

# ***Population Health in Practice: Providing Interventions Across the Health Continuum***

***Case Study: Clinical Care  
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# Presentation Overview

- The Framework: Foundation, Transformation and Population Health
- Defining “Health” and “Population Health”
- Population Health in Practice at CBH
  - Care Management Transformation
  - Beyond Managed Levels of Care
  - Specific Interventions
  - Moving outside of “Utilizers”

- **1<sup>st</sup> WAVE: Building the Foundation**

- De-institutionalization  
*(Getting people into the community)*
- Expanding Network of Providers
- Creating CBH (Administrative Infrastructure)
- Creating the Department & a single payor system

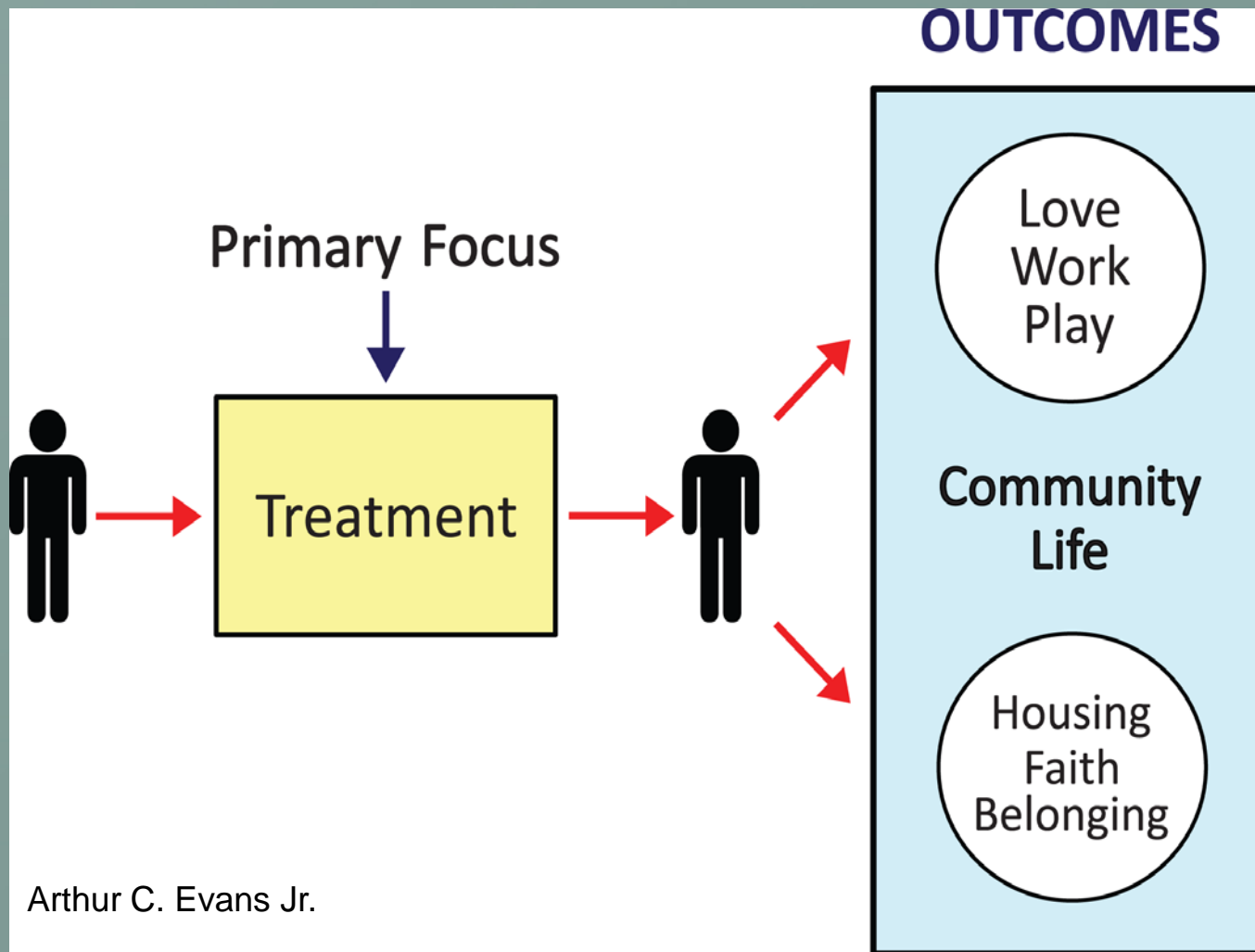
- **2nd WAVE: Transformation Decade**

- Improving quality of life (recovery, resilience, self-determination)  
*(Helping people to be a part of the community)*
- Creating Learning Organization

- **3<sup>rd</sup> WAVE: Population Health**

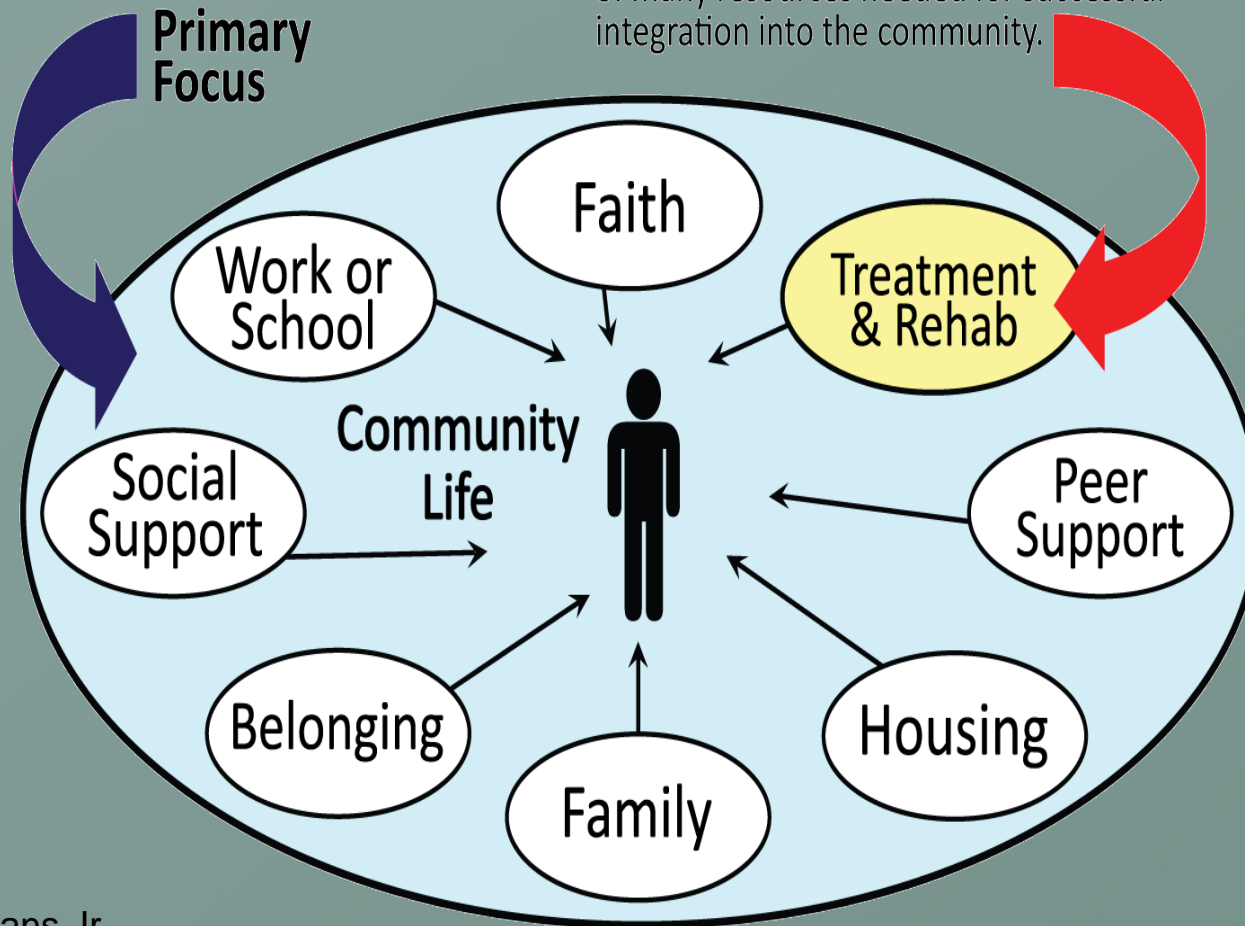
- Promoting Health & Wellness for the population  
*(Promoting healthy Communities)*
- Single unifying framework for all services and populations
- Reaching everyone
- Efficiency and Effectiveness

# TRADITIONAL TREATMENT MODEL

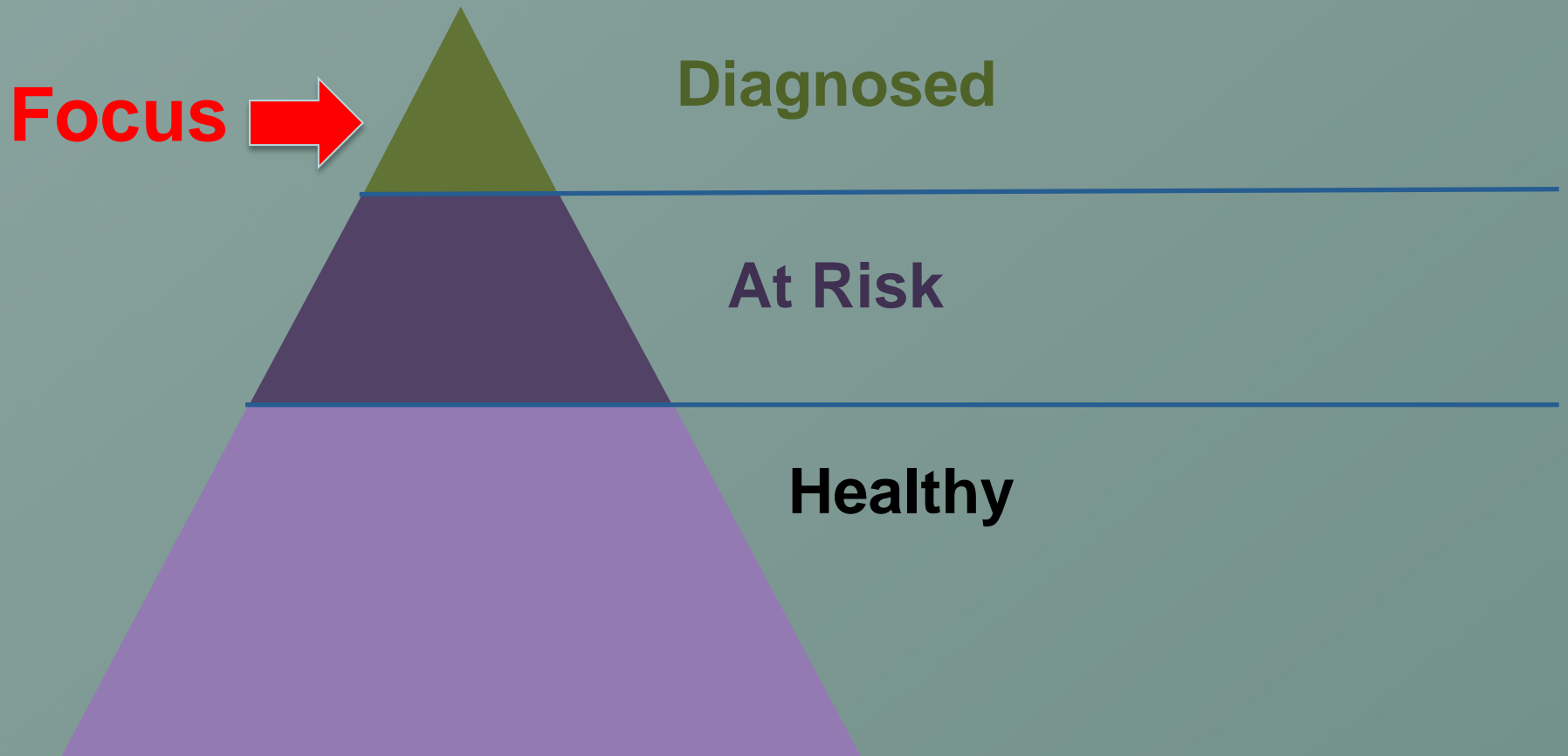


# Recovery Oriented System of Care

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

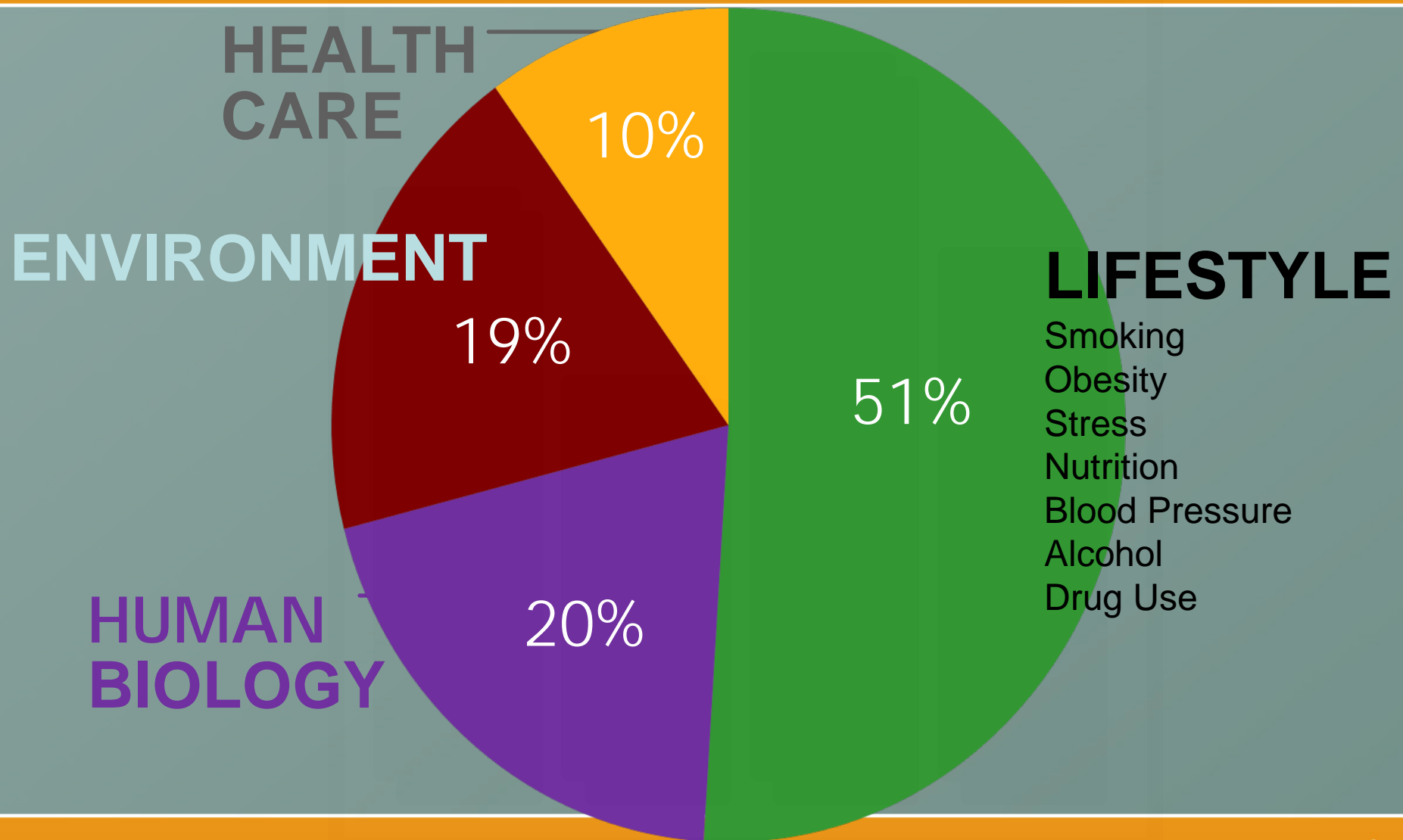


# Our Current Healthcare Approach





# Factors that Influence Health Status





# WHO definition of 'health'

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity



# Population Health

**...the health outcomes of a group of individuals, including the distribution of such outcomes within the group.**

These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group

*Kindig and Stoddart, 2003*

# The 5 Principles Needed for a Population Health Approach



- 1. Attend to the whole population**
- 2. Promote health, wellness, and self determination**
- 3. Provide prevention and early interventions**
- 4. Address the social determinants of health**
- 5. Empower individuals and communities to keep themselves healthy**

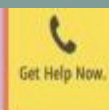
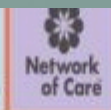




# Wellness Promotion

## Faith and Spiritual Affairs (FSA) Initiative

- Vision: Optimal health and well-being for all of Philadelphia's Faith and spiritual communities including health providers
- Utilizes the public health approach to educate communities of faith with Evidence Based trainings, workshops and conferences
- Focus on educating on the signs and symptoms of behavioral health along with local behavioral health resources and programs (e.g. Mental Health First Aid)



## Help Yourself, Help Others®

[Mental Health First Aid »](#)

Learn to identify, understand, and respond to signs of behavioral health challenges or crises.

[Behavioral Health Screening »](#)

If you feel sad, anxious or stressed, this screening tool can help you decide if you need further help.

[Calendar »](#)

Find awareness events, screenings or trainings, post your own event to the calendar, or request event support from DBHIDS.

[Blog »](#)

Thoughts and updates from Dr. Arthur C. Evans, Jr., Commissioner of DBHIDS and staff.

*The Philadelphia Department of Behavioral Health and Intellectual disability Services (DBHIDS) offers these tools and resources for everyone seeking to support and improve the mental health and well-being of themselves or those they care about.*

[Wellness Corner](#)



# HealthyMindsPhilly.org

- An online tool and resource to support and improve the mental health and well-being of all Philadelphians.
- Partnership with Screening for Mental Health Inc. (SMH) to offer a virtual resource designed to provide awareness and education on behavioral health issues and to offer helpful information.
- Online screening tool that is quick, free and anonymous so Philadelphians can find out about their own mental and emotional well-being.
- A “**check-up from the neck up**”

# Social Determinants of Health

Those elements of social structure most closely shown to affect health and illness, including:

- INCOME INEQUALITY
- FOOD SECURITY
- HOUSING QUALITY
- SOCIAL STATUS
- NEIGHBORHOOD CONDITION
- EMPLOYMENT OPPORTUNITY
- DISCRIMINATION
- CULTURAL NORMS
- SOCIAL EXCLUSION
- POLITICAL MARGINALIZATION
- PHYSICAL ISOLATION
- PUBLIC SERVICE SYSTEMS

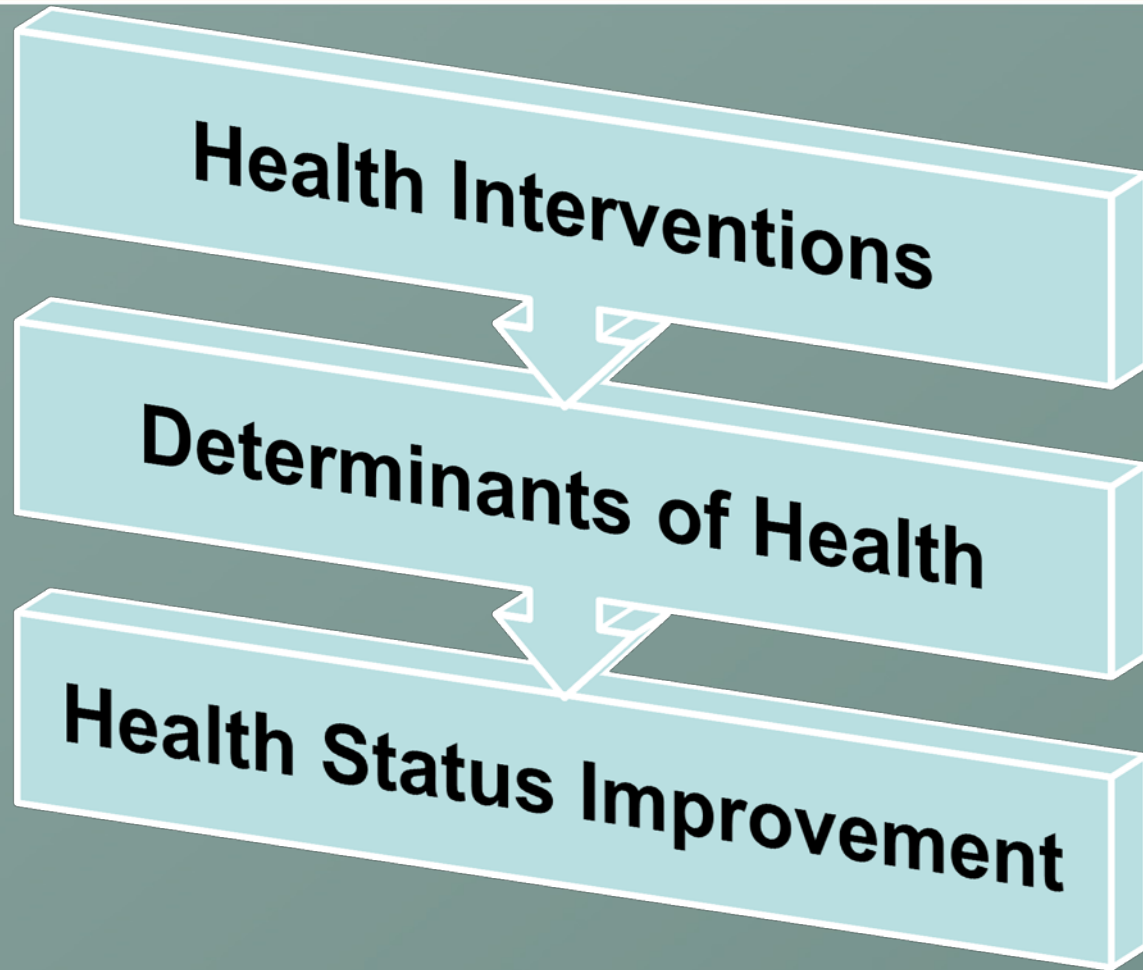
The Adler School's Institute on Social Exclusion, 2010



# Engaging Males of Color (EMOC)

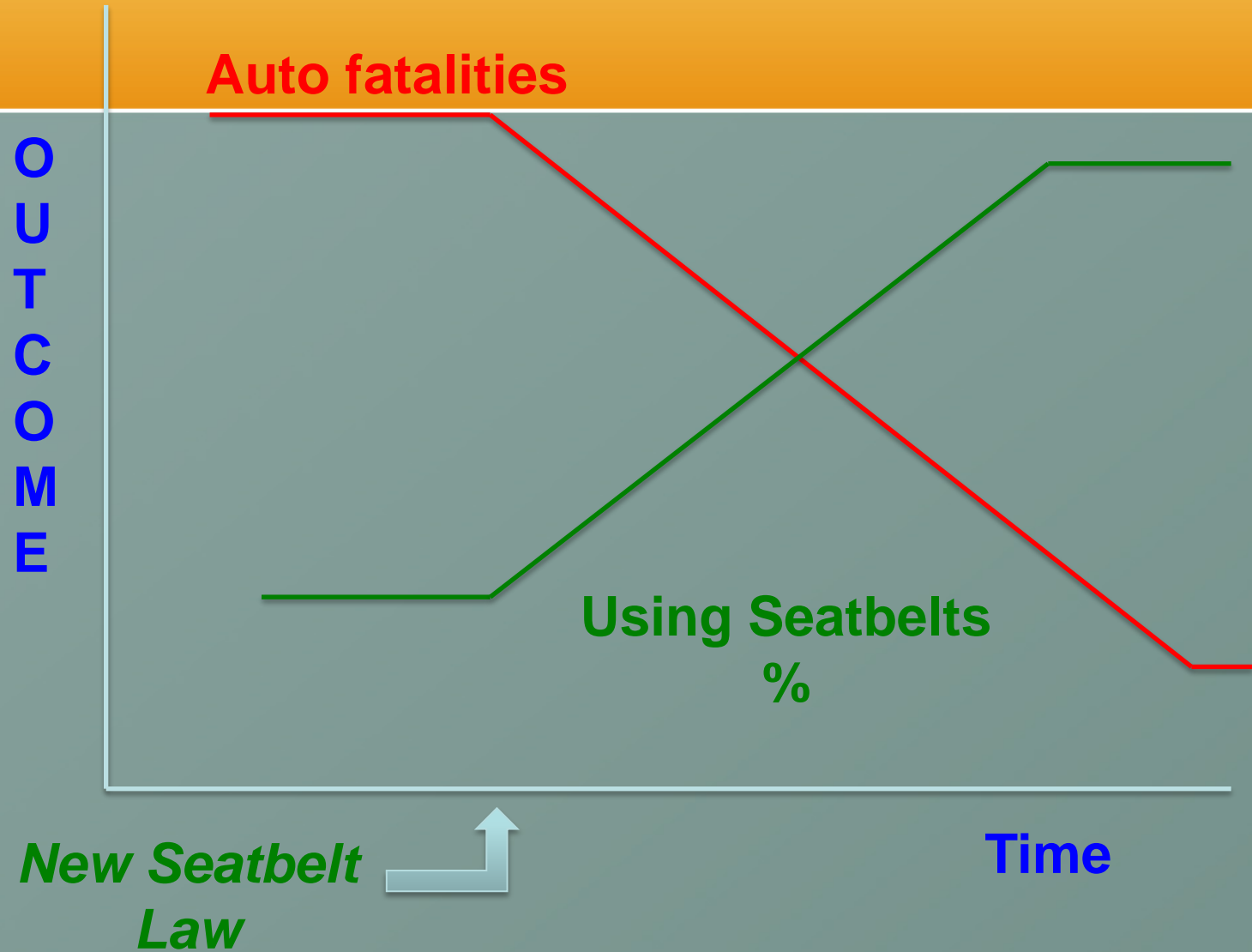
- Initiative under the direction of our Commissioner Dr. Arthur Evans
- Designed to address the impact of health, economic & educational disparities experienced by males of color.
- Goals are;
  1. to promote better understanding and awareness of behavioral health challenges
  2. reduce the associated stigma
  3. improve the quality of life for males of color throughout the Philadelphia region.

# Population Health: Dr. Fabius



# Health Interventions

- **CREATE TAXES** (tobacco, ETOH)
- **CREATE LAWS** (seatbelts, helmets, 'health in all policies')
- **CREATE MEDICAL BREAKTHROUGHS** (vaccines, prenatal testing)
- **CREATE SAFER WORKPLACES** (OSHA)



# Population Health in Practice

- Evolving Practices in Care Management
- Expanding beyond historically Managed Levels of Care
- Specific Initiatives
- Moving outside of “utilizers”



# Transforming Care Management

- Historically, care management focused on cost containment and therefore on the most expensive levels of care
- Significant resource allocation to utilization review of inpatient levels of care
- Although mandated to ensure services provided are medically necessary there as not adequate attention to underlying factors or focus on ensuring community success



# Transforming Care Management

- Developing a risk model for re admission using clinical factors, utilization rates and social determinants.
- Allows for assignment of relative risk for individuals and for the tailoring of interventions according to needs
- Data and analytics are utilized for identification of cohorts which allow for specific care management interventions



# Transforming Care Management

- Practices that allow us to predict who is likely to be “sick” again and who is likely to remain “well”
- Begins the process of up streaming who is likely to get sick again
- Incorporates social determinants
- Empowerment

# Expanding Care Management

- Care Management has traditionally focused on individuals at costliest levels of care ie inpatient
- Outpatient level of care has not been care “managed”
- Opportunity to work not at the individual but at the provider/community level
- New paradigm of management



# Expanding Care Management

- Focus upon agency level outcomes alignment with best practices
- Information and data sharing will be a big component but can also be built into P4P etc
- Attending to an expanded population—still the sick but focusing on how to keep the less sick less sick.



# Specific Initiatives: Benzodiazepines

- Concerns about benzodiazepine prescribing rates in the network and safety
- Particularly relevant given opioid crises
- Steps included
  - (1) the creation & dissemination of network guidelines
  - (2) network education
  - (3) requirement that agencies devise specific policies
  - (4) follow up monitoring

# Specific Initiatives: Benzodiazepines

- Up streaming—addressing those who are not on benzodiazepines but are at risk for becoming so
- Entire population—focuses on those both at risk for being placed on benzodiazepines and those already on

# Specific Initiatives: PEACE

- The PEACE program
- DBHIDS funded clinical program out of Horizon House focusing on early onset psychosis
- Emerging literature on early intervention in psychotic disorders
- Evidence based and cost effective
- Up Streaming



# Specific Initiatives: Smoking

- Smoking is a major cause of morbidity and mortality for our members
- In 2015, Smoking was prohibited across the inpatient CBH network
- Network Intervention through policy allowing for wellness, empowerment and resiliency

# Beyond “Utilizers”

- The non-involved offer both challenges and opportunities
- We need to move beyond the involved to reach the whole population
  - Mental Health First Aid
  - Screenings
  - Mural Arts



# Beyond “Utilizers”

- Point of first contact
- Education of new members offers a significant opportunity through mailings, internet materials and in house trainings
- Wellness Apps
  - Wellness apps available for use at point of entry
- Expanding Community Education
  - Wellness Lectures in the community
  - Member orientation, forums and regular dissemination of information.

# Beyond “Utilizers”

Resource Support for members:

- Assisting members with needs beyond treatment referrals
- Advocating for social policy and legislation
  - Pre K, Head Start, HealthCare Access, Income inequality, K2
- Braided funding opportunities and grants
  - Expanding the scope of Medicaid
  - Innovative funding approaches