THE HEALTHRISE STORY

Improving Chronic Care for Underserved Populations

Jessica Daly, MPH
Director, Global Health
Medtronic Foundation
The HealthRise Story

WHY HEALTHRISE?

THE HEALTHRISE MODEL

THE FUTURE
“There were so many patients who weren’t doing well and were slipping, and I feel like the HealthRise program was really there to catch them.” - Clinic provider, US
The Global Burden
2014/2015

GLOBAL DEATHS

PREMATURE DEATHS CAUSED BY NCDs IN LOW/MIDDLE INCOME COUNTRIES THROUGH 2030

- **67%** NCDs
- **24%** Other
- **9%** Injuries

**40M** ANNUAL DEATHS FROM NCDs

**31.5M** ANNUAL DEATHS FROM NCDs IN LMIC

SOURCE: IHME Global Burden of Disease

Underserved Populations Bear the Biggest Burden
Lancet Task Force on NCDs and Economics

KEY TAKEAWAYS

- Catastrophic health expenditure occurs >60% of some patient populations with NCDs
- Being uninsured increases the risk of catastrophic health expenditure in patients with NCDs
- Targeting of the poorest groups needs to be a primary consideration in prioritizing services that are included in insurance programs to achieve universal health coverage
- Addressing the household economic burden of NCDs is an important step in efforts to achieve global development goals
“[CHWs] They are not people from outside, but they are people among us. They did not come from foreign, they are our people.” - Patient, India
**WHAT IT IS**

**Multi-country, multi-year initiative**

**Goal:** Contribute to 25% reduction in premature mortality associated with hypertension and diabetes among underserved populations.

**Objectives:**
1. Increase screening and diagnosis (detection)
2. Increase management and control of hypertension and diabetes (improved clinical outcomes)

**Approaches:**
1. Empower patients
2. Strengthen frontline health workers
3. Advance policy and advocacy
HealthRise Lifecycle

ASSESS BARRIERS/OPPORTUNITIES
FORM PARTNERSHIPS (2014-)

IMPLEMENT LOCAL SOLUTIONS
MONITOR PROGRESS (2016-2018)

EVALUATE (2018)
DISSEMINATE (2019)

10 PUBLIC-PRIVATE PARTNERSHIPS
>80 ADVISORY COMMITTEE MEMBERS

9 CARE MODELS TESTED
>80K SCREENED; >10K FOLLOWED

% OF US ENROLLEES WITH CONTROLLED DISEASE

SUSTAIN/SCALE
HealthRise: A Global Partnership
Global Coordination + Implementation + Evaluation

GLOBAL DIRECTION
1. Criteria for partner selection/ interventions
2. Thought leadership
3. Public-Private Partnerships

IMPLEMENTATION
1. Program administration and management
2. Stakeholder engagement
3. Technical assistance

MONITORING AND EVALUATION
1. Needs assessments/ baseline
2. Monitor progress
3. Endline evaluation

*Management partners at country level
## Intervention Mix, Evaluation Design, Baseline and Endline Targets

<table>
<thead>
<tr>
<th>Site/Underserved</th>
<th>Dominant Model</th>
<th>Intervention Mix</th>
<th>Evaluation design: Mixed-method, quasi-experimental design</th>
<th>Baseline Control</th>
<th>Target Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA: Hennepin, MN</td>
<td>Low-income Afr Amr; Latino</td>
<td>Integrate CP/CHWs with primary care teams to address social determinants of health and self-care?</td>
<td>Patient-level data via EMR and secondary sources for intervention and comparison groups; Interviews with key-informants</td>
<td>75% 45%</td>
<td>78% 53%</td>
</tr>
<tr>
<td>USA: Ramsey, MN</td>
<td>Low Income Latino, Hmong, Migrant</td>
<td>CP/CHW integration to primary care</td>
<td></td>
<td>63% 52%</td>
<td>73% 57%</td>
</tr>
<tr>
<td>USA: Rice, MN</td>
<td>Low-income Latino, Somali refugees</td>
<td>Care coordination, insurance navigation, Somali/culturally tailored services</td>
<td></td>
<td>51% 48%</td>
<td>65% 65%</td>
</tr>
<tr>
<td>India: Udaipur, Raj</td>
<td>Rural, tribal, slum dweller</td>
<td>Village saturation with ASHAs (screen, refer, follow-up); peer groups</td>
<td>Patient-level data for intervention groups, pre/post comparison</td>
<td>16% 49%</td>
<td>50% 55%</td>
</tr>
<tr>
<td>India: Shimla, HP</td>
<td>Rural poor in public health system</td>
<td>MIS/HealthCard for patients/FLHW; ASHAs screen, refer, follow-up; peer groups</td>
<td>Health facility and patient surveys, intervention and comparison groups interviews and focus groups,</td>
<td>9% 37%</td>
<td>50% 40%</td>
</tr>
<tr>
<td>S Africa: Pixley, NC</td>
<td>Rural poor, largely unemployed</td>
<td>Integrate DM and HTN screening, diagnosis and referral to HIV/TB and community/primary care</td>
<td>Health facility and patient surveys, interviews and focus groups, intervention and comparison groups</td>
<td>11% 38%</td>
<td>70% 80%</td>
</tr>
<tr>
<td>S Africa: Umgun, KZN</td>
<td>Low income, large HIV co-morbidity</td>
<td>Door-to-door Dr/CCG visits; HIV/TB cross referral and adherence</td>
<td></td>
<td>10% 42%</td>
<td>40% 60%</td>
</tr>
<tr>
<td>Brazil: TO, Minas Gerais</td>
<td>Low income (HDI &lt;.6)</td>
<td>Can public health system (SUS) be strengthened through FHLW training; telehealth and patient education?</td>
<td></td>
<td>25% 26%</td>
<td>50% 52%</td>
</tr>
<tr>
<td>Brazil: VC, Bahia</td>
<td>Urban poor/low wage industrial workers</td>
<td>CHW training; telehealth web training; patient follow-up</td>
<td>Patient-level data for intervention groups</td>
<td>25% 26%</td>
<td>50% 52%</td>
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</tbody>
</table>

**Note:** IHME collected control site data, but did not match intervention sites.
## HealthRise Endline
### A Mixed Method Evaluation

<table>
<thead>
<tr>
<th>Level</th>
<th>Mode</th>
<th>Assessment (Option 1)</th>
<th>Assessment (Option 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Facility-based case-control data</td>
<td>Enrollees, when compared to controls, will have greater utilization of follow-up primary care; or enrollees will have better dose-response</td>
<td>Enrollees, when compared to controls, will have better outcomes</td>
</tr>
<tr>
<td></td>
<td>Qualitative</td>
<td>After enrolling in the program, patients have a greater sense of empowerment &amp; knowledge of HTN and DM</td>
<td>Patients report changes in attitudes/practice; report observed beneficial changes in healthcare system</td>
</tr>
<tr>
<td>System</td>
<td>Facility survey</td>
<td>Intervention area facilities will have improved stocks, EMR, and equipment compared to control area facilities</td>
<td>Improvement in identifying high risk patients resulting in increased patient flow</td>
</tr>
<tr>
<td></td>
<td>Qualitative</td>
<td>Healthcare workers felt more knowledgeable and prepared to provide care for HTN and DM</td>
<td>Improvement in capacity, provider/ FLHW empowerment and satisfaction</td>
</tr>
<tr>
<td>Policy</td>
<td>Qualitative</td>
<td>Change in policies and treatment for HTN and DM</td>
<td>Improved implementation of protocols, guidelines, SOPs</td>
</tr>
</tbody>
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### MIXED METHODS
#### Quantitative
- Case-Control or Dose-Response
- Health records and facilities-based surveys

#### Qualitative
- Process assessments
- Focus groups and interviews
"They ask like family members, sit close by, with love, they explain properly.” - Patient, India
## Global Preliminary Results
### Objective 1: Screening and Diagnosis

<table>
<thead>
<tr>
<th></th>
<th>Hypertension</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals screened</td>
<td>59,342</td>
<td>56,642</td>
</tr>
<tr>
<td>Individuals above threshold</td>
<td>6,441</td>
<td>2,563</td>
</tr>
<tr>
<td>New diagnosed</td>
<td>1464</td>
<td>295</td>
</tr>
</tbody>
</table>
## Global Preliminary Results
### Objective 2: Management and Control

### Statistically significant reductions in SBP and A1c in Brazil

<table>
<thead>
<tr>
<th></th>
<th>BRAZIL</th>
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<tbody>
<tr>
<td></td>
<td>Victoria De Conquista</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>average A1C decline</td>
<td>0.9 (0.5-1.4), p&lt;0.001</td>
</tr>
<tr>
<td>% change</td>
<td>25 (12.2 - 37.8) p&lt;0.001</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
</tr>
<tr>
<td>average mmHg decline</td>
<td>4.2 (3.1 -5.2), p&lt;0.01</td>
</tr>
<tr>
<td>% change</td>
<td>10.5(7.8-13.2) p&lt;0.001</td>
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### No significant differences between HealthRise patients and comparison areas in India and South Africa

<table>
<thead>
<tr>
<th></th>
<th>INDIA</th>
<th>SOUTH AFRICA</th>
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<tbody>
<tr>
<td></td>
<td>Shilma</td>
<td>Pixley K Seme</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% meeting targets (A1C&lt;8%)</td>
<td>H 65(56.0 - 73.9)</td>
<td>H 59.5 (42.4 -74.5)</td>
</tr>
<tr>
<td></td>
<td>C 66.(56.5 - 74.4)</td>
<td>C 58.1(45.2 - 69.9)</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% meeting targets (SBP&lt;140 and DBP&lt;90)</td>
<td>H 45(38.6 - 51.7)</td>
<td>H 55.3(38.7-70.7)</td>
</tr>
<tr>
<td></td>
<td>C 58.1(50.3 - 65.6)</td>
<td>C 41.8(31.9-52.3)</td>
</tr>
</tbody>
</table>

H = HealthRise, C = Comparison
% of patients meeting treatment targets significantly higher in Hennepin county.

Better performance of diabetes patients in Hennepin and Ramsey counties compared to comparison areas.
Targeting the Frontline in Community-based Interventions
Care Provision Made Possible by Community Health Workers

3,637 HEALTH WORKERS TRAINED

South Africa 778
Brazil 979
US 33
India 1847

>60% CHWs

SCOPE OF WORK OF CHW

• Promote awareness and screen target population for diabetes and hypertension.
• Refer patients to health facilities and provide follow up support
• Part of the care coordination teams
• Equip with appropriate technology to perform screening and record results
• Perform door to door visits and home-based care
• Expand community-based education and counseling
• Support patient empowerment activities and support groups
HealthRise Countries: Promising Practices
Spotlight on Scalable Local Solutions

- Community - clinic coordination via CHWs/Community Paramedics
- Grocery store wellness “spoke”

- Clinical Nurse Mentorship
- CHWs Equipped with BP Machines and Glucometers
- Patient Support Groups Tackle Social Determinants of Health

- Patient Support Groups
- Electronic Health Card

- Clinical Decision Support System
- A1C Point of Care
- Local Diabetes and Hypertension Associations
“After tests, I came to know and now I believe that even we can have a good life ahead.” - Patient, India
Broader Implications
Emerging Lessons for Future Action

WHAT WE LEARNED

1. Frontline Health Workers offer tremendous capacity to provide follow-up, link to care, navigate social determinants, and support adherence at household level

2. Patient empowerment in self-care drives results, often aided by CHW to lifestyle support and therapy adherence and facilitate through peer groups

3. Despite large number of individuals screened, low yield of confirmed cases was observed. This reinforces the inefficiency of screening camps

4. Investing in user-friendly, integrated and interoperable health information systems to strengthen health systems is critical

5. Sustainable programs result from highly engaged, multi-stakeholder contributions

HOW IT’S INFORMING OUR WORK

1. Honing the focus towards optimizing the health workforce at the point of care for underserved, to scale lessons, innovations and impact

2. Refining our selection methodology for new partners to incorporate what we’ve learned about key organizational capabilities and local stakeholder buy-in, particularly public sector

3. Listening closely to identify the best partnership for the future
THANK YOU

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