

# Moving Healthcare Upstream:

## Optimizing healthcare value

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 @RishiManchanda

**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.**

**Good Value?**

**Good Care?**

**Veronica's new clinic asked routine questions about housing risks, identified her problem, and developed a plan to address housing risks.**



**Veronica got better. So did her home.**

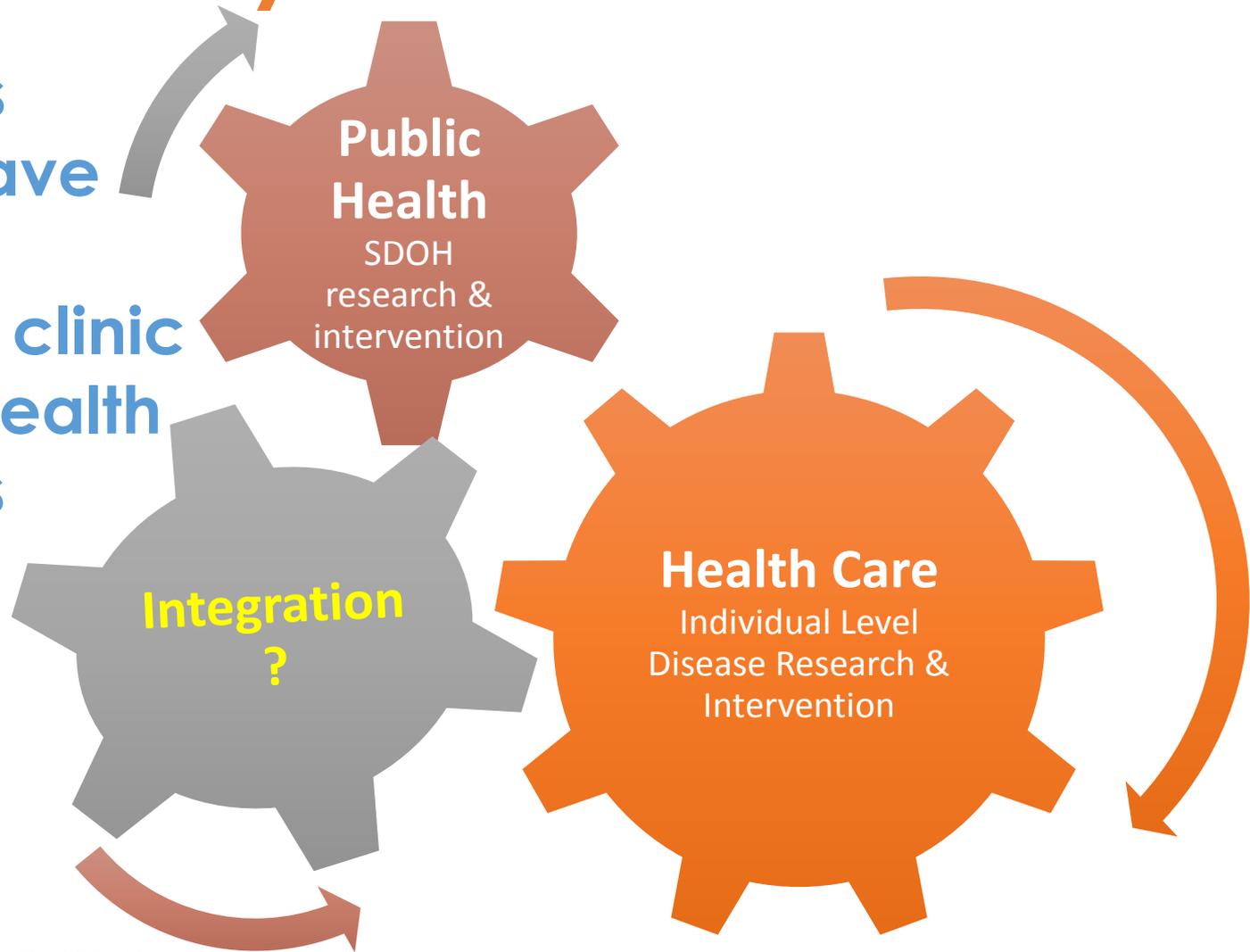
**That's Better Value**

**That's Better Care**

# “Why didn’t my doctors ask about my home before?”

Social determinants matter but have not been integrated in clinic practice or health care systems

This leads to stories like Veronica’s... Lower value, substandard care

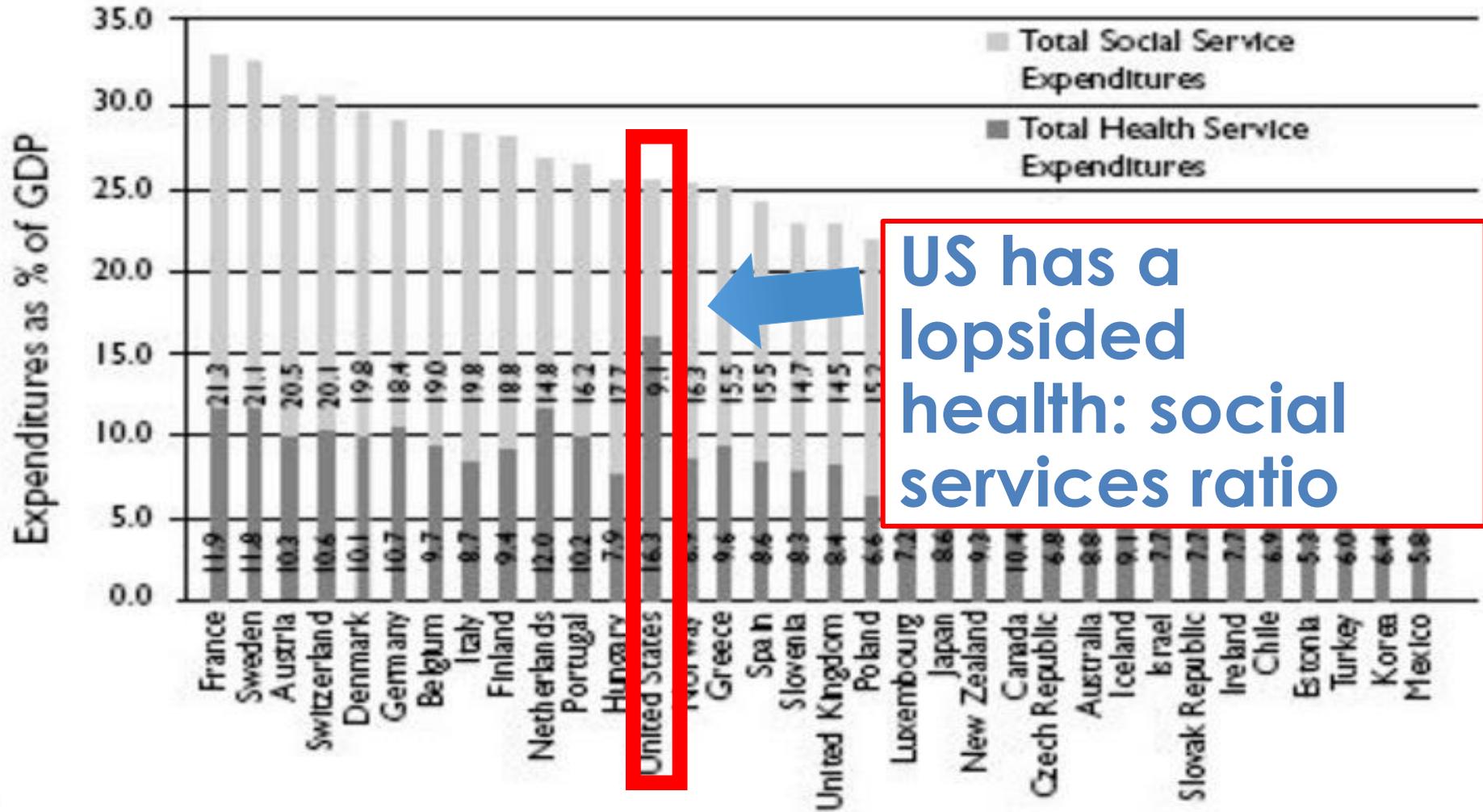


**Why aren't we  
getting better  
value?**

**“The best bathroom on the block”  
business model**

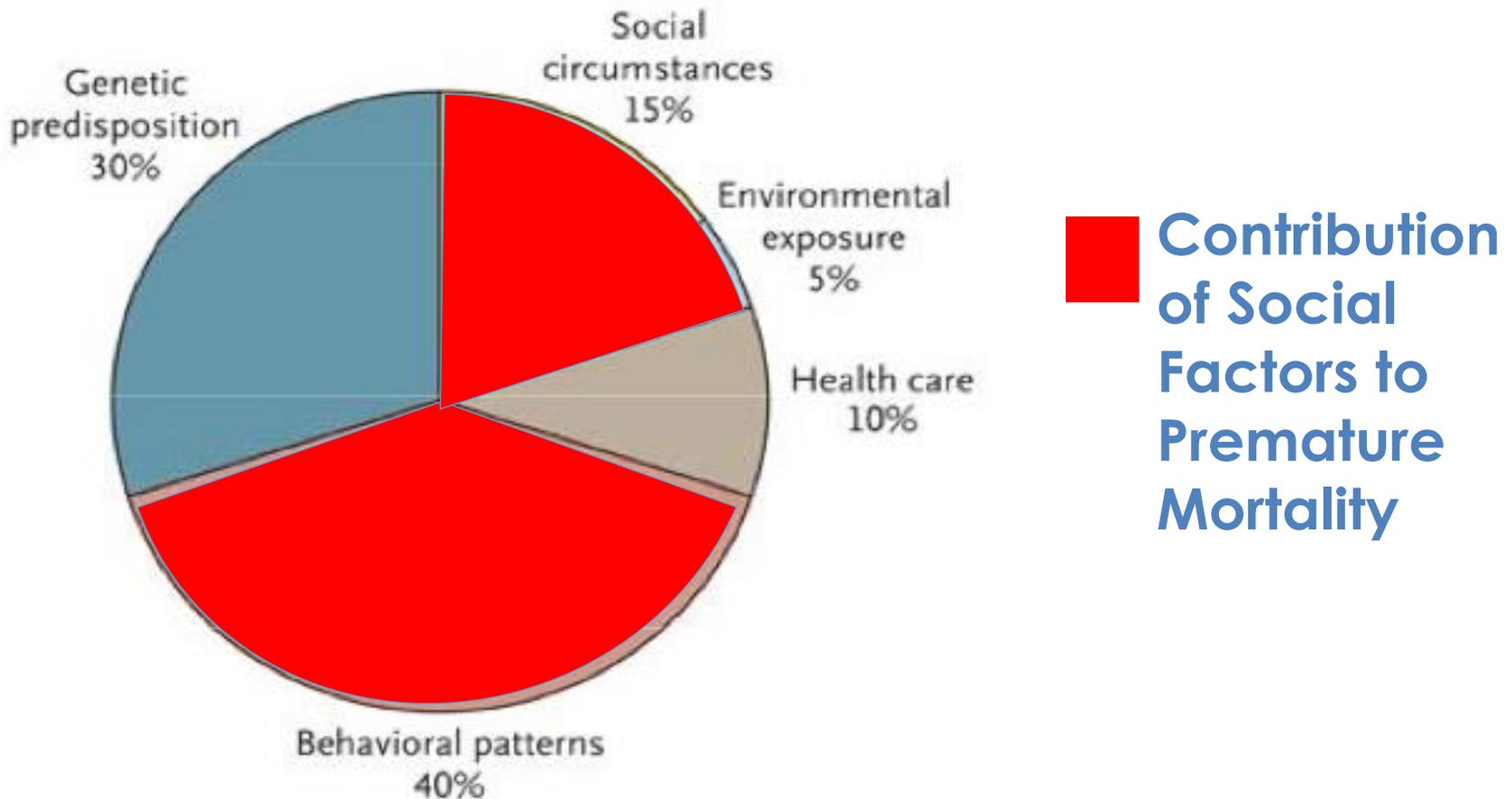


# Lopsided



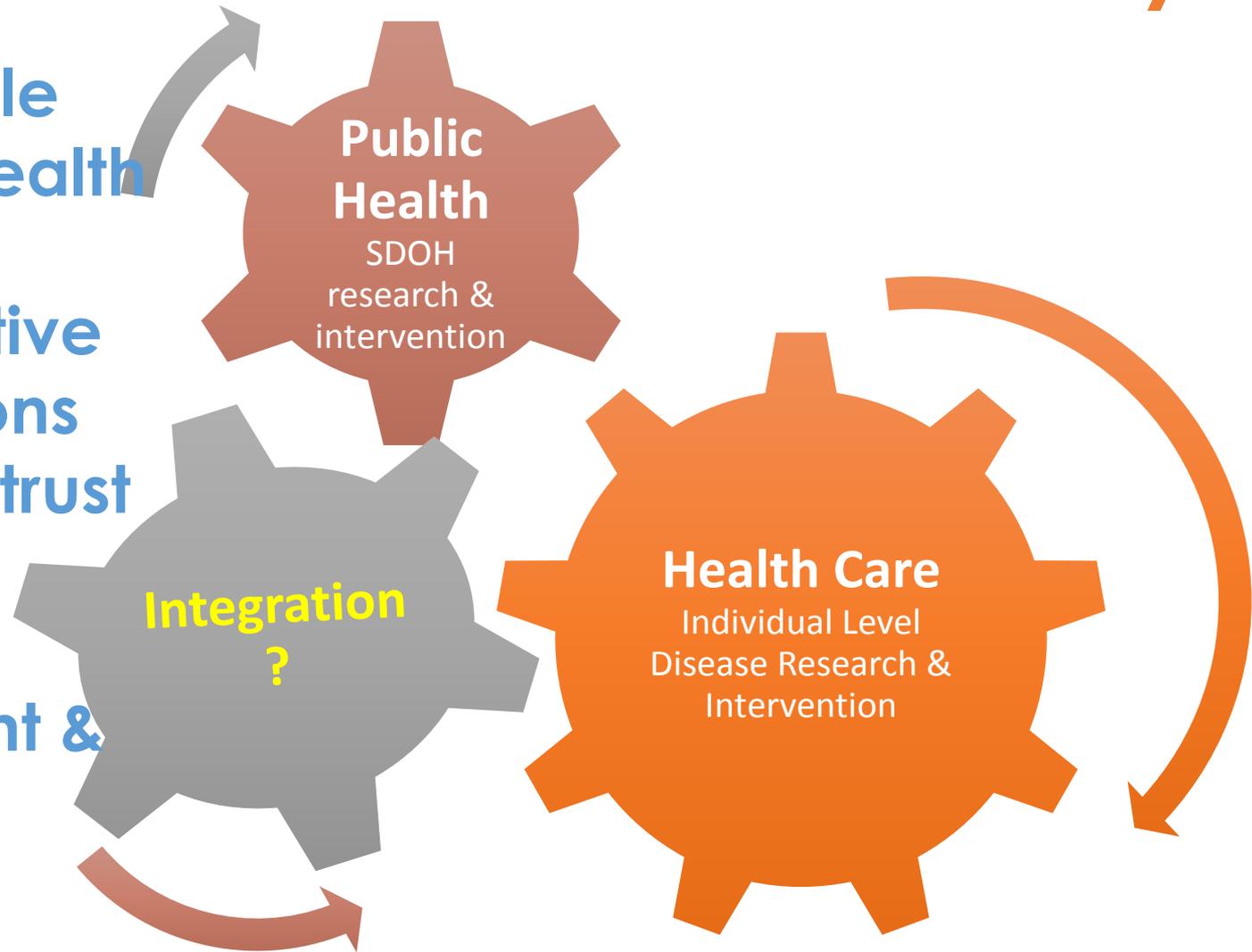
# Social factors contribute to 60% of premature death

Proportional Contribution to Premature Death

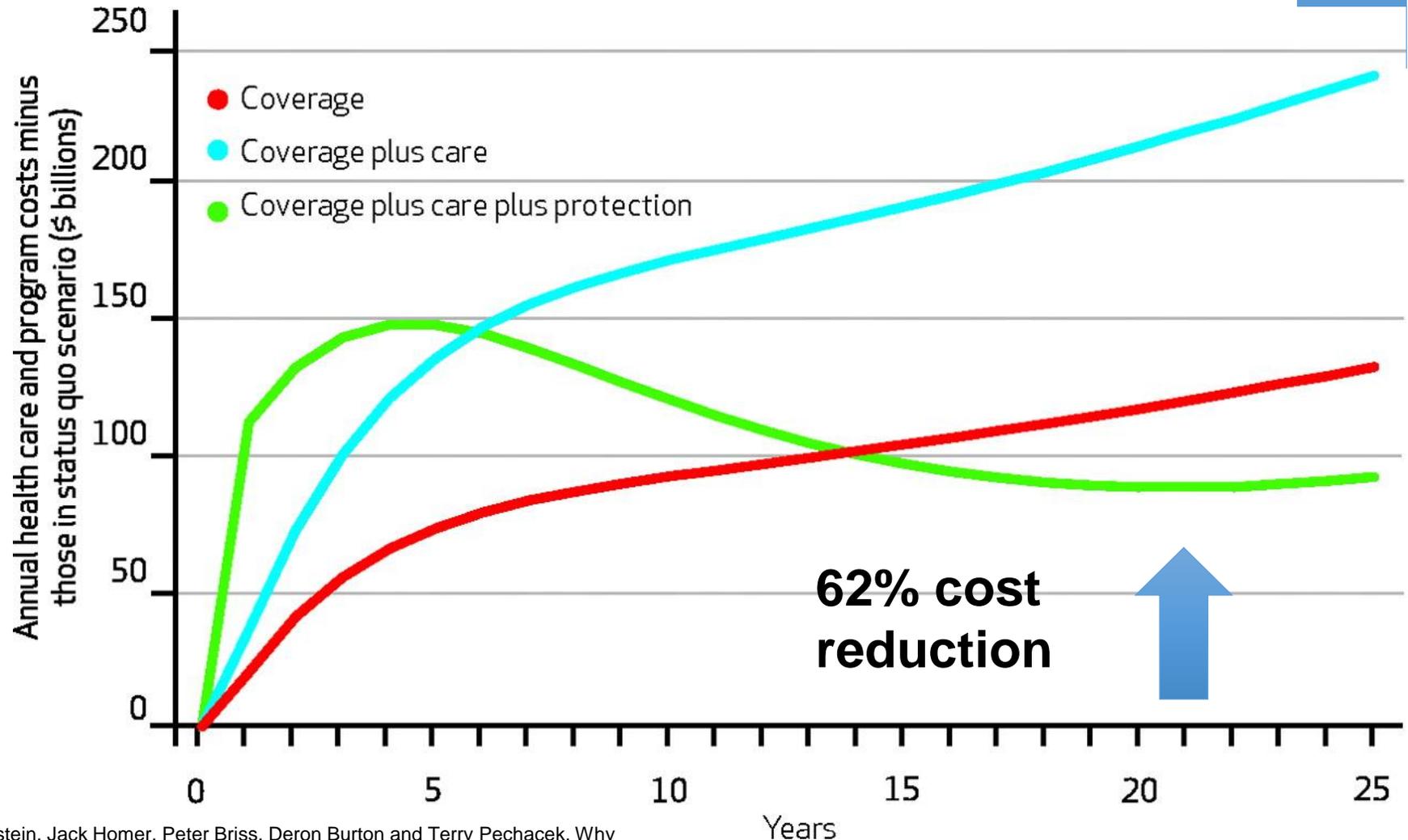


# Lack of social determinants integration in healthcare is costly

- Preventable illness & health disparities
- Less effective interventions
- Patient distrust
- Poor workforce recruitment & retention
- Wasteful spending



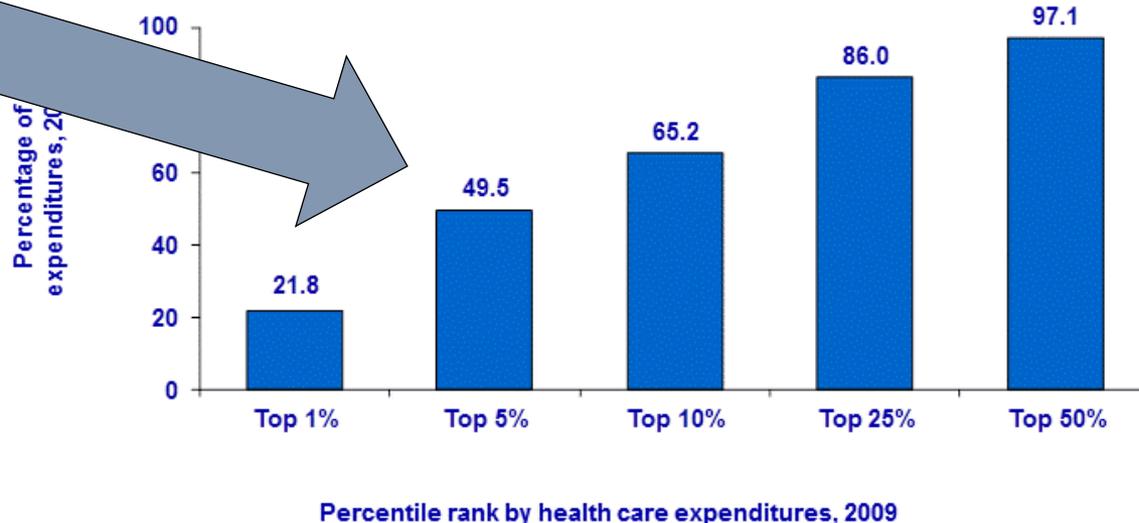
# The cost curve bends by improving care, coverage & social determinants



# High-utilizers: A sign and symptom of missed opportunities



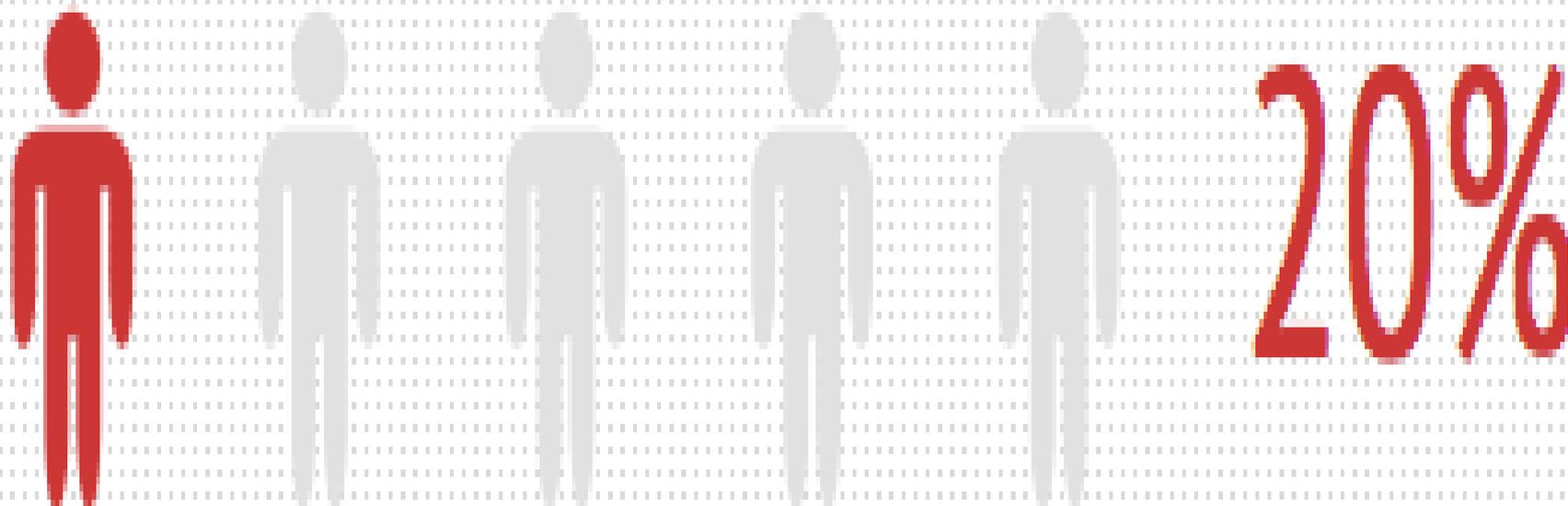
Figure 1. Concentration of health care expenditures, U.S. civilian noninstitutionalized population, 2009



Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey (HC-129), 2009

In 2009, 5% of the population accounted for nearly 50% of overall US health care spending

• Cohen, S. *The Concentration of Health Care Expenditures and Related Expenses for Costly Medical Conditions, 2009*. Statistical Brief #359. February 2012. Agency for Healthcare Research and Quality, Rockville, MD. [http://www.meps.ahrq.gov/mepsweb/data\\_files/publications/st359/stat359.shtml](http://www.meps.ahrq.gov/mepsweb/data_files/publications/st359/stat359.shtml)



U.S. doctors equipped to address patients' social needs

Robert Wood Johnson Foundation  
"Health Care's Blind Side" December 2011

*How do we move to  
the NEW way while  
getting paid for the  
OLD way?*

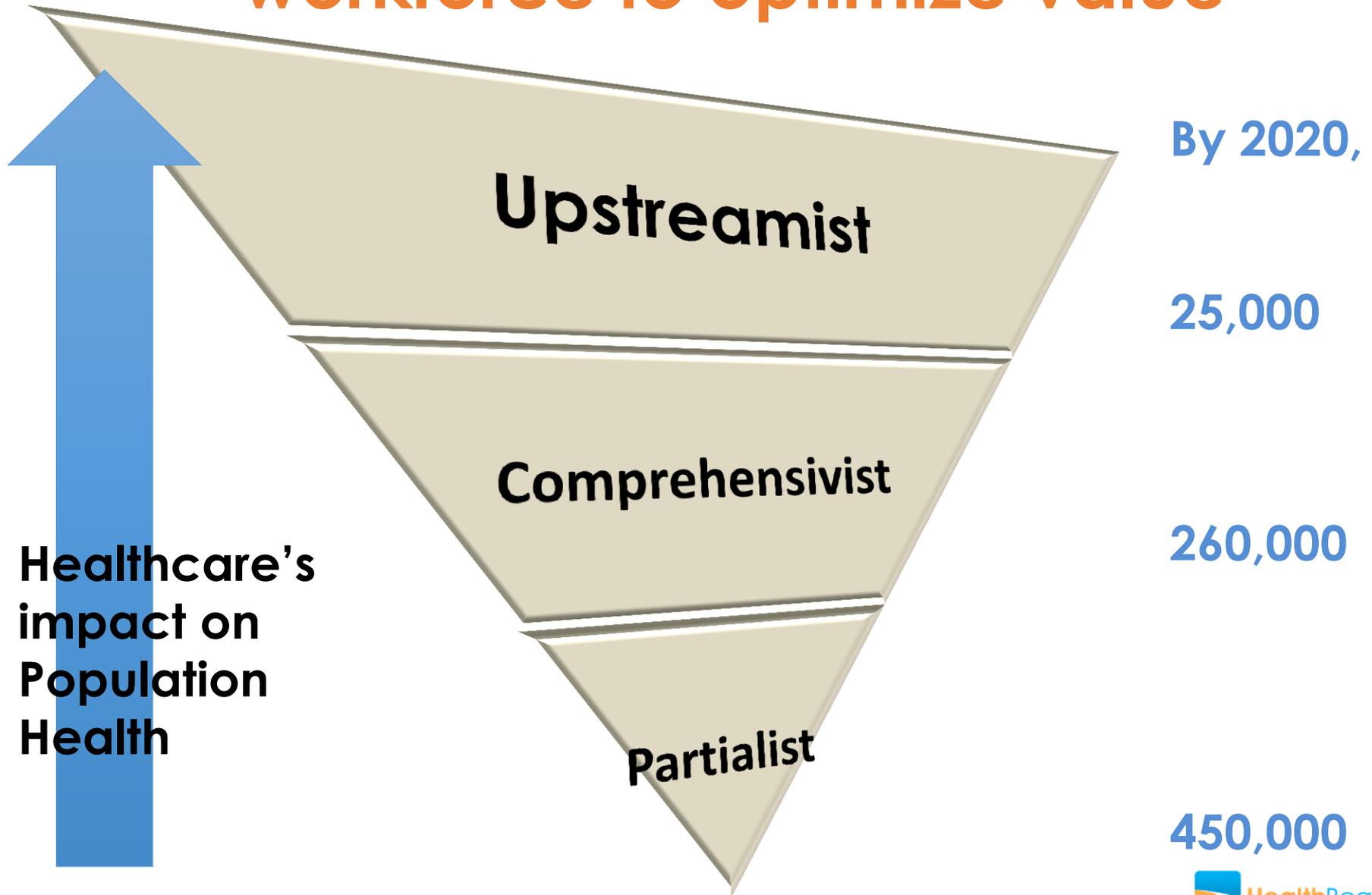


# Healthcare can be better but care teams and clinics need

- ❑ Redesign
- ❑ QI Training & Tools
- ❑ Incentives
- ❑ Actionable data
- ❑ Support networks &
- ❑ A sense of purpose to address the social determinants of health



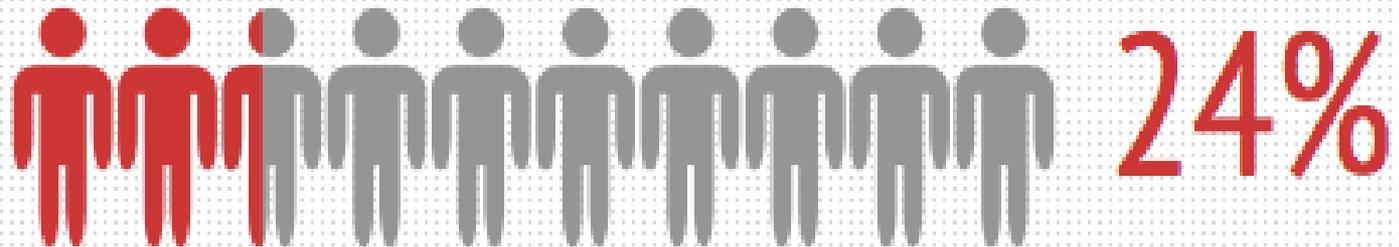
# Redesign the healthcare workforce to optimize value



# With fresh quality improvement approaches, providers can feel better about addressing upstream factors

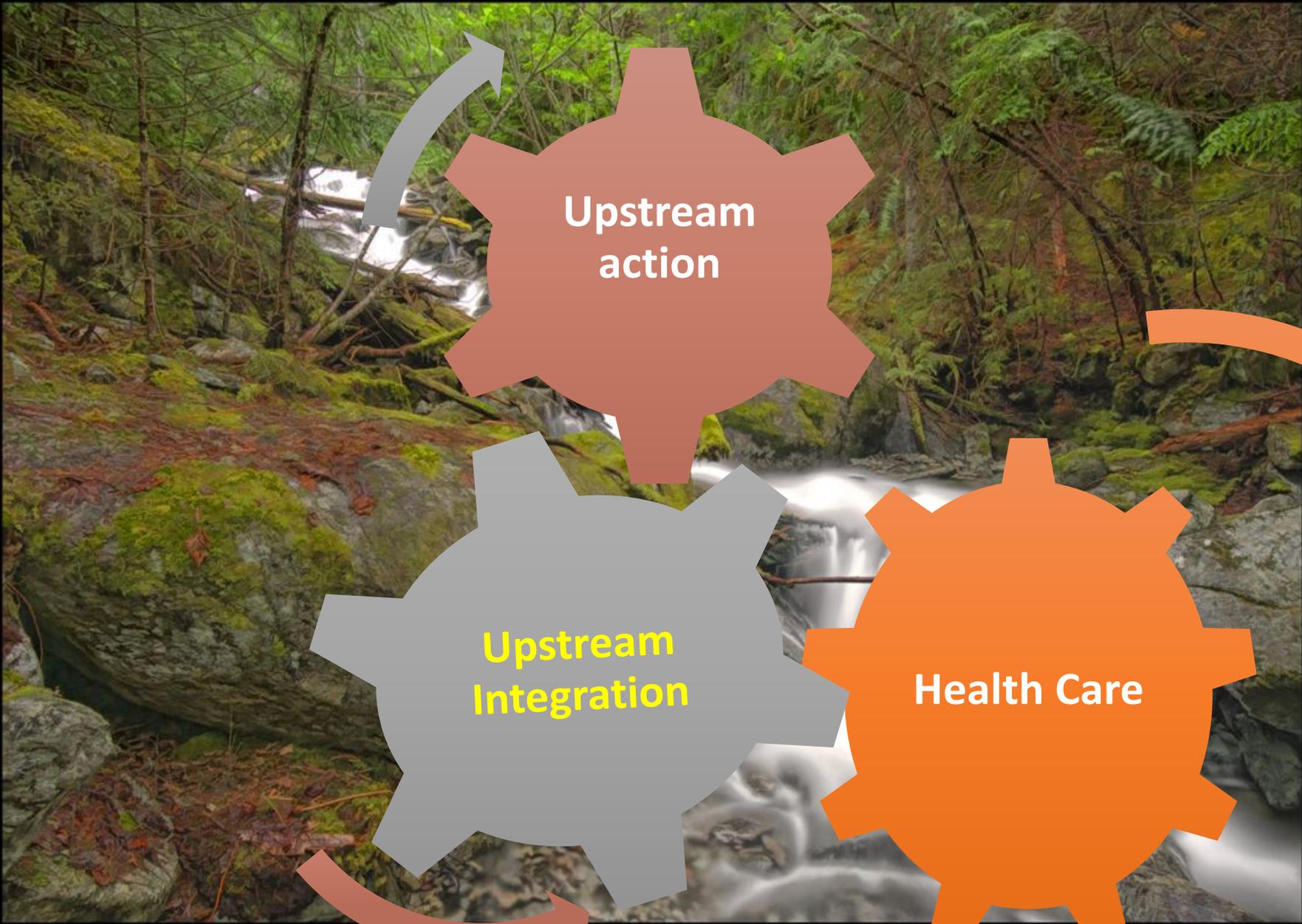
Provider confidence to address housing & other social needs (v1.0)

Baseline



After





**Upstream  
action**

**Upstream  
Integration**

**Health Care**

# Upstreamists

optimize healthcare, value, and happiness by systematically improving the ability of clinics to address upstream problems

# Quality Improvement for Upstream Healthcare

## HealthBegins.org

### 1. Mobilize

An online learning network over 800 members & growing

### 2. Equip

Workshops for Upstreamists  
Community Health Detailing

### 3. Design

Partner: Providers, Payers, AMCs, Clinics, Health Tech  
Identify and Create Opportunities

# Upstreamist Workshops: QI-based training for clinical upstream interventions



Linda Sharp @lindarella\_la · May 6

Workshop for upstreamists- Galveston, TX  
[@HealthBegins](#)

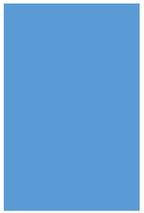


[View more photos and videos](#)

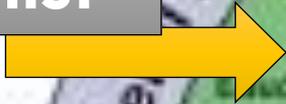
# Clinicians use 'Upstreamist Project Canvas' to develop QI solutions

<p><b>POPULATION</b> <u>List your target population</u></p> <p>1</p> <p>Reflect on Clinic and Community interests</p> <p><i>Whose needs are you not meeting to achieve the Triple Aim?</i></p>	<p><b>PROBLEM</b> <u>List the problems facing your target population.</u></p> <p>2</p> <p>Start with the health problem of interest.</p> <p>List upstream causes: <i>Proximate:</i> <i>Underlying:</i> <i>Principal:</i></p>	<p><b>UNIQUE VALUE PROPOSITION</b> <u>A single clear compelling message that turns an unaware person into an interested stakeholder.</u></p> <p>3</p> <p><i>"e.g. Project Healthy Homes: Removing Indoor Allergens to prevent costly COPD exacerbations among adult Medicaid Patients"</i></p>	<p><b>SOLUTION</b> <u>Outline a clinically-integrated solution for an addressable upstream cause</u></p> <p>4</p> <p><i>How will the clinic help?</i> Screen - Triage- Exam - Chart/Code - Educate - Refer - Follow-up-</p>	<p><b>KEY METRICS</b> <u>List key numbers that will tell you how well the upstream intervention is working.</u></p> <p>6</p> <p>Acquisition: Activation: Referral: Retention: Results:</p>
<p><b>EARLY ADOPTERS</b> Split broad population segments into smaller ones to hone in on target group.</p> <p><i>What do they do?</i> <i>What do they prefer?</i> <i>Where do they live, work, eat, learn or play?</i></p>	<p>Identify an <u>Addressable</u> upstream cause</p> <p><b>GOOB</b></p> <p><b>EXISTING ALTERNATIVES</b> How is the health problem currently addressed?</p> <p><i>How is the addressable upstream cause of that problem currently addressed?</i></p>	<p><b>MAKE YOUR UVP SMART</b> A single sentence that turns UVP into a SMART objective</p> <p>Specific – Measurable - Achievable - Relevant - Time-dated -</p>	<p><i>Does it have major potential?</i> <i>Is it feasible?</i></p> <p><b>CHANNELS</b> <u>How will you reach the target population?</u></p> <p>5</p> <p>Clinic Community</p>	<p><b>KEY PARTNERS</b> <u>List internal &amp; external stakeholders &amp; initiatives</u></p> <p>7</p> <p><i>Is an economic and/or business case helpful?</i></p>
<p><b>COST STRUCTURE</b> Estimate Total Costs, Fixed Costs (FC), &amp; Variable Costs (VC)</p> <p>8</p>		<p><b>BENEFIT/ REVENUES:</b> List potential funding. Estimate benefits of SMART objective (Step 3). e.g. individual health, clinic &amp; community benefits (costs avoided; added revenue; value created)</p> <p>9</p> <p>Consider Project Net Costs, Net Benefits, and Breakeven Point</p>		
<p><b>POPULATION</b></p>	<p><b>PROBLEM</b></p>	<p><b>UNIQUE VALUE PROPOSITION</b></p>	<p><b>SOLUTION</b></p>	<p><b>KEY METRICS</b></p>

# What's "addressable" in healthcare?



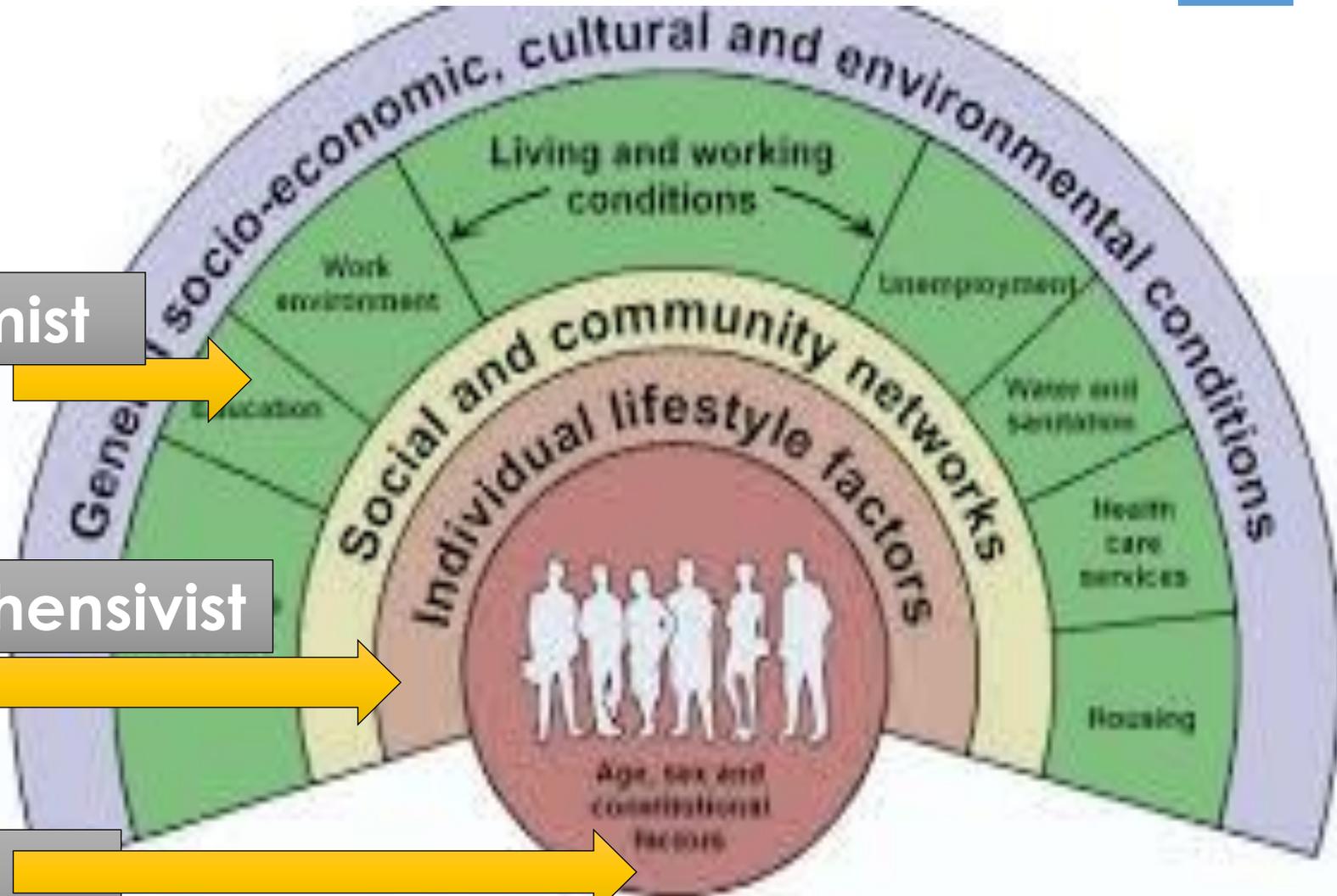
Upstreamist



Comprehensivist



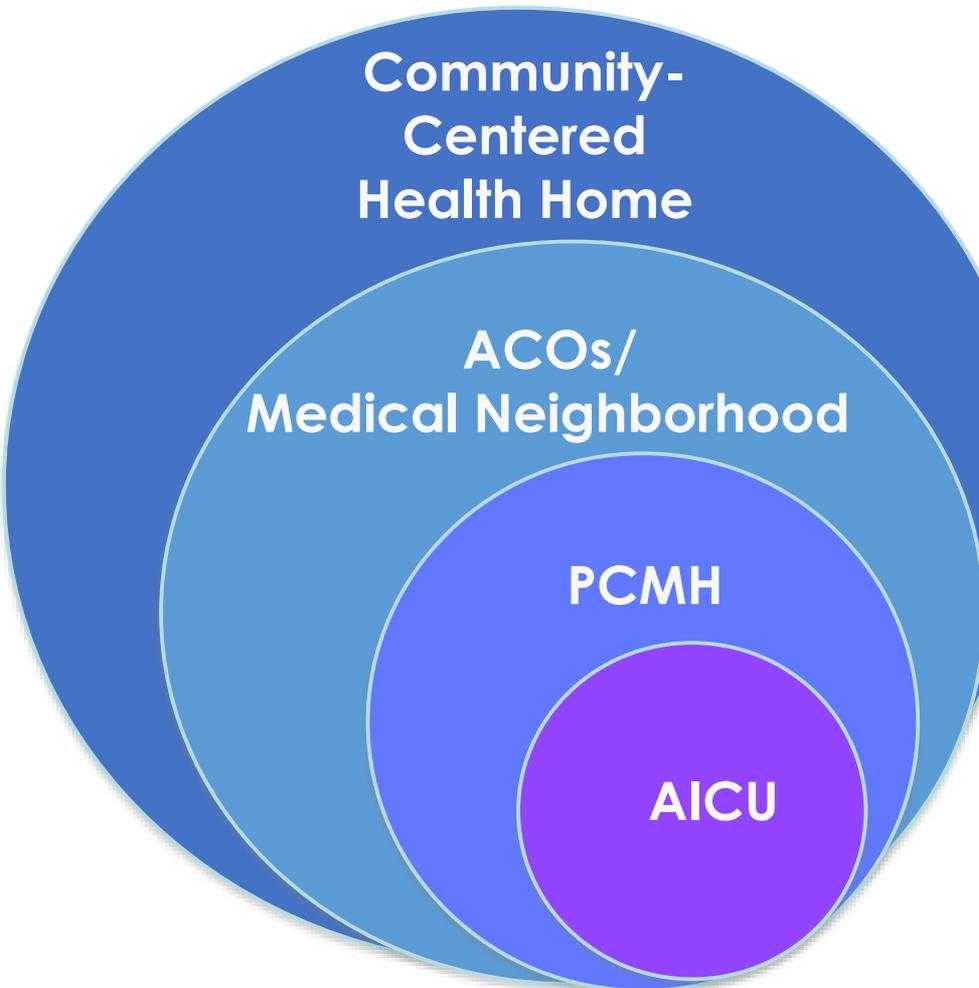
Partialist



# Current opportunities

- Managed Care Medicaid
- Complex Care Coordination
- High Utilizers
- ACOs
- Preventable hospitalizations for Ambulatory-Care Sensitive Conditions
- Public Hospitals, CHNA, and Community Benefits
- Community Health Teams
- Clinic-level redesign & learning

# Clinical opportunities to leverage upstream interventions and achieve the Triple Aim



## Community-Centered Health Home

- Clinic, public health, policy and community stakeholders coordinate to address upstream social and environmental conditions. **Upstream Rx** → Engage clinic staff and patients in data-driven advocacy

## Accountable Care Organizations (ACOs)/ Medical Neighborhood

- Clinical “neighbors” share costs and/or savings to coordinate care for a population. **Upstream Rx** → Include social service providers in ACOs.

## Patient-Centered Medical Home (PCMH)

- Clinic primary care redesign to improve access, continuity, and coordination. **Upstream Rx** → Use QI framework to integrate upstream data and interventions in redesign

## Ambulatory Intensive Caring Unit (AICU)

- Intensive multidisciplinary outpatient care management for complex, high-utilizer patients. **Upstream Rx** → Use QI framework to integrate upstream data and interventions in redesign

# Vermont's Community Health Teams are part of the PCMH



# PCMH 2014 is a big opportunity for upstream integration

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

## Individual Factors

### Sociodemographic

- Sexual orientation
- Race/ethnicity
- Country of origin/U.S. born or non-U.S. born
- Education
- Employment
- Financial resource strain: Food and housing insecurity

### Psychological

- Health literacy
- Stress
- Negative mood and affect: Depression and anxiety
- Psychological assets: Conscientiousness, patient engagement/activation, optimism, and self efficacy

### Behavioral

- Dietary patterns
- Physical activity
- Nicotine use and exposure
- Alcohol use

## Individual-Level Social Relationships and Living Conditions

- Social connections and social isolation
- Exposure to violence

## Neighborhoods/Communities

- Geocodable domains: Socioeconomic and race/ethnic characteristics

# Recommended Approach to Social Domains in EMRs

Customized  
Community  
domains

Core domains

System Redesign

UPSTREAM TOOLS	Screen	Find Resource	Referral Manage	EMR Integration	Community/ Patient Participation
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<b>SAAS</b>					
• Healthify	+	+	+	#	
• Health Leads	+	+	+	#	
• Help Steps	+	+			
• Purple Binder		+	+		
• Aunt Bertha/ OneDegree		+			
• Community Detailing- HB		+			+
• HealthRX		+	+/-		+
<b>Enterprise – Built</b>	+	+	+	+	+/-
<b>County / Other</b>		+			

# “Community Health Detailing”

- 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

Trained over 100 high school 'detailers'  
"Yelp for Health" tool now at UCLA



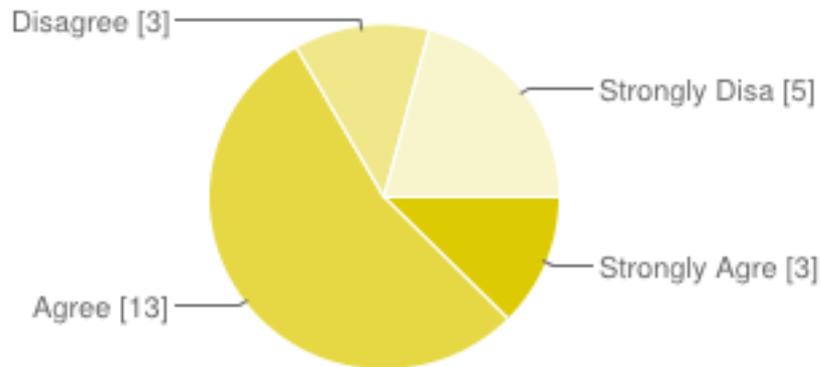
Mapping



Detailing

# Learners: increased self-efficacy to address social needs and improve healthcare

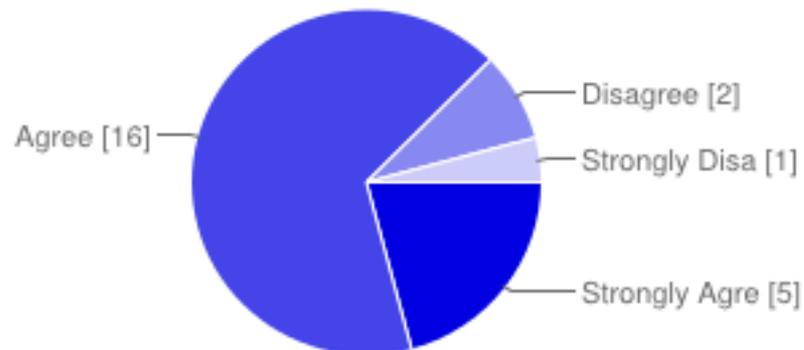
I am confident that I could help clinics to take better care of patients with social needs



Strongly Agree	3	13%
Agree	13	54%
Disagree	3	13%
Strongly Disagree	5	21%



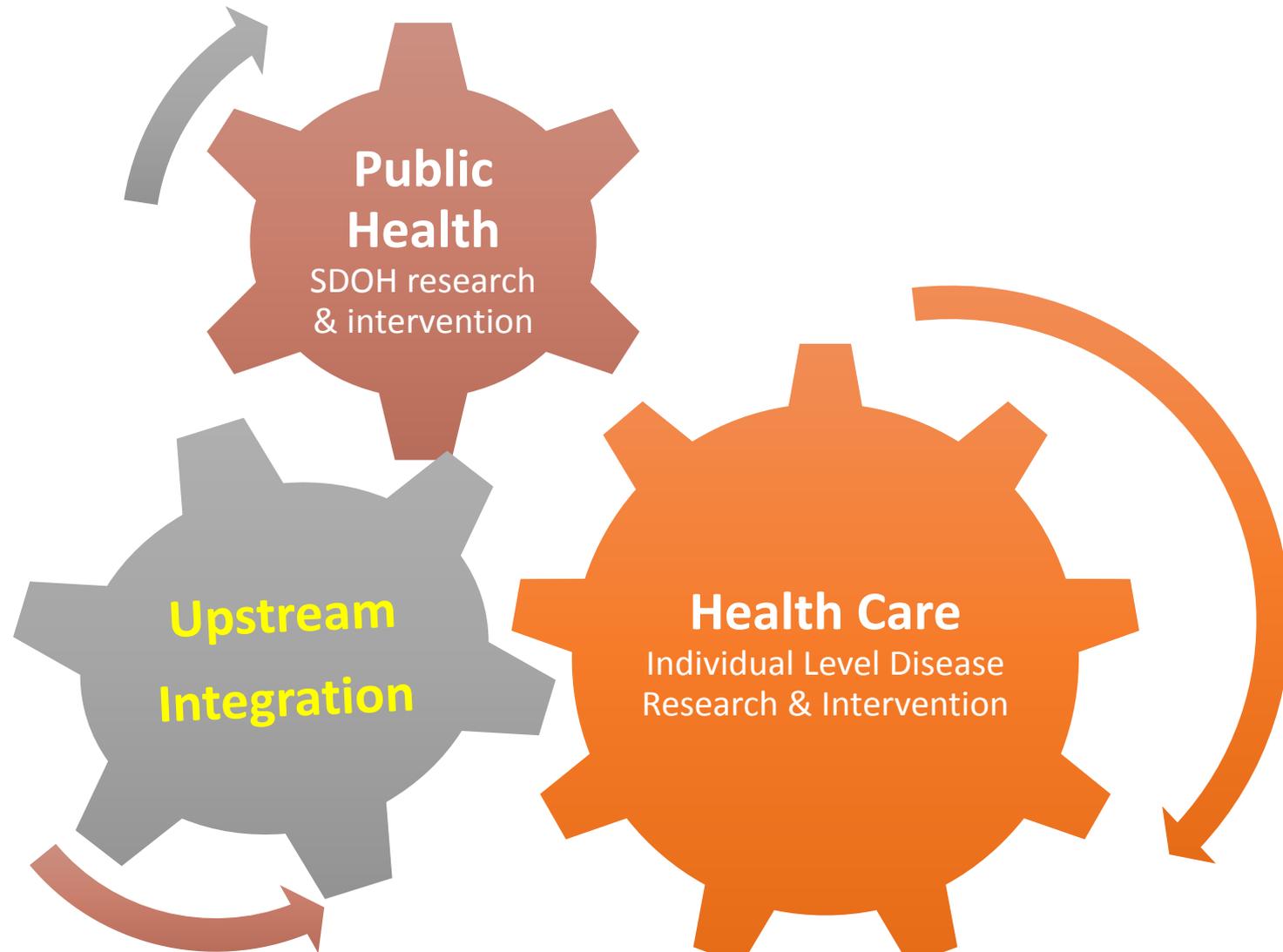
I am confident that I could find the best services to help someone if he or she had a social need that wasn't being dealt with



Strongly Agree	5	21%
Agree	16	67%
Disagree	2	8%
Strongly Disagree	1	4%



# Advance Triple Aim by supporting “Upstreamist” approaches in healthcare



**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**

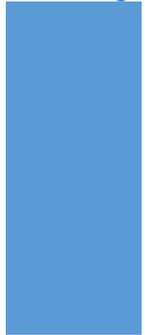
**We can't get health care right without addressing social determinants of health**

# Better Care and Better Value are possible



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# Quality Improvement for Upstream Healthcare



[HealthBegins.org](http://HealthBegins.org)