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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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
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. 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 Zealand
Improving Health Equity Has Significant Health Impacts

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 Zealand
Interventions With The Greatest Impact

Community Life

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 Zealand
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

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.

The Health Impact Pyramid


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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

Determinants Of Health & Their Contributions To Premature Death

- Behavioral patterns, 40%
- Genetic predisposition, 30%
- Social circumstances, 15%
- Environmental exposure, 5%
- Health care, 10%

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


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Why Does Health Care Cost So Much?¹


DETERMINANTS

- Genetics, 20%
- Healthy Behaviors, 37%
- Socio-economic & Physical Environment, 22%
- Interactions, 15%
- Access To Care, 6%

NATIONAL HEALTH EXPENDITURES

- Medical Services, 90%
- Healthy Behaviors, 9%
- Access To Care, 6%
- Genetics, 20%
- Socio-economic & Physical Environment, 22%
- Interactions, 15%
- Other, 1%
Social Deprivation Predicts Health Care Needs & Outcomes

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

Examples: Welfare Time Limit Increases Deaths

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
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 components²

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

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 Zealand
Addressing the Social Determinants of Health – Philadelphia, PA

• Improve clinical outcomes and fiscal performance

• Example: Permanent Supportive Housing Initiative
  – Since 2008, over 1000 individuals moved into permanent housing
  – 94% of cohort remain housed with improved health status
  – Generated millions in savings over the years
  – Per member per day costs reduced from $85 to $18

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 Zealand
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 Zealand
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.

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. 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

Population Health Approach

Goal

Effective & Efficient Clinical Care

Mitigate Risk & Early Intervention

Keeping People Healthy

People

Diagnosed

At Risk

Healthy


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# Philadelphia Impact

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<tr>
<th>Public Health Goals</th>
<th>Managed Care Goals</th>
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<tr>
<td>More engaged community around behavioral health issues</td>
<td>Per person cost has decreased</td>
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<tr>
<td>Cross systems capacity to address behavioral health issues</td>
<td>Millions saved in avoidable readmissions</td>
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<td>More competency</td>
<td>Improved clinical outcomes</td>
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<td>Greater awareness</td>
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## 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.
QUESTIONS
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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