2015 Hospital Quality Institute Conference

California's Preeminent Quality and Patient Safety Conference

11:00 a.m. – 12:00 p.m.

Upstream of Respect and Reliability in Care

Rishi Manchanda, MD, MPH
Health Begins

Introduced by:

Joe Wilkins
CHA Board of Trustees

Boris Kalanj, MSW
Hospital Quality Institute

Hospital Quality Institute
Leadership in quality and patient safety

The speaker for this session has no conflict to disclose.

Is your healthcare system upstream ready?

Rishi Manchanda MD MPH

@RishiManchanda

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1) What upstream problems impact your patients' health?

2) What are you already doing to address social determinants? Is that work strategic and structured?

3) How confident are you in your hospital's ability to impact upstream problems affecting your patients' health and the health of your system?

Screening for Food Insecurity

1. Within the past 12 mo, we worried whether our food would run out before we got money to buy more. (Yes or No)
2. Within the past 12 mo, the food we bought just didn't last and we didn't have money to get more. (Yes or No)

Adapted from Hager et al.[35] Although an affirmative response to both questions increases the likelihood of food insecurity existing in the household, an affirmative response to only 1 question is often an indication of food insecurity and should prompt additional questioning.

Compared with higher-income diabetics, lower-income diabetic adults have a 27% higher rate of hospital admissions due to end-of-the month food insecurity

Health Affairs

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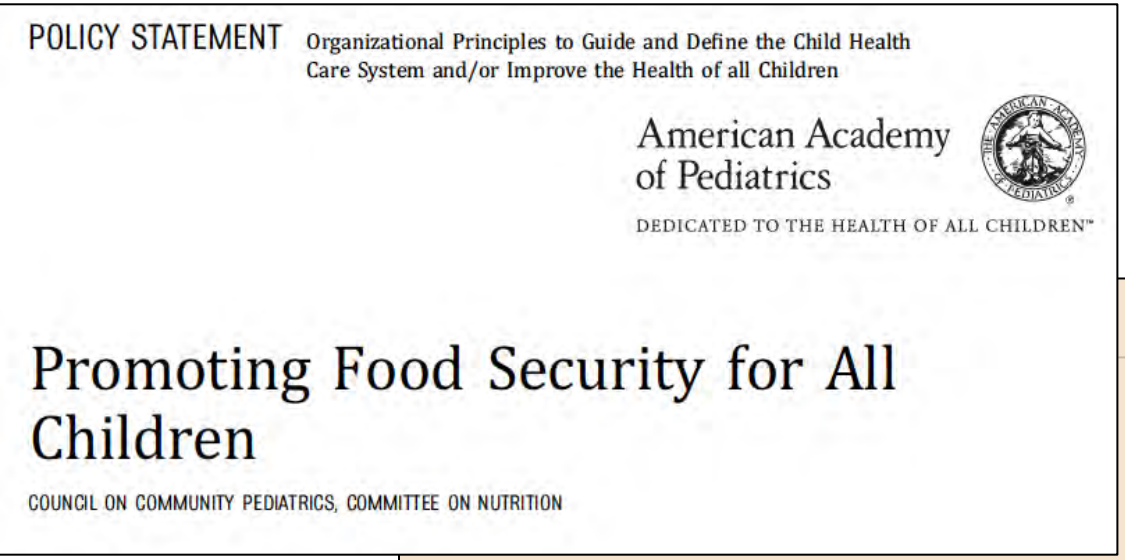
Expand

Exhaustion Of Food Budgets At Month's End And Hospital Admissions For Hypoglycemia

Hilary K. Seligman[1,*], Ann F. Bolger[2], David Guzman[3], Andrea López[4] and Kirsten Bibbins-Domingo[5]

In 2013, 1 in 5 children lived in a home that met the US Department of Agriculture (USDA) definition of a food-insecure household.



POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Promoting Food Security for All Children

COUNCIL ON COMMUNITY PEDIATRICS, COMMITTEE ON NUTRITION

October 2015: The AAP enters the fight against hunger

The New York Times

HEALTH

Pediatricians Are Asked to Join Fight Against Childhood Hunger

By CATHERINE SAINT LOUIS OCT. 23, 2015

Galloping inequality:

Average family wealth (savings, home, car, property)

Federal Reserve Survey of Consumer Finances

	1983	2013
Bottom 10% of families	$702	- $2,050 (debt)
Families at middle of income distribution	$80,000	$80,000
Top 10% of families	$3 million	$8 million

Total household debt (credit cards, student loans, home, car)$11.85 trillion and climbing

Courtesy of Tom Bodenheimer

The health system may worsen societal inequality

Patient-level inequality

- Poorest quintile of households spends 20% of income on health care; highest quintile spends 3% [Bodenheimer & Grumbach, Understanding Health Policy, 7th edition, 2016]
- Disparities between higher and lower income (often minority) populations are rampant in health care

System-level inequality

- Primary care grossly under-resourced compared to specialty/hospital care, insurers and pharma
- Our nation is an outlier...Healthcare spending dwarfs spending in other social services

Courtesy of Tom Bodenheimer

The problem: Our healthcare system doesn't know how to help

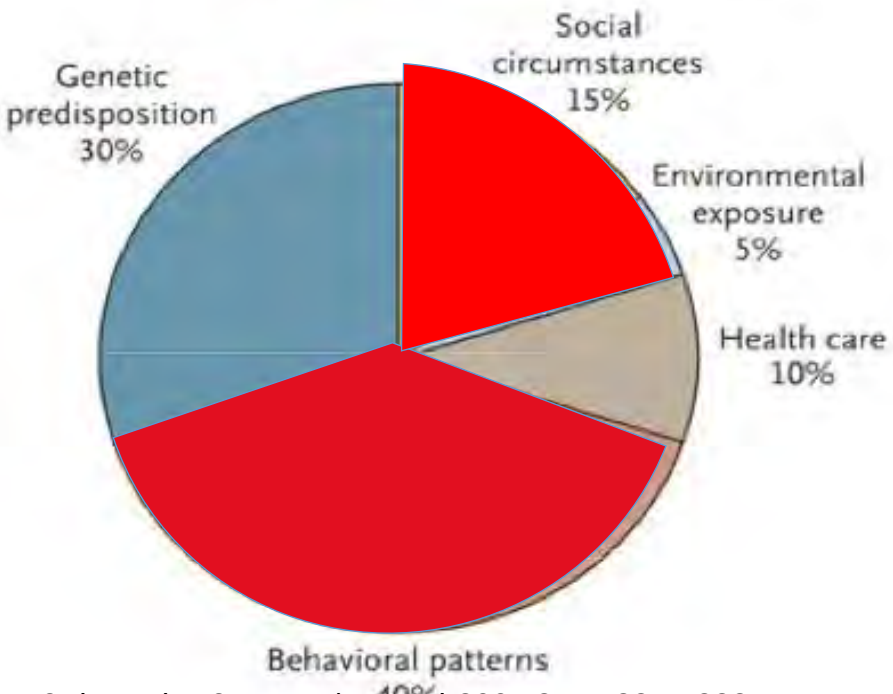
"I'm a primary care pediatrician in [a rural county]. Highest teen preg rate, meth addiction, high school drop out rate... Many more issues.

Understand upstream approach for years. Try my best but falls by the wayside as I don't have rescources - No help, city/ county overwhelmed.

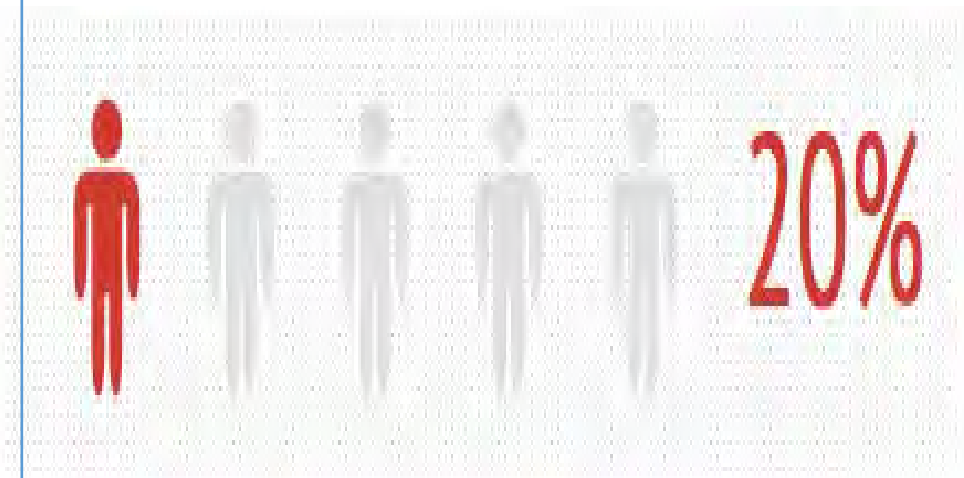
Patients lost to follow up- I'm seeing over 30 a day. How to manage? Would like to discuss."

Social factors account for 60% of premature death & impact the Quadruple Aim

Proportional Contribution to Premature Death



Schroeder S. N Engl J Med 2007;357:1221-1228



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

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

But only 1 in 5 MDs have confidence to address them

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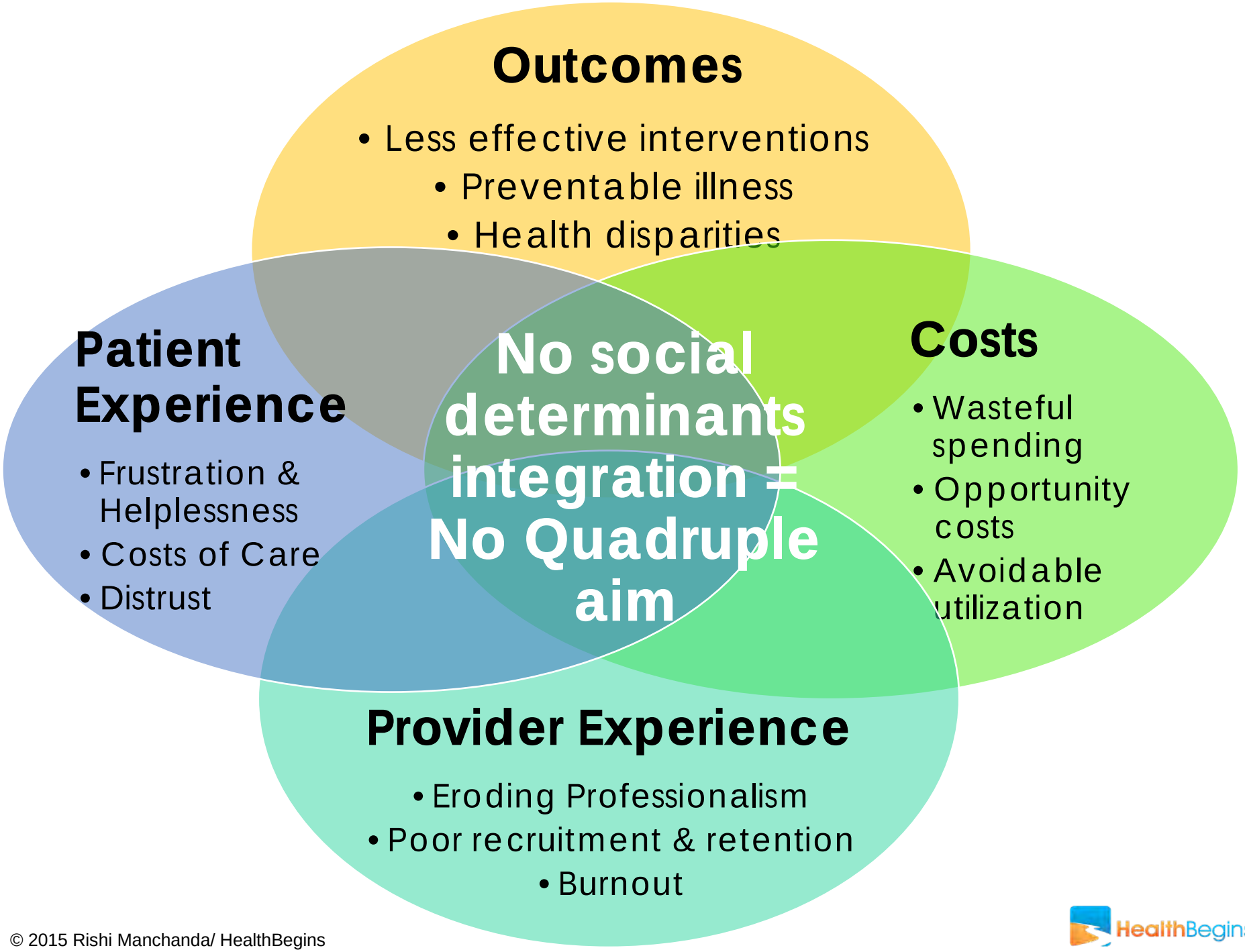

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A new story of us

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1) Get Ready

Assess the maturity of your clinic processes & environment to address social determinants of health (Self-Assessment)

2) Get Set

Engage colleagues, key stakeholders, and community partners to plan (Staff & stakeholders)

3) Go Upstream

Launch targeted initiatives using 'Upstream Quality Improvement' (Systems/Process Design)

Implement robust tools/best practices to address patients' social needs & connect to resources (Solutions)

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Get Ready
& Get Set

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Upstream Readiness Assessment for healthcare (Manchanda 2015)

	Limited or unclear	Moderate	Robust
1. Favorable environment (social norms/external incentives/regulations/state contracts/community partners)			
2. Perceived alignment & value of change among stakeholders			
3.Executive sponsorship			
4.Team roles/project ownership			
5. Scope (Population/Geography and/or Number of SDOH addressed)			
6. SDoH program design components (including Evaluation and defined Metrics of success)			
7.SDoH Integration in clinical services & workflows			
8.Continuous performance/ quality improvement processes			
9.Dedicated infrastructure (including Information Systems and Human Resources)			
10. SDoH financing			
Total			

Step 2: What's the perceived value of a change that would better address social determinants of health?

Limited or unclear	Moderate	Robust
A loosely organized group and/or a limited number (up to 1/3) of organizational members think that improving the ability to assess and address social determinants of health is needed, important, beneficial, or worthwhile.	One or more individuals or organized groups with influence and/or a sizeable number of organizational members (up to 2/3) think that improving the ability to assess and address social determinants of health is needed, important, beneficial, or worthwhile.	One or more individuals or well organized groups with influence, and/or a overwhelming number of organizational members (more than 2/3) think that improving the ability to assess and address social determinants of health is needed, important, beneficial, or worthwhile.

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Step 3: Do you have executive sponsorship to advance social determinants interventions?

Limited or unclear	Moderate	Robust
Senior executive leadership recognizes need to address and integrate social determinants of health but has limited understanding of potential performance impacts and of processes to integrate social determinants in business workflows Leadership of social determinants programs is in middle management ranks. Senior leadership provides endorsement but has not defined clear performance goals. Resources are hard to procure and roadblocks are hard to clear.	At least one senior executive deeply understands the concept of social determinants and healthcare integration and how that integration can improve performance. A senior executive has taken clear leadership over, and responsibility for, social determinants integration. A senior executive works with specific middle managers and/or frontline staff and is prepared to commit resources, make changes, and remove roadblocks for social determinants integration	There is strong alignment among senior executives and middle managers regarding the importance of social determinants integration in healthcare. A network of executives and managers from different departments and business lines help to promote social determinants integration. A team of senior executives are actively engaged in social determinants integration and manage the integration process through vision, influence, and clear lines of delegated authority to managers and staff.

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Step 4: Team Roles and Ownership of Social Determinants Integration

Limited or unclear	Moderate	Robust
The owner for social determinants of health processes is an individual or group informally charged with improving social determinants for patients and communities. The owner group or individual can lobby and encourage managers and frontline workers to improve processes that address social determinants of health.	A senior manager or group occupies an official role created by executive leadership to advance projects related to social determinants of health and healthcare integration. The owner has some control over IT, personnel, evaluation, and specific program budgets and has some authority to convene a team to improve social determinants of health processes.	A senior manager or group owner directing the social determinants work belongs or has direct access to the organization's senior-most decision-making body. The owner is supported by a team of senior executives and network of managers across departments, and has direct control over budget and personnel choices.

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Get Set:

Who are your key partners and stakeholders?

Use the results of your CHNA and readiness assessment to reflect and focus

Who are your upstreamists?

Whose job will it be to implement your upstream solution?

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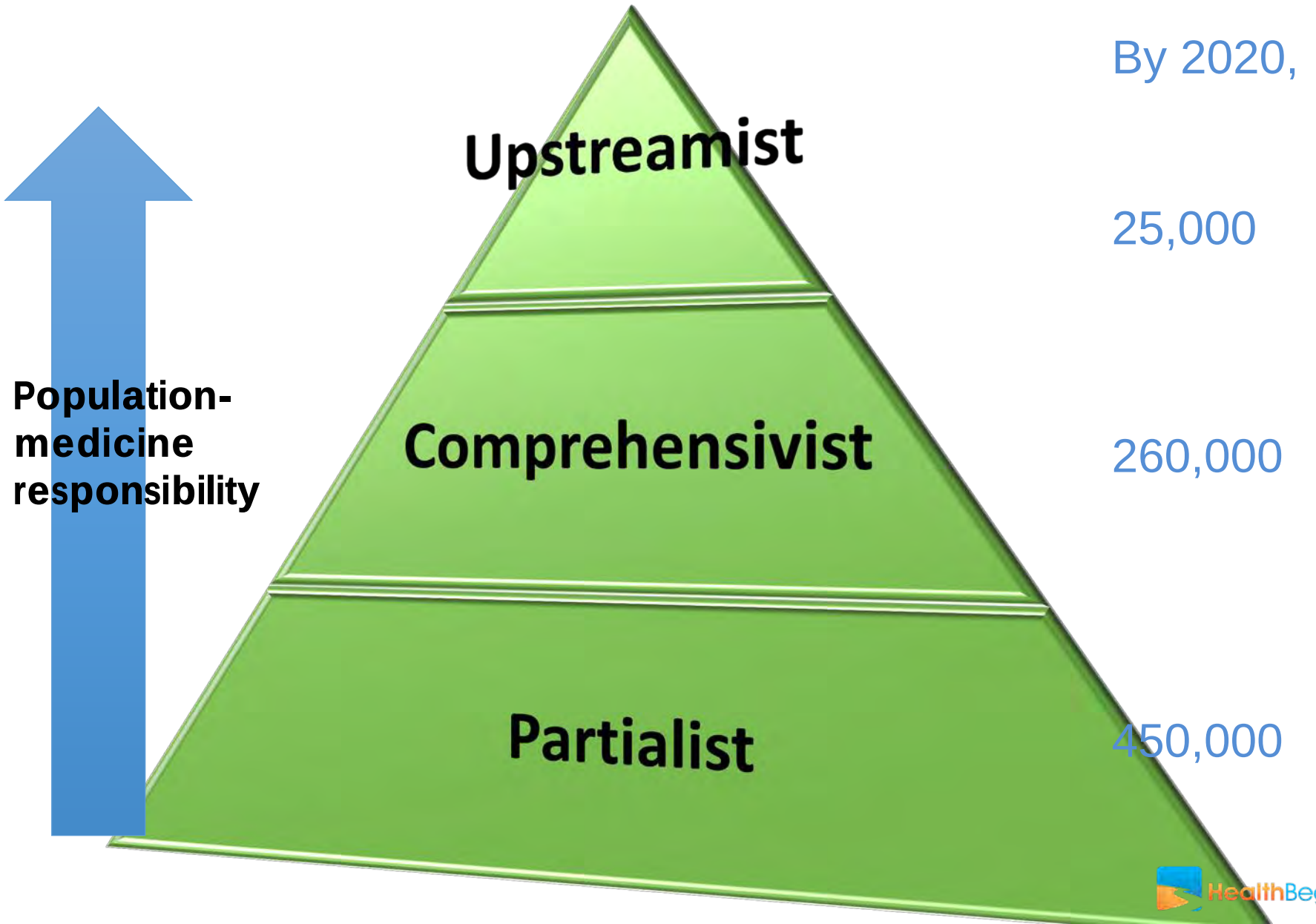
A workforce model for US healthcare



Go Upstream using QI

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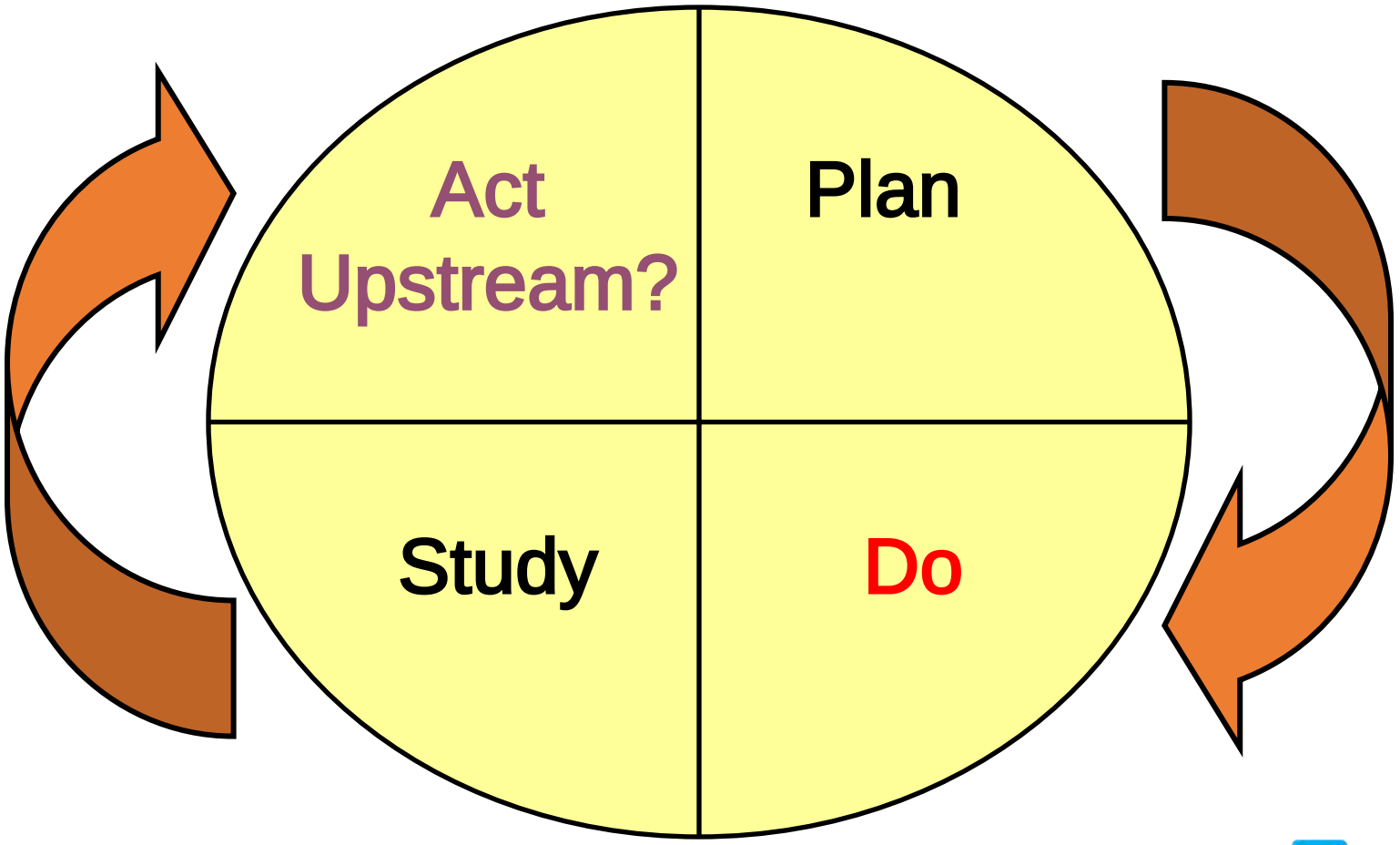
How many healthcare Plan-Do-Study-Act cycles (PDSAs) address social factors?



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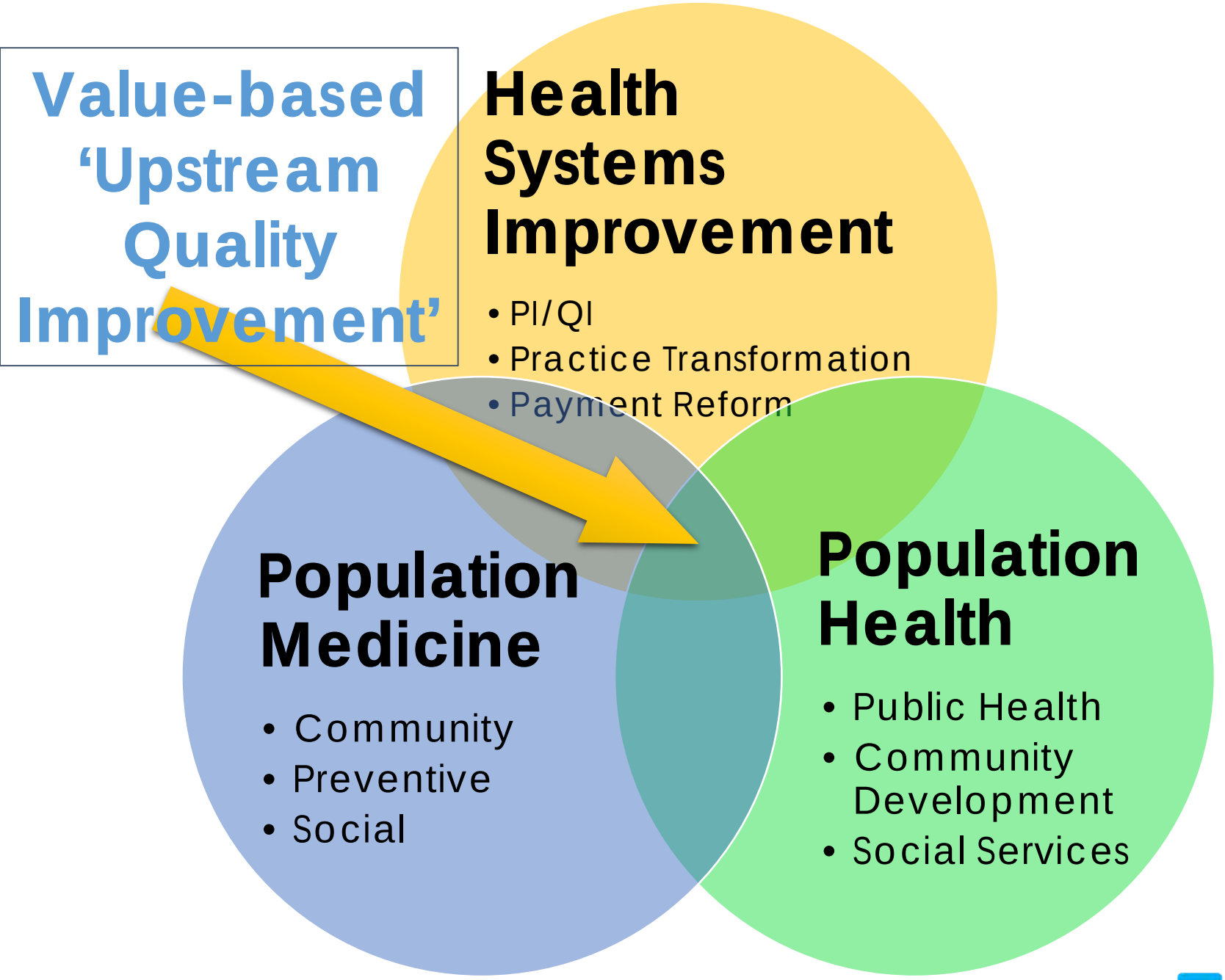

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Plant your flag

"FoodRx: A campaign to end hunger and improve outcomes among our patients"

- Improve Screening of Food Insecurity by 30% within 6 months

- Improve Provider Confidence & Patient Satisfaction to address Food Insecurity by 30% within 6 months

- Reduce Hospital Readmissions related among Food-Insecure patients by 30% within 18 months

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Pick a starting point: Upstream QI matrix

Example: Diabetes & Food insecurity (R. Manchanda 2014)

	Patient-Level	Health Care Organization Population-Level	General Population-Level
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 families at risk for DM	Advocate for local increase in minimum wage and supports for low-income families, particularly those at risk of DM
Secondary Prevention	Poverty screening & financial assistance for DM patients at-risk of end-of-month hypoglycemia	Subsidize vouchers to local Farmer's Market or hire a financial counselor for low-income DM patients	Change timing and content WIC & school food programs to avoid food insecurity among DM
Tertiary Prevention	Reduce ED use among high-utilizer severe diabetics using food and income support referrals	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

An 'QI Project Canvas' to develop upstream interventions

POPULATION

Identify your target population

1

Reflect on Clinic and Community interests

Whose needs are you not meeting to achieve the Triple Aim?

EARLY ADOPTERS

Split broad population segments into smaller ones to hone in on target group. Review "Bridges to Health" approach.

What do they do?
What do they prefer?
Where do they live, work, eat, learn or play?

PROBLEM

List the problems facing your target population. Then identify an Addressable upstream cause

3

Start with the health problem of interest.

List upstream causes:
Proximate:
Underlying:
Principal:
Addressable:

EXISTING ALTERNATIVES

How is the health problem currently addressed?

How is the addressable upstream cause of that problem currently addressed by and for patients?

GOOB

UPSTREAM VALUE PROPOSITION (UVP)

A single clear compelling upstream-aligned message that turns an unaware person into an interested stakeholder.

4

"e.g. Project Healthy Home: We remove Indoor Allergens to prevent costly upper respiratory illnesses among adult Medicaid patients who frequently visit the emergency department"

MAKE YOUR UVP SMART

A single sentence that turns UVP into a SMART objective

Specific –
Measurable -
Achievable –
Relevant –
Time-dated -

UPSTREAM QI SOLUTION

Outline a clinically-integrated, QI-based solution for the addressable upstream cause

5

How will the clinic help?
Screen for upstream cause–
Triage–
Exam -
Chart/Code -
Educate -
Refer -
Follow-up-

Does it have major potential?
Is it feasible?

KEY PARTNERS

List internal & external stakeholders & initiatives

7

Is an economic and/or business case helpful?

CHANNELS

How will you reach the target population?

6

Clinic

Community

KEY METRICS

List key numbers that will tell you how well the upstream intervention is working.

8

TEAM Who needs to be on your Upstream QI team? Revisit Step 1

2

Within healthcare system?
Within community-based organization(s)?
[illegible] what type of power can they leverage?

FINANCING: Estimate Annual Cost/Benefits 9

A) Estimate Total Annual Project Costs (Fixed & Variable)
B) Estimate multi-level benefits of SMART objective (Step 4) in terms of a) costs avoided; b) added revenue; c) value created.
C) List funding sources. Consider Net Costs, Benefits, and [illegible]

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Upstream QI Project Workflow	Care Team Member	Role/ Process	Tools/Data Sources	Metric
Screen				
Triage				
Exam				
Chart/Code				
Refer				
Follow-up				

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

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Upstream Risks Screening Tool

"Everyone deserves the opportunity to have a safe, healthy place to live, work, eat, sleep, learn and play. Problems or stress in these areas can affect health. We ask our patients about these issues because we may be able to help."

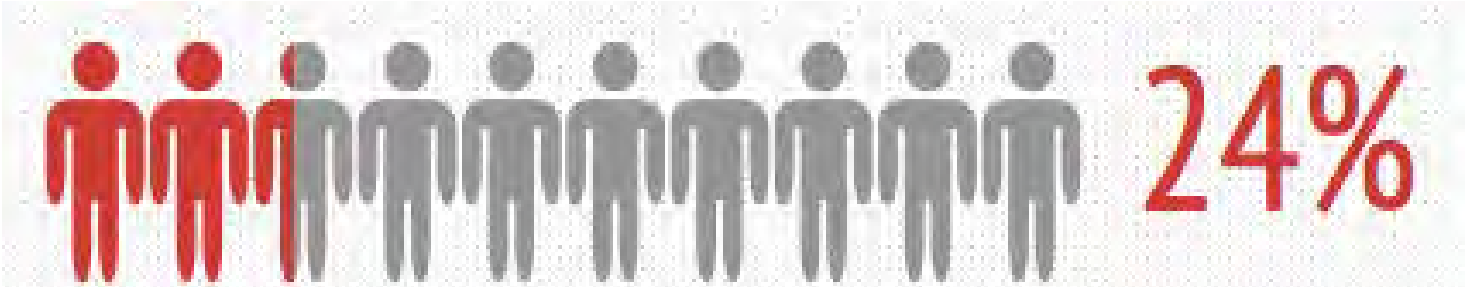
Question	Response	For Staff only: Review	Referral Plan Complete?
What's your name?	_____ _____ First Last		
What's your date of birth?	____ / ____ / _____ Day Month Year		
1a. What is the highest level of school you have completed? Check one.	☐ Elementary School ☐ High School ☐ College ☐ Graduate / Professional School		
1b. What is the highest degree you earned? Check one.	☐ High school diploma ☐ GED ☐ Vocational certificate (post high school or GED) ☐ Associate's degree (junior college) ☐ Bachelor's degree ☐ Master's degree ☐ Doctorate		☐
1c. Are you concerned about your child's learning, performance, or behavior in school?	☐ YES ☐ NO ☐ Not applicable		☐
2. Choose one of the following. Which best describes your current occupation?	☐ Homemaker, not working outside the home ☐ Employed (or self-employed) full time ☐ Employed (or self-employed) part time ☐ Employed, but on leave for health reasons ☐ Employed but temporarily away from my job (other than health reasons)		☐

Manchanda, Rishi and Gottlieb, Laura (2015). Upstream Risks Screening Tool and Guide V2.6. HealthBegins; Los Angeles, CA.

*Several domains have been adapted from (Institute of Medicine). 2014. Capturing social and behavioral domains and measures in electronic health records: Phase 2. Washington, DC: The National Academies Press

With ‘upstream’ quality improvement, we can create community-integrated healthcare systems that make sense

Baseline



After 11 months

Healthcare provider confidence to address housing & other social needs

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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

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Questions?

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Thank you!

Rishi Manchanda, MD, MPH
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