



# Upstreamists & School Based Health Centers:

*California School Based  
Health Centers Association  
March 7, 2014*

*Rishi Manchanda MD MPH*

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 Care?

Veronica went to a clinic that asked her routine questions about housing-related risk factors, identified her problem and developed a treatment plan.



Veronica  
and her home  
got better.

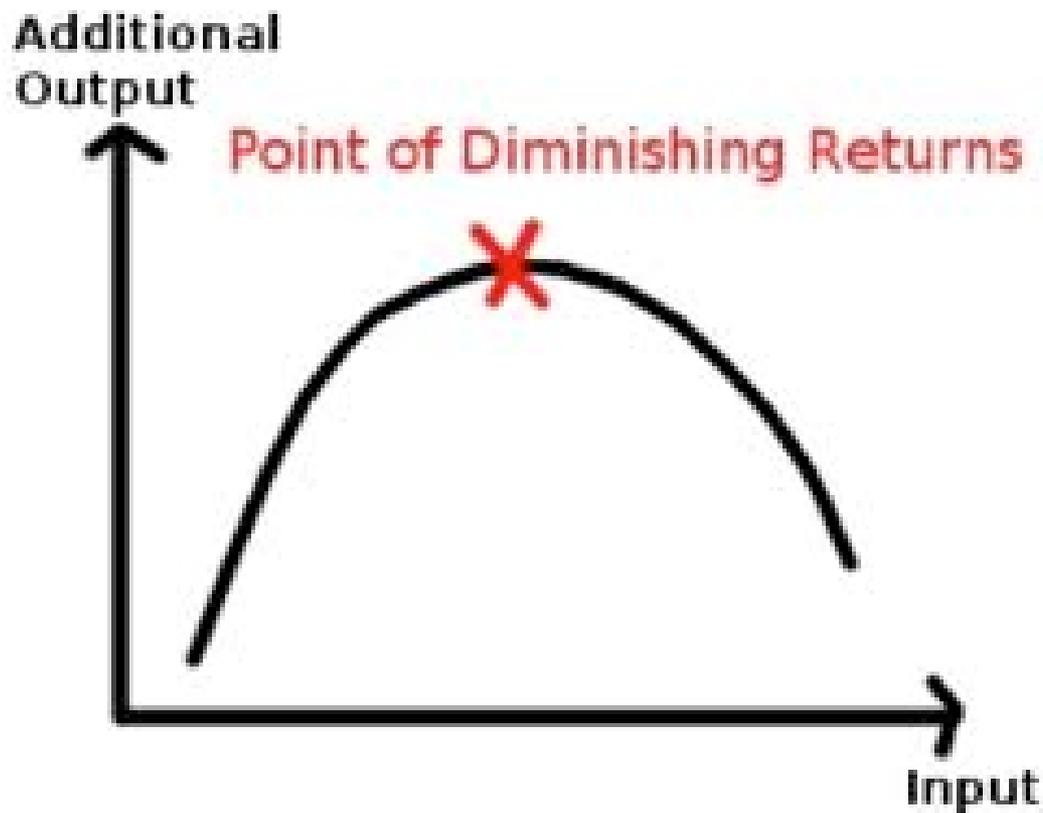
# Better Care



At the intersection of medicine  
and the social determinants of  
health,

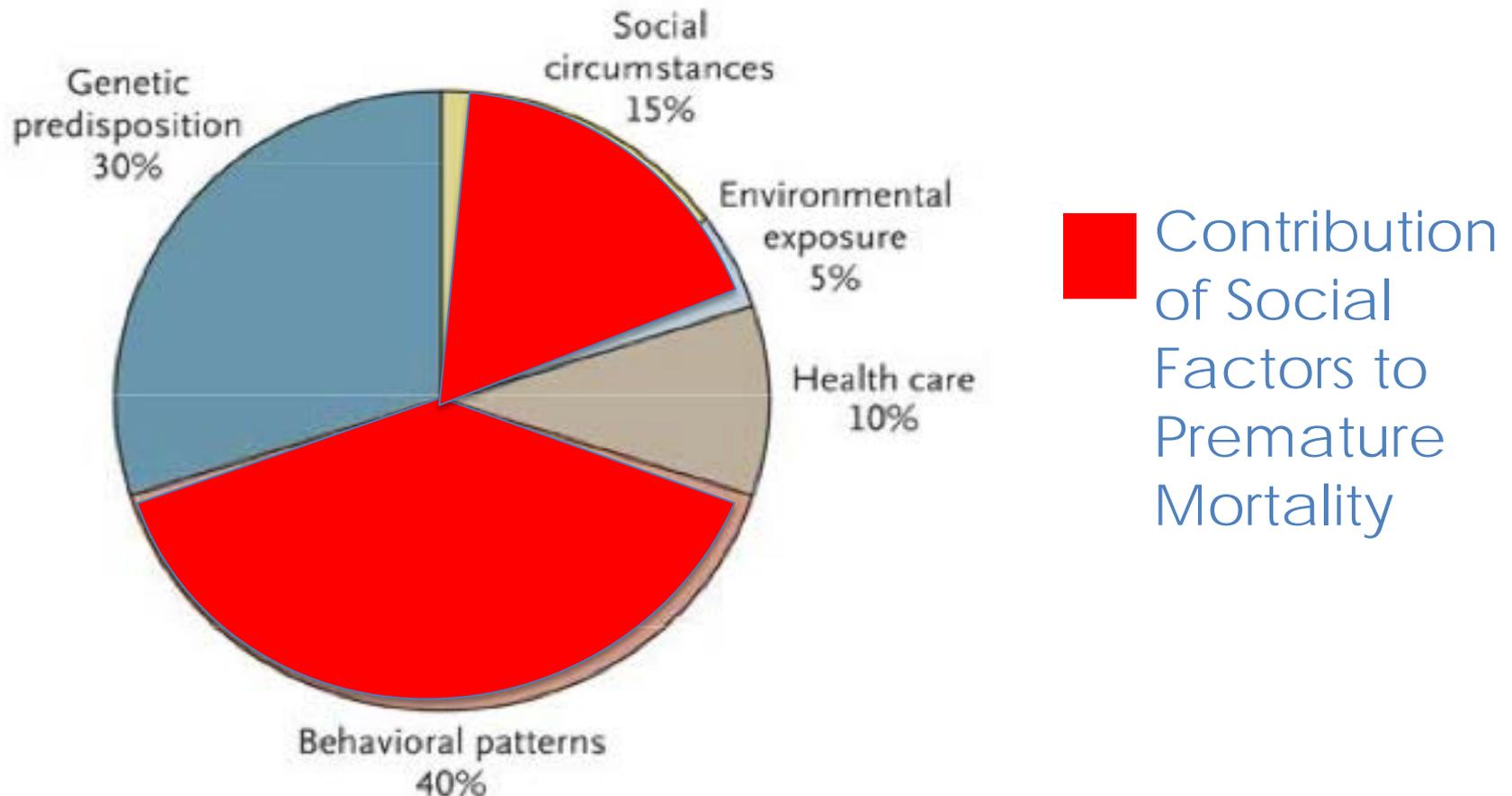
the current standard of care isn't  
good enough

Treating people without tackling the conditions that make them sick is a losing, substandard value proposition



# Social factors contribute to 60% of premature death

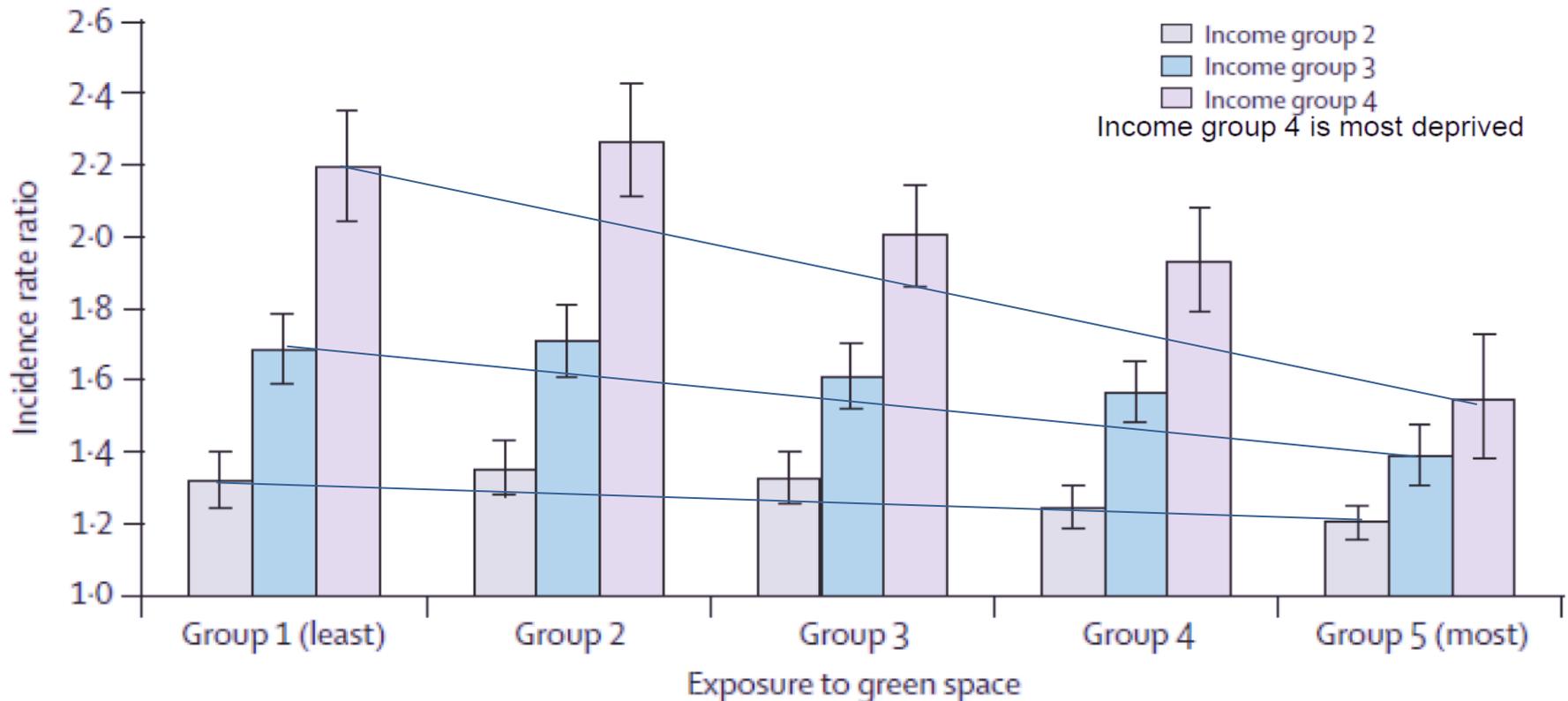
**Proportional Contribution to Premature Death**



# Place and Health

## Zip code more than important than genetic code

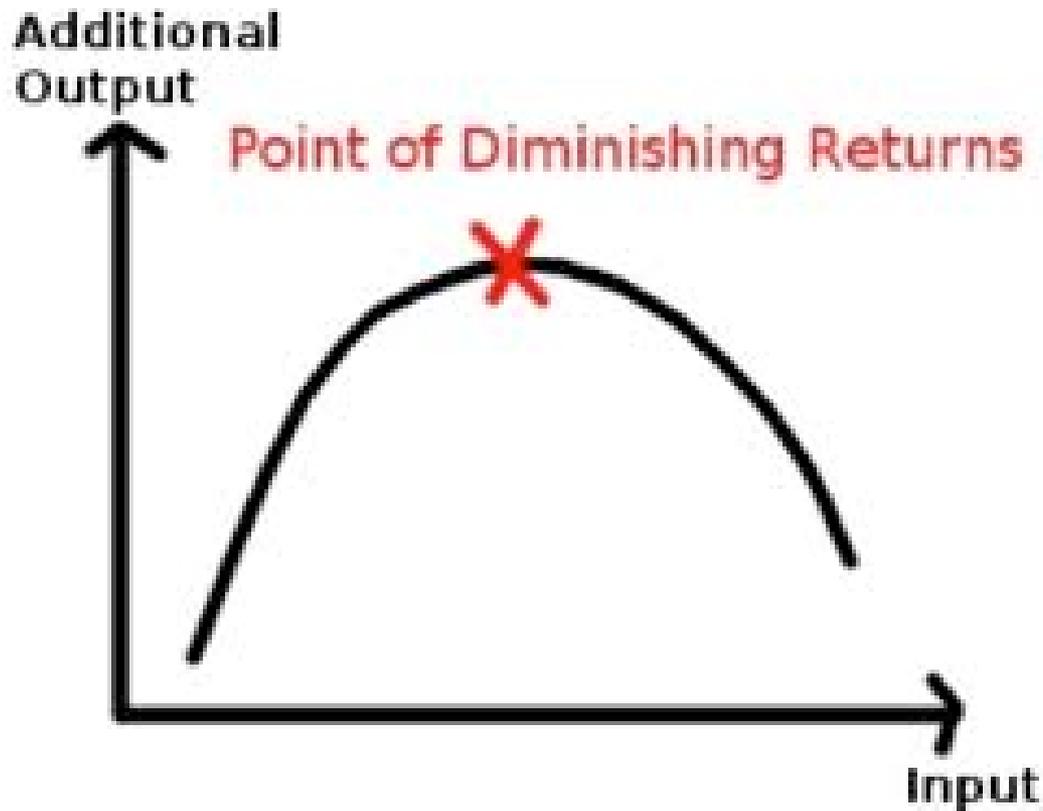
### Deaths from circulatory disease



Epigenetics is helping us to understand how zip code - and other social and environmental factors - shape genetic code



Treating people without tackling the conditions that make them sick is a losing, substandard value proposition



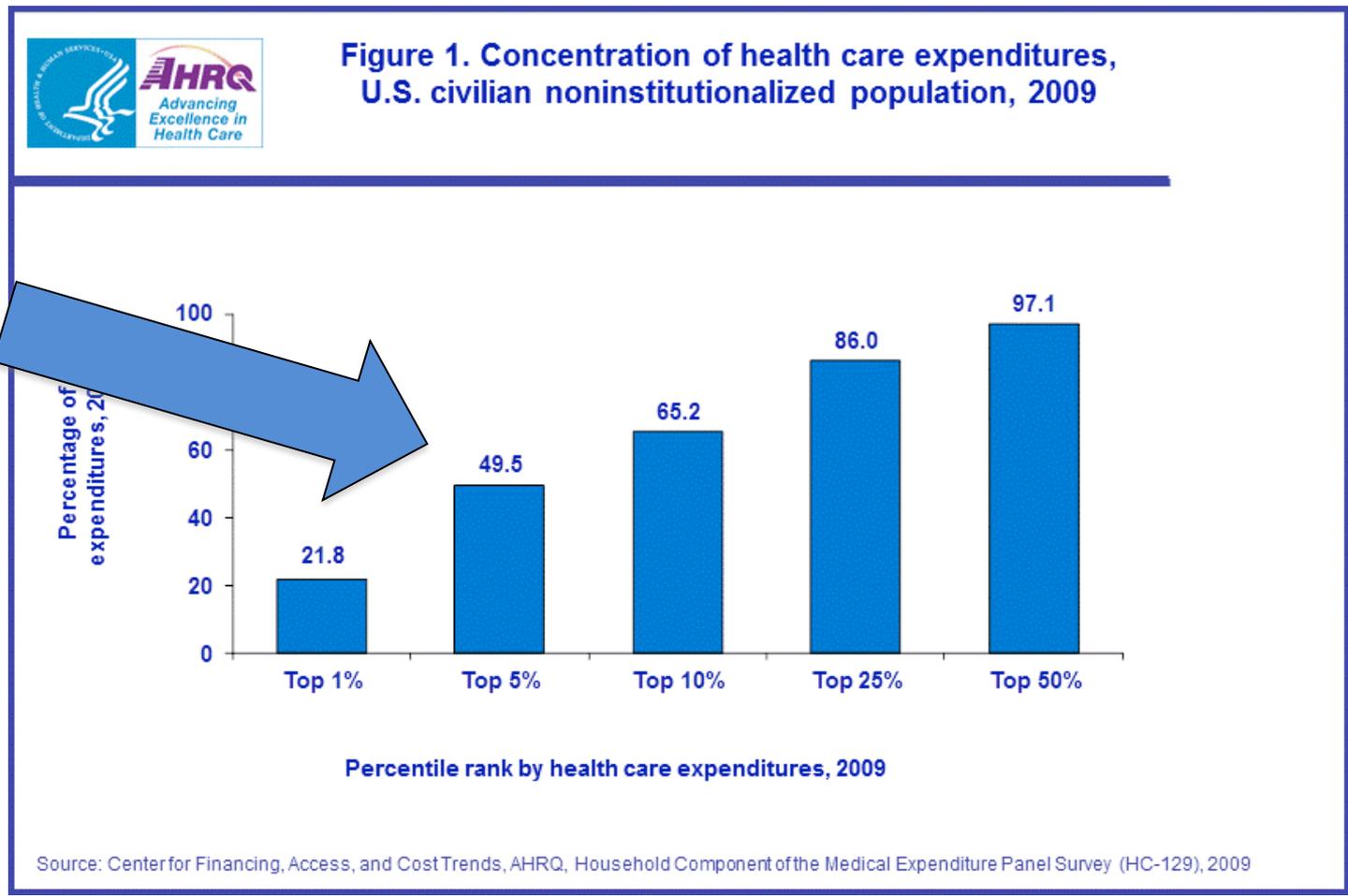
# Costs of substandard care

- Preventable illness & health disparities
  - \$1.24 Trillion over 3 yrs (2003-06)
- Less effective healthcare interventions
- Patient distrust & mis-engagement
- Workforce recruitment & retention costs
- Wasteful spending:
  - 1/3 healthcare spending (\$750 billion) is wasteful (IOM)
- **Clinic costs:**
  - Efficiency and Productivity
  - Competitiveness?
  - Payments? (as payers shift from fee-for-service to value-based payments)



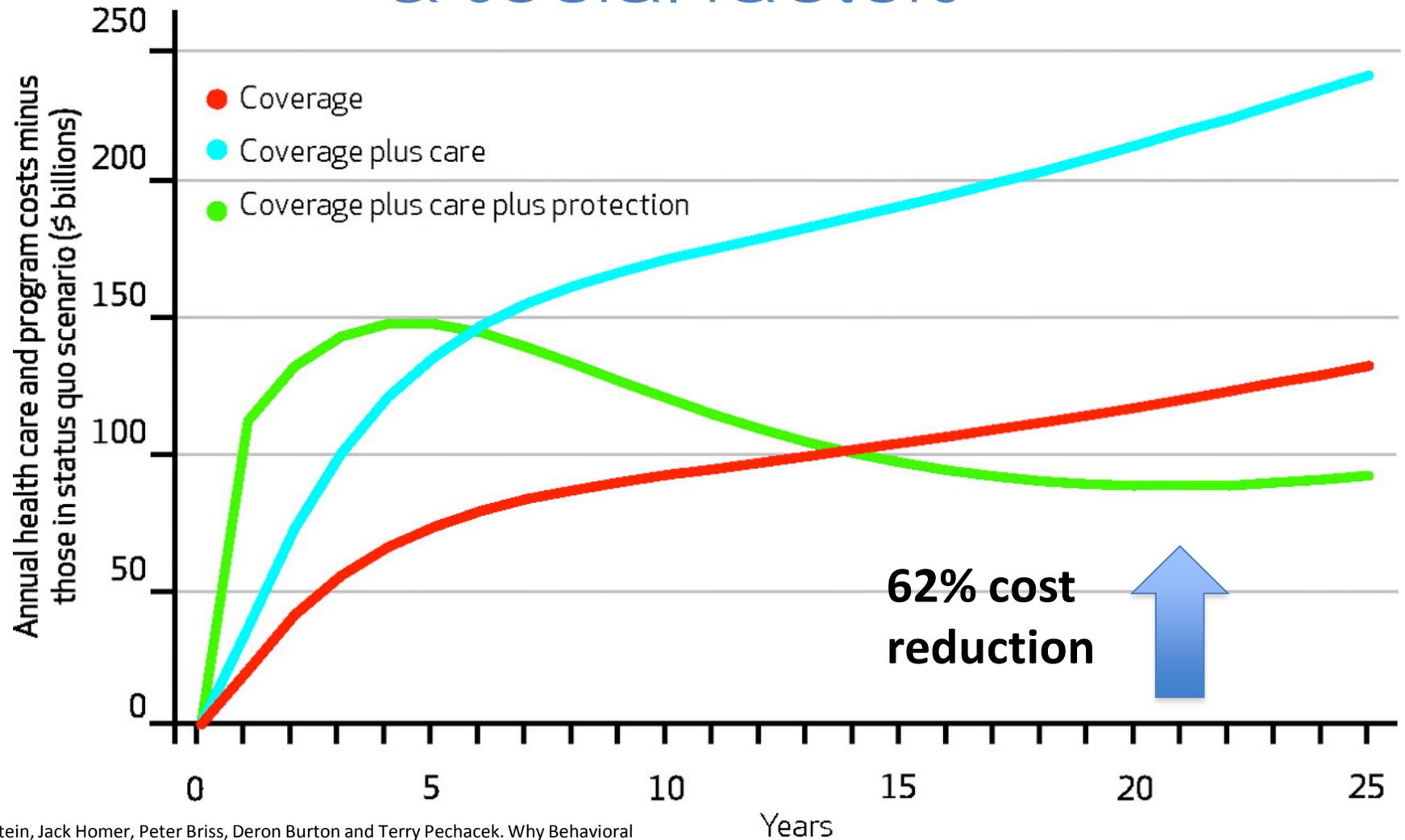
# High-utilizers: A sign and symptom of missed opportunities

**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)

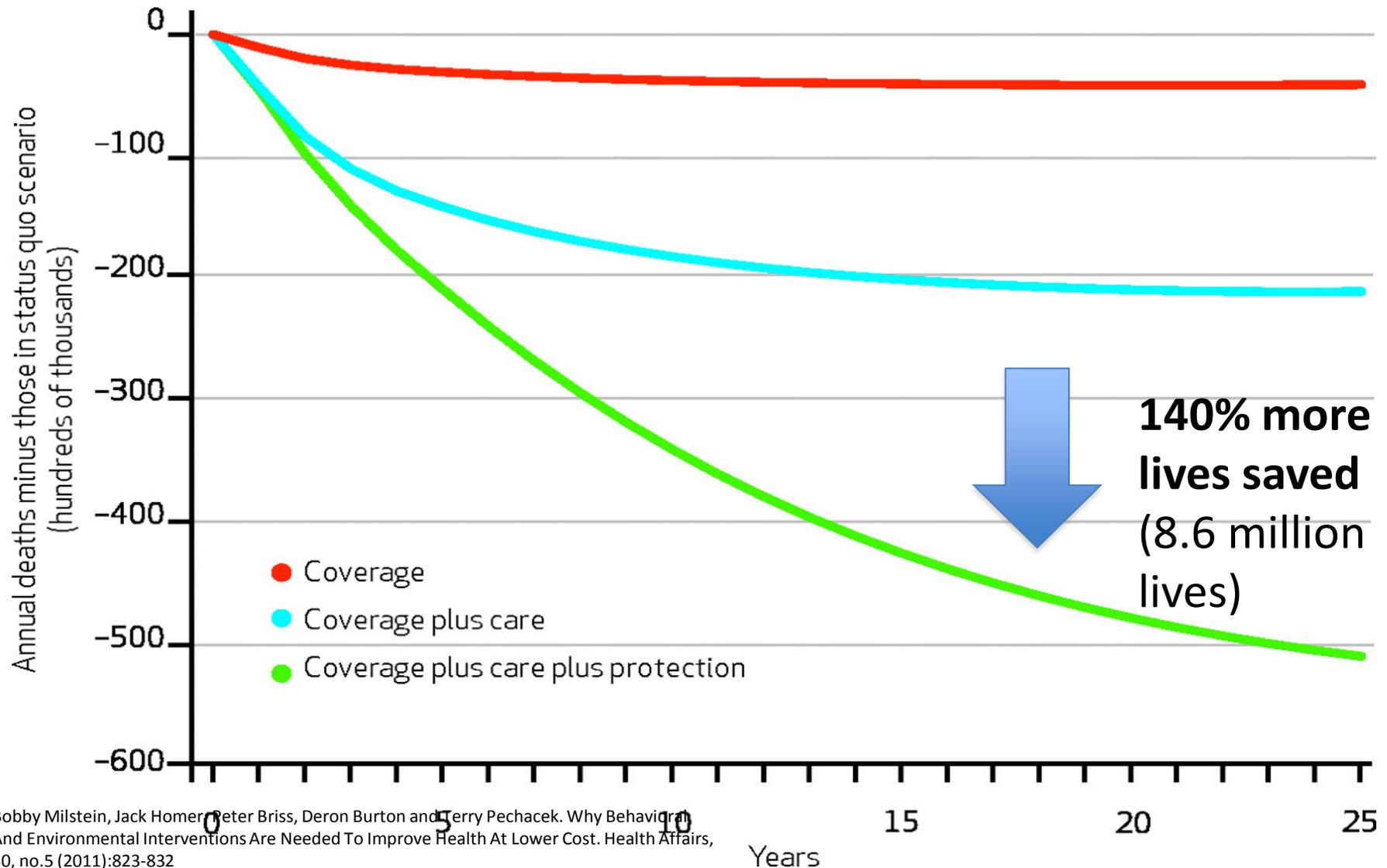
# The cost curve only bends by improving care, coverage & social factors



**62% cost reduction**



# Addressing social factors can save more lives







Glimpses  
of a better standard  
of care are out there



# Is your clinic providing a high value, better standard of care?

Does it:

- 1) Regularly identify the health and social needs of the community it serves?
- 2) Have a dedicated person or team working to address the social conditions that make people sick at a patient and population level?
- 3) Routinely screen patients for risk factors in their homes, workplaces, and community?



# Are you providing the best value in your clinic?

Does your clinic:

4) Routinely connect patients with social and environmental needs to resources in the community?

5) Go beyond the level of the individual patient and help improve social and environmental conditions in the community?

6) Reflect an upstreamist approach in the way it funds its work?

# Moving upstream

- Business case
- Community & Policy Engagement
- Data and Technology
- Design principles
- Workforce

# Design considerations to address social needs in practice

- Most EHRs are not care management tools.
  - Without these tools, clinics cannot act on SDOH
- Clinics require support to make design changes to current practice workflows
  - Finding, referring and linking with community resources remains a common design challenge
- Workforce requires training & support AND to be held accountable by their systems to ask and act on social domains. (i.e. an Upstreamist mode 



20%

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



# Smart medicine starts upstream



# Perilous Waters

These everyday forces flow together to shape our health

## Unequal power

Gross inequity in power and opportunity disrupts both mental and physical health.



## Low income

Wealthier people tend to be healthier, no matter their race.



## Poor education

The lower your education level, the less healthy you're likely to be.



## Social isolation

A lack of social support can lead to depression and even heart disease.



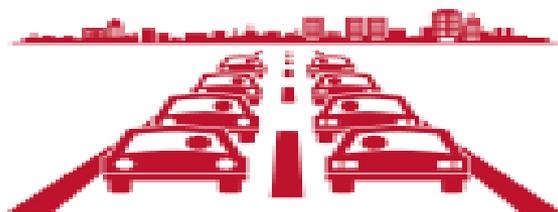
## Pollution

Industrial toxins and car exhaust fuel asthma and cancer.



## Sprawl

As suburbs spread and commutes lengthen, people walk less and sit more.



## Cars as kings

Streets designed mainly for car traffic discourage walking and biking.



## Unhealthy houses

Mold, pests, and unsafe conditions foster asthma, allergies, and injuries.



## Health care access

If you're uninsured or have few clinics nearby, you're less likely to see a doctor.



## Food options

What's available and affordable naturally influences what we eat.

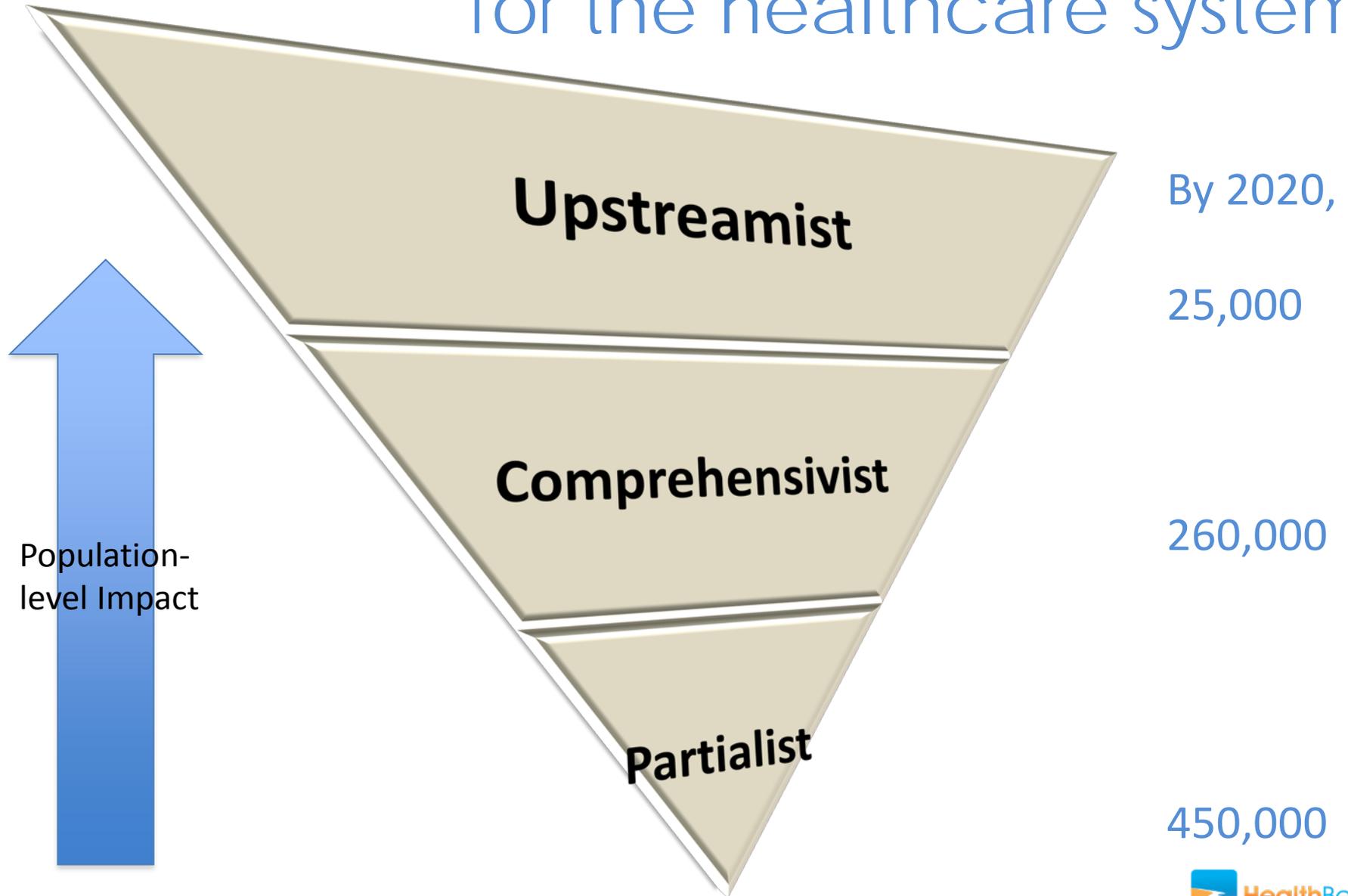


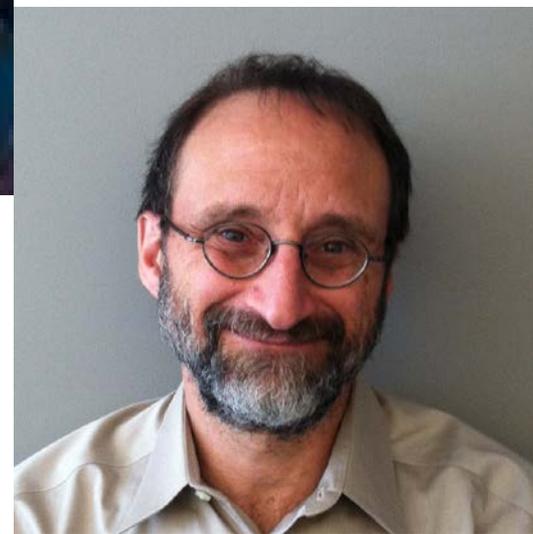
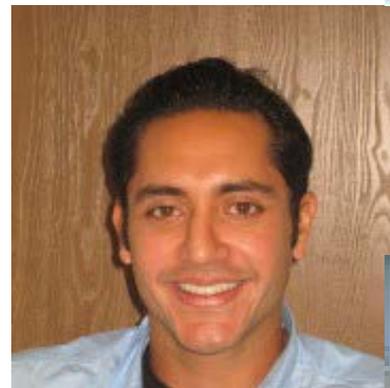
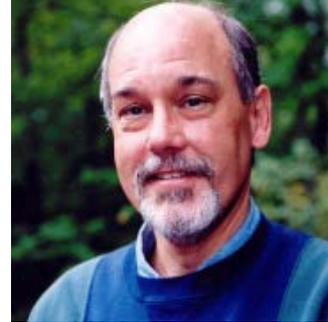
## Unsafe streets

Violence keeps people indoors and produces injuries, trauma, and chronic stress.



# A better workforce model for the healthcare system





# Upstreamists help ensure that their healthcare systems move upstream systematically:

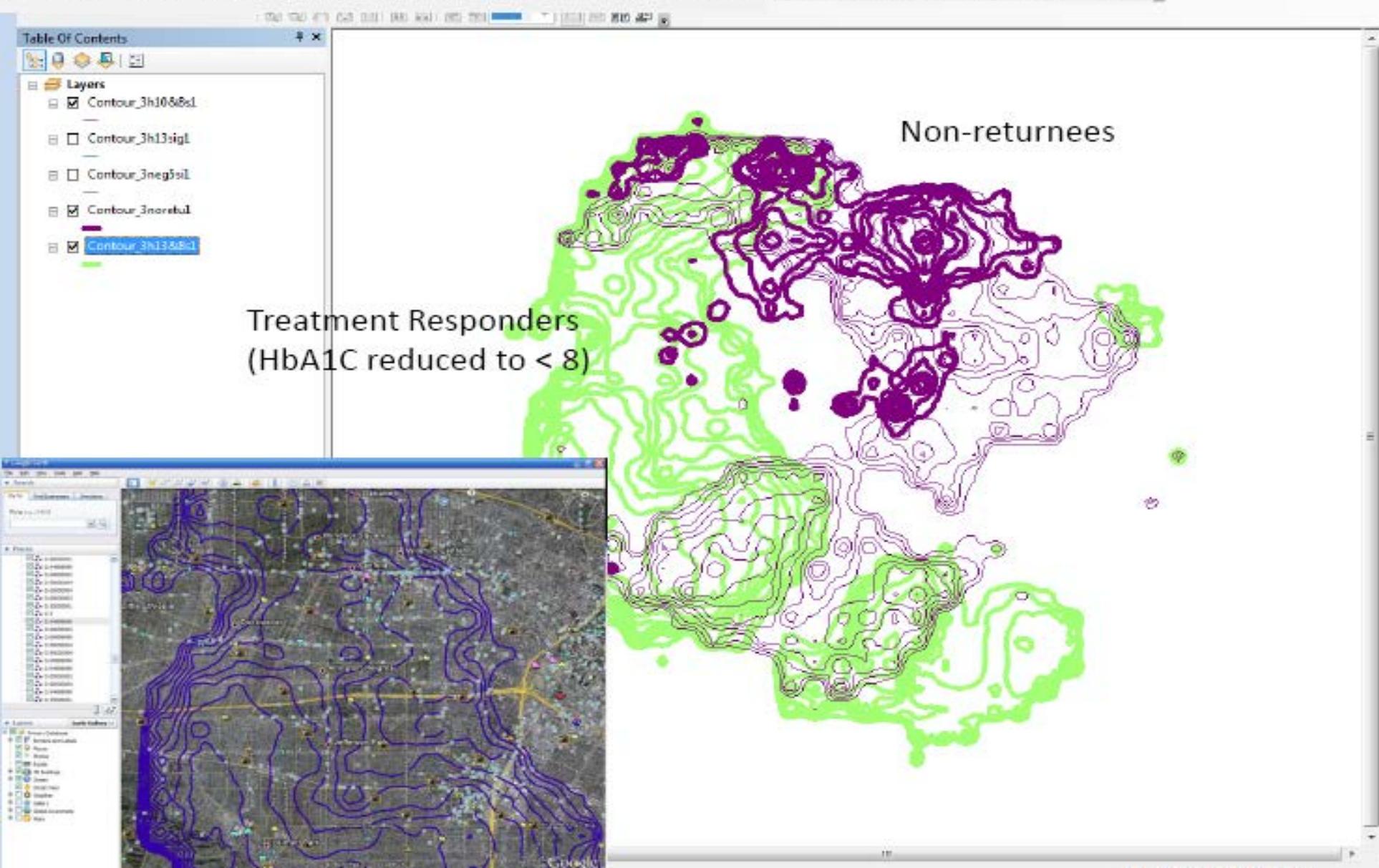
- Ask about where patients live, work, eat, and play using EHRs and other tools
- Integrate upstream interventions into clinic workflow
- Address upstream problems at patient, clinic, and population levels

# Upstreamists:

- Collaborate across disciplines
- Apply leadership, advocacy, organizing skills
- Are creative, resourceful, and persistent
- Command clinical credibility
- Have entrepreneurial problem-solving skills
- Have applied knowledge of public health & social determinants of health

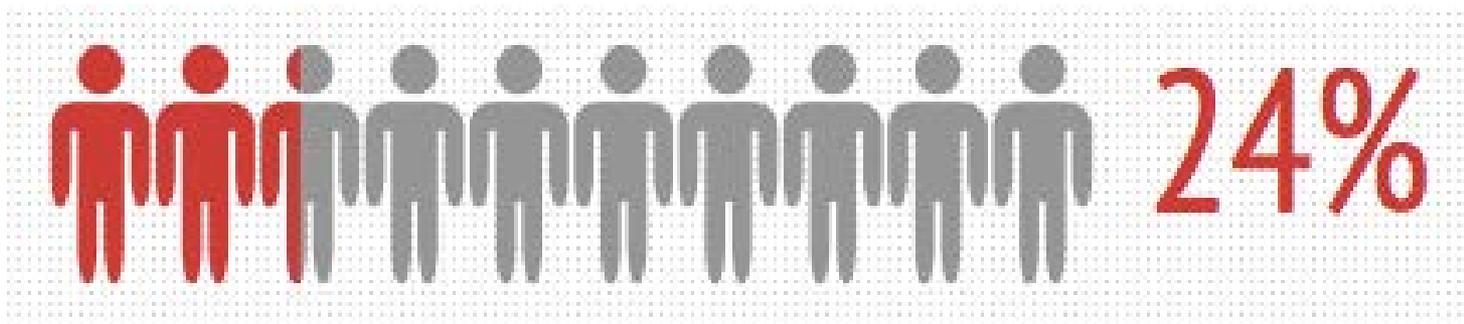
# Upstreamist tools: Geomapping

## Predicting patient outcomes

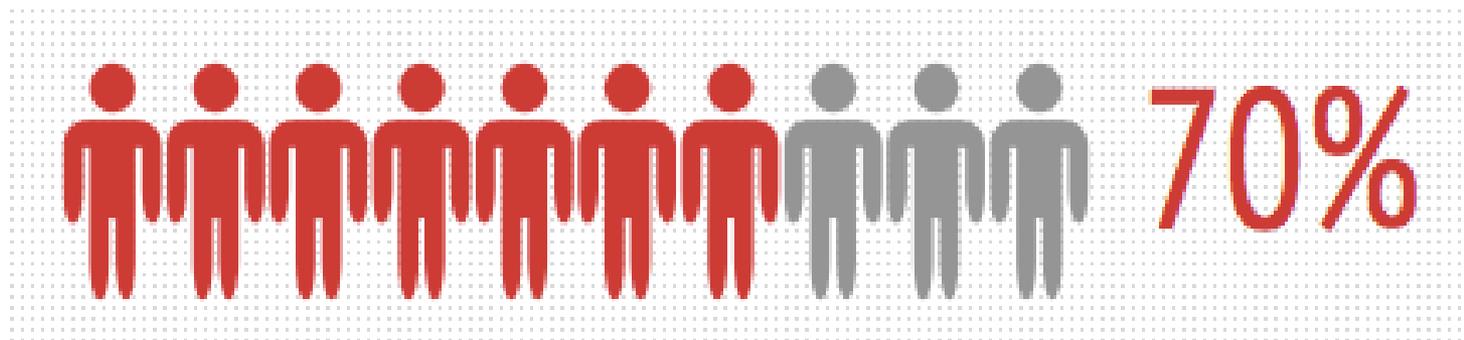


# Provider confidence to address housing & other social needs

Before



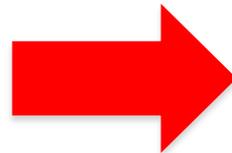
After



Source: Rishi Manchanda. Change in Clinicians' Self-reported Efficacy to address Social Determinant of Health: A Case Study from South Los Angeles. (Abstract)



# A new model: Community Health Detailing



Pharmaceutical detailing

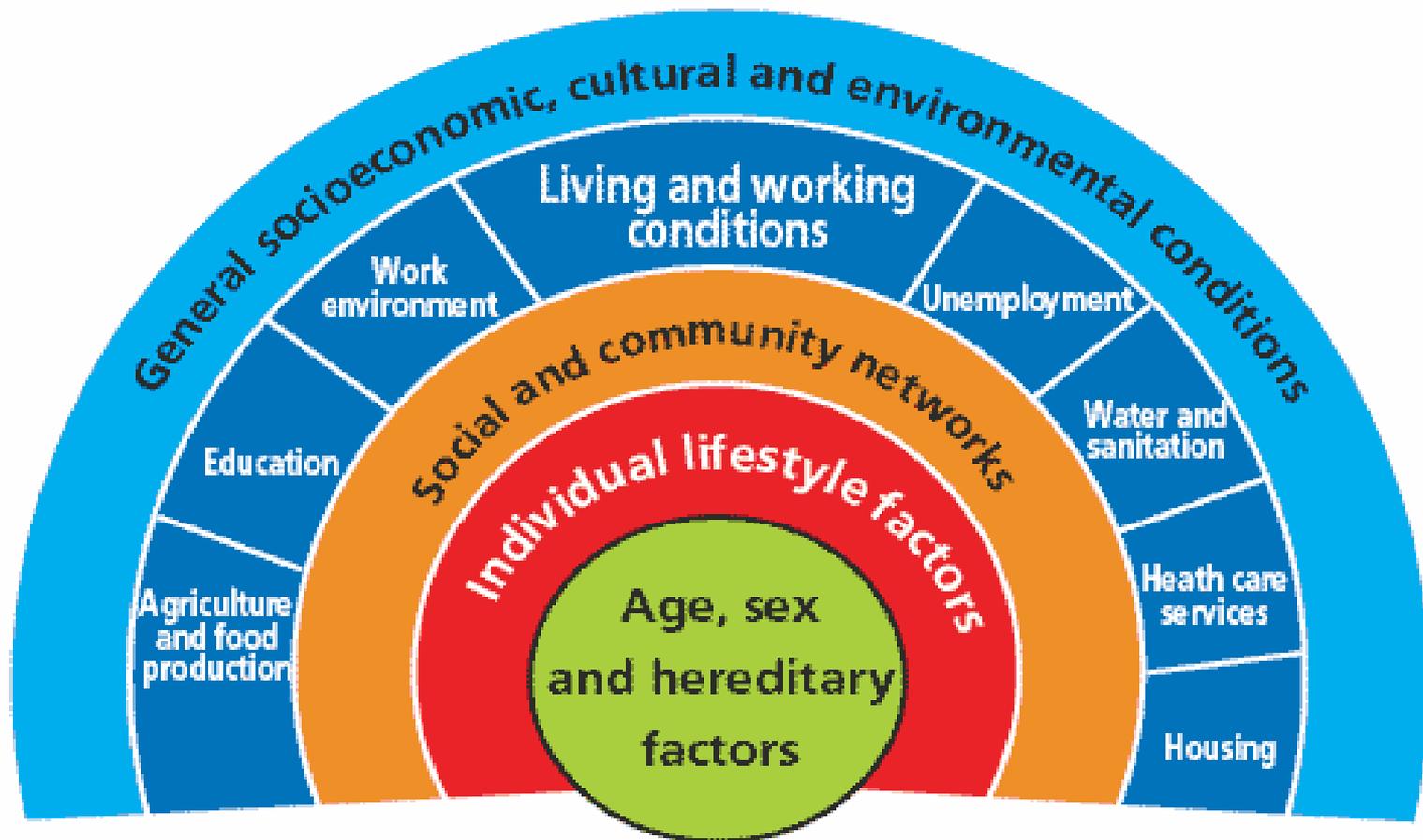


Community detailing

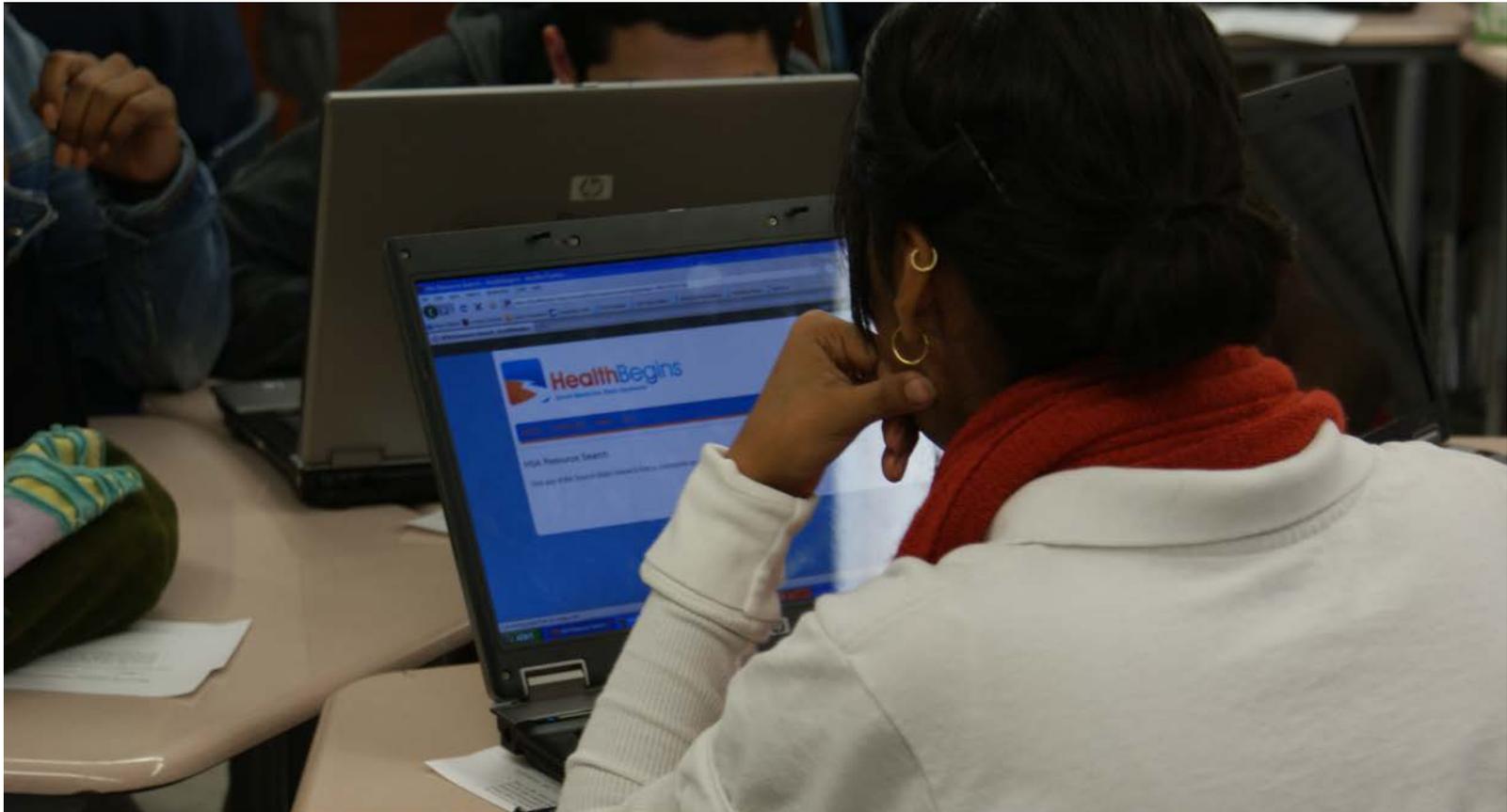
# Community Health Detailing: Using a community-powered “Yelp for Health”



# Modules based on social determinants of health



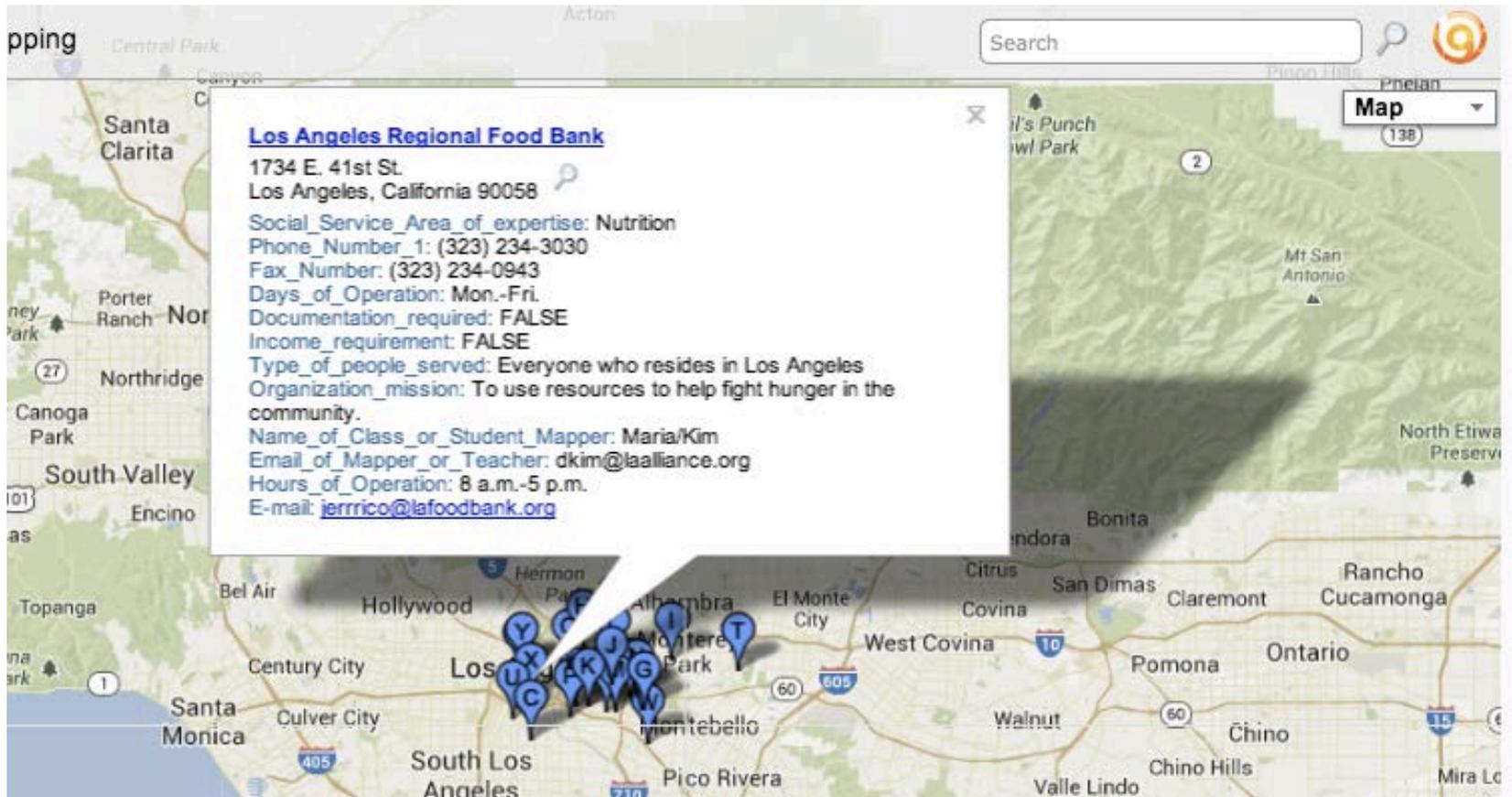
# Module research in the classroom



# Students 'Detailing' MDs at UCLA

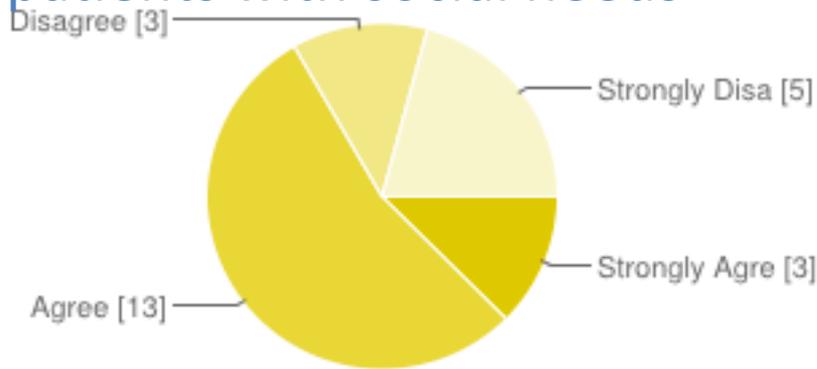


# Results: Students update and map community resources



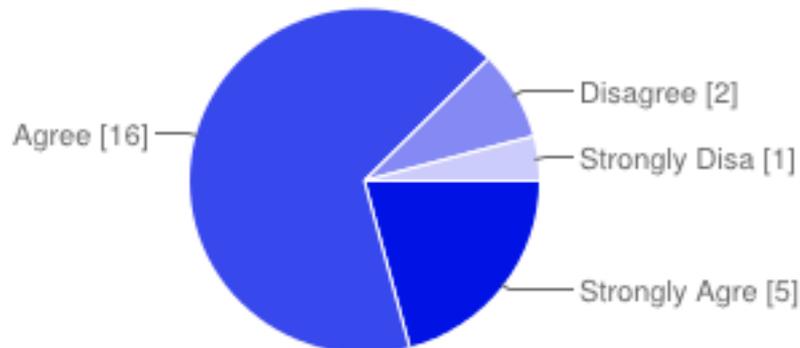
# Results

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



Strongly Agree	<b>3</b>	13%
Agree	<b>13</b>	54%
Disagree	<b>3</b>	13%
Strongly Disagree	<b>5</b>	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	<b>5</b>	21%
Agree	<b>16</b>	67%
Disagree	<b>2</b>	8%
Strongly Disagree	<b>1</b>	4%

# Community-built "Yelp" -like tool: Find help for patients with social needs



Welcome, admin | Logout

EVERYWHERE

Search for

Near

SEARCH

What you are looking for?

In which area?

EDUCATION

EMPLOYMENT

FOOD

HEALTH

HOUSING

LEGAL SERVICES

RECREATION

TRANSPORTATION

ADD LISTING

Blog > Places > Un > Neighborhood Housing Services

Tweet 0

Like 0

+1 0

To provide all information a person or home owner needs in order to not get their homes foreclosed. Also, attorney's are available

Accessibility: ★★★★★

Communication: ★★★★★

Effectiveness: ★★★★★

Professionalism: ★★★★★

Quality: ★★★★★

Rating: 0.0/5 (0 votes cast)

Review

**PLACE CATEGORIES:** Emergency Shelter.

**PLACE TAGS:** Emergency Shelter.

### Contact info :

Suite 200, 3926 Wilshire Blvd.,  
Los Angeles, CA 90010

### Phone :

(888)-895-2674

### Website:

<http://nhslacounty.org/contact>.

Contact Person : Directory

Languages Spoken : English and Spanish

### Add to Favorites ▼

SEARCH

### ALSO IN THE NEIGHBOURHOOD

No Image Available

#### Neighborhood Housing Services

0

To provide all information a person or homeowner needs in order to not get their

TOP RATE LISTING



# Workshops for Upstreamists



JOIN THE NETWORK

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## We make Upstreamists\*

What if clinics could help patients get healthy and save money by addressing the social & environmental conditions that make them sick?

[Learn More](#)

Your Email \*

Your City \*

We mobilize, teach and help healthcare professionals to design successful upstream solutions that improve health and lower costs.

\*'Upstreamists' are healthcare professionals and innovators equipped to transform care and the social and environmental conditions that make people sick.

Some Of The Partners We've Worked With

[Contact](#)

# Workshop Outputs

Participants learn how to develop clinic upstream interventions

- Project Plan
- Budget
- Powerpoint deck

- Connected to strategic priorities

- Learn from Community/Content Experts

- Support via Skype





# HealthBegins' Roadmap for Upstreamists

## **DESIGN:**

Step 1: Define Population and Its Needs

Step 2: Identify Intervention

Step 3: Design Evaluation Plan

## **IMPLEMENTATION**

Step 4: Pilot Intervention Project

Step 5: Collect & Review Data

## **SPREAD**

Step 6: Celebrate Success and Spread





We Can't Get Health Care right  
without addressing SDOH

We can't get healthcare as a  
right without addressing SDOH

To improve SDOH, it is necessary,  
but not sufficient, to engage and  
transform health care

# A better standard of care is possible





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The Upstream Doctors is available on Kindle, Nook, or from the iBookstore. It can be purchased for US\$1.99 each.



# Opportunities to align





# Opportunities

- Preventable hospitalizations for Ambulatory-Care Sensitive Conditions
- Managed Care Medicaid
- Complex Care Coordination
  - Medicaid Health Homes
- ACOs



# Medicaid ACOs: Hennepin

Hennepin Health, Minnesota

- Several county organizations share financial risk (a medical center, health plan, social services organization, and Federally Qualified Health Center)

*CHCS - Advancing Medicaid Accountable Care Organizations: A Learning Collaborative*  
(Maine, Massachusetts, Minnesota, New Jersey, Oregon, Texas, & Vermont)

# Vermont's Community Health Teams

