Issue Brief

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Being accountable means working upstream

To successfully build and sustain accountable communities, we must address social determinants of health. Social and environmental factors are often at the root of illness; at the very least, they can have a profound impact on health. Some may be obvious, such as the connection between indoor mold, roaches and asthma. Others, such as childhood trauma, can be more difficult to identify. What's clear is that these factors do affect health.[1,2,3]

The question is how to identify *and* address these factors, and mitigate the issues they create. An accountable community doesn't merely look at admissions, readmissions, illness, emergency department visits, etc. It identifies root causes. It takes into consideration housing, transportation, access to healthy food and other non-medical concerns—social determinants of health. It's all connected.

What's needed is a health system that has the will and the ability to do this.

Among the voices calling for such a system is Mary Willy, DO, FAAP, of Western Colorado Pediatric Associates. She is an advocate and practitioner of trauma-informed care, which recognizes and addresses the impact trauma, especially childhood trauma, has on long-term health status. (See sidebar on page 3.)

Another voice is that of Rishi Manchanda, MD. What we need, he says, is a health system that looks beyond the medical model, beyond symptoms, and improves health where it begins. That's not at the hospital. It's not in a doctor's office. It's in the rest of the world: where we live, eat, work, learn and play—where we spend the majority of our lives.

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It's called upstreaming, and Manchanda is an upstreamist. He teaches clinicians to consider the "upstream" social and environmental conditions that often are at the root of sickness. He's

[1] Bharmal, et al. Understanding the Upstream Social Determinants of Health. Santa Monica, CA: RAND Corporation, 2015. http://www.rand.org/pubs/working_papers/WR1096.html.

[2] Bachrach D., et al. "Addressing patients' social needs: an emerging business case for provider investment," Commonwealth Fund report, May 2014.

[3] van Walraven, C. "The Utility of Unplanned Early Hospital Readmissions as a Health Care Quality Indicator," *JAMA Intern Med.* 2015;175(11):1812-1814.

> *"Unmet social and environmental needs—substandard housing, lack of transportation, legal issues, etc.—confound and complicate the lives of our patients."*
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> **President of HealthBegins**

president of HealthBegins, which supports clinicians as they work to improve health—where it begins.

The notion of upstreaming is based on a parable; here's how he tells it:

> *This is a parable of three friends who arrive at a river with a waterfall. It's a beautiful scene, but it's shattered by the cries of a child—actually several children—in need of rescue in the water. The first friend says, "I'm going to rescue those who are about to drown, those at most risk of falling over the waterfall." The second friends says, "I'm going to build a raft. I'm going to make sure that fewer people need to end up at the waterfall's edge. Let's usher more children to safety by building this raft." Over time, they're successful—but not as much as they want to be. More children slip through. Finally, the two friends look up and see that their third friend is nowhere to be seen. They finally spot her. She's in the water. She's swimming away from them upstream, rescuing children as she goes, and they shout to her, "Where are you going? There are children here to save." And she says back, "I'm going to find out who or what is throwing these children in the water."* [4]

Social determinants confound and complicate

"Unmet social and environmental needs—substandard housing, lack of transportation, legal issues, etc.—confound and complicate the lives of our patients," Manchanda says.

He cites work he's done with homeless veterans in South Central Los Angeles. "They would show up repeatedly in the emergency department—high-cost, high utilizers of the emergency department. But what they needed was a 'hot [meal] and a cot.'" Only when Manchanda and his colleagues began to address their circumstances—that they were homeless and had social and legal needs—were they able to divert people to more appropriate resources and thereby reduce total costs.

The problem is that too often these needs go unaddressed. "When I see a patient with unmet social needs and can't help them, two things happen. First, I stop asking who they are as people and start looking at them as cases. That's unsatisfying for patients, but also for clinicians. They are working with one hand tied behind their backs; that leads to burnout. All those things we see in malfunctioning teams start to emerge."

Something has to change.

Systemic change, one step at a time

To integrate social determinants of health—and especially to start moving upstream—requires rethinking and restructuring systems. That includes modified business models, staffing, workforce,

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[4] Adapted from Manchanda's TED Talk. https://www.ted.com/talks/rishi_manchanda_what_makes_us_get_sick_look_upstream

Understanding trauma-informed care

Trauma-informed care (TIC) is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms, acknowledges the role trauma has played in their lives and responds to the *effects* of trauma. Core values include safety, trustworthiness, choice, collaboration and empowerment. [5,6,7]

The Substance Abuse and Mental Health Services Administration[8] frames it thusly: "A program, organization, or system that is trauma-informed

1. Realizes the widespread impact of trauma and understands potential paths for recovery;
2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist re-traumatization."

A traumatic event involves physical, emotional or sexual abuse. It can also be related to war, community violence, neglect, maltreatment, loss of a caregiver/loved one, natural disasters, terrorism, witnessing violence or experiencing trauma vicariously. It may also result from chronic adversity, or chronic, severe or life-threatening injuries, illness and accidents. It interferes with the ability to cope.[9]

Background and evolution

The concept of TIC gained attention—and began to crystalize—after the Vietnam War and the identification/understanding of PTSD.[10,11] This led to the development of evidence-based models of trauma treatment.[12] The feminist movement provided another significant influence in the 1970s through the voices of rape and domestic abuse survivors.[13] Likewise, growing attention to child abuse played a role. By the mid-1980s, TIC was widely adopted as a way to understanding the cascade of symptoms observed after traumatic life events.[14]

Subsequently, the Adverse Childhood Experiences (ACE) study heightened awareness of the prevalence and impact of childhood trauma on adult health and wellbeing.[15] The CDC-Kaiser Permanente ACE study, one of the largest investigations of childhood abuse and neglect and later-life health and wellbeing, was conducted from 1995 to 1997.[16] The CDC continues ongoing surveillance of ACEs.[17]

TIC is now applied in a wide range of settings, from mental health and substance abuse treatment providers to child welfare systems and even schools and criminal justice institutions.[18]

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[5] Trauma-Informed Care Charles Wilson, *Encyclopedia of Social Work,* Nov. 2013

[6] http://www.traumainformedcareproject.org/ (The Trauma Informed Care Project of Orchard Place/Child Guidance Center)

[7] National Center for Trauma Informed Care (www.samsha.gov/nctic, 2013)

[8] NCTIC, http://www.samhsa.gov/nctic/trauma-interventions

[9] Presentation: " What does Trauma Informed Care really mean?" J. Kellie Evans, LCSW, CSOTP The Up Center May 1, 2013 http://www.cpe.vt.edu/ocs/sessions/csa-trauma.pdf

[10] Presentation: " What does Trauma Informed Care really mean?" op cit

[11] Trauma-Informed Care, *Encyclopedia of Social Work* op. cit.

[12] Trauma-Informed Care, *Encyclopedia of Social Work* op. cit.

[13] Burgess, A. W., & Holmstrom, L. L. (1974). Rape trauma syndrome. *American Journal of Psychiatry,* 131, 981–986.

[14] Trauma-Informed Care, *Encyclopedia of Social Work* op. cit.

[15] Presentation: "What does Trauma Informed Care really mean?" op. cit.

[16] "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults," *American Journal of Preventive Medicine* 1998; https://www.cdc.gov/violenceprevention/acestudy/about.html

[17] https://www.cdc.gov/violenceprevention/acestudy/about.html

[18] Trauma-Informed Care, *Encyclopedia of Social Work* op. cit.

workflow, tools, care design, etc. It's not an app to download or a turnkey program. It's work. But it's work practices have done before, he says.

"The good news is that we already know how to do this, and we can apply performance management techniques used in health care to move upstream; we already have the tools. We just need to modify the toolkit slightly to more effectively identify and recognize social determinants of health, and create quality improvement projects that integrate with upstream partners. We've done it for electronic records, and we're doing it for behavioral health."

And while sustainable change requires a systemic approach, physicians can start simply, Manchanda says. It comes back to using quality improvement tools. He recommends testing changes on a small scale using Plan-Do-Study-Act cycles. First identify the clinical problem among a certain set of patients—something that's keeping you up at night. Consider upstream causes. Come up with a hypothesis and then ask your patient. Then take steps to get started:

1. **Identify the problem.** One example: Poor people with diabetes are significantly more likely to go to the hospital for hypoglycemia at the end of the month—when food budgets are tight—than at the beginning.[19] Are your patients with diabetes becoming hypoglycemic at the end of the month? Why?

2. **Ask questions and listen.** Start with one patient, then five. Asking the question is simple, but it makes a tremendous difference. Generally, clinicians don't ask patients about where they live, about their environment. But they should.

   For clinicians, it's often easier to take the path of least resistance, says Willy. Even the simplest question, such as "What's the scariest thing that happened to you or your family since I last saw you?" can open a can of worms. But the simple act of asking the question, followed by some really good listening, can open the door. Empathetic listening is therapeutic; it can lead to identifying and addressing the major obstacles that affect a patient's quality of life and, ultimately, their current and long-term health.

3. **Identify resources.** Manchanda encourages providers to mobilize local community resources to create a solution. Your care team can extend to include food banks and public health, including social services.

   It's essential to pull in social services organizations, but that can be hard. Those organizations are underfunded. "They are starting from a different level in terms of capacity." His counsel: Engage policymakers and payers to put money where their mouths are. Ultimately, payment models will need to consider the role of these organizations, he says.

Empathetic listening is therapeutic; it can lead to identifying and addressing the major obstacles that affect a patient's quality of life and, ultimately, their current and long-term health.

Still stumped? Connect with other clinicians who are trying to do the same thing you are. They are out there, he says. "A lot of folks are trying small projects. Learn, borrow, shamelessly steal." Then make it work in your practice.

Trauma-informed care

Different organizations are taking different, often multiple, approaches to address social determinants. Willy's focus is on trauma-informed care. Trauma, especially childhood trauma, is one key upstream social determinant. Certain social determinants create trauma, and trauma itself is a social determinant of health. "Research shows that many chronic diseases of adulthood are related to

[19] Seligman HK, Bolger AF, Guzman D, López A, Bibbins-Domingo K. Exhaustion of food budgets at month's end and hospital admissions for hypoglycemia. Health Aff (Millwood). 2014 Jan;33(1):116-23.

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adverse childhood experiences.[20,21,22,23] We need to find a way to break that cycle and decrease recidivism to improve health not only in the current generation, but in future ones," explains Willy.

In trauma-informed care, the question shifts from "what is wrong with you" to "what happened to you?" Providers reinterpret behaviors previously attributed to mental illness or being a "bad kid" to be a potentially reversible consequence of a bad event or series of events.

Research demonstrates that experiencing a traumatic event significantly increases the likelihood of persistent physical, mental and addiction problems.[24,25,26,27] Since roughly 60 percent of adults in the United States report experiencing abuse or other difficult family circumstances during childhood, or at least once in their lives, and an estimated 26 percent of children in the United States will witness or experience a traumatic event before they turn four,[28] the potential impact of trauma is tremendous.

Trauma-informed care is increasingly being recognized in the medical setting. In pediatrics, it's been a core topic for the last several years, Willy says.

Like Manchanda, Willy emphasizes the importance of getting to the root cause and breaking down silos. Because her practice integrates behavioral health, she has a head start. Integrating behavioral health into primary care makes it easier to provide trauma-informed care. With the behavioral health professional embedded in the practice, it is much more efficient to identify community resources. The behavioral health professional is able to identify, build and sustain those relationships. Members of her practice team meet monthly with various community organizations so they can stay aligned.

She'd like to see even greater collaboration. "What's needed most is consistency." She wants a community-based approach that pulls in schools, county agencies, public health, the legal system, etc. to develop a process. This would include standard screening and follow up—for all practices. And of course, what's needed is consistent insurance coverage, she says.

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> **Western Colorado Pediatric Associates**

[20] Menschner C., Maul A. "Key Ingredients for Successful Trauma-Informed Care Implementation." Center for Health Care Strategies April 2016

[21] "Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study." *American Journal of Preventive Medicine,* 14, no. 4 (1998): 245-258.

[22] Shonkoff J.P., A. S. Garner, et al. "The Lifelong Effects of Early Childhood Adversity and Toxic Stress." *Pediatrics,* 129, (2012b): 232–246.

[23] Public Health Management Corporation (2013). *Findings from the Philadelphia Urban ACE Survey.* www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf407836.

[24] Menschner op. cit.

[25] "Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study op. cit.

[26] Shonkoff J.P. op. cit.

[27] *Findings from the Philadelphia Urban ACE Survey.* Op. cit.

[28] National Center for Mental Health Promotion and Youth Violence Prevention, "Childhood Trauma and Its Effect on Healthy Development," July 2012. http://sshs.promoteprevent.org/sites/default/files/trauma_brief_in_final.pdf

Changing payment, changing the culture, expanding the definition

Payment may be the biggest hurdle for anyone trying to address social determinants, be it childhood trauma or homelessness. Willy is fortunate: Western Colorado Pediatric Associates is part of the State Innovation Model, which received funding to create a coordinated, accountable system of care that improves integration of physical and behavioral health services.

That's important, because fee-for-service doesn't pay for looking beyond the symptoms. But value-based payment represents one of the most important developments in upstreaming. It broadens the conversation beyond biological and even psychological health. "The shift to value-based payment reform cannot be overstated as a driver," Manchanda says.

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Demonstrate community success: address social determinants of health

There are "small but significant signals" that the Centers for Medicare & Medicaid Services is moving forward, and that sets the pace for other payers, he says. Perhaps most notable is that the Centers for Medicare & Medicaid Services Innovation Center has created a program—the Accountable Health Communities model—to address social determinants of health.

The goal: Make beneficiaries struggling with unmet health-related social needs aware of the community-based services available to them, and enable them to receive assistance in accessing those services. Slated for a 2017 launch, it will focus on the health-related social needs of Medicare and Medicaid beneficiaries, including building alignment between clinical and community-based services at the local level.

Although there is plenty of money in the health care sector, there's very little for housing or transportation or other areas that have a direct impact on health. New and innovative value-based community models can put a dent in that.

Some payers are already doing work in this space, and with the Accountable Health Communities model, Manchanda says, CMS is sending a strong message to other payers that this is important.

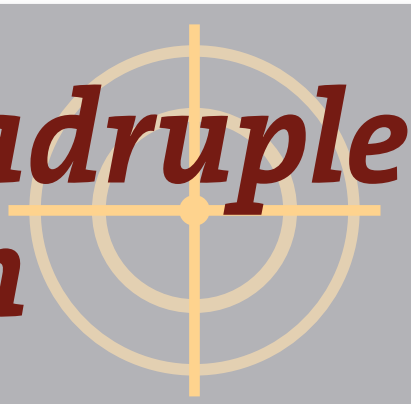
There are other drivers supporting adoption. Interest is growing because research continues to show that addressing social determinants of health will improve patient outcomes and lower costs. And then there are cultural drivers, including a shift in the power dynamics of health care. He identifies several examples: the "pit crews" Atul Gawande describes,[29] increasing use of community health workers, more informed patients, and greater attention to community stakeholders. "We are broadening our approach and our understanding," he says.

The vision of what constitutes—and drives—health is broadening, too, albeit gradually. But we're not there yet, he says. Until we understand the social determinants of health and begin to make changes upstream, we won't achieve the Triple Aim, much less the Quadruple Aim. (See sidebar.)

It comes back, says Manchanda, to asking questions of our patients, looking at them as human beings. "We need to ask questions about symptoms and pills, but that's just the beginning. Until we ask about mold, about housing, about food, we aren't going to find the cause—or the cure."

[29] See http://www.newyorker.com/news/news-desk/cowboys-and-pit-crews

A PATH TO THE Quadruple Aim



There's an urgency to upstreaming, or evaluating early and often what determines illness, Manchanda says, and he likes to frame it using the Quadruple Aim:[30]

- Improve the health of populations—bettering patient outcomes;
- Enhance the patient experience of care (including quality, access and reliability);
- Control the per capita cost of care; and
- Improve clinician satisfaction.

In terms of **improving the health of populations,** the science is abundantly clear: social factors and the environment have a more profound impact on premature mortality than does health care.[31,32,33]

This also goes to achieving the second aim, **the patient experience of care.** When patients walk into a health care system that has considered the complexity of their life, that treats them as a whole person and not as a disease or a number, it makes a difference. "From lived experience as a provider, I can tell you that leads to more patient joy, greater trust and higher satisfaction with their care."

Achieving the third aim is trickier, but if the treating clinician considers social determinants there can be an immediate difference in cost and outcomes. Looking at high-cost, high-need patients—hot spotting[34]—has been very successful in prioritizing what to focus on to achieve the third aim, **controlling per capita costs.** But, Manchanda points out, these are downstream solutions. "We have high-cost, high-needs patients because we are missing the opportunities to assess upstream issues." By failing to address these early enough, we as a society find ourselves in dire straits. That, he says, is frustrating for everyone, including clinicians.

And that gets to the fourth aim, **provider satisfaction.** Manchanda calls this "joy at work." "I know firsthand there's a link between my ability to successfully help my patients meet their social needs and my happiness." He points out that a strong predictor of burnout is a physician's perception of a clinic's inability to meet the social needs of its patients.[35]

"So this doesn't just matter for patients. It doesn't just matter to society and public health and to the broader issue of equity. It also matters inside the clinic." It matters to physicians, other clinicians and the staff.

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[30] Bodenheimer T, Sinsky C. "From triple to quadruple aim: care of the patient requires care of the provider." *Ann Fam Med.* 2014 Nov-Dec;12(6):573-6.

[31] Bharmal op.cit

[32] Bachrach, op. cit.

[33] van Walraven, op. cit.

[34] hotspotting.camdenhealth.org/

[35] Olayiwola JN achieving the Quadruple Aim in Primary Care: Challenges and Opportunities Feb.2015. Unpublished research

RISHI MANCHANDA, MD
President of HealthBegins

RISHI MANCHANDA is president of HealthBegins, an organization that provides health care providers with upstream quality improvement tools to improve care and the social determinants of health. He is also chief medical officer for a large self-insured employer. Previously, he worked for the VA Greater Los Angeles Healthcare System, where he was the lead physician for homeless primary care, and for a network of community health centers, where he directed clinical and community programs that improved health outcomes by focusing on social risk factors, such as slum housing and food insecurity. He earned his bachelor's, medical, and MPH degrees from Tufts University and was the first graduate of UCLA's combined internal medicine and pediatrics residency.

MARY WILLY, DO
Western Colorado Pediatric Associates

MARY WILLY joined Western Colorado Pediatric Associates in July 2007. She has been a practicing pediatrician since 2003.

She previously was an assistant professor of pediatrics at the West Virginia School of Osteopathic Medicine and also practiced at Greenbrier Valley Medical Center, Lewisburg, West Virginia. She completed her residency at Mercy Children's Hospital at the Medical College of Ohio and graduated from Ohio University College of Osteopathic Medicine. She also attended college at Ohio University. She is board certified through the American Academy of Pediatrics and is affiliated with St. Mary's Hospital and Medical Center.

About Rocky Mountain Health Plans

Founded in Grand Junction, Colo. in 1974, as a locally owned, not-for-profit organization, Rocky Mountain Health Plans provides access to affordable, quality health care enabling its more than 229,000 members across the Western Slope to live longer, healthier lives.

About the Community

Western Colorado is creating an accountable community that uses health IT in a meaningful way, adopts value-based payment models, coordinates care and empowers patients to take charge of their health.

We aspire to ensure the following:

- High-quality health care is affordable and accessible to all.
- Those who purchase health care are assured that care is effective, safe and appropriate.
- Patient care is a team effort, with roles that are well-defined, connected and collaborative.
- Patients have access to the support and information they need to take charge of their health and make their own decisions.
- Payment reform will foster reimbursement models that support accountability for population health and resource use.
- Information technology supports population health, helping providers predict outcomes, prioritize interventions and prevent disease.
- Health data is a community resource used in a secure way to support coordinated care at the population, practice and personal levels.
- Investments in information technology and health system transformation will improve quality of life and economic well-being across the state.
- Health is a community resource that requires leadership, stewardship, individual responsibility, community support and ongoing maintenance.

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