In OECD, for every $1 spent on health care, about $2 is spent on social services.

In the US, for $1 spent on health care, about 55 cents is spent on social services.
## Social Factors and Health Outcomes

Societal-level social determinants have individual-level impact

<table>
<thead>
<tr>
<th>Issue</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low education, lack of social support, and social exclusion</td>
<td>Poor self-management and reduced care plan adherence</td>
</tr>
<tr>
<td>Housing and transportation issues</td>
<td>Increased health care costs and utilization</td>
</tr>
<tr>
<td>Health disparities and psychosocial issues</td>
<td>Preventable hospitalizations and mortality</td>
</tr>
</tbody>
</table>
The Upstream Approach: What would happen if we were to spend more addressing social & environmental causes of poor health?
The Burden of Chronic Disease

Determinants of Health & Contribution to Premature Death

- Behavioral Patterns: 40%
- Predisposition: 30%
- Social Circumstances: 15%
- Environmental Exposure: 5%
- Health Care: 10%

Source: Stephen A. Schroeder, MD. We Can Do Better. NEJM 357:12
Targeted Patient Population Management with Increasing Disease/Disability

- End of Life
  - Complex Chronic Illnesses with major impairment
  - Chronic Condition(s) with Mild Functional &/or Cognitive Impairment
  - Chronic Condition with Mild Symptoms
  - Well - No Chronic Conditions or Diagnosis without Symptoms

- Hot Spotters!

- Home Palliative Care
- Post Acute and Long Term Supports and Services
- Evidence Based Self-Management, Home Assessment and HomeMeds
<table>
<thead>
<tr>
<th>Evidence Based Self-Management</th>
<th>Assessments, Care Coordination &amp; Coaching</th>
<th>Efficient Delivery System Provider Networks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Disease</td>
<td>HomeMeds</td>
<td>Evidence-Based Leadership Council</td>
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<tr>
<td>Chronic Pain</td>
<td>Adult Day/CBAS Assessment</td>
<td>Care Coordination Network</td>
</tr>
<tr>
<td>Diabetes (billable)</td>
<td>Home Safety Evaluation</td>
<td>Care Transitions Provider Network</td>
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<tr>
<td>A Matter of Balance</td>
<td>Home Palliative Care</td>
<td></td>
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<tr>
<td>Savvy Caregiver</td>
<td>Short &amp; Long-Term Care &amp; Service Coordination</td>
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<tr>
<td>Powerful Tools for Caregivers</td>
<td>Care Transitions Interventions</td>
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<tr>
<td>Arthritis Foundation</td>
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<tr>
<td>Exercise &amp; Walk with Ease</td>
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<tr>
<td>UCLA Early Memory Loss</td>
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</tbody>
</table>
Some Leading Evidence-Based Programs

SELF-MANAGEMENT
- Chronic Disease Self-Management
- Tomando Control de su Salud
- Chronic Pain Self-Management
- Diabetes Self-Management Program

PHYSICAL ACTIVITY
- Enhanced Fitness & Enhanced Wellness
- Healthy Moves
- Fit & Strong
- Arthritis Foundation Exercise Program
- Arthritis Foundation Walk With Ease Program
- Active Start
- Active Living Every Day

MEDICATION MANAGEMENT
- HomeMeds

FALL RISK REDUCTION
- Stepping On
- Tai Chi Moving for Better Balance
- Matter of Balance

DEPRESSION MANAGEMENT
- Healthy Ideas
- PEARLS

CAREGIVER PROGRAMS
- Powerful Tools for Caregivers
- Savvy Caregiver

NUTRITION
- Healthy Eating

DRUG AND ALCOHOL
- Prevention & Management of Alcohol Problems
The Imperative

• Critical to invest in solutions:
  • The social determinants of health
  • Prevention
  • Care coordination

• It takes a village
  • Need interorganizational teams to meet the needs of increasingly complex, older patient populations
  • Responsibility cannot solely reside with the physician

• To meet this imperative, we must partner

LAACHA is the way!
Table Discussion

• How do *we*, as members of LAACHA, move forward as an alliance to work *together* to increase the reach of effective, evidence-based community health interventions? (Specific ideas)

• What resources will be necessary to achieve *our* endeavor?