The Health Center Program

MassLeague of Community Health Centers
Community Health Institute, 2017
May 3, 2017

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Chief Medical Officer
Bureau of Primary Health Care (BPHC)
Health Resources and Services Administration (HRSA)

Mission

Improve the health of the nation’s underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services
Key Strategies

- Increase access to primary health care services
- Modernize primary care infrastructure and systems
- Improve health outcomes
- Promote performance-driven, innovative organizations

Increase Impact of Health Center Program

Increase Access

National Impact

24,295,946 patients served

1 in 13 people in the US

1 in 10 children in the US

188,852 health center employees

Increase Access
National Impact


<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless Patients</td>
<td>1,191,772</td>
</tr>
<tr>
<td>Agricultural Workers</td>
<td>910,172</td>
</tr>
<tr>
<td>School-Based Patients</td>
<td>649,132</td>
</tr>
<tr>
<td>Public Housing Patients</td>
<td>1,510,842</td>
</tr>
<tr>
<td>Veterans</td>
<td>305,520</td>
</tr>
</tbody>
</table>

Increase Access
Program Growth


**Patients**

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>17,122,535</td>
</tr>
<tr>
<td>2010</td>
<td>19,469,467</td>
</tr>
<tr>
<td>2013</td>
<td>21,726,965</td>
</tr>
<tr>
<td>2015</td>
<td>24,295,946</td>
</tr>
</tbody>
</table>

Growth from 2008-2015 (% Increase)

- Patients: 7,173,411 (41.9%)
Increase Access
Program Growth

Grantees

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Grantees</td>
<td>1,080</td>
<td>1,124</td>
<td>1,202</td>
<td>1,375</td>
<td>295 (27.3%)</td>
</tr>
</tbody>
</table>


Modernize and Improve Primary Care Delivery

EHR Adoption

2015

All Sites 92%

Some Sites 6%

No EHR 2%

Patient Centered Medical Home

2016

PCMH Recognized 68%

No PCMH Recognition 32%

Over 1,020 (74%) of health centers are participating in Health Center Controlled Networks

Improve Health Outcomes and Reduce Health Disparities

Perinatal Measures

<table>
<thead>
<tr>
<th>Low Birth Weight Babies</th>
<th>Patients Entering Prenatal Care in the First Trimester</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Estimates</td>
<td>UDS 2015</td>
</tr>
<tr>
<td>National Estimates</td>
<td>UDS 2015</td>
</tr>
<tr>
<td>8.0%¹</td>
<td>7.6%</td>
</tr>
<tr>
<td>71.0%²</td>
<td>73.0%</td>
</tr>
</tbody>
</table>


Improve Health Outcomes and Reduce Health Disparities

Chronic Disease Management

<table>
<thead>
<tr>
<th>Adults with Hypertension whose Blood Pressure is Under Control</th>
<th>Diabetic Patients whose Diabetes is Under Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Average</td>
<td>UDS 2015</td>
</tr>
<tr>
<td>National Average</td>
<td>UDS 2015</td>
</tr>
<tr>
<td>53.0%³</td>
<td>63.8%</td>
</tr>
<tr>
<td>54.4%³</td>
<td>70.2%</td>
</tr>
</tbody>
</table>

Improve Health Outcomes and Reduce Health Disparities

Preventive Services

Percentage of Children Ages 19-35 Months who Receive Immunizations

<table>
<thead>
<tr>
<th></th>
<th>HP2020 Baseline</th>
<th>National Average</th>
<th>UDS 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>68.4%(^1)</td>
<td>71.6%(^2)</td>
<td>77.5%</td>
</tr>
</tbody>
</table>

Source:
1 National Immunization Survey (NIS), CDC/NCIRD and CDC/NCHS, 2012.

Colorectal Cancer (CRC) Screening:
80% by 2018 Public Health Campaign

CRC Screening by PCMH

<table>
<thead>
<tr>
<th>CRC Screening Rates</th>
<th>0.0%</th>
<th>10.0%</th>
<th>20.0%</th>
<th>30.0%</th>
<th>40.0%</th>
<th>50.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCMH</td>
<td>38.7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No PCMH</td>
<td>32.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

National Partnerships

- National Colorectal Cancer Roundtable TA resources
  1. EHR Best Practice Workflow and Documentation Guide
  2. 80% by 2018 Communications Guidebook to reach the unscreened
  3. American Cancer Society CRC Health Center Learning Collaborative in New England and West Virginia
Promote Innovative Organizations

Integrate with Primary Care:

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Funding Opportunity</th>
<th>Awards</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>Mental Health Service Expansion</td>
<td>433</td>
<td>$105.8 M</td>
</tr>
<tr>
<td>Substance Use</td>
<td>Substance Abuse Service Expansion</td>
<td>271</td>
<td>$94 M</td>
</tr>
<tr>
<td>Oral Health</td>
<td>Oral Health Service Expansion</td>
<td>420</td>
<td>$155.9 M</td>
</tr>
<tr>
<td>HIV/Public Health</td>
<td>Partnerships for Care</td>
<td>22</td>
<td>$30 M</td>
</tr>
</tbody>
</table>

Successes:
- Hiring BH staff
- Staff training/education
- Policies/procedures
- Huddles for team based care
- Integrating EHR
- Expanding into addiction services

Challenges:
- Recruitment/retention BHCs
- Lack of desired competencies for BHI
- Lack of bilingual staff
- Partnering with professional schools
- Mental health stigma
- Lack of resources re: autism

RESOURCE: The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS)
Health Center Depression Screening Innovation Community
Monthly roundtable discussions
Resources, webinars, direct TA
Substance Abuse Service Expansion (SASE)

• Progress at 9 months:
  • 92% have at least one provider with Drug Addiction Treatment Act (DATA) Waiver
  • 50% have increased the number of providers with DATA Waiver
    • 67% increase in DATA Waivers
  • 15,000 patients received MAT

• Resources:
  • Opioid Addiction Treatment ECHO
  • Substance Abuse Warmlines

Substance Abuse Service Expansion

Facilitators
• Language interpretation
• SBIRT integrated in EHR
• Shared medical appointments for transitional age youth
• Support groups for young adults
• Use of telemedicine

Challenges
• Recruitment/retention
• DATA waiver training not widely available for NPs and PAs
• State regulatory restrictions on MAT
• Coordinating and managing workflow for MAT
• Coordinating with internal and external partners
• Confidentiality and release of records from external treatment facilities
Behavioral Health and Substance Abuse Services Integration

- Mental health patients increased by 19% from 2014 to 2015
- Mental health personnel increased by 22% from 2014 (6,372 FTEs) to 2015 (7,780 FTEs)
- Depression screenings and follow up for patients increased by nearly 12% from 2014 (38.8%) to 2015 (50.6%)

Oral Health Integration

Investments to Increase Access to Oral Health:
- Oral Health Services Expansion (OHSE)
  - $156 Million supporting 420 Health Centers
  - 1,600 new dentists, dental hygienists, assistants, technicians to serve nearly 785,000 new patients
  - Increase access to oral health care services and improve oral health outcomes

- Oral Health T/TA National Cooperative Agreement (NCA)
  - National Network for Oral Health Access (NNOHA)
    - T/TA for health centers to provide new high quality oral health services, enhance quality of oral health services, report on oral health care quality
Oral Health Integration

- 90% health centers provide preventive dental services either directly or via contract
- In 2015, 13.2M dental visits were provided with an increase of 42% since 2010
- 5.2M dental patients were served in 2015 with an increase of 38% since 2010
- 4,108 dentists and 1,921 dental hygienists work at health centers
- HRSA UDS Dental Sealant Measure in 2015, achieved 42.4%, exceeding HP2020 goal of 28.1%

Health Center Dental Patients and Visits from 2010-2015

Source: HRSA Uniform Data System (UDS)

UDS 2015 Dental Sealants Measure

<table>
<thead>
<tr>
<th>Numerator</th>
<th>121,312</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>285,799</td>
</tr>
<tr>
<td>%</td>
<td>42.5%</td>
</tr>
</tbody>
</table>

Percentage of children, age 6-9 years of age, at moderate to high caries risk, who received a dental sealant on a first permanent molar during the measurement period.
Primary Care HIV Integration

In 2015, HRSA-funded health centers continued working to increase access and improve health outcomes for patients living with HIV

- 1.3 million patients tested for HIV
- 155,000 HIV patients served at over 630,600 visits
- 74.7% of HIV patients linked to care

Partnerships for Care (P4C) Health Centers have:
- Improved HIV testing and care capacity
- Established multidisciplinary HIV care teams
- Enhanced EHR and trained HIV care teams
- Developed partnerships with local and state entities for enabling services and linkage/re-engagement in care

1.3 million patients tested for HIV
155,000 HIV patients served at over 630,600 visits
74.7% of HIV patients linked to care

PrEP Service Delivery by Health Centers

- Developed and disseminated HIV PrEP Health Center Technical Assistance Resource
  - BPHC supports adopting PrEP into clinical practice for at risk patients as part of routine primary care
  - Health Center Program/Section 330 funding can be used for PrEP, including medication and health center visits for follow-up and related services
  - Offered services must be provided in accordance with applicable clinical guidelines regardless of insurance status and/or ability to pay
- Working with partners to support PrEP training and technical assistance
Public Health and Primary Care Integration

*Health Centers Respond to their Community*

- Emergent public health issues, examples:
  - Zika virus infection
  - Opioid epidemic
- Social Determinants of Health Academy
- Partnership for Care

Health Center Workforce

- Health Center Workforce Workgroup
- National Cooperative Agreements:
  - CHC Inc
  - Association of Clinicians for the Underserved
- Collaborations with Bureau of Health Workforce, Federal Office of Rural Health Policy
- FTCA coverage for health center volunteer health professionals
- Telehealth
Preparing for New Payment and Delivery Models

**BPHC Key Strategies Prepare Health Centers**

- **Demonstrate impact:**
  - Access
  - Quality of care
  - Cost-effectiveness
  - Population management

- **Getting there:**
  - QI, performance management
  - Optimization of HIT/HIE
  - Expertise with most complex populations
  - Care integration
  - Addressing social determinants of health

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**Health Center Controlled Network Accomplishments**

![Bar chart showing progress in various metrics over YR 3 Closeout.](chart.png)

- ONC certified EHRs: Baseline 83.8%, YR 3 Closeout 99.0%
- EPs using EHRs: Baseline 81.9%, YR 3 Closeout 98.8%
- EPs attesting to MU: Baseline 63.2%, YR 3 Closeout 73.4%
- EPs receiving MU payments: Baseline 68.1%, YR 3 Closeout 74.7%
- HCs meeting at least one HP2020 goal: Baseline 74.0%, YR 3 Closeout 97.3%
- HCs with PCMH recognition status: Baseline 0%, YR 3 Closeout 81.2%

Source: FO HRSA-15-237, HCCN awardees, final report
Looking Ahead

- Priority areas
  - Opioid epidemic/substance abuse treatment services
  - Mental health
  - Childhood Obesity

HRSA/BPHC
- Care integration/Social determinants of health
- Coordinated strategy to improve diabetes control
- Intimate partner violence strategy
- UDS Modernization
- New Compliance Manual, Change in Scope, Operational Site Visits
- Enhance bi-directional communication with health center clinicians
Role of State, Regional, and National Partners

Local
- Health Centers
- PCAs
- HCCNs
- NCAs
- BPHC and Federal Partners

State
Regional
Federal

Health Center Program Resources

- **Website**: [www.bphc.hrsa.gov](http://www.bphc.hrsa.gov)
  - Includes many Technical Assistance (TA) resources

- **Weekly E-Newsletter**: Primary Health Care Digest
  - Sign up online to receive up-to-date information

- **BPHC Helpline**: [www.hrsa.gov/about/contact/bphc](http://www.hrsa.gov/about/contact/bphc)
  - EHB questions/issues
  - FTCA inquiries

- **BPHC Project Officer**:
  - Address specific questions about your health center’s grant or look-alike designation

- **National Cooperative Agreements & Primary Care Associations**:
  [bphc.hrsa.gov/qualityimprovement/strategicpartnerships](http://bphc.hrsa.gov/qualityimprovement/strategicpartnerships)
Thank You!

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