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”
• 1st 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

• 3rd 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

Primary Focus

Treatment

OUTCOMES

Love
Work
Play

Community
Life

Housing
Faith
Belonging

Arthur C. Evans Jr.
Recovery Oriented System of Care

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

Primary Focus

Community Life

- Faith
- Work or School
- Social Support
- Belonging
- Family
- Housing
- Peer Support
- Treatment & Rehab

Arthur C. Evans Jr.
Our Current Healthcare Approach

Focus

Diagnosed

At Risk

Healthy
Factors that Influence Health Status

- **Health Care**: 10%
- **Environment**: 19%
- **Human Biology**: 20%
- **Lifestyle**: 51%

Lifestyle includes:
- Smoking
- Obesity
- Stress
- Nutrition
- Blood Pressure
- Alcohol
- Drug Use
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
- Determinants of Health
- Health Status Improvement
Health Interventions

- CREATE TAXES (tobacco, ETOH)
- CREATE LAWS (seatbelts, helmets, ‘health in all policies’)
- CREATE MEDICAL BREAKTHROUGHS (vaccines, prenatal testing)
- CREATE SAFER WORKPLACES (OSHA)
Auto fatalities

Using Seatbelts%

New Seatbelt Law

Time
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 readmission 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