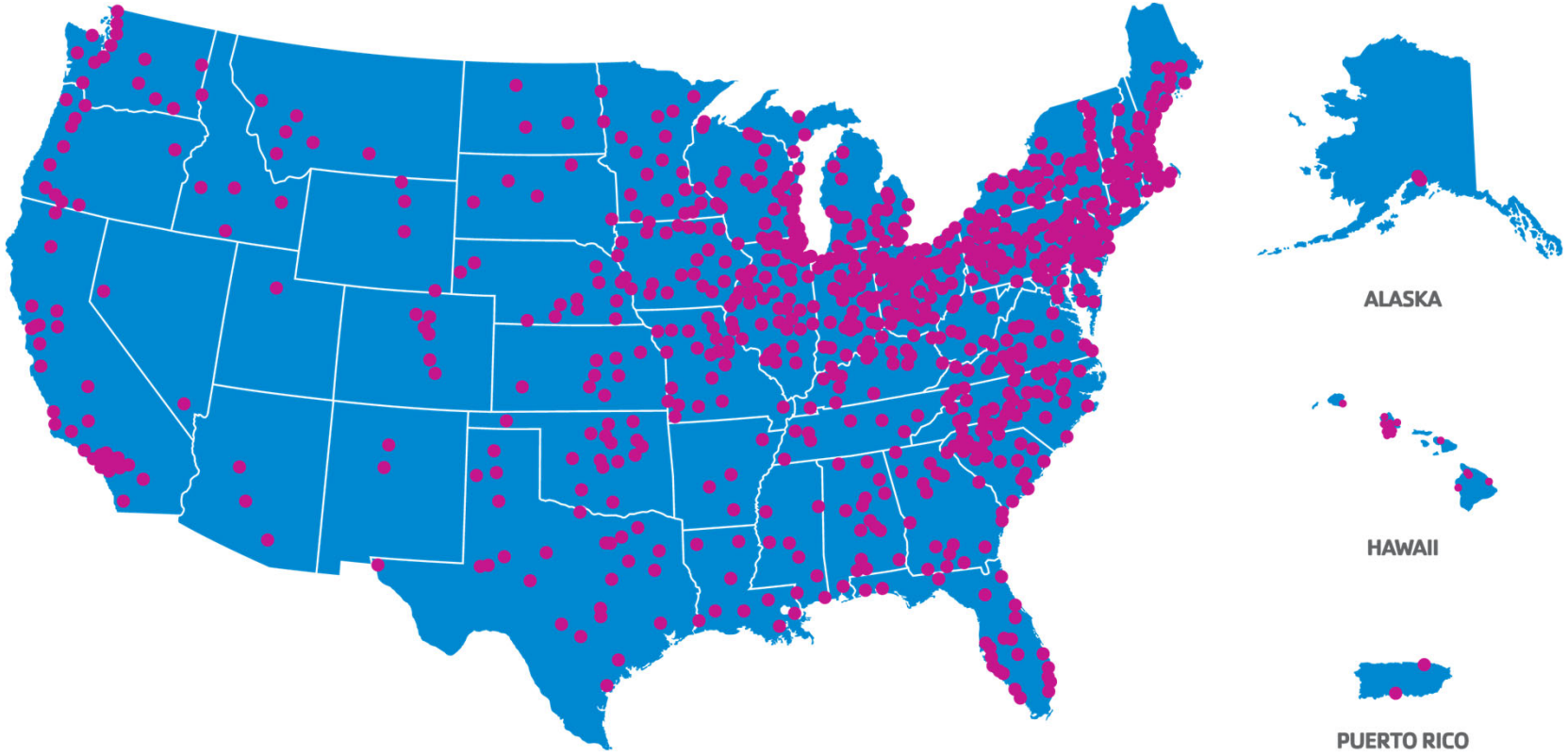
YMCA as a community partner in improving health outcomes



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

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.

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.

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.

Healthier Communities Initiative
Across 247 communities, Ys have used a collective impact model to implement policy, system, 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.

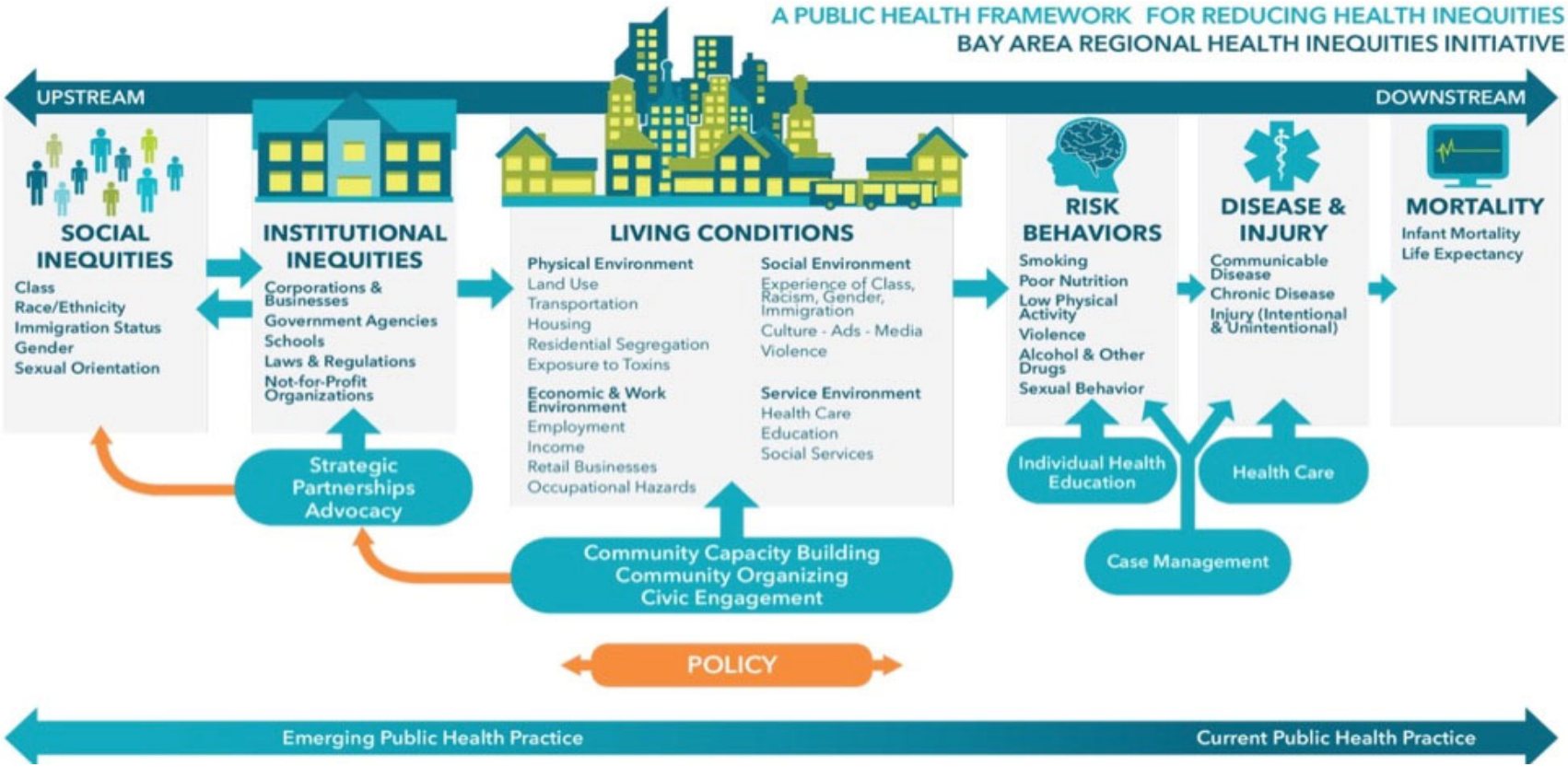
More rigor is necessary for healthcare systems, public health and community partners to address HRSNs and, more broadly, SDOH, at scale

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)



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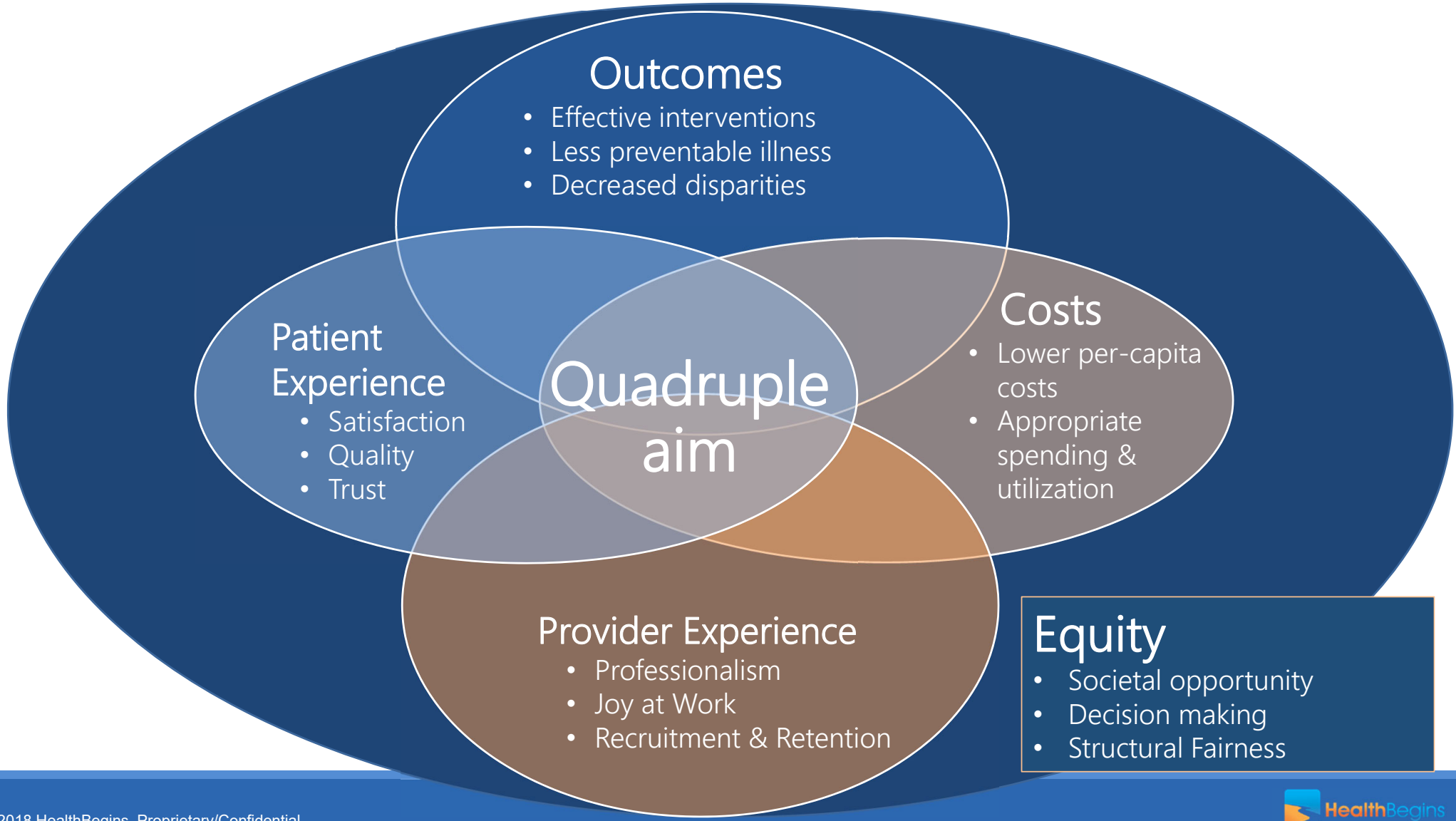

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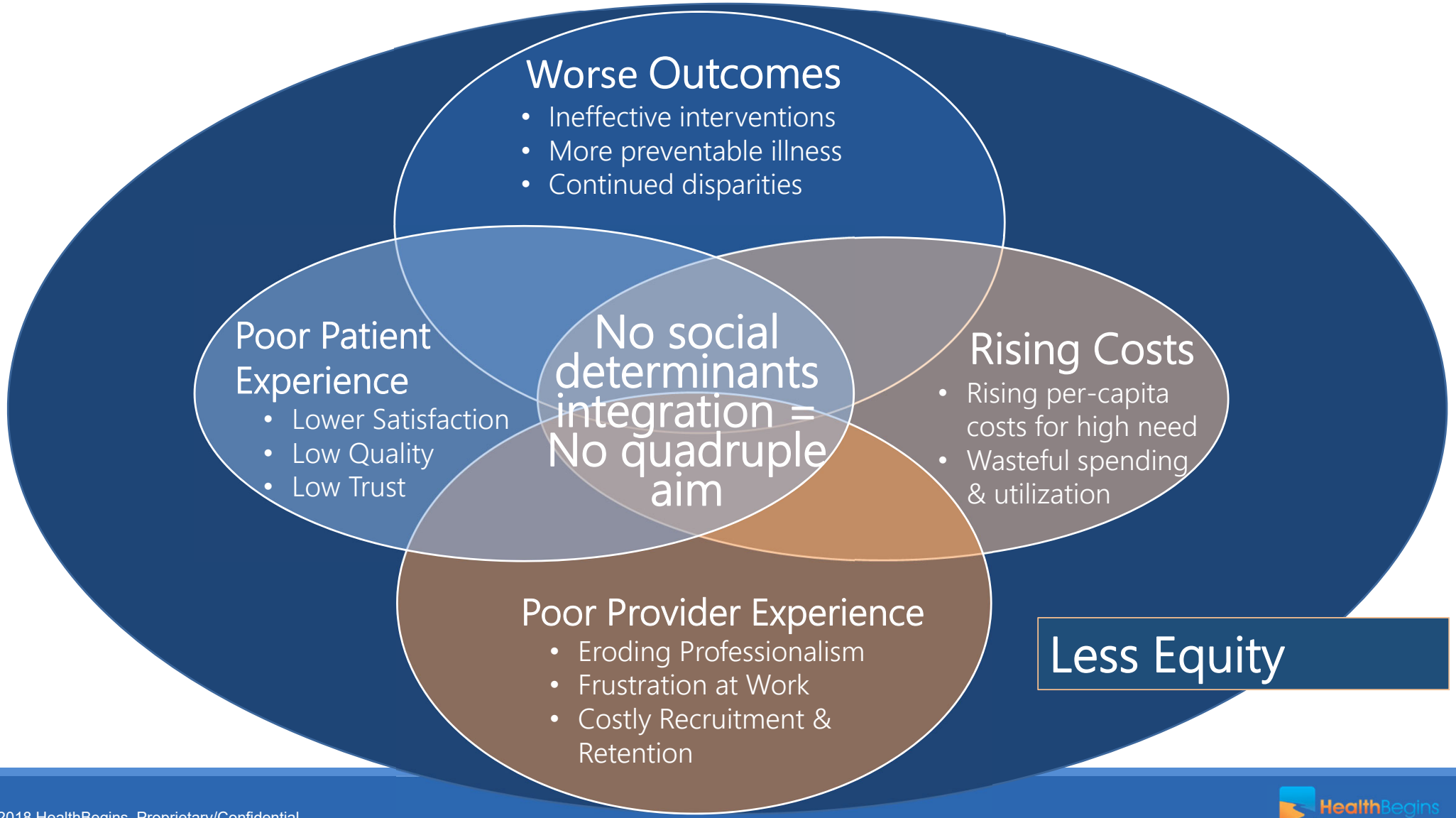

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More rigor (**strategic**, financial, operational) is necessary for healthcare systems and their community partners to address HRSNs and, more broadly, SDOH, at scale

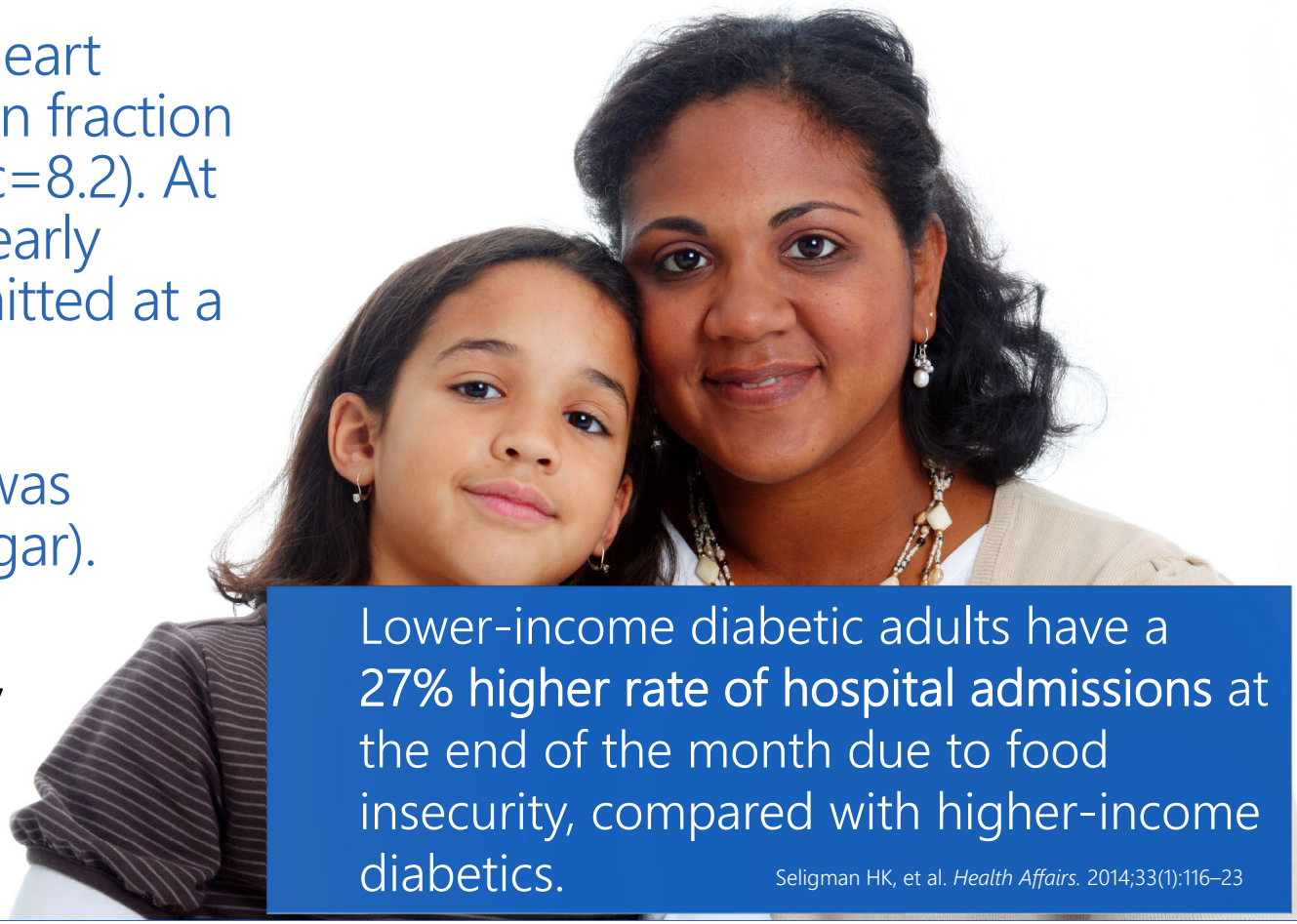
Meet Mrs. M

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



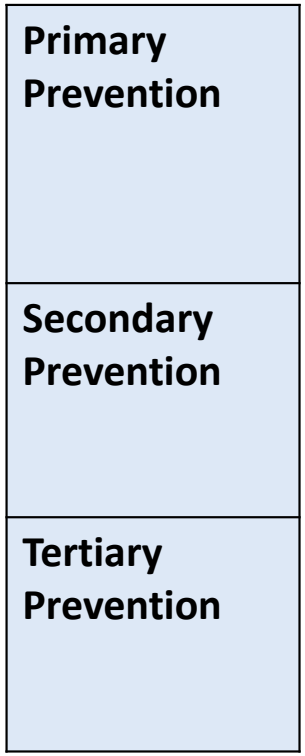
Lower-income diabetic adults have a **27% higher rate of hospital admissions** at the end of the month due to food insecurity, compared with higher-income diabetics.

Seligman HK, et al. *Health Affairs.* 2014;33(1):116–23

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



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

	Barriers	Solutions
Primary Prevention	Overconsumption of trans fats, refined grain products and high-salt foods, especially among lower-income families	Support ban on trans fats, a tax on refined grain products with added salt and sugar, with subsidy support for healthier foods
Secondary Prevention	Poor access to healthy affordable food for employees with CVD and other comorbidities	Subsidize vouchers to a farmer's market, incorporate the DPP into benefits plan for at-risk employees
Tertiary Prevention	No tailored food or income support for high-utilizer, high-need diabetics	Reduce hospital use among high-utilizer diabetics using medically-tailored meals

Source: University of Ottawa. https://www.med.uottawa.ca/sim/data/Prevention_e.htm

Stakeholder priorities also differ by level of intervention

Patient /Client Level of Intervention	Organization Level of Intervention	Community Level of Intervention
Interventions directed toward **individual beneficiaries** (e.g. patients, clients)	Interventions directed toward **organizations and their stakeholders** (e.g. employees, vendors, partners, investors)	Interventions directed toward **entire communities or broad populations** (e.g. zip codes, cities, states)

Examples of SDOH-related barriers and solutions

	Patient /Client Level of Intervention	Organization Level of Intervention	Community Level of Intervention
Barriers	Limited screening for food insecurity among patients with CVD	Physical spaces and organizational policies not conducive for healthy activity or eating for all employees	Policy barriers limit access to WIC & school food to avoid food insecurity among families of CVD patients
Solutions	Poverty screening & financial assistance for patients at-risk of end-of-month hypoglycemia	Provide on-site Farmers' Market, gym, walking trails, or financial counseling for employees and dependents	Change timing and content WIC & school food programs to avoid food insecurity among families with CVD

Bring clinical & community stakeholders together to chart a course for population health with the Upstream Strategy Compass™

Upstream Strategy Compass™	**Patient Level of Intervention**	**Organization Level of Intervention**	**Community Level of Intervention**
Primary Prevention			
Secondary Prevention			
Tertiary Prevention			

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)

Upstream Strategy Compass™	**Patient Level of Intervention**	**Organization Level of Intervention**	**Community Level of Intervention**
Primary Prevention	Financial literacy, support, & nutrition programs for low-income families with strong family history of DM	Provide on-site Farmers' Market, gym, walking trails, or financial counseling for employees and dependents	Support ban on trans fats or a tax on refined grain products with added sugar, with subsidy support for healthier foods
Secondary Prevention	Poverty screening & financial assistance for DM patients at-risk of end-of-month hypoglycemia	Subsidize vouchers to a farmer's market, incorporate the DPP into benefits plan for prediabetic employees	Change timing and content WIC & school food programs to avoid food insecurity among DM
Tertiary Prevention	Reduce hospital use among high-utilizer diabetics using medically-tailored meals	Coordinate with local banks, collectors, lenders, to reduce debt burden for utilizer diabetics	Support legislation/ regulations to provide financial and "hotspotter" services to severe diabetics

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.

Choose "early win" solutions to

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

(example: diabetes and food insecurity)

Clinical role

CBO role

Upstream Strategy Compass™	Patient/Team Level of Intervention	Organization Level of Intervention	Community Level of Intervention
Primary Prevention			Advocate for local increase in supports for low-income families, particularly those at risk of DM
Secondary Prevention		Subsidize vouchers to local Farmer's Market or hire a financial counselor for low-income DM patients	Support, Lead
Tertiary Prevention	Reduce hospital use among high-utilizer severe diabetics using food and income support	Lead, Support	Partner, Partner

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

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.

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.

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.

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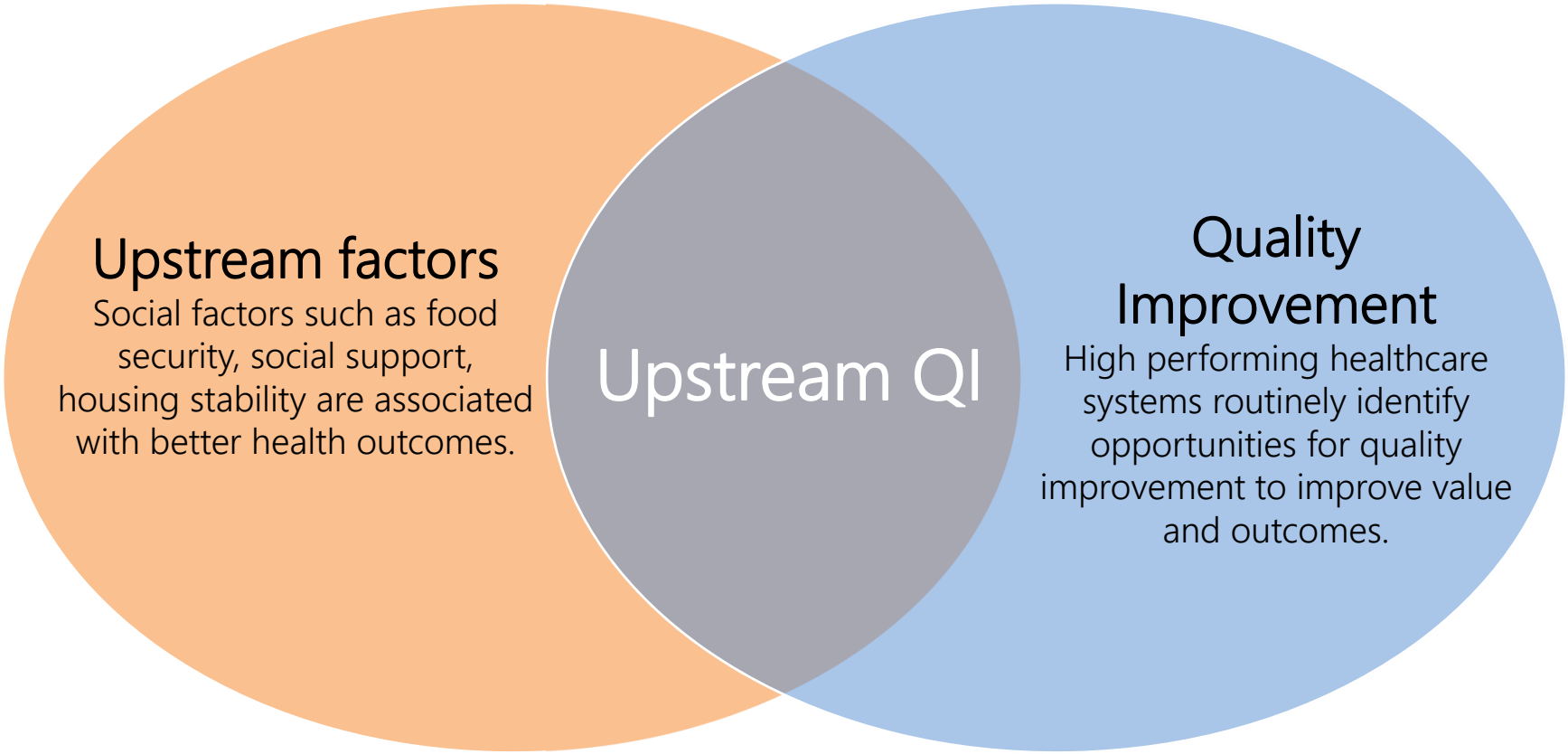
Upstream Quality Improvement



We need to get clinical and community partners on the same page to chart a course for population health

Upstream Strategy Compass™	**Patient Level of Intervention**	**Organization Level of Intervention**	**Community Level of Intervention**
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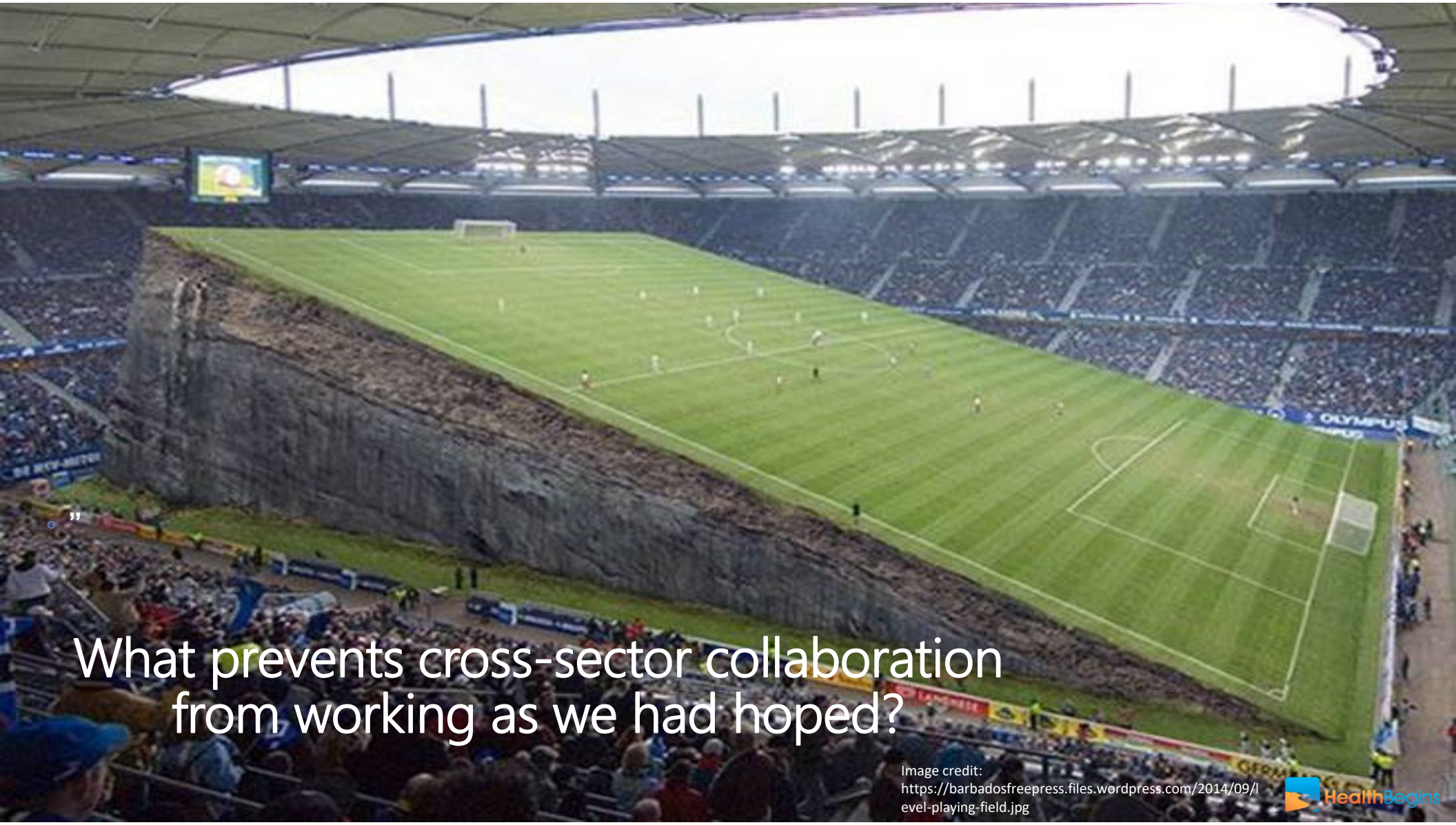

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What prevents cross-sector collaboration from working as we had hoped?

Image credit: https://barbadosfreepress.files.wordpress.com/2014/09/level-playing-field.jpg

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MARK PETERSON/REDUX

Structural Racism and health inequities

"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]

Bailey Z.D., Krieger N., Agnor M., Graves J., Linos N., Bassett M.T. Structural racism and health inequities in the USA: Evidence and interventions. The Lancet. 2017;*389*(10077):1453–1463.

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]

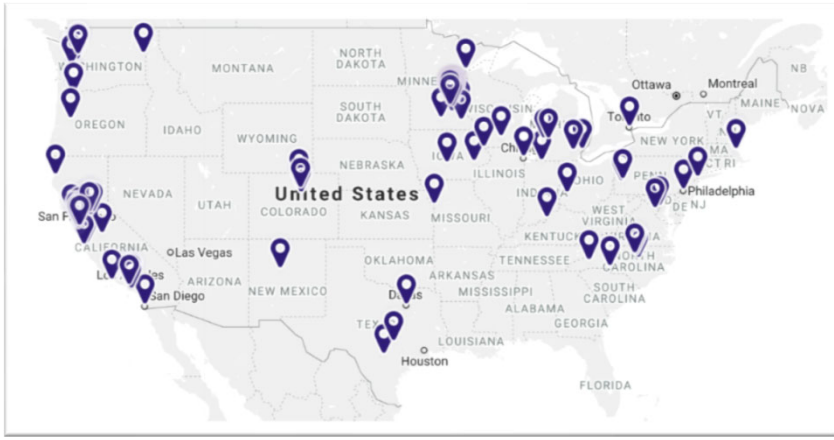
- **Institutional racism** refers specifically to discriminatory policies and practices carried out…[within and between individual] state or non-state institutions on the basis of racialized group membership. [Krieger, 2014]
- **Individual and interpersonal racism** = Prejudgment, bias, or discrimination based on race by an individual

Bailey Z.D., Krieger N., Agnor M., Graves J., Linos N., Bassett M.T. Structural racism and health inequities in the USA: Evidence and interventions. The Lancet. 2017;*389*(10077):1453–1463.
Krieger N. Discrimination and health inequities. Int J Health Serv 2014; 44: 643–710

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




LIBERATION IN THE EXAM ROOM: RACIAL JUSTICE AND EQUITY IN HEALTHCARE

As health care providers, we want the best for our patients. This includes equitable treatment and health outcomes. Good intentions are important, but how do we ensure that the impact on the patient matches our good intent? Committing to health equity requires us to

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?

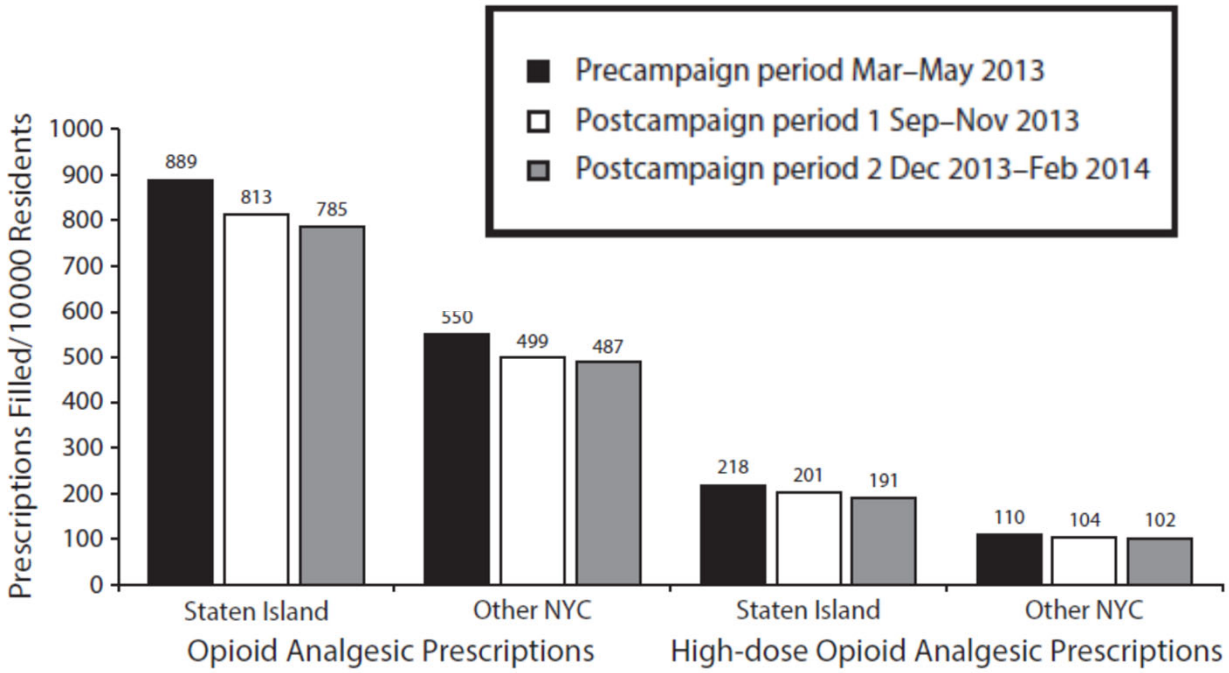
Detailing

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).

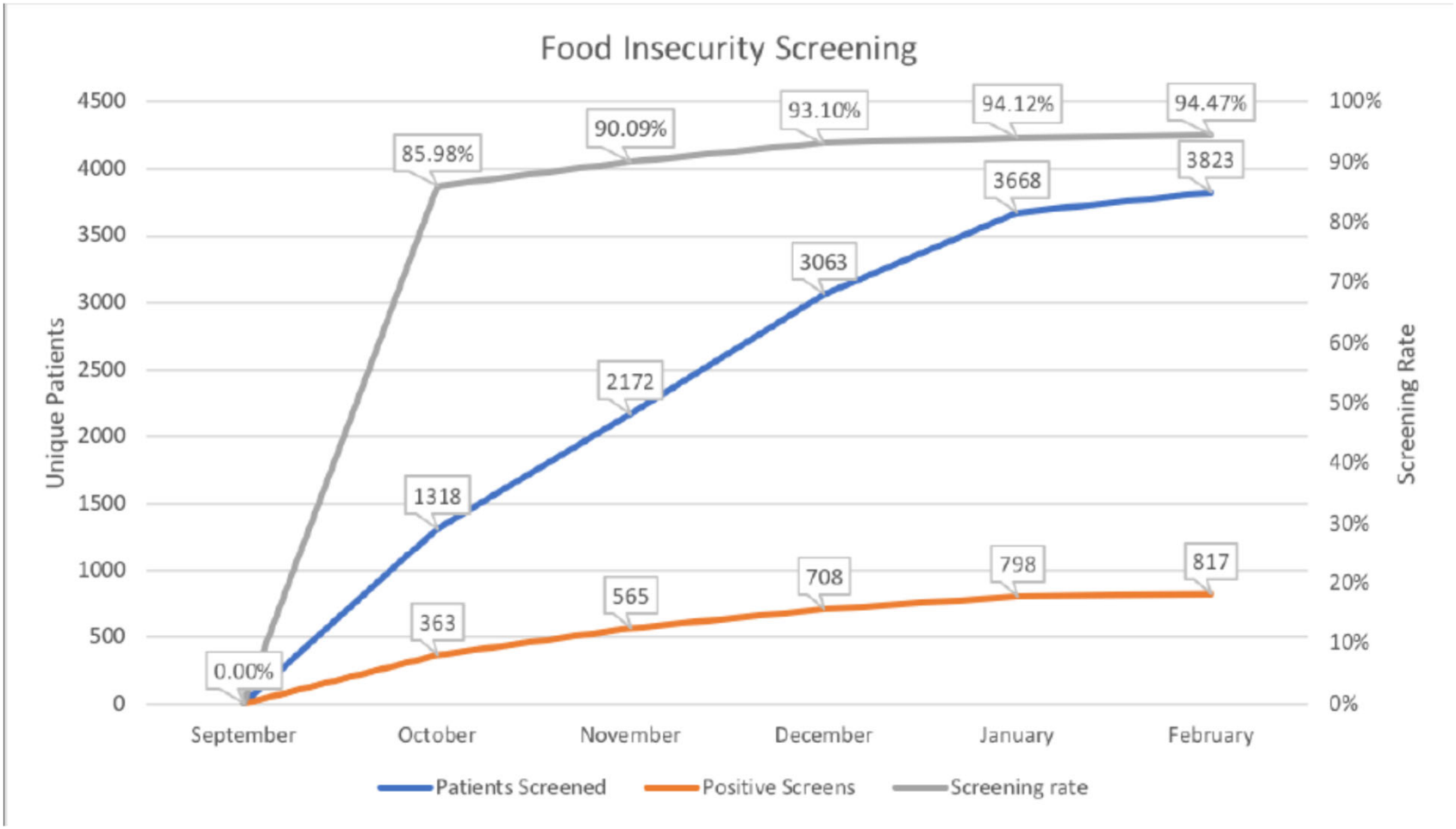
Community Health Detailing™
Original demo: High school students in LA

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



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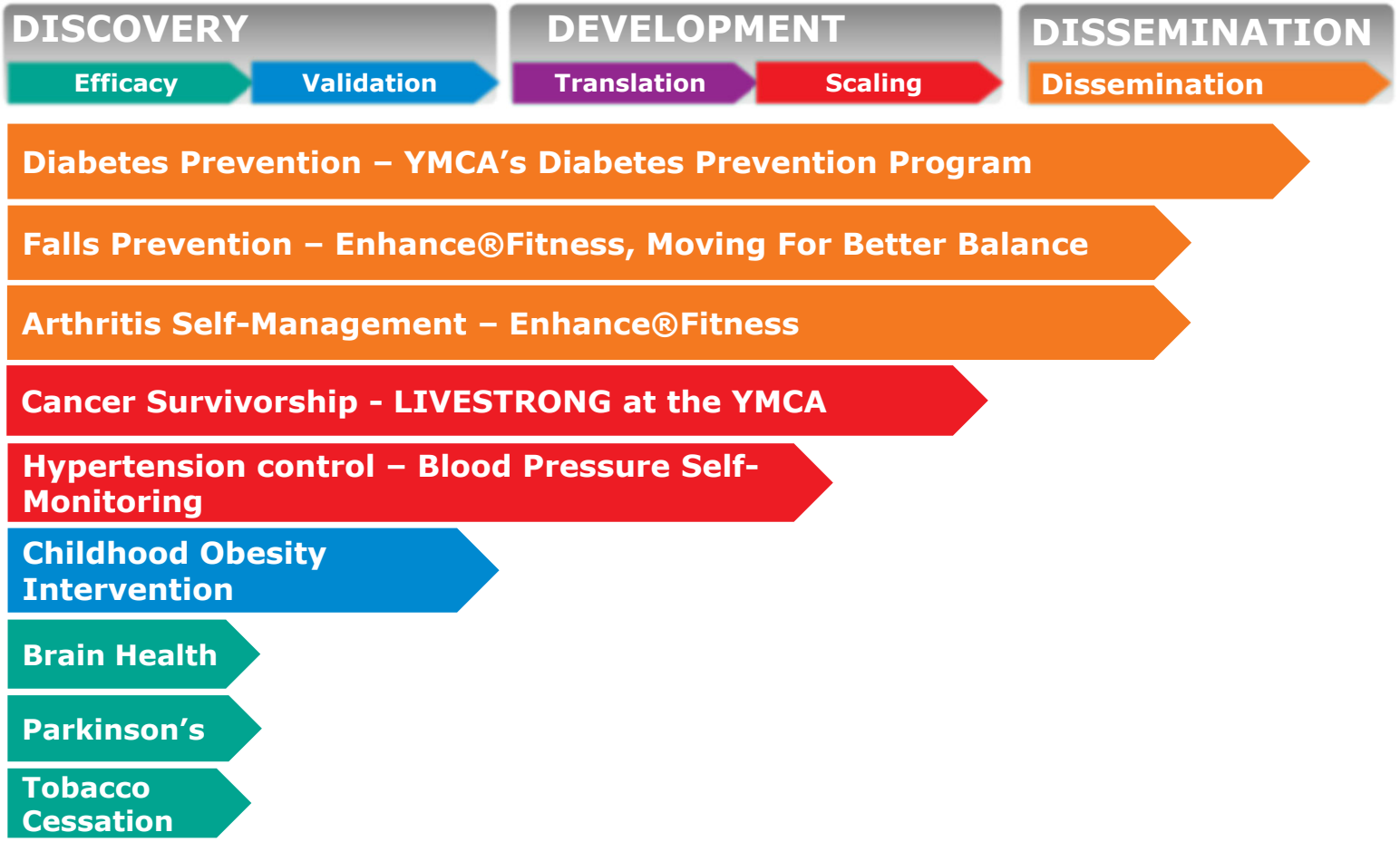
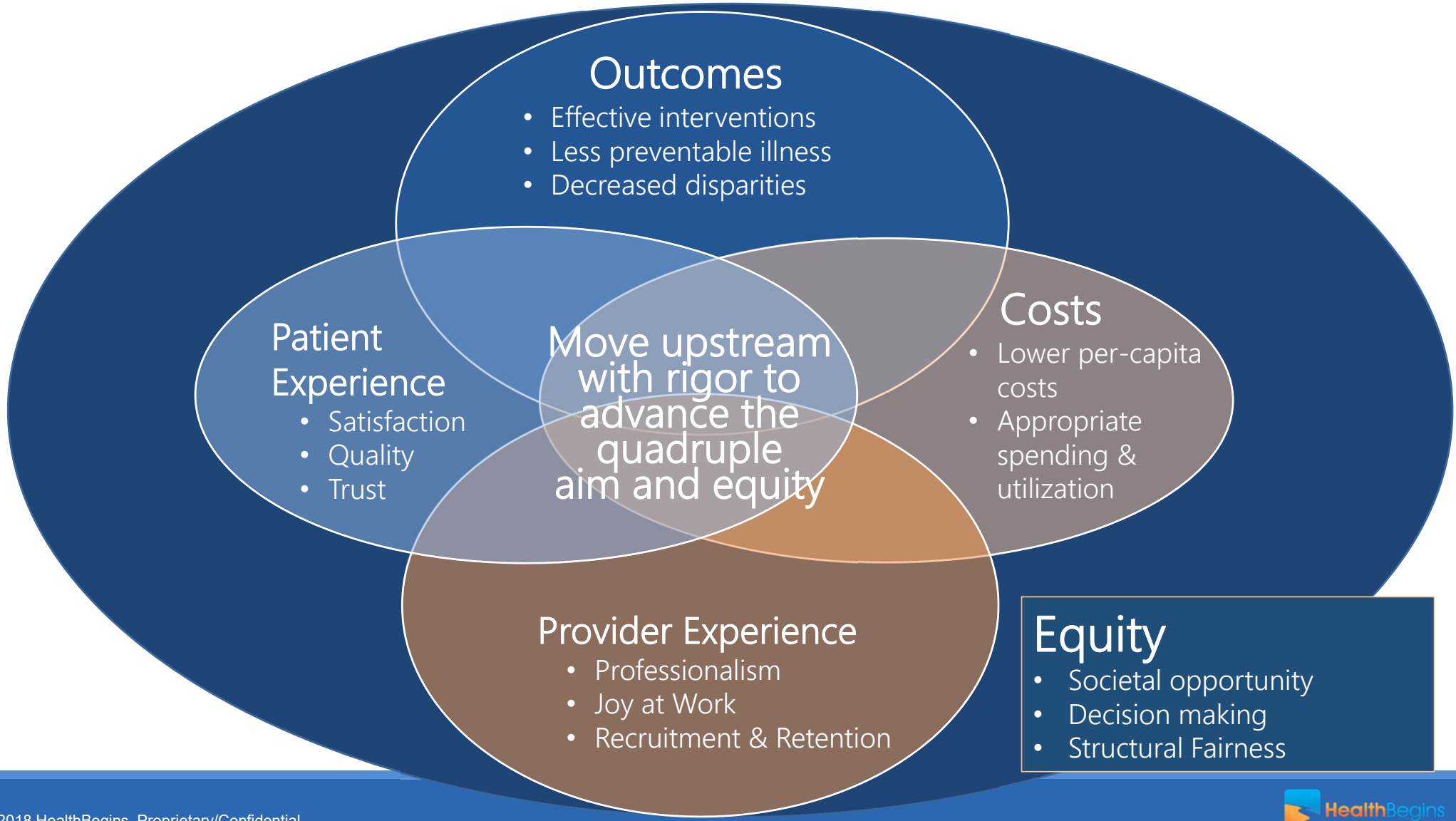
HOW CAN WE TAP THE POWER OF COMMUNITY TO LEVERAGE AND SCALE EVIDENCE-BASED PROGRAMS?





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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?)***

A) Share answers to question with tablemates
B) Discuss as a larger group

Thank you!

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