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THE IMPORTANCE OF SOCIAL DETERMINANTS OF POPULATION HEALTH MANAGEMENT

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Arthur C. Evans, Jr. PhD is the Commissioner of Philadelphia's Department of Behavioral Health and Intellectual disAbility Service (DBHIDS) – a $1 billion healthcare agency. His work as Commissioner continues his lifelong commitment to serving people who are underserved and ensuring that effective, high-quality healthcare is accessible to all. Dr. Evans has been recognized nationally for his work in behavioral healthcare policy and the transformation of service delivery systems. Prior to his work in Philadelphia, Dr. Evans was the Deputy Commissioner for the Connecticut Department of Mental Health & Addiction Services, where he led major strategic initiatives for the Connecticut behavioral healthcare system. He was instrumental in implementing a recovery-oriented policy framework, addressing healthcare disparities, and increasing the use of evidence-based practices, leading edge research, and community engagement. He holds faculty appointments at the University of Pennsylvania School Of Medicine and the Philadelphia College of Osteopathic Medicine and has held faculty appointments at the Yale University School of Medicine and Quinnipiac University.

Paul Block, PhD is a licensed clinical psychologist with more than 30 years of clinical, administrative, and community service experience linking strategy to performance in the behavioral health sector. He is currently the Vice President for Behavioral Health Services at Riverside Community Care, managing a continuum of services from outpatient and home based therapy through emergency services, hospital diversion programs, and the state's contracted trauma responder, focusing on services for diverse, disadvantaged, and underserved communities and populations. He is also leading a project to bring children's mental health services to Senegal, at the request of local and national leaders. Dr. Block's scholarship includes publications and national conference presentations on health policy, social and behavioral determinants of health, human services leadership, integrated care and behavioral medicine, and cognitive science of treatment. His focus has been on the link between strategic vision and specific procedures for effective, sustainable execution in the community lives of clients. Dr. Block earned his Bachelor's degree in psychology with honors and in philosophy from Brown University, Rhode Island. He went on to complete his Doctorate degree in clinical psychology at New York University, New York.

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OPDC/Lundbeck's interaction with Open Minds is through PsychU, an online, non-branded portal dedicated to providing information and resources on important disease state and care delivery topics related to mental illness. One of the methods employed for the sharing of information will be the hosting of virtual fora. Virtual fora conducted by OPDC/Lundbeck are based on the following parameters:

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OPDC/Lundbeck and/or their paid consultants do not expect to be able to answer every question or comment during a PsychU Virtual Forum; however, they will do their best to address important topics and themes that arise.

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Objectives

To understand

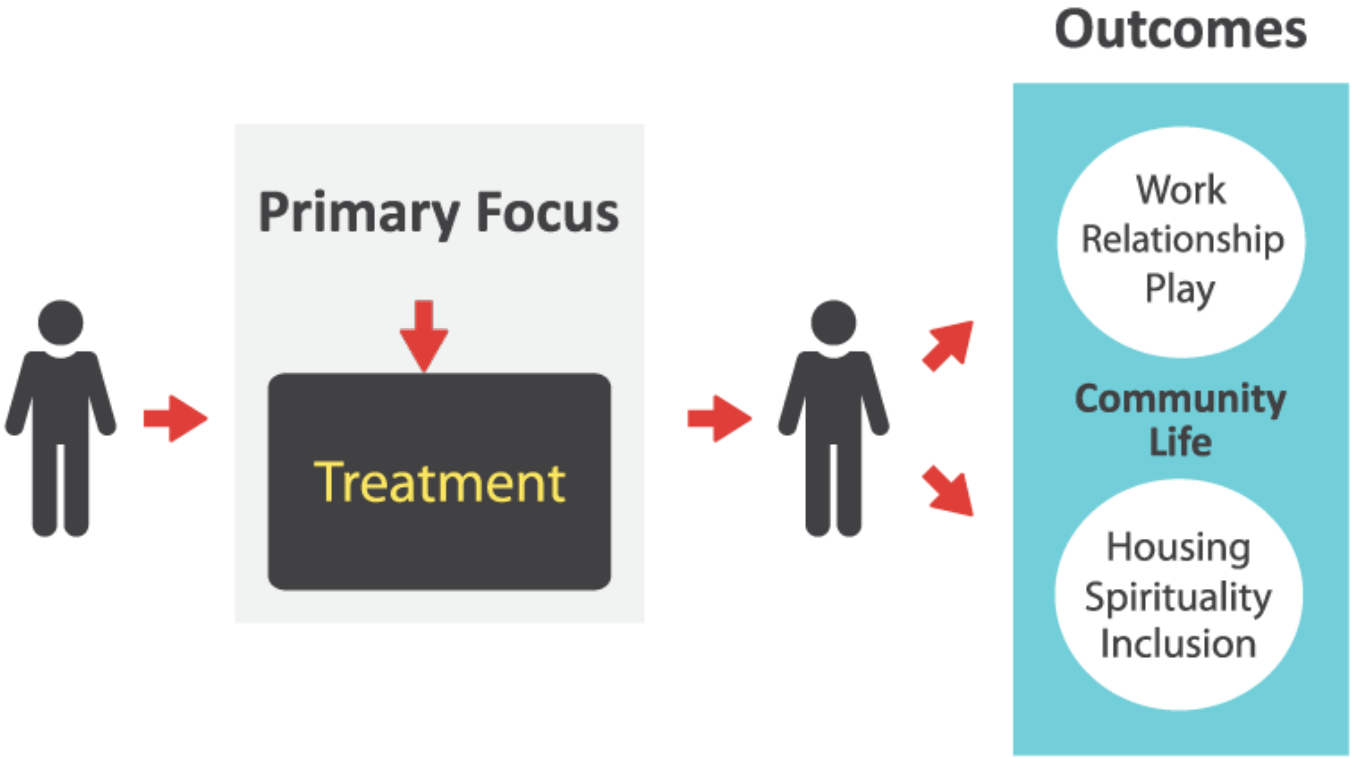
- The connection between social determinants of health and the well-being of a population
- Why social determinants of health must be addressed, especially for people with behavioral health needs
- The public health perspective: What can be done to lessen the impact of adverse social conditions on a population's health

The Connection Between Social Determinants Of Health And The Well-being Of A Population

Discussion Question

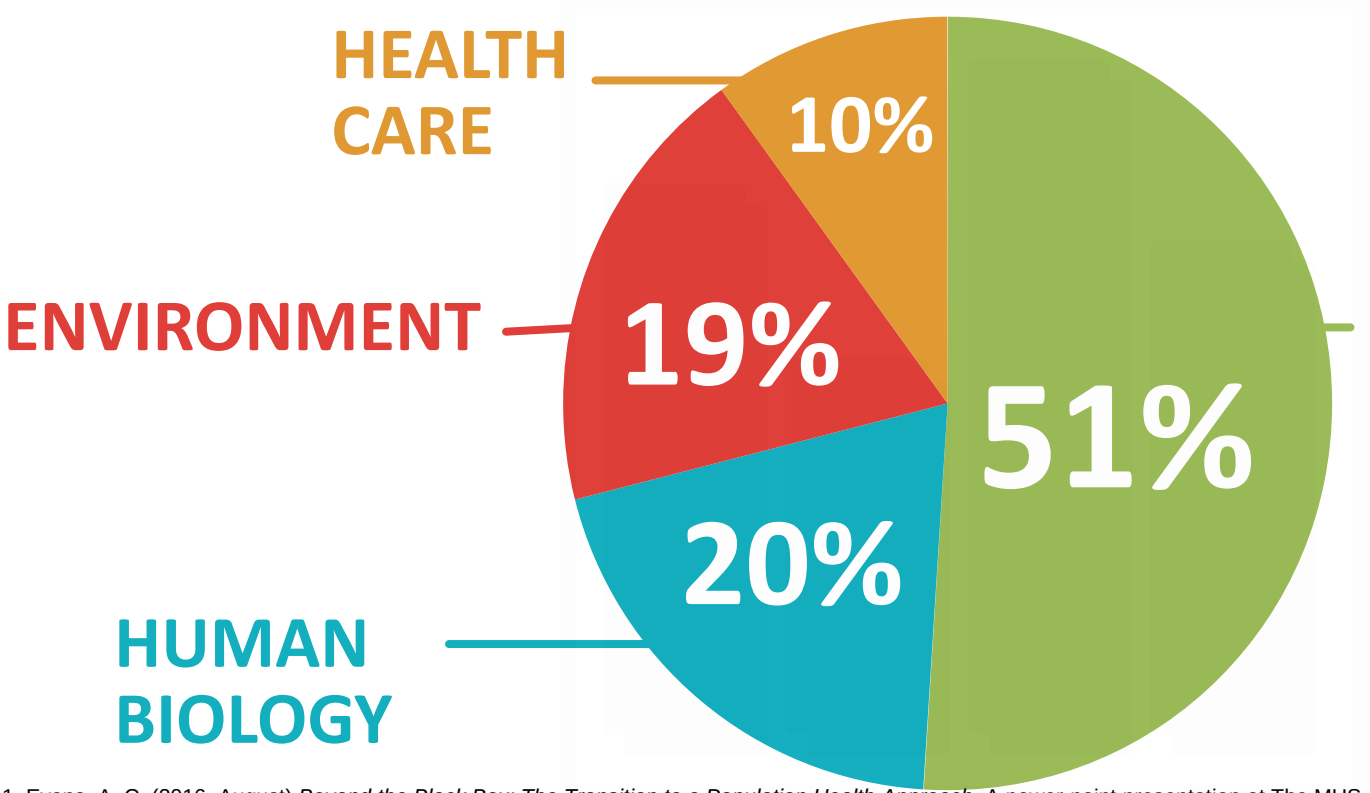
What are some of the challenges currently faced by the U.S. health care system, especially as it relates to keeping populations healthy?

Traditional Treatment Model



1. 1. Evans, A. C. (2016, August) *Beyond the Black Box: The Transition to a Population Health Approach.* A power point presentation at The MHS Conference, Auckland, New Zeeland

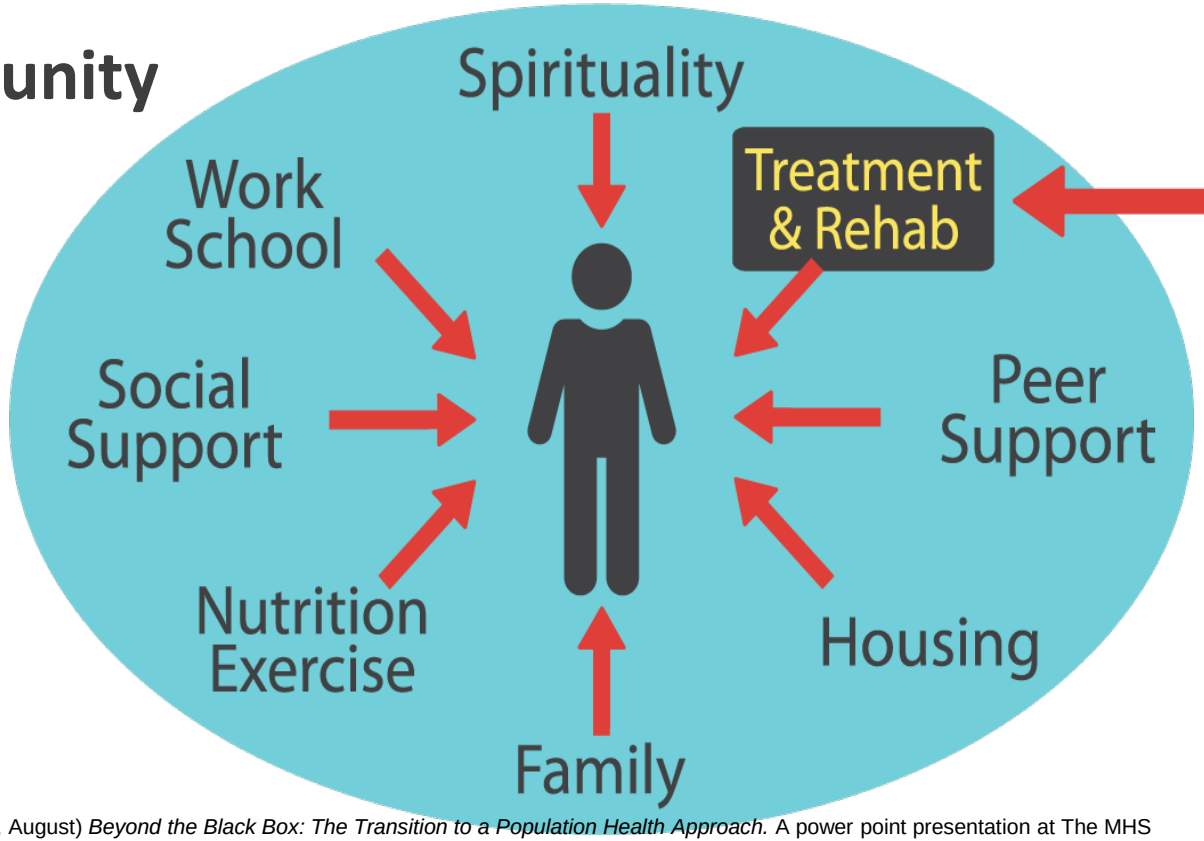
Improving Health Equity Has Significant Health Impacts



- Smoking
- Obesity
- Stress
- Nutrition
- Blood Pressure
- Alcohol
- Drug Use

1. 1. Evans, A. C. (2016, August) *Beyond the Black Box: The Transition to a Population Health Approach.* A power point presentation at The MHS Conference, Auckland, New Zeeland

Interventions With The Greatest Impact



In this model, clinical care is viewed as one of many resources needed for successful integration into the community.

1. Evans, A. C. (2016, August) *Beyond the Black Box: The Transition to a Population Health Approach.* A power point presentation at The MHS Conference, Auckland, New Zeeland

Polling Question

What do you think is the most important social determinant of health in the area where you live and work?

A. Economic stability
B. Education
C. Social and community acceptance
D. Access to health care and health literacy
E. Safe community, access to healthy foods, sufficient housing

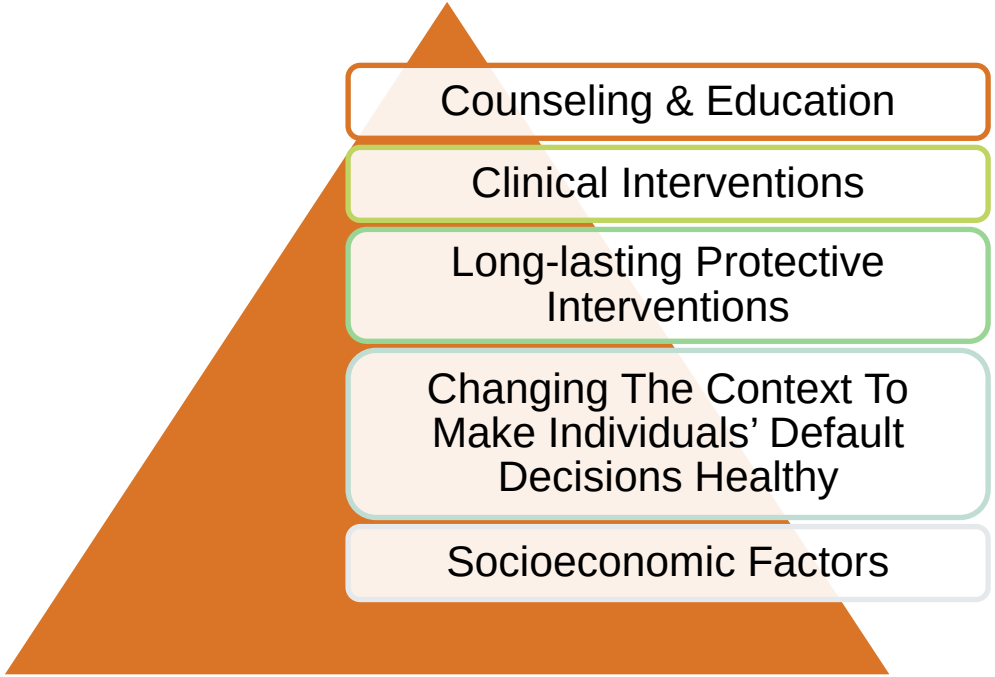
Health Disparities Have Significant Economic Impacts[1]

Eliminating disparities in morbidity and mortality for people with less than a college education would have an estimated economic value of $1.02 trillion.

Eliminating racial and ethnic disparities would reduce medical care costs by $230 billion and indirect costs of excess morbidity and mortality by more than $1 trillion over four years.

1. Thornton, R. L. J. (2016, August). Evaluating Strategies For Reducing Health Disparities By Addressing The Social Determinants Of Health. Retrieved October 2016 from http://content.healthaffairs.org: http://content.healthaffairs.org/content/35/8/1416.full

The Health Impact Pyramid[1]



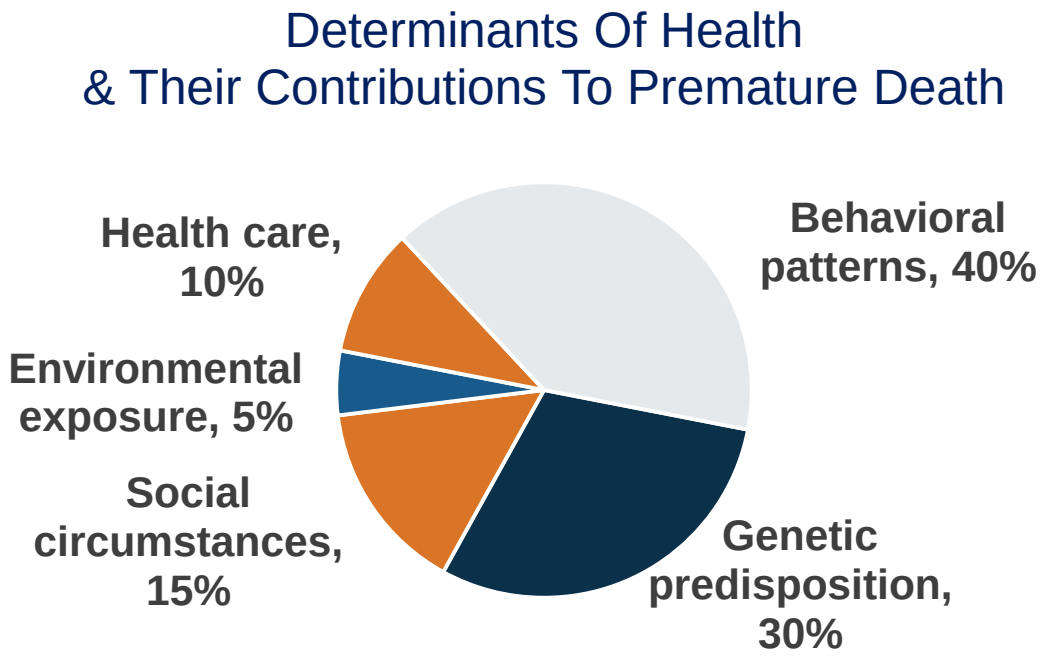
1. Frieden, T. R. (2010, April). A Framework for Public Health Action: The Health Impact Pyramid. Retrieved October 2016 from www.ncbi.nlm.nih.gov: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/pdf/590.pdf

Why Social Determinants Of Health Must Be Addressed, Especially For People With Behavioral Health Needs

Discussion Question

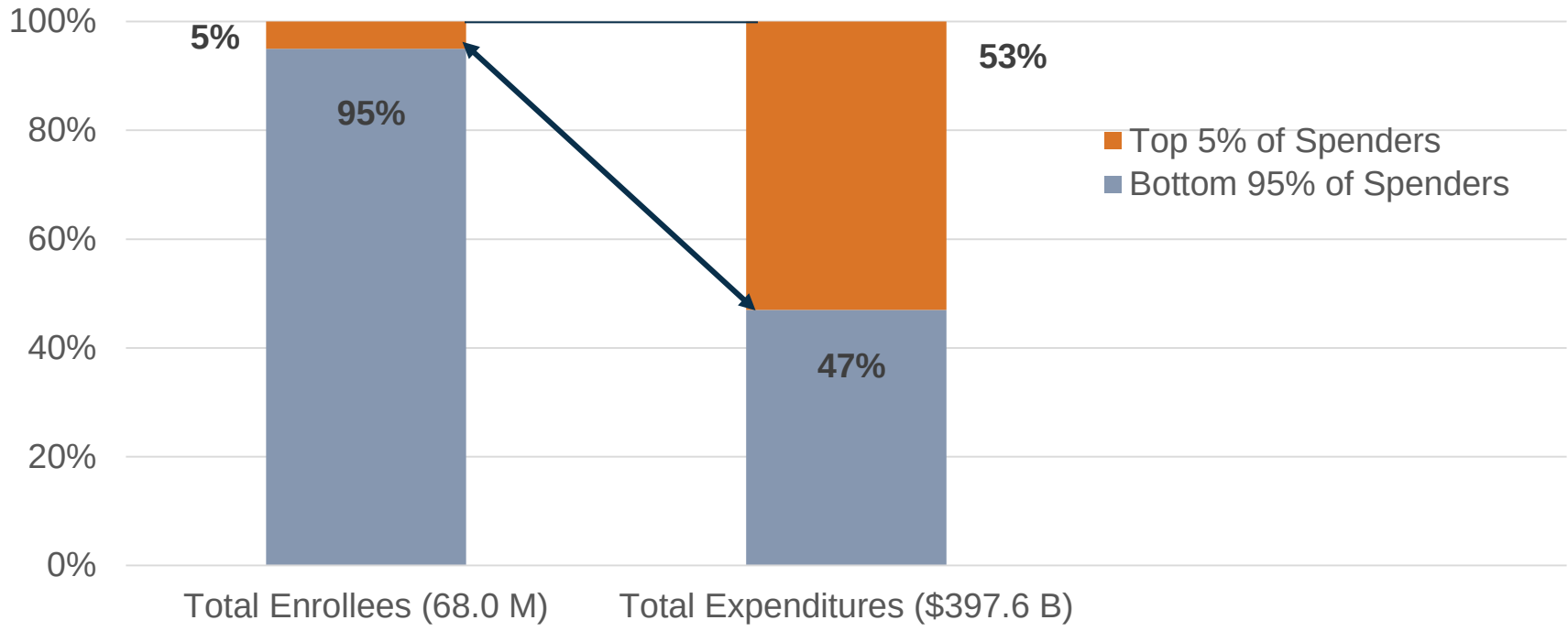
Why would better management of social factors make a difference in health outcomes of people with behavioral health needs?

How Are The 5% Different?
Social Determinants[1]



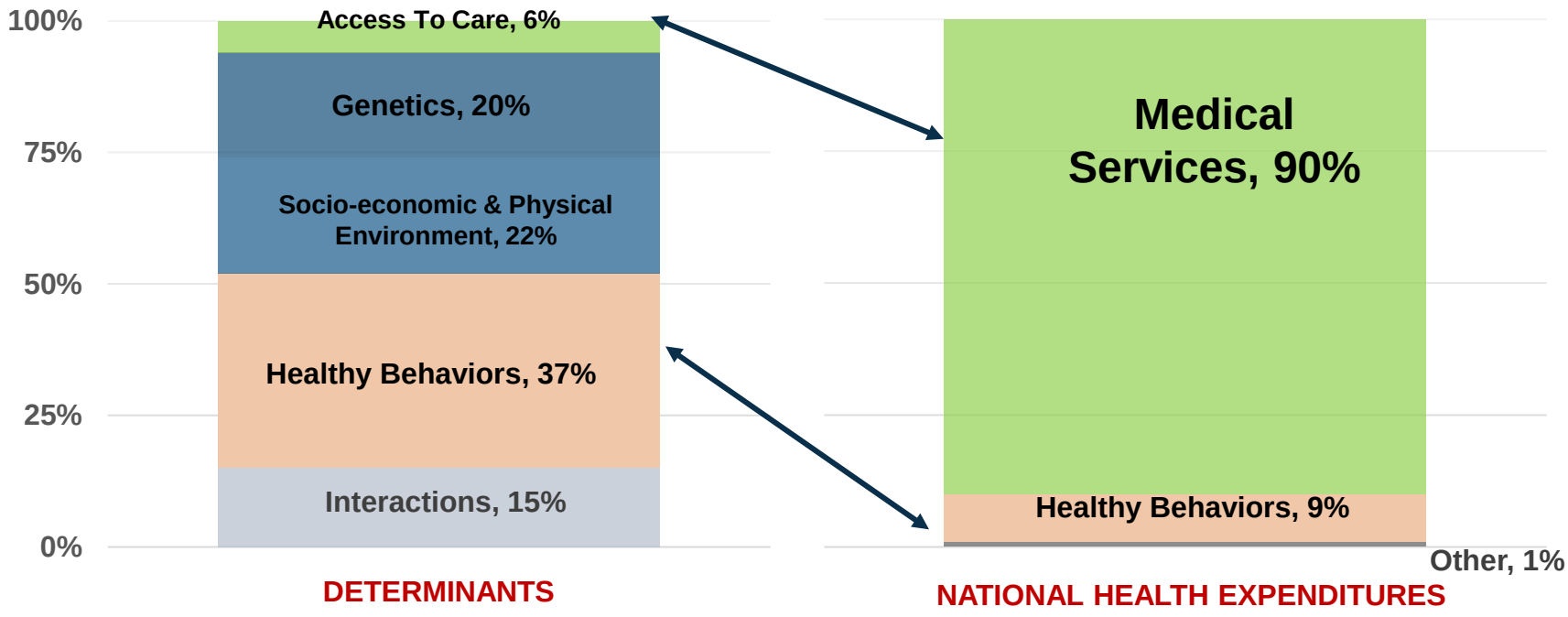
1. Schroeder, S. A. (2007, September 20). We Can Do Better — Improving the Health of the American People. Retrieved October 2016 from www.NEJM.org: http://www.nejm.org/doi/pdf/10.1056/NEJMsa073350

5% Of Medicaid Enrollees Account For More Than 50% Of Spending (2011)[1]



1. Paradise, J. (2015, March 9). Medicaid Moving Forward. Retrieved October 2016 from www.KFF.org: http://kff.org/health-reform/issue-brief/medicaid-moving-forward/

Why Does Health Care Cost So Much?[1]



1. Grogan, P. S. (2013). Healthy People / Healthy Economy Annual Report Card 2013. Retrieved October 2016 from www.NEHI.net: http://www.nehi.net/writable/publication_files/file/hphe.final_2013_3rd_report_card.pdf

Social Deprivation Predicts Health Care Needs & Outcomes[1]

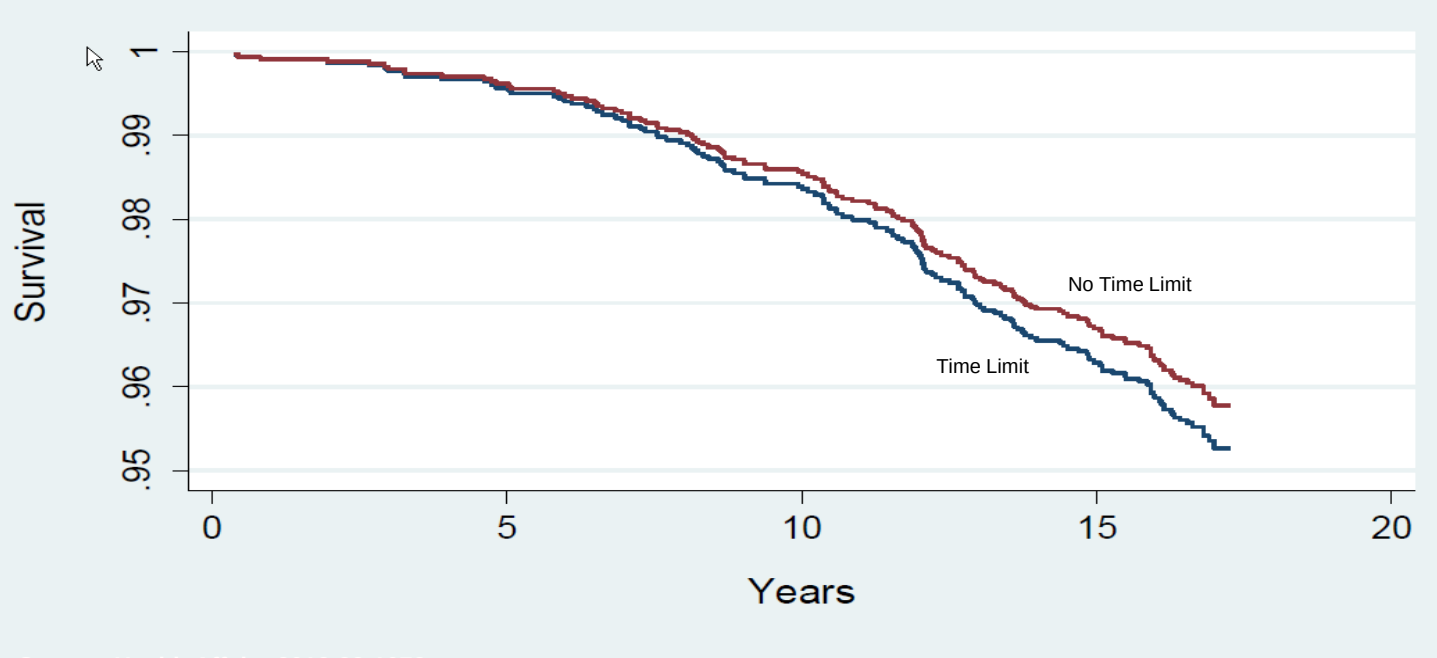
The Graham Center's Social Deprivation Index (SDI) is a stronger predictor of health care utilization and effectiveness than poverty

- SDI is strongly associated with hospitalization in state (RI) and national (Dartmouth Atlas) data
- SDI is very strongly associated with emergency department visits
- SDI is very strongly associated with avoidable hospitalization rates

1. Robert Graham Center. (2013, March 4). Coordinated Health Planning Project: Final Report of Findings. Retrieved October 2016 from www.graham-center.org: http://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Primary%20Care_Rhode%20Island.pdf

Examples: Welfare Time Limit Increases Deaths[1]

A Randomized Trial in Florida



1. Muennig, P. (2013, June). *Survival curves for participants in Florida s Family Transition Program (Treated) and in traditional Aid to Families with Dependent Children (Not Treated) in Escambia County".* Retrieved from Health Affairs: http://content.healthaffairs.org/content/suppl/2013/05/23/32.6.1072.DC1/2012-0971_Muennig_Appendix.pdf

POLLING QUESTION

In the U.S. for every $1 spent on health care, how much is spent on social services?

A. $2
B. $1.50
C. $1
D. $0.75
E. $0.50

The Public Health Perspective: What Can Be Done To Lessen The Impact Of Adverse Social Conditions On A Population's Health?

The Philadelphia Approach to Population Health

The City of Philadelphia is moving to address behavioral health care and intellectual disability through a population health approach.[1]

Key components[2]

- Public education and training
- Prevention and early intervention
- Community engagement
- Cross-system collaboration
- Evidence based treatment services
- Innovative treatment services

1. Department of Behavioral Health and Intellectual disAbility Services (DBHIDS). (2015). About Us. Retrieved October 2016 from Department of Behavioral Health and Intellectual disAbility Services (DBHIDS): http://www.dbhids.org/about/
2. Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) . (2015). *Community.* Retrieved October 2016 from Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) : http://dbhids.org/community/

Integrating physical health and behavioral is essential for implementing a population health approach.

Discussion Question

What are some examples of social determinants in Philadelphia that are being leveraged to improve the health of its population?

Addressing the Social Determinants of Health

- Income and Income Distribution
- Education, Unemployment and Job Security
- Employment and Working Conditions
- Early Childhood Development
- Food Insecurity
- Housing
- Social Exclusion
- Social Safety Network
- Health Services
- Aboriginal Status
- Gender Race and Disability.

1. Evans, A. C. (2016, August) *Beyond the Black Box: The Transition to a Population Health Approach.* A power point presentation at The MHS Conference, Auckland, New Zeeland

Addressing the Social Determinants of Health – Philadelphia, PA

1

- Improve clinical outcomes and fiscal performance
- Example: Permanent Supportive Housing Initiative
  - Since 2008, over 1000 individuals moved into permanent housing[1]
  - 94% of cohort remain housed with improved health status[2]
  - Generated millions in savings over the years
  - Per member per day costs reduced from $85 to $18[4]

1. Evans, A. C. (2015, April 21). *Philadelphia Succeeds Without 'Asylums".* Retrieved October 2016 from www.PHILLY.com: http://www.philly.com/philly/blogs/public_health/Philadelphia-succeeds-without-asylums.html
2. Evans, A. C. (2015, April 21). Philadelphia Succeeds Without 'Asylums". Retrieved October 2016 from www.PHILLY.com: http://www.philly.com/philly/blogs/public_health/Philadelphia-succeeds-without-asylums.html
3. Chisholm, L. (2010). Savings Lives, Saving Money. Cost-effective Solutions to Chronic Homelessness in Philadelphia. Retrieved October 2016 from Projecthome.org: https://projecthome.org/sites/projecthome.org/files/Saving%20Lives,%20Saving%20Money.pdf
4. Evans, A. C. (2016, August) *Beyond the Black Box: The Transition to a Population Health Approach.* A power point presentation at The MHS Conference, Auckland, New Zeeland

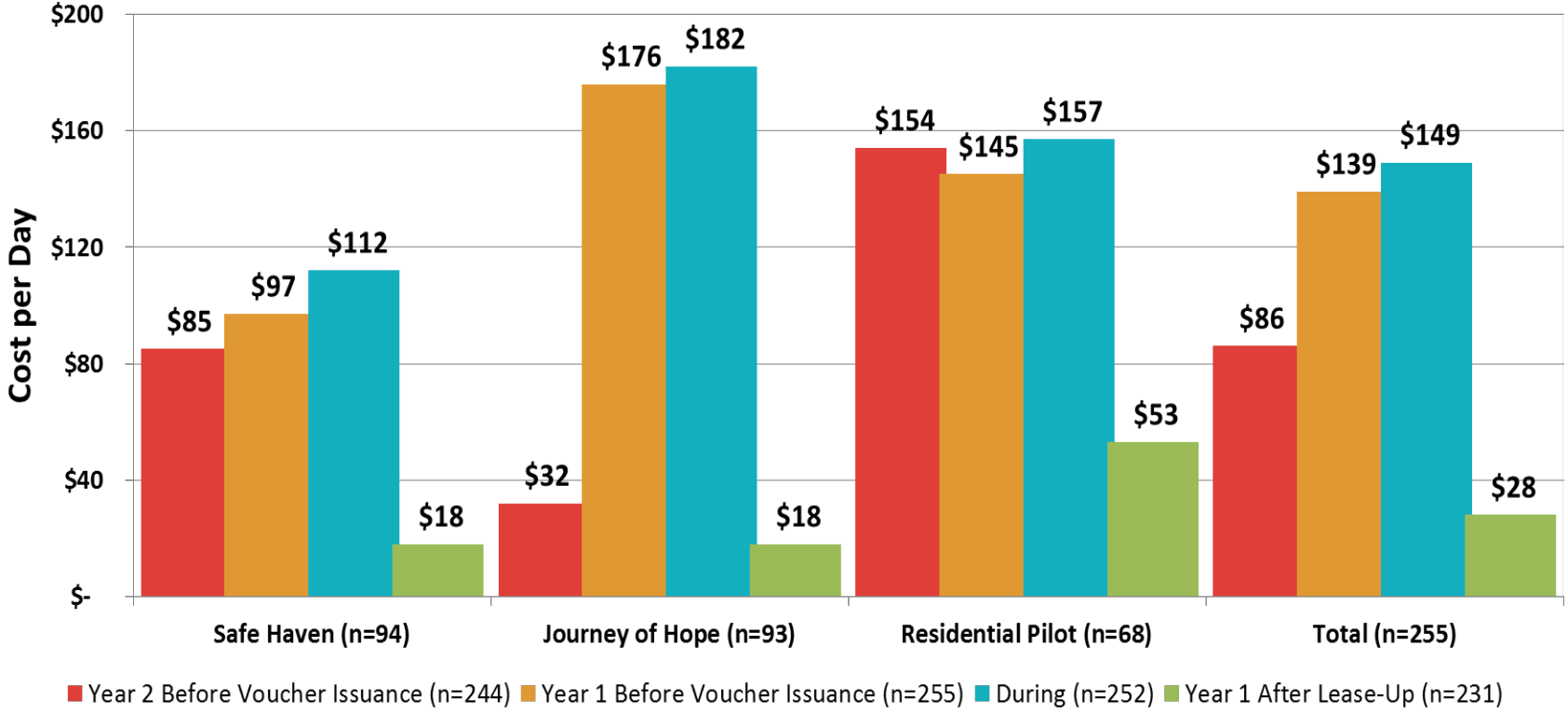
Multiple Pathways to End Homelessness

- **Housing First**
  - Targeted outreach to individuals with longest histories of homelessness, collaboration with the Veteran's Administration
- **Journey of Hope**
  - Specialized residential substance abuse treatment programs for people experiencing long-term homelessness
- **Safe Havens / Shelters**
  - Referrals exclusively for persons experiencing chronic street homelessness
  - In 2015, 554 persons served, 239 discharged to a positive next step, primarily supportive housing

1. Evans, A. C. (2016, August) *Beyond the Black Box: The Transition to a Population Health Approach.* A power point presentation at The MHS Conference, Auckland, New Zeeland

Average Cost per Day over Time (*n*=255)

Note: Annualized average cost calculated by total (sum) cost/365 days year 2 before voucher issuance, year 1 before voucher issuance and year 1 after lease-up; during period equates to total (sum) cost/days between voucher issuance and lease-up.



1. Evans, A. C. (2016, August) *Beyond the Black Box: The Transition to a Population Health Approach.* A power point presentation at The MHS Conference, Auckland, New Zeeland

Discussion Question

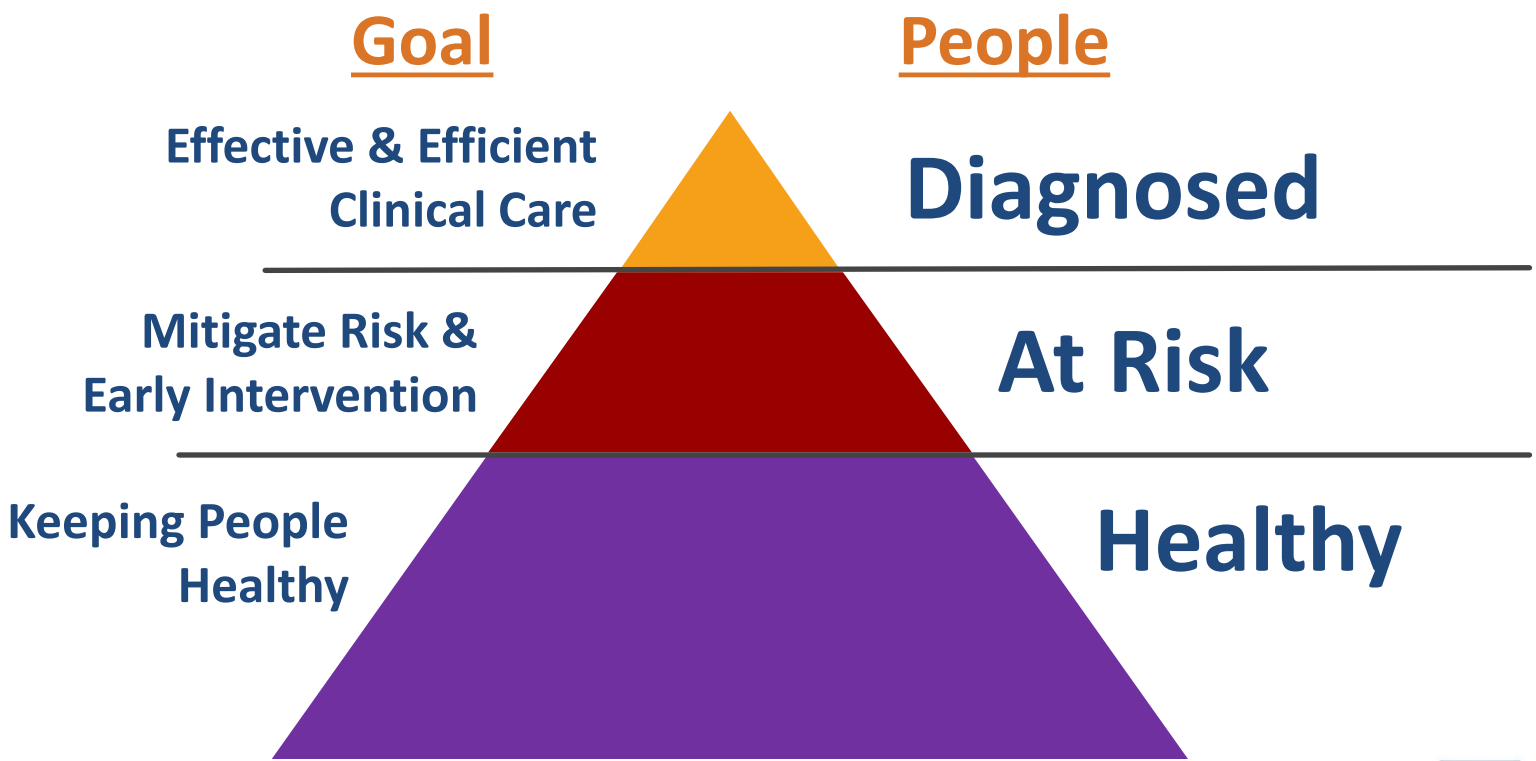
How do you know if a population management approach is working? What evidence should you look for?

The 7 Competencies Needed for Population Health Management[1]

1. Working at the community and group level
2. Working upstream
3. Broad set of strategies
4. Working with non-diagnosed populations
5. Deliver health promotion interventions
6. Working in community and other non-clinical settings
7. Health activation approaches and empowering others

1. Arthur C. Evans, J. (2015). Emerging Role of a Public Health Framework to Address Population Health Management. 2015 Open Minds Performance Management Institute. Clearwater, FL: *OPEN MINDS*.

Population Health Approach



1. Evans, A. C. (2016, August) *Beyond the Black Box: The Transition to a Population Health Approach.* A power point presentation at The MHS Conference, Auckland, New Zeeland

Philadelphia Impact[1]

Public Health Goals	More engaged community around behavioral health issues
	Cross systems capacity to address behavioral health issues
	More competency
	Greater awareness
Managed Care Goals	Per person cost has decreased
	Millions saved in avoidable readmissions
	Improved clinical outcomes

1. Arthur C. Evans, J. (2015). Emerging Role of a Public Health Framework to Address Population Health Management. 2015 Open Minds Performance Management Institute. Clearwater, FL: *OPEN MINDS*.

Where Are We Headed?

A Call To Action!

Given the impact of behavioral health conditions the field must begin using a public health frame	A public health frame gives us the opportunity to improve overall **population health**, while simultaneously allowing us to administer more efficient healthcare systems	These are doable and effective strategies

This information is based on the presenter's professional experience.

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QUESTIONS

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CLOSING

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Upcoming Virtual Forum*

Meeting The Challenges In Caring For Patients With Schizophrenia:
Roles Of The Pharmacist

12 pm to 1 pm EST

Featuring:
Larry Cohen, PharmD, BCPP, FASHP, FCCP, FCP
Larry Ereshefsky, PharmD, FCCP, BCPP

***Register** at www.psychu.org/events