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POPULATION HEALTH SCIENCE SUMMIT: NEW APPROACHES, NEW MODELS, NEW OPPORTUNITIES “FLASH TALK”

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TRANSCRIPT

Dr. Anita Everett: Thank you and I guess I want to do want to say thank you to Arthur for having me here, but I also want to say that was a tough act to follow. Thank you for that and I'm a little bit more in the applied space. I've got a couple orienting comments and foundations I want to lay and then I want to end my talk by talking a little bit about some of the use cases for population health that we use on a daily basis at SAMHSA. I am Anita Everett, I'm the director of the Center for Mental Health Services at SAMHSA.

It's been referenced earlier a number of different grant programs that we operate and then I will explain a little bit more about that later. First, I want to encourage you to think about this room that we're in, we're in a room of big ideas, this is an idea. This is called Aspire, which is inspirational I think, and many of us have been in this room many different times for various different inspirational events and activities that have happened. I'm also standing immediately in front of the Capitol, which at various times, it serves as an inspiration for us.

Now I see a little bit of laughing about that it may not be the best inspiring conversation right now. There's those of us who are federal employees are wondering about government closure in the next couple of weeks, things like that but a big idea, Washington itself is a room of big ideas. Given that and given the intellectual capital that we've got in the room, I want to also encourage us to think a little bit, most of us have a basic foundational understanding of cognitive behavioral therapy.

I want to encourage us to think just a little bit about the way we conceptualize ourselves and I'd like to invite you to think of yourself wherever you are in life and whatever position or role you're in as an influencer. That's a modern term that has to do with the reputation or roles that are developed through social media but each of you I assert to you are influencers in one way or another and or could be with regards to thinking about moving down the field with regards to population health.

Many of you are teachers, what are you doing right now to teach either about population health or to encourage students to think about going into careers that involve public health? Actually, when I first came here, I was a little bit concerned it would be a room of psychologists, but I actually have learned there's quite a few public health professionals here as well, which is really nice to see. You're an influencer, if you're a teacher, if you're a writer, if you're an editor of a journal, if you're a provider.

If you belong to a professional organization, you engage with the American Psychological Association, you have potential to have an influence across. Use your influence and explicitly think about your influence potential to think about these broader ideas of population health. One other framing comment I want to give is the notion of innovation itself. There is an actual rigor to

innovation, there are many different tools that have been described. I think the credit in the academic realm goes to Clayton Christensen for thinking about different innovation tools.

One of the innovation tools that is talked about that we use quite a bit at SAMHSA that it will be familiar to those who work in Washington is at the notion of analogous learning. In former lives that might have been also called the Bragg and Steele sort of technology, but analogous learning is the more proper name for that. By analogous learning, I think a lot of us see things, see ideas, see structures in other places, and then we put them into the context that we're working in and we can learn from that, from the analogies that go across that.

With that, I do want to have us now think just a little bit about back to the notion of big ideas. Some of the big ideas that have moved to public health in the last little bit, last maybe say century or so. Individuals, academics like Dr. Sandra Galea, describe phases or key terms or eras of public health. He roughly describes and there are many others who've written about this, and it's actually taught as our public health colleagues will know in basics of public health.

Public Health 1.0, we're in the era of infectious disease and communicable disease where largely our lifespan was driven by access to and our inability to access or underdeveloped treatments for infectious diseases. We were reminded of that recently in the last three years with COVID where we had a little bit of a back into our lives being managed in our lifespan. In fact, as was demonstrated earlier by Dr. Insel, our lifespan being shortened by the effects of COVID but look where we are now, three years later, three and a half to four years later.

We have no cure for COVID, but we have effective measures and we know that if you're vaccinated, you have a much less chance of acquiring COVID, certainly of dying by it and much-diminished course than otherwise would be the case. We've come a long way with that phase of public health. Second phase has to do with behavior and modifiable risk factors, cardiovascular risk factors, and things like smoking. We've actually done really well with regards to smoking, still there are many more of us that smoke than should.

In a population like ours, many other places in the world that have upwards of 50% to 60% smoking rates but we're down to below 20%. Every year, it gets a little bit lower and a little bit lower so those health risks, that era of public health and awareness of that is we're doing pretty well with regards to that. I also want to suggest that to really fully realize all the potentials in the health risk and health behavior, we probably aren't going to have to as was mentioned earlier by some of the things vertically.

I think a lot of us that have kids, many in our generation are more still like french fries, hamburgers, those diet things that aren't necessarily the best for us. I think some of us might not have been so keen on the idea of kale salads, our kids are not keen on the idea of iceberg lettuce salads because of their relative lack of nutritional value. Anyway, I think there are some things that we're doing there that's a Public Health 2.0. Now we're in what's been characterized as Public Health 3.0.

One of the foundational notions of Public Health 3.0 is that in order to live well to in fact, at the end, expand our lifespan, it really is addressing social determinants and those features that are going to come together to help us. We've had a couple of examples already back from Arthur, and as well as from Tom about the relative contribution that health delivery makes compared to other aspects of health. I think all of us are aware that health delivery is between 11% and 20% of the contribution to our lifespan overall.

We have to get out of that mode of being stuck in the health delivery component. One of the things I thought was going to come out and I think Vikram Patel did this pretty well, I was thinking about the difference between American culture and other nations. If you are one health professional for us population of millions of individuals, how do you think about your time parsing your benefits? You can't do that with health delivery, you have to do it with public health strategies and initiatives.

I want to just make sure everyone's got basic familiarity with some of the techniques that are used in public health. Part of my reason for bringing that up, is because that is a strategy that's out there that you can steal from or borrow from as you think about your opportunity to be an influencer and make some differences. These are some of the ideas and Public Health 3.0 was largely talked about during the Obama administration. It was really supported and developed in that era as a part of the overall Affordable Care Act strategies that went on.

There are five main components to Public Health 3.0. One of those is embrace the role of public health departments' potential to be a community health strategist. I think by analogy, that's actually what's happening today, the APA has convened a group of strategists, people who are in positions to make a difference and so thinking about this new opportunity there. That is actually what the second thing is, cultivate new partnerships. It's only through those new working together and that was really beautifully demonstrated by Dr. Harkins in the example from Lexington, working together with new partners to achieve the goal.

Consider accreditation, and that's a movement. Most health departments at this point in time aren't accredited. At one point, the accreditation standards excluded behavioral health initiatives. If you were a local health department, and you identified suicide across your county or your jurisdiction as an initiative you wanted to take on, you couldn't count that toward accreditation. That's changed and now that counts. Well over half of Americans lives in the areas of public health departments that are accredited.

It's a movement that continues to gain momentum and gain status and is a really concrete thing that some of your students, some of your mentees could work in or could take jobs in. Public Health 3.0 the fourth element has to do with document access with data and metrics. I think that's part of what Dr. Evans is hoping that we'll get out of this is getting harder data on things that we know work. Then enhance public health funding, which always has to happen, and we've talked briefly about money here.

Those are some of the big ideas I wanted to have you talk about, it's that three-layer thing, which was just a dominant theme today. Now what I'd like to do is just demonstrate a couple of ways that we use population health at SAMHSA. A lot of what we do have the privilege of doing, which is really privilege and brings a lot of pleasure to us is design work. A typical thing for us will be Congress will say, "We're worried about our kids. We want to have more school-based mental health programs."

Oh, by the way, if you could have something that also identifies shooters in advance and gets rid of them, we would love it. That's tricky for us because we don't like to have a direct association between violence and any occurrence of mental illness. Honestly, we take their money if they want to fund school-based mental health services and try to work it out there. How do we approach that? We've gotten a lot of money for that. We have \$240 million just in the last year that we've gotten to support these programs.

How would we do that? Just let me invite you to think just a little bit about if you're hired as a school psychologist and you're brought in by the principal or a superintendent of a school system to

look at school mental health, just broadly, how would you do that? We use a public health framework, and we require that. The dance for us at SAMHSA always is what we can require grantees to do through what we call required activities and what Congress doesn't want us to be too micromanagey or too much into the details.

We're always trying to look for broad principles. In particular with the school-based programs, one of the things that we are trying to do is to create something that stays in place after our money is gone because our typical grants are three to five years. In the case of the school base, they're five years. We landed on and had been really reinforcing pretty rigidly the notion of really Arthur's triangle, the universal. The layer there is cultivating a climate that has restorative justice as components of it, has a social-emotional learning as a component of it, and applies across the whole school.

We do have a line of work that's particularly on trauma-informed schools as a part of it. Then another congressman was really interested in suicide. Some of our AWARE grantees are working on suicide prevention across, but all of them require that universal layer, that curated culture of the school itself. The next layer is the sum layer, the selected layer, and that's kids who are at risk of having identified or potentially identifiable problems. Dads in prison, Mom just lost the job and she's the sole breadwinner for the family.

Teaching the schools how to become aware of and develop some way to identify and work with kids who have some risk but haven't crossed that diagnostic threshold. Then the small very tip of our universal thing is the indicated, which we characterize as having some pathway to treatment for the kids who actually need treatment. You have a triangle with a wide base that has to do with a culture or universal, something that affects all the kids in the school and the teachers and the faculty and the other staff that work there.

The next tier and the sum, and then the very few that actually cross into needing actual treatment. That's one example of how we use the population health strategies to work on that. It sounds easy now, but that actually was quite debated in our group. Many of our staff who've seen certain things work and not work wanted to have one particular brand of something or one particular requirement for this or that. We really have tried to stick with where we have stuck with those three elements because we believe they're foundational and they will exist beyond the time of our grant funding.

Our grants, by the way, they are competitive for the most part, but they're not nearly as competitive as some of the NIH grants currently are. I'm saying that to you now as a group of individuals who may want to-- I want to invite you to take a look at some of the grant series that we have. I think Dr. Harkins' example of what happened in Kentucky is a really good example of that. One other use case that I'll talk just a little bit about as a recent--came up in the last couple weeks, is the case of Maui in Hawaii. What would we do if we could build a system there in Maui?

Probably many of you have been there. Maui's a population framework of about 165,000 people, which by coincidence, but roughly the size of the original catchment area that was envisioned by the Kennedy Community Health Center Services Act 150,000 was that catchment area size. We thought, one of the exercises for us is given the grant programs that we currently have, what would we put in place to have an initial response, but also a longitudinal response. If this is a once-in-a-lifetime opportunity and Congress wants to give some money to Hawaii, to work on that, how would we put those elements together?

We did create an immediate crisis response grant. That's part of our role that we do anyway. That is an opportunity to train locals. It's a task. It includes elements of task shifting of locals that are

trained that go in and check on their neighbors that have been affected by a disaster. This could happen beyond the immediate area that was involved in the fire. There were a couple places in Maui itself that were affected by the fire. That was one thing that we put in place.

The next one was thinking about the age spectrum and thinking about the longitudinal situation in Maui, we identified our infant and early childhood program as something that, given our wish, would be universally available or could be universally available. That is a program that teaches parents with young children how to work with, how to parent them, how to address trauma, and how to set up good relationships that would hopefully build in resilience. The next thing that we set up was these AWARE programs that I just told you about school-based programs.

There are 19 K-12 schools across Maui. We proposed to put just one AWARE program in every single one of those schools, recognizing that all the kids would be affected in one way or another by trauma, even if they weren't involved in a directly impacted area. Then the third thing that we built in, or we requested funds for, is to develop a CCBHC, which is more to the few end of the spectrum that will need ongoing help, that will be suffering with PTSD and other things that might be more diagnosable.

One important element of the CCBHC and thank you to Tom for mentioning that earlier. One important requirement of the CCBHC is that it also provides crisis services. Anywhere on the island beyond that, the crisis services arm could reach out to the community and respond to crises that are in place hopefully and our wish for that is in lieu of law enforcement. Working on that.

We've got lots of other use cases, but I think that's probably the end of my time. I want to thank everybody, and I invite you to talk with me or apply for one of our grants. We are the application of population health, I think. Thank you.