



Integration of Public Health/Preventive Care and Primary Care in the Health Centers

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Overview of the Health Center Program

- Mission
- Who we Serve
- Why The Health Center Program lends itself to PM/PH integration
- Potential areas where integration are mutually beneficial to the communities we serve




Primary Health Care 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

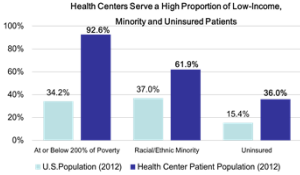


Health Center Program
Grantee Overview—Calendar Year 2013 

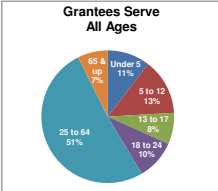
21.7 Million Patients

- 93% Below 200% Poverty
- 34.9% Uninsured
- 62% Racial/Ethnic Minorities
- 1,131,414 Homeless Individuals
- 861,120 Agricultural Workers
- XXX,XXX Residents of Public Housing

Health Centers Serve a High Proportion of Low-Income, Minority and Uninsured Patients




Grantees Serve All Ages



- 1,202 Grantees with 9,000+ Service Sites
- 85.6 Million Patient Visits
- Over 157,000 Staff
- 10,733+ Physicians
- 8,156+ NPs, PA, & CNMs

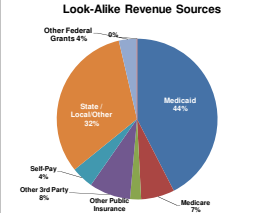
Source: Uniform Data System, 2012, Service Sites: HRSA Electronic Handbooks 4

Health Center Program
Look-Alike Overview—Calendar Year 2013 

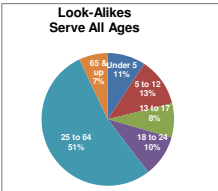
1,027,960 Patients

- 92.8% Below 200% Poverty
- 32% Uninsured
- 69% Racial/Ethnic Minorities
- 20,011 Homeless Individuals
- XX,XXX Agricultural Workers

Look-Alike Revenue Sources




Look-Alikes Serve All Ages



- 100 Look-Alikes with 270+ Service Sites
- 3.7 Million Patient Visits
- Over 6,504 Staff
- 588 Physicians
- 325 NPs, PA, & CNMs

Source: Uniform Data System, 2013, Service Sites: HRSA Electronic Handbooks 5



Required Primary Health Services 

- Health Services related to
 - Family medicine
 - Internal medicine
 - Pediatrics
 - Obstetrics & Gynecology
- Diagnostic Laboratory and Radiologic services
- Preventive Health Services
 - Prenatal and perinatal services
 - Screening for breast, cervical, & colorectal cancers
 - Well Child Services
 - Screening for communicable diseases
 - Voluntary family planning services
 - Preventive Dental Services



 **Primary Health Services cont.** 

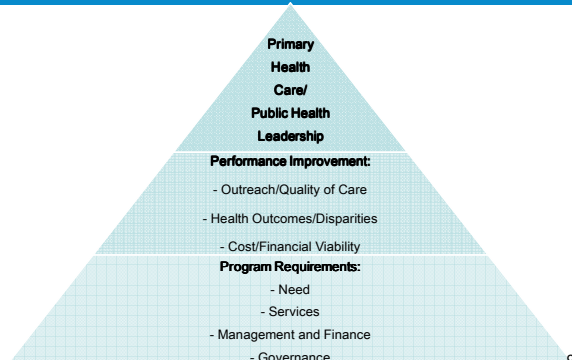
- Medical Emergency Services during and After-Hours
- Pharmaceutical services
- **Case Management services**
- **Enabling Services**
- **Outreach Services**
- **Health Education**



 **Additional/Specialty Services** 

- Legislative Authority for 330 program supports additional and specialty services within the federal scope
 - Necessary for the adequate support of the primary health services
 - Demonstrate need in population
 - Show how service is Supportive of Primary Care

 **Primary Health Care Our Focus** 



Primary Health Care/ Public Health Leadership


Performance Improvement:

- Outreach/Quality of Care
- Health Outcomes/Disparities
- Cost/Financial Viability

Program Requirements:

- Need
- Services
- Management and Finance
- Governance

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Primary Health Care and Public Health Leadership 


- National Quality Strategy
<http://www.ahrq.gov/workingforquality/ngs/>
- Tobacco Cessation
<http://betobaccofree.hhs.gov/index.html>
- HHS Action Plan to Reduce Racial and Ethnic Health Disparities
http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf
- National Prevention Strategy
<http://www.healthcare.gov/prevention/nphpphc/strategy/index.html>
- National HIV/AIDS Strategy
<http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf>

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Primary Health Care and Public Health Leadership 

- National Oral Health Initiatives
<http://www.hrsa.gov/publichealth/clinical/oralhealth/>
- Behavioral Health Initiatives
<http://bphc.hrsa.gov/technicalassistance/topics/clinicalcareservices/index.html#Behavioral>
- Healthy Weight Collaborative
<http://www.collaborateforhealthyweight.org/>
- Million Hearts Campaign
<http://millionhearts.hhs.gov/>
- Text4baby
<http://www.cdc.gov/women/text4baby/index.htm>
- Viral Hepatitis Initiative
<http://www.hhs.gov/ash/initiatives/hepatitis/index.html>


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BPHC Quality Strategy 

Better Care • Healthy People & Communities • Affordable Care

<p>Strategy Implementation</p> <ol style="list-style-type: none"> 1. Programs/Policies 2. Funding 3. Technical Assistance 4. Data/Information 5. Partnerships/Collaboration 		<p>Priorities & Goals</p> <ol style="list-style-type: none"> 1. Implementation of QI/QA Systems <i>Health Centers fully implement their QI/QA plans</i> 2. Adoption and Meaningful Use of EHRs <i>Health Centers implement EHRs across all sites & providers</i> 3. Patient-Centered Medical Home Recognition <i>Health Centers receive PCMH recognition</i> 4. Improving Clinical Outcomes <i>Health Centers meet/exceed HP2020 goals on at least one UDS clinical measure</i> 5. Workforce/Team-Based Care <i>Health Centers are employers/providers of choice and support team-based care</i>
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Current Program Impact: Key National Indicators 

% of Health Centers with EHR Implementation (2013)

- 88% have EHRs at all sites used by all providers
- 8% have EHRs at some sites used by some providers

% of Health Centers Achieving Patient-Centered Medical Home Recognition (as of June 2014)


- 80% of all health centers are participating in Patient-Centered Medical Health Home Initiatives (PCMHHI) and 50% have achieved Patient-Centered Medical Home (PCMH) recognition

% of Health Center Meeting/Exceeding Healthy People 2020 Goals (2012):


- 59% Meet/Exceed Hypertension Control Goal of 61%
- 11% Meet/Exceed Diabetes Control (HbA1c ≤9) Goal of 84%
- 37% Meet/Exceed Early Entry into Prenatal Care Goal of 78%
- 61% Meet/Exceed Low Birthweight Goal of 7.8%

Individual and State health center profiles with performance and compliance data are now available to the public on the HRSA web site. See: <http://bhpc.hrsa.gov/uds/datacenter.aspx?a=d&year=2012>

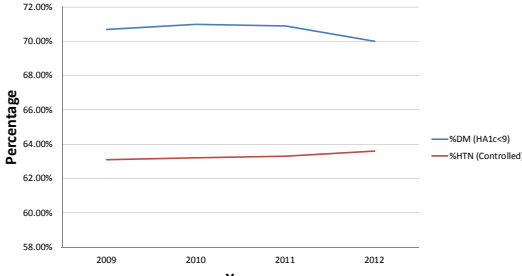
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Potential Areas for PH/Preventive Medicine Integration 

- Implementation of QI/QA plan
 - Assess quality improvement and impact of plan on health outcomes
- Population Health
- Team-based care from PCMH Model
- Lifestyle interventions for Lifestyle Responsive Conditions

UDS Trend Data 2009 -2012 

Outcome Measures/Health Disparities



Year	%SDM (HbA1c≤9)	%HTN (Controlled)
2009	70.5%	63.5%
2010	71.0%	63.8%
2011	70.8%	64.0%
2012	70.0%	64.2%

Source: Uniform Data system, 2012, HRSA Electronic Handbooks



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