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OUR FUTURE**
ECONOMIC
MOBILITY SUMMIT
Building pathways for upward mobility



WELCOME

National Data

Unemployment and Mental Health:

Unemployed individuals, particularly those aged 18 to 25, show significantly higher rates of depression compared to employed counterparts, according to data from the Behavioral Risk Factor Surveillance System (BRFSS) (2010).

Health Outcomes and Employment Status:

- Research by the National Institute for Occupational Safety and Health (NIOSH) shows that adverse health outcomes increase with the duration of unemployment.
- Individuals unable to work report the highest rates of poor health, with over 50% experiencing fair or poor general health and diagnosed depression.

Public Health Implications:

- These findings emphasize the strong correlation between unemployment and poor mental health outcomes.
- Addressing health is essential for improving unemployment strategies and outcomes.



Social Determinants of Health and Depression



Associations between social determinants of health, perceived discrimination, and body mass index on symptoms of depression among young African American mothers

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Millender, E., Barile, J. P., Bagneris, J. R., Harris, R. M., De Faria, L., Wong, F. Y., Crusto, C. A., & Taylor, J. Y. (2020). Associations between social determinants of health, perceived discrimination, and body mass index on symptoms of depression among young African American mothers. *Archives of Psychiatric Nursing*, 34(6), 449–455. <https://doi.org/10.1016/j.apnu.2020.09.014>

Safety Nets

Child Psychiatry & Human Development

<https://doi.org/10.1007/s10578-024-01744-9>

RESEARCH

Exploring the Interplay of Social Safety Nets, Race, Ethnicity, and Nativity on Psychological Distress Among Low-Income Mothers

Eugenia Flores Millender^{1,2,3}  · Melissa Radey³ · Beren Crim Sabuncu³ · Qiong Wu⁴ · Lenore McWey⁴

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Millender, E. F., Radey, M., Sabuncu, B. C., Wu, Q., & McWey, L. (2024). Exploring the interplay of social safety nets, race, ethnicity, and nativity on psychological distress among low-income mothers. *Child Psychiatry & Human Development*. <https://doi.org/10.1007/s10578-024-01744-9>

THANK YOU

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Health is Wealth: Advancing Health Equity Through Economic Mobility

Darcy J. Davis, President & CEO
Health Care District of Palm
Beach County



Ensuring Access to Critical Care

As a safety net healthcare system, we serve rural, low-income, older adults, and homeless populations.



Mobile Clinics and
Community Health
Centers

Over 1 million adult
and pediatric visits
in 10 years



Lakeside Medical
Center

Only acute-care facility with
an ER in a 23-mile radius of
the Glades



Skilled Nursing
Facility

Long-term care safety
net for 100 years

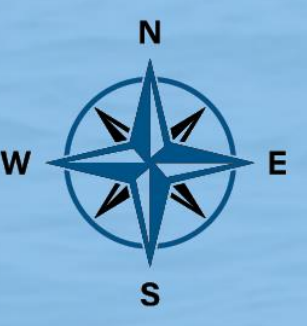


School Health

172 Public Schools

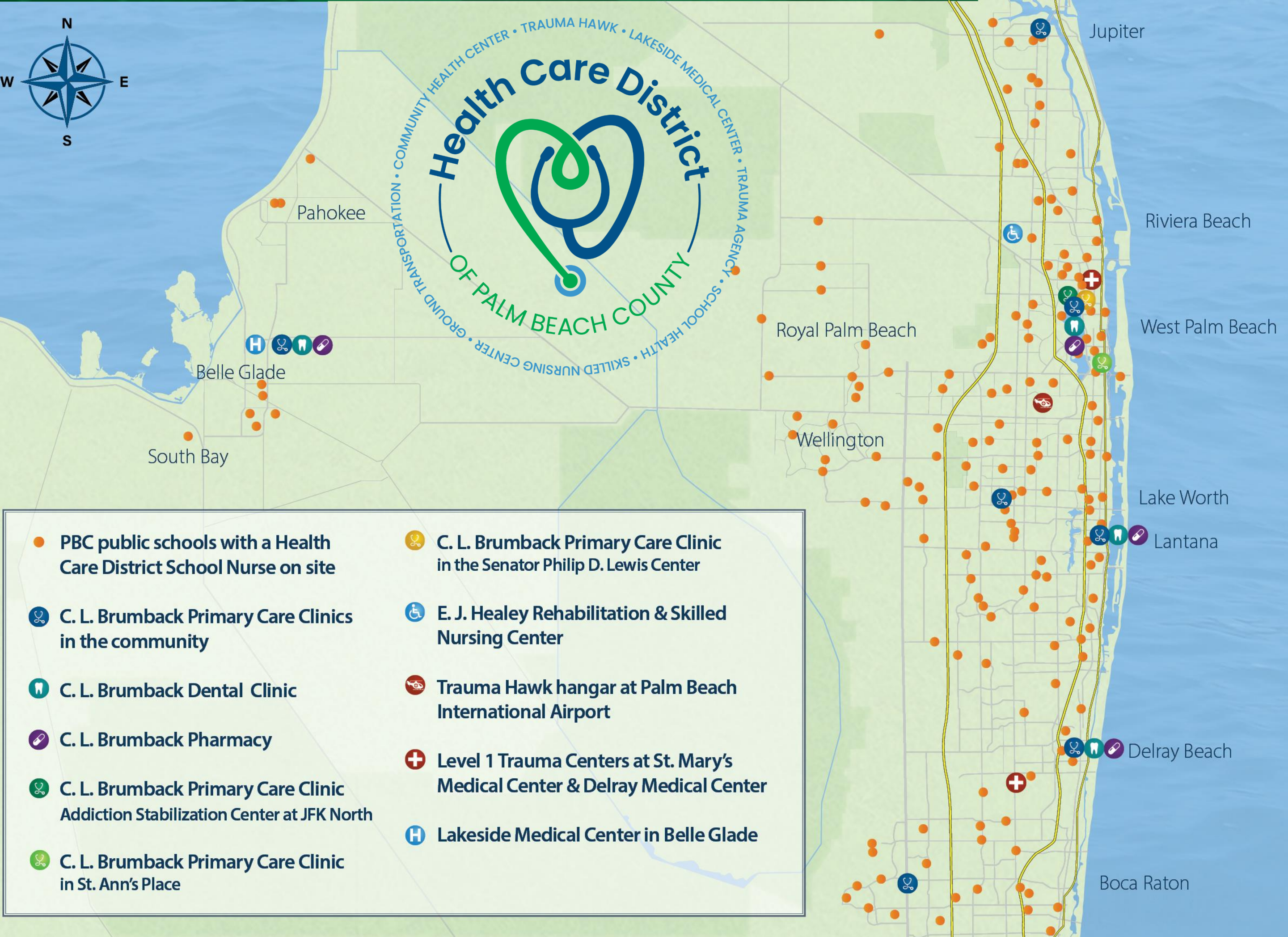
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Health Care District
OF PALM BEACH COUNTY

COMMUNITY HEALTH CENTER • TRAUMA HAWK • LAKESIDE MEDICAL CENTER • TRAUMA AGENCY • SCHOOL HEALTH • SKILLED NURSING CENTER • GROUND TRANSPORTATION



- PBC public schools with a Health Care District School Nurse on site
- C. L. Brumback Primary Care Clinics in the community
- C. L. Brumback Dental Clinic
- C. L. Brumback Pharmacy
- C. L. Brumback Primary Care Clinic Addiction Stabilization Center at JFK North
- C. L. Brumback Primary Care Clinic in St. Ann's Place
- C. L. Brumback Primary Care Clinic in the Senator Philip D. Lewis Center
- E. J. Healey Rehabilitation & Skilled Nursing Center
- Trauma Hawk hangar at Palm Beach International Airport
- Level 1 Trauma Centers at St. Mary's Medical Center & Delray Medical Center
- Lakeside Medical Center in Belle Glade

Our Reach



Coordinated Care for Overall Wellness

Goal: Ensuring access to high-quality health care for all, regardless of income or circumstances.

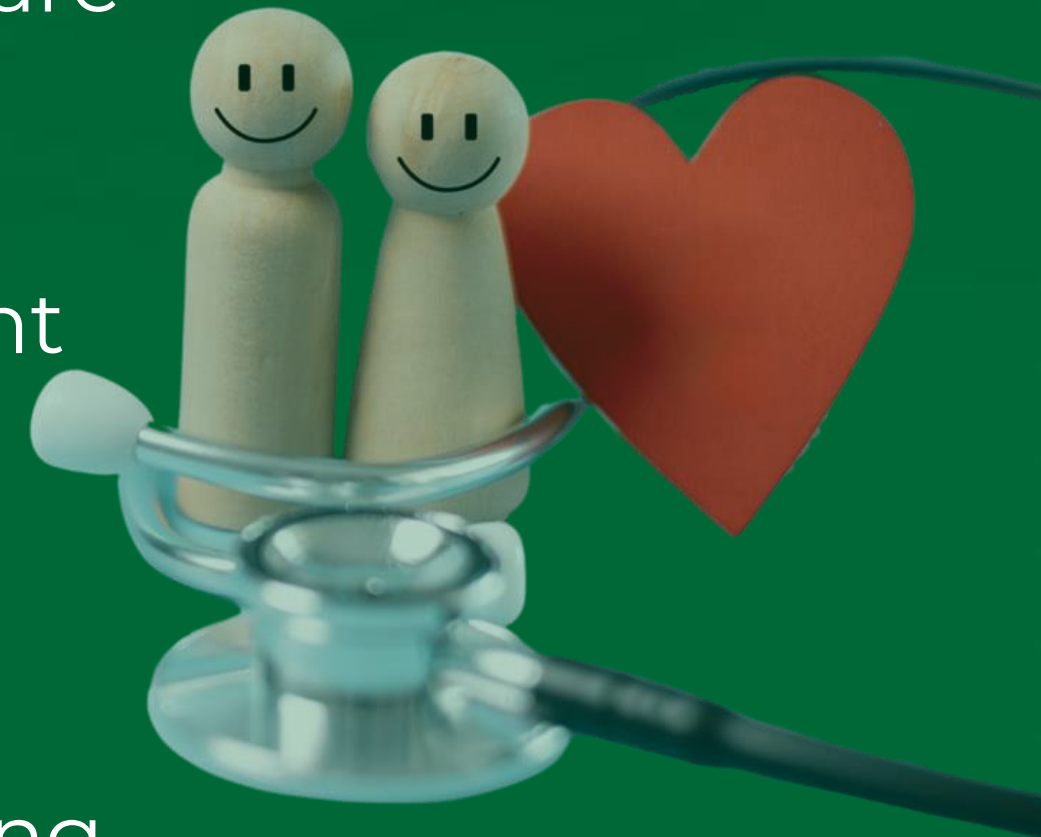
Critical Elements:

- No patient turned away due to inability to pay
- Specialty care through District Cares program
- Community partnerships/sponsored programs
- Addressing root causes of economic instability, such as untreated mental health conditions

Behavioral Health Care Access

Comprehensive Care Approach to Behavioral Health/Substance Use:

- Integrating mental health services with primary care, dental, and pharmacy services
- Upstream prevention of Baker Acts through out-patient care
- Pilot Programs with Law Enforcement
- Expanding access to psychiatric assessment and treatment
 - Medication-Assisted Treatment (MAT)
 - Group and limited individual therapy sessions
 - Care coordination with referrals to social services (housing, transportation, etc.)



Looking Ahead

Crisis Center for Mental Health and Substance Abuse

Sustainable solution to a critical need in the community for generations.

Atlantis Flagship Community Health Center

State-of-the-art center offering comprehensive and expanded health care, accessible in a convenient location for all.

Northend Rise

Serving as the wellness pillar for mutual mission investments.

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THANK YOU

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The background of the slide features a teal-tinted image of several hands of different skin tones reaching up to hold a globe. The hands are positioned around the globe, symbolizing global unity and shared responsibility. The text is overlaid on this image.

Department of Health Palm Beach County Economic Mobility Summit

**Health Equity in Medicine - Equity, Social Determinants
and Upstream/Downstream Factors**

**Dr. Jyothi Gunta, MD
Director DOH-Palm Beach
December 9, 2024**

Learning Objectives



1. Define the equity and social determinants of health.
2. Discuss how social determinants of health impact the health status of individuals and communities (positive/negative).
3. List upstream and downstream factors.
4. Define Upstream Medicine.
5. Identify how upstream factors effect downstream health outcomes.
6. Review how addressing upstream factors can lead to improvements in downstream health.

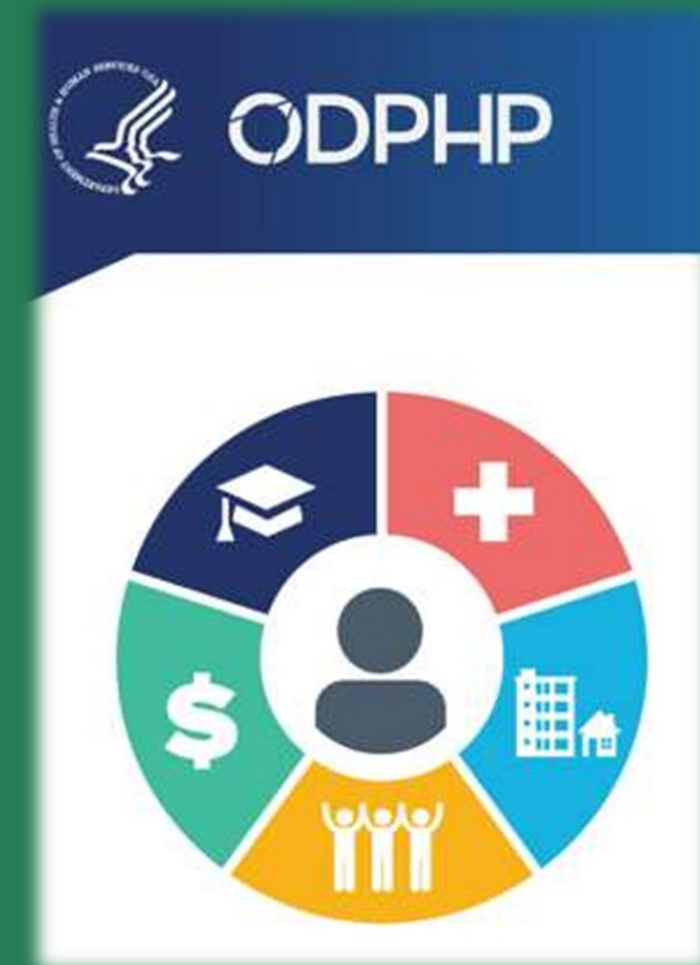


From whom does Public Health get its directions?



Healthy People 2030

- Attain healthy, thriving lives and well-being free of **preventable** disease, disability, injury, and premature death.
- Eliminate **health disparities**, achieve **health equity**, and attain **health literacy** to improve the health and well-being of all.
- Create **social, physical, and economic environments** that promote attaining the full potential for health and well-being for all.
- Promote **healthy development, healthy behaviors**, and well-being across all life stages.
- **Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.**



Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.

What is HEALTH EQUITY?



Health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.” Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.

One of the primary goals of CDC’s National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) is to achieve health equity by eliminating health disparities and achieving optimal health for all Americans. NCCDPHP addresses health equity through its programs, research, tools and resources, and leadership.

Source:

<https://www.cdc.gov/chronicdisease/healthequity/index.htm>

Equality ~~≠~~ Equity



Equality



Equity



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What are the SDH?



Social Determinants of Health



... “the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality of life outcomes and risks.” (CDC, 2021).

SOCIAL DETERMINANTS FACTORS THAT INFLUENCE YOUR HEALTH

The conditions in which you live, learn, work and age affect your health. Social determinants such as these can influence your lifelong health and well-being.

HOUSING 6.5 million children live in low-income neighborhoods that are more than a mile from a supermarket.	INCARCERATION The incarceration rate in the U.S. grew by more than 220% between 1980 and 2014, though crime rates have fallen. 	POVERTY
HEALTHY FOOD 	ENVIRONMENT 	GRADUATION
LITERACY 	ACCESS TO CARE 	HEALTH COVERAGE More than 89% of U.S. adults had health coverage in 2014. But 33 million Americans still lacked insurance.

The **NATION'S HEALTH**
A PUBLICATION OF THE AMERICAN PUBLIC HEALTH ASSOCIATION
www.thenationshealth.org/sdoh

SDH

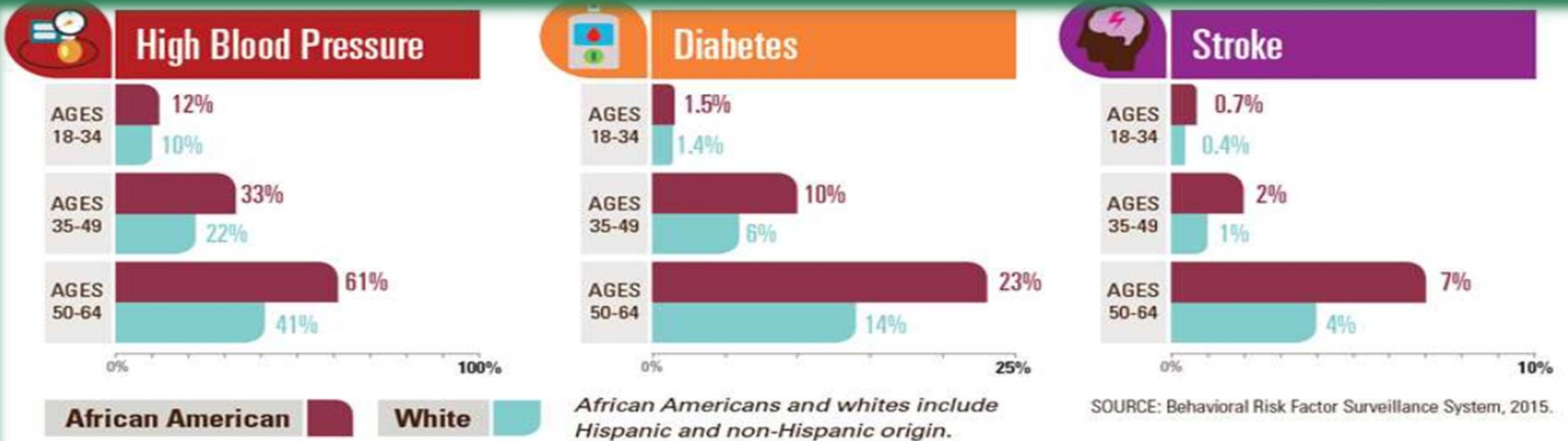
A little more terminology...and background

SOCIAL JUSTICE:
Justice in terms of the
distribution of wealth,
opportunities and
privileges within a
society.



Source:
Determinants of Equity, King
County
Office of Equity and Social
Justice Courtesy King County

The Impact of SDOH: Health Disparities



African Americans are more likely to die at early ages from all causes.

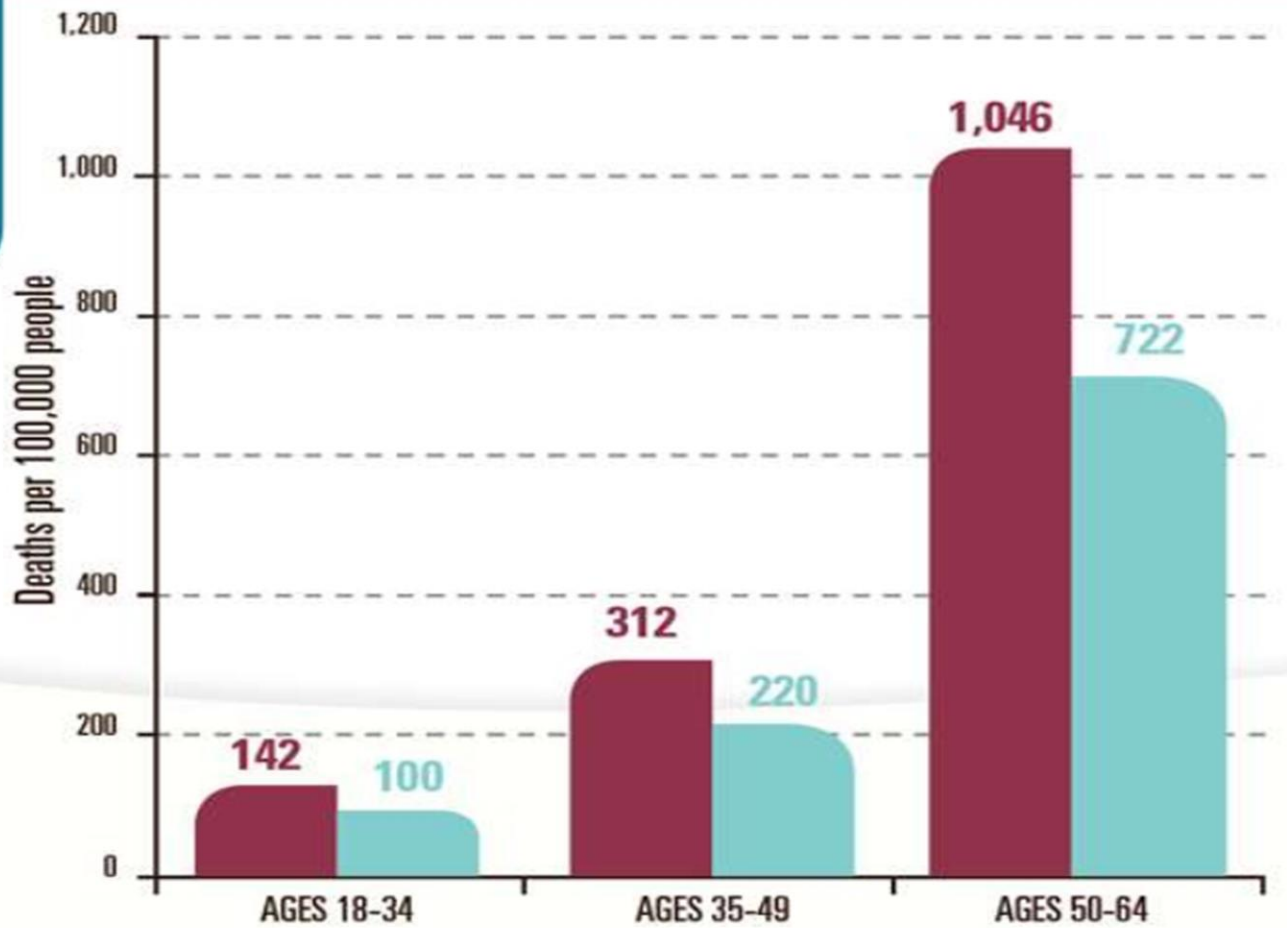


Image source: <https://www.cdc.gov/vitalsigns/aahealth/index.html>

SOURCE: US Vital Statistics, 2015.



Where you live matters



Source:
<https://www.rwjf.org/en/library/articles-and-news/2015/09/city-maps.html>



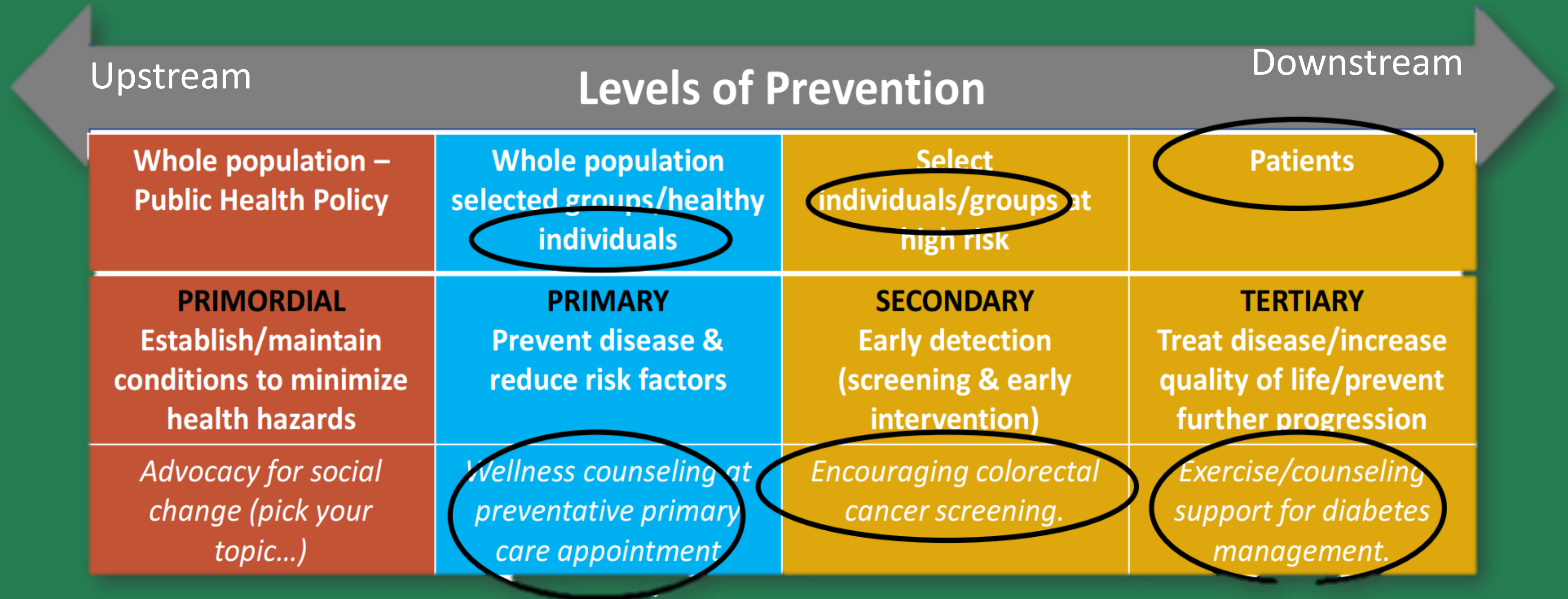
The Impact of SDOH: Health Disparities

African Americans have the highest mortality rate for all cancers combined compared with any other racial and ethnic group. (Source: U.S. Department of Health and Human Services Office of Minority Health, “Cancer and African Americans,” available at <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=16> (last accessed Feb 2021).)

Hispanic women are 40 percent more likely to have cervical cancer and 20 percent more likely to die from cervical cancer than non-Hispanic white women. (Source: U.S. Department of Health and Human Services Office of Minority Health, “Cancer and Hispanic Americans,” available at <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=61> (last accessed April 2020).

21.5 percent of Hispanic adults over age 20 have been diagnosed with diabetes compared with 13 percent of white adults over age 20. (Source: Centers for Disease Control and Prevention, “Health, United States Spotlight: Racial and Ethnic Disparities in Heart Disease,” available at <https://www.cdc.gov/nchs/hus/spotlight/2019-heart-disease-disparities.htm> (last accessed April 2020).

Upstream vs Downstream in Health



Upstream vs Downstream Health



Public Health Policy— Whole Population	Whole Population Selected groups/healthy individuals	Selected individual/groups at high risk	Patients (In hospital or office)
PRIMORDIAL Establish or maintain conditions to minimize health hazards	PRIMARY Prevent disease and reduce risk	SECONDARY Early detection (screening and early intervention)	TERTIARY Treat disease/increase quality of life/prevention of further progression
Advocacy for social change (pick your topic) Birth outcomes	Wellness counseling at preventive primary care visits	Encouraging screenings PAPs, HPV immunizations, STIs, Family Planning	Counseling for management of Gestational DM and avoiding further disease

What is UPSTREAM MEDICINE?

Upstream Medicine “Be Upstreamist”

- Avoid addressing just the “symptoms”
- Focus on and address roots causes, while avoiding victim blaming
 - How are the social determinants playing a role in the patterns you see?
- Think about how to systematically address the SDOH
 - Bring that perspective into day-to-day medical practice

Upstream QI Matrix

	Patient-Level	Health Care Organization Population-Level	General Population-Level
Primary Prevention	Financial literacy, support, & nutrition programs for low-income families with strong family history of DM	Provide on-site Farmers' Market, gym, walking trails, or financial counseling for families at risk for DM	Advocate for local increase in minimum wage and supports for low-income families, particularly those at risk of DM
Secondary Prevention	Poverty screening & financial assistance for DM patients at-risk of end-of-month hypoglycemia	Subsidize vouchers to local Farmer's Market or hire a financial counselor for low-income DM patients	Change timing and content WIC & school food programs to avoid food insecurity among DM
Tertiary Prevention	Reduce ED use among high-utilizer severe diabetics using food and income support referrals	Coordinate with local banks, collectors, lenders, to reduce debt burden for utilizer diabetics	Support legislation/regulations to provide financial and "hotspotter" services to severe diabetics



AMA's 8 Practice-Based Steps: SDOH

1. Understand and engage your community
2. Engage key leadership
3. Assess your readiness
4. Select and define your plan
5. Assess SDOH at the patient level
6. Link patients to SDOH resources
7. Evaluate and refine (PDSA Cycles/QI)
8. Celebrate successes



Source: The American Medical Association. Addressing Social Determinants of Health (SDOH) Beyond the Clinic Walls. Available at: <https://edhub.ama-assn.org/steps-forward/module/2702762#r8>



Suggestions to address the SDOH

- Patient level:
 - Ask about social challenges in sensitive/caring/respectful way
 - Refer patients to benefits and support services
- Practice level:
 - Reduce barriers to access and quality of care for hard to reach groups
 - Patient support/navigators
- Community level:
 - Partner with community groups, coalitions, public health organizations
 - Use your experiences in clinic/research to advocate for social change
 - Get involved in community needs assessment
 - Get involved in community engagement/empowerment

KEY PRACTICE POINTS

- 1. Join in this work with intention.** Check your implicit biases. Engage in self-reflection in how you engage and communicate with your patients.
- 2. Don't make assumptions about your patients.** Dig deeper and have meaningful conversations. Where do they live? Work? Play? Pray? Shop for food? Transportation? What kind of stress do they deal with?
- 3. Avoid victim-blaming.** It is easy to place the burden on the patient. Consider the systems and structures that have led them to an illness and as you diagnose and make recommendations.
- 4. Practice health literacy.** Assess your practices, workflows, internal and external communication.
- 5. Make a commitment to engage at multiple levels.** In your practice. In your profession. With your colleagues. Continue to advocate for systems change.
- 6. Engage in interprofessional collaboration!**

Resources

- AAFP – The EveryONE Project <https://www.aafp.org/family-physician/patient-care/the-everyone-project.html>
- Healthy People 2030: <https://health.gov/healthypeople>
- Racial Equity Tools: <https://www.racialequitytools.org/>
- Life Expectancy (RWJF) (zip code comparison tool): <https://www.rwjf.org/en/library/interactives/wherewouliveaffectshowlongyoulive.html>
- Access Health Literacy in Your Organization: <https://www.cdc.gov/healthliteracy/researchevaluate/organization-assessment-tools.html>
- Social Determinants of Health: Know What Affects Health: <https://www.cdc.gov/socialdeterminants/index.htm>



Resources to Watch

- A Tale of Two Zip Codes:
<https://www.youtube.com/watch?v=Eu7d0BMRt0o>
- What is an “Upstreamist” in Health Care?:
<http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Rishi-WhatIsAnUpstreamist.aspx>
- Unnatural Causes: Is Inequality Making Us Sick?:
https://www.pbs.org/unnaturalcauses/hour_01.htm

THANK YOU



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