

Healthy People 2020: Who's Leading the Leading Health Indicators?



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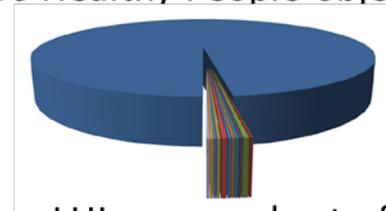


Who's Leading the Leading Health Indicators?



- **Leading Health Indicators are:**
 - Critical health issues that, if addressed appropriately, will dramatically reduce the leading causes of preventable deaths and illnesses
 - Linked to specific Healthy People objectives
 - Intended to motivate action to improve the health of the entire population

1200 Healthy People objectives



LHIs are a subset of
Healthy People
objectives



Who's Leading the Leading Health Indicators?

Featured Speakers:

- **Carter Blakey** – Deputy Director, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services
- **Judith Steinberg, MD, MPH** - Chief Medical Officer, Bureau of Primary Health Care, Health Resources and Services Administration
- **Peter Kelleher** - CEO, Partnership for Successful Living, New Hampshire

Carter Blakey

Deputy Director, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services



Importance of Access to Health Services

- Regular and reliable access to health services may prevent disease and disability, and increase life expectancy.
- Health insurance coverage helps patients gain entry into the health care system.
- Health insurance and a usual source of care, like a primary care provider, help to ensure access to health care.

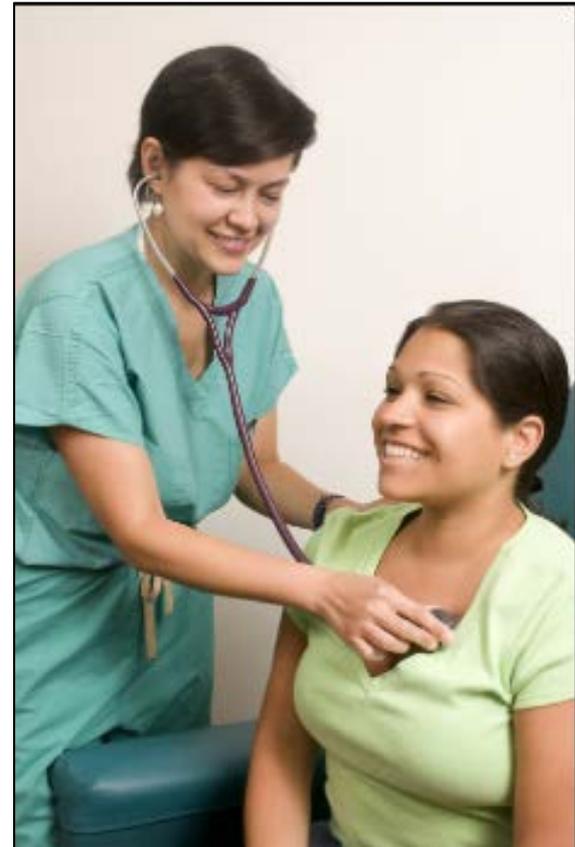
- Routine checkups for infants, adolescents, and children help to:
 - Ensure healthy growth and development
 - Keep on track with regular vaccinations

- Access to routine care may assist in:
 - Managing weight, blood pressure, and cholesterol levels
 - Detecting cancer(s) at earlier stages

Access to Health Services Leading Health Indicators

Healthy People
2020

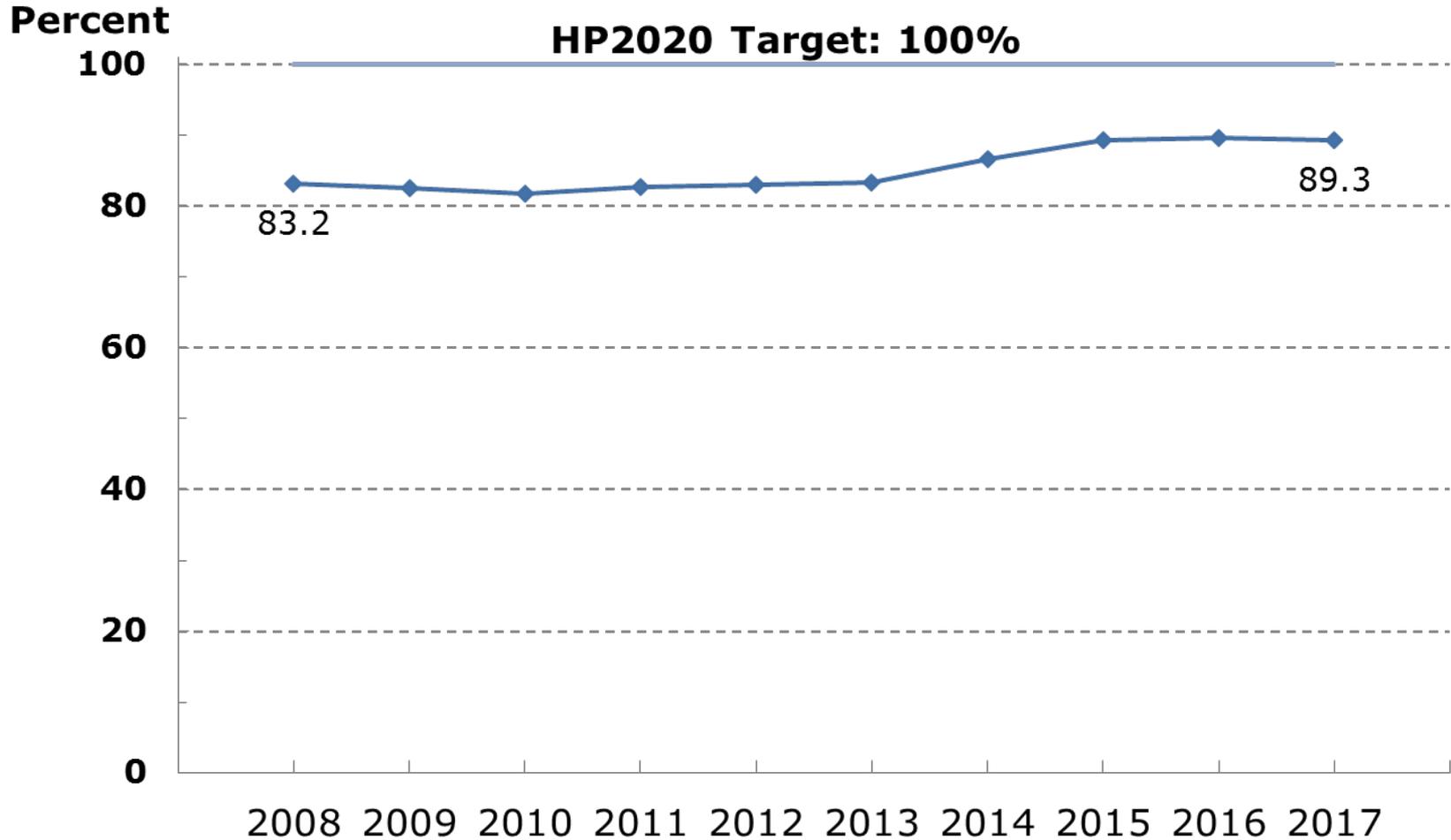
- Persons with medical insurance (AHS-1.1)
- Persons with a usual primary care provider (AHS-3)



ODPHP

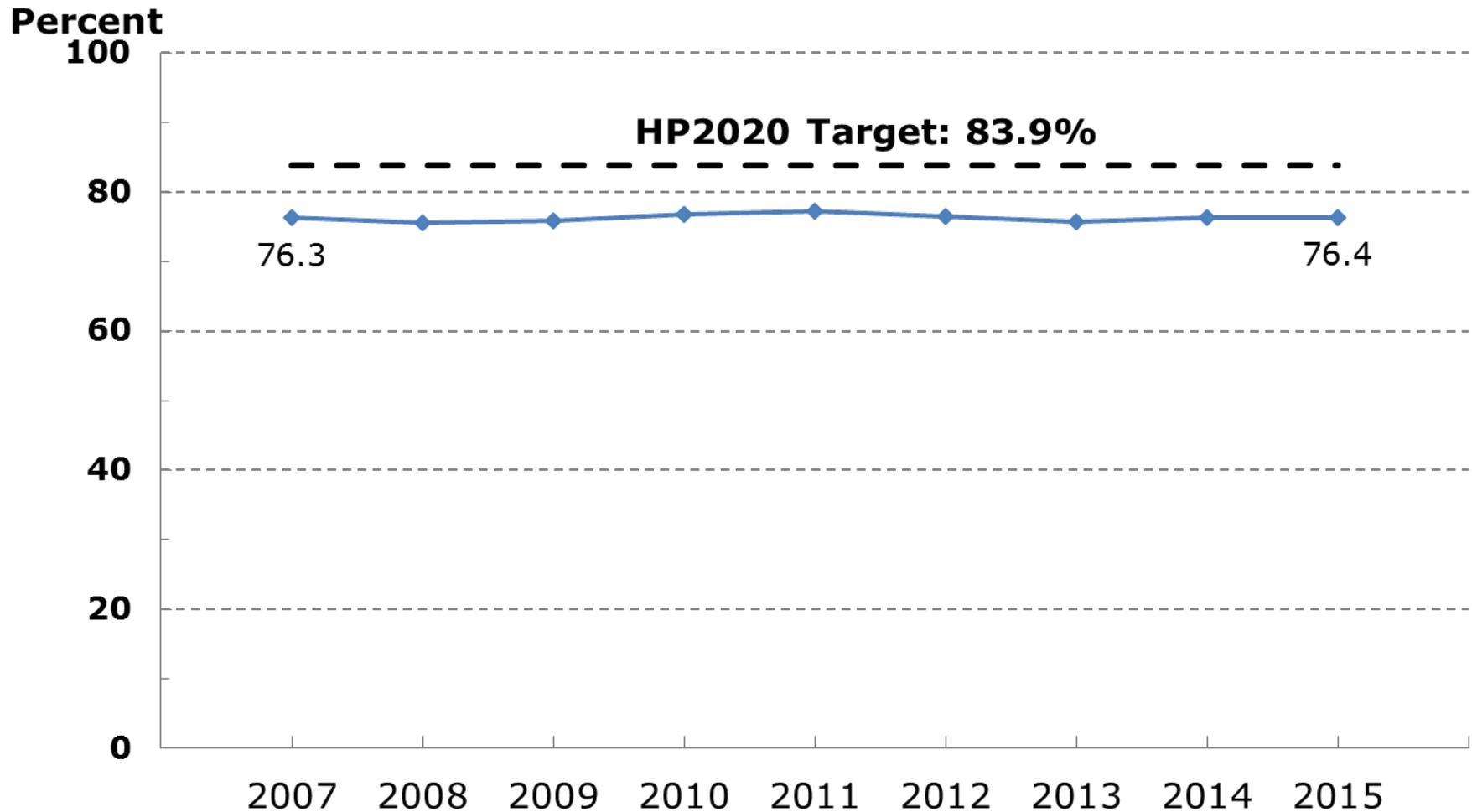
Office of Disease Prevention
and Health Promotion

Persons Under 65 Years with Health (Medical) Insurance



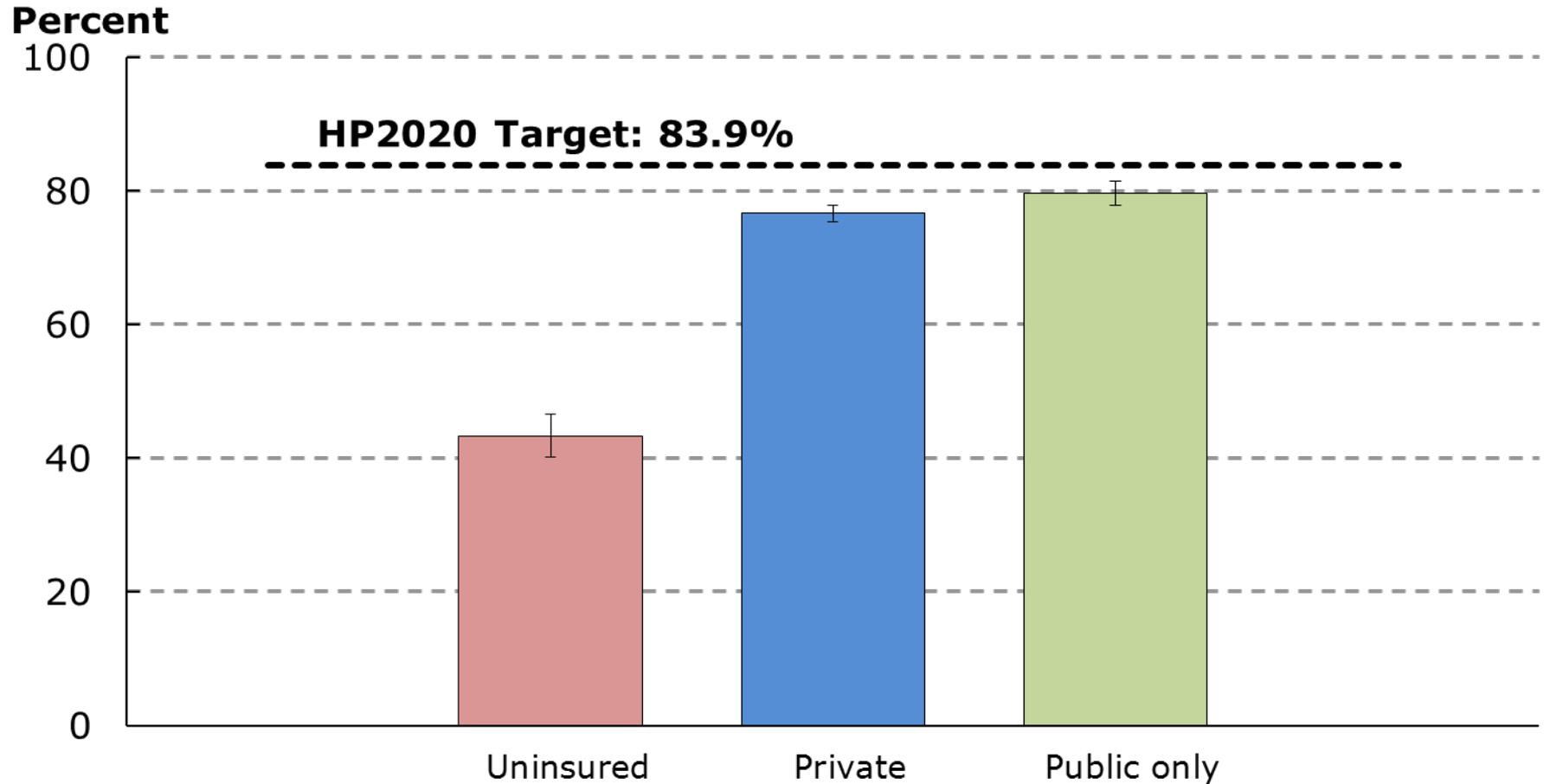
Obj. AHS-1.1
Increase desired

Persons with a Usual Primary Care Provider



Obj. AHS-3
Increase desired

Persons Under 65 Years with a Usual Primary Care Provider by Health Insurance Status, 2015

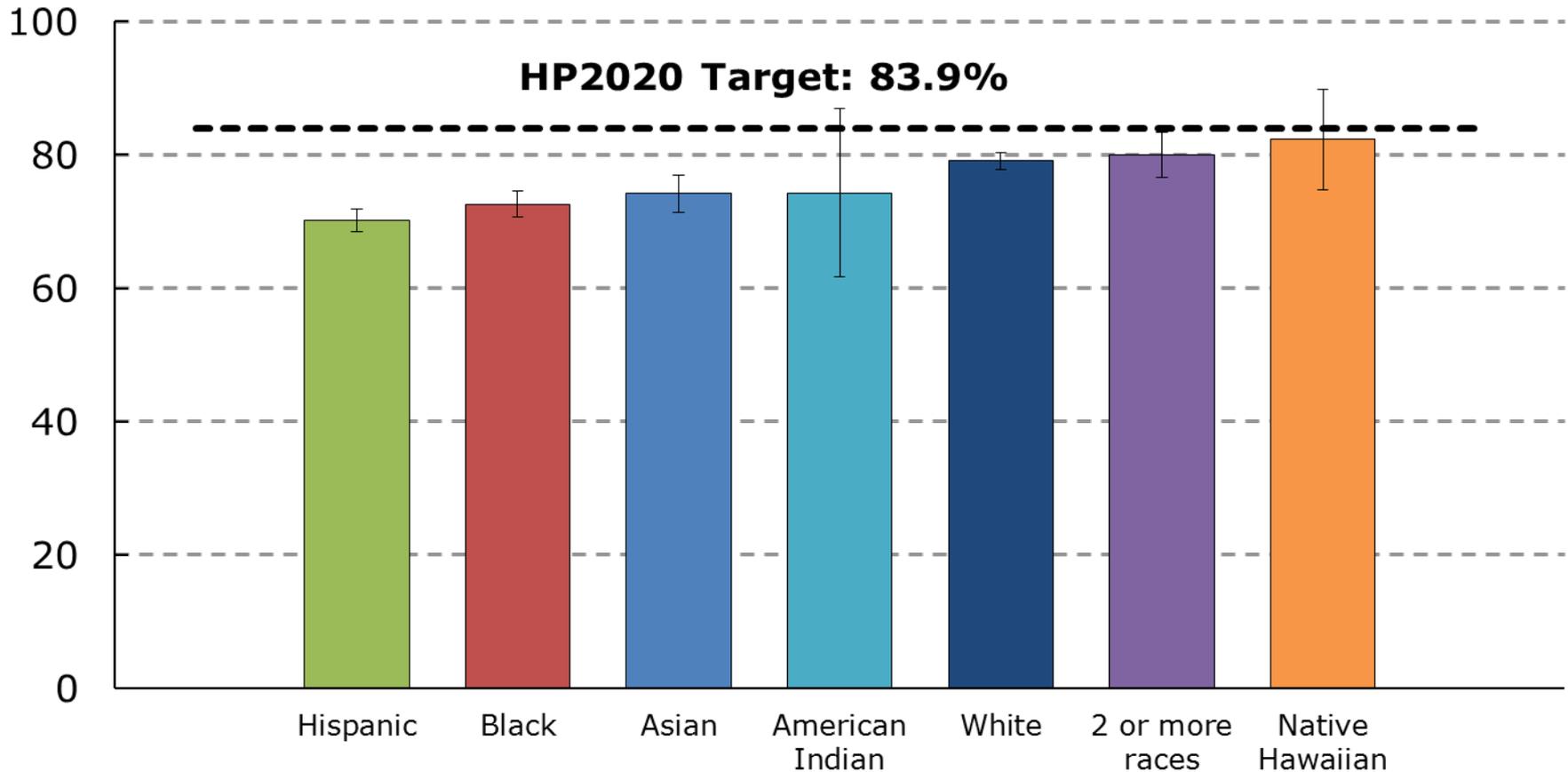


NOTES: I=95% confidence interval.
SOURCE: Medical Expenditure Panel Survey (MEPS), AHRQ.

Obj. AHS-3
Increase desired

Persons with a Usual Primary Care Provider by Race and Ethnicity, 2015

Percent



NOTES: I=95% confidence interval. Black and White exclude persons of Hispanic origin. Persons of Hispanic origin may be of any race. American Indian includes Alaska Native. Native Hawaiian includes Other Pacific Islander. Respondents were asked to select one or more races. Single race categories are for persons who reported only one racial group.

SOURCE: Medical Expenditure Panel Survey (MEPS), AHRQ.

Obj. AHS-3
Increase desired



Health Center Program

Healthy People 2030 Leading Health Indicator (LHI)

Access to Health Services

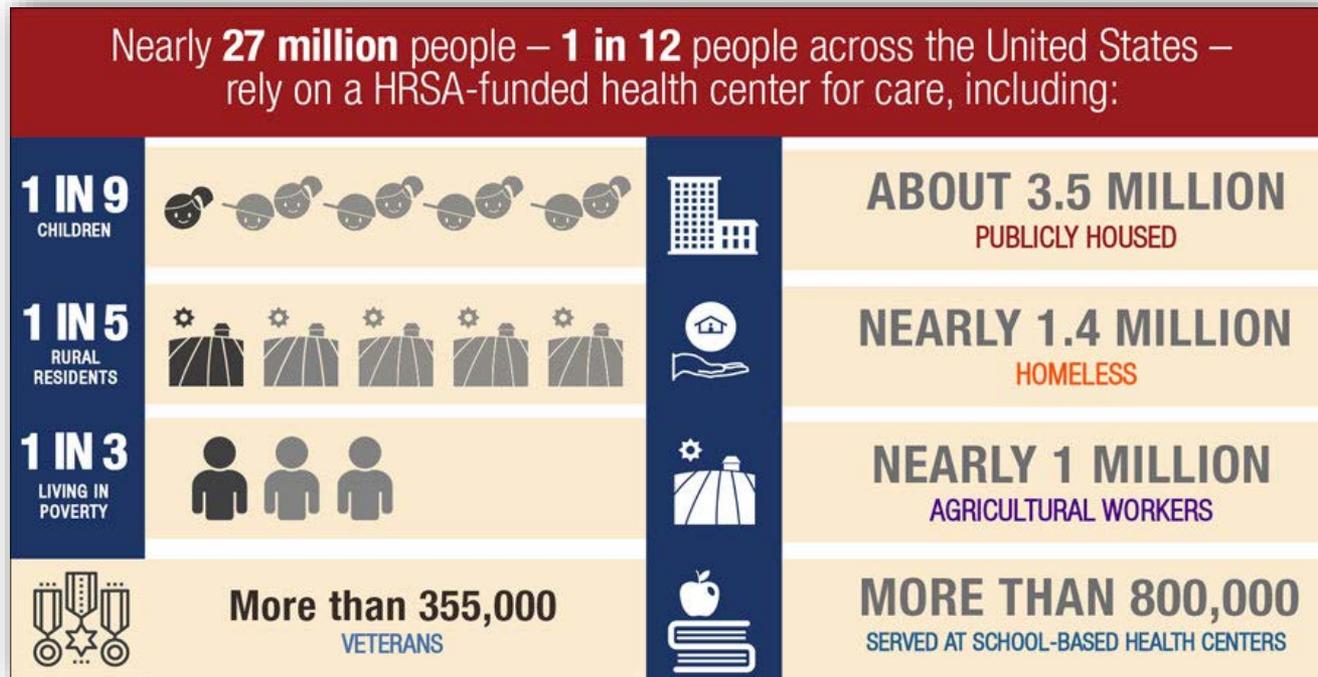
September 20, 2018

Dr. Judith Steinberg, Chief Medical Officer
Bureau of Primary Health Care (BPHC)
Health Resources and Services Administration (HRSA)



Health Center Program: National Impact

Mission: Improve the health of the nation's underserved communities and vulnerable populations



Source: Uniform Data System, 2017



Increasing Access to Comprehensive Care

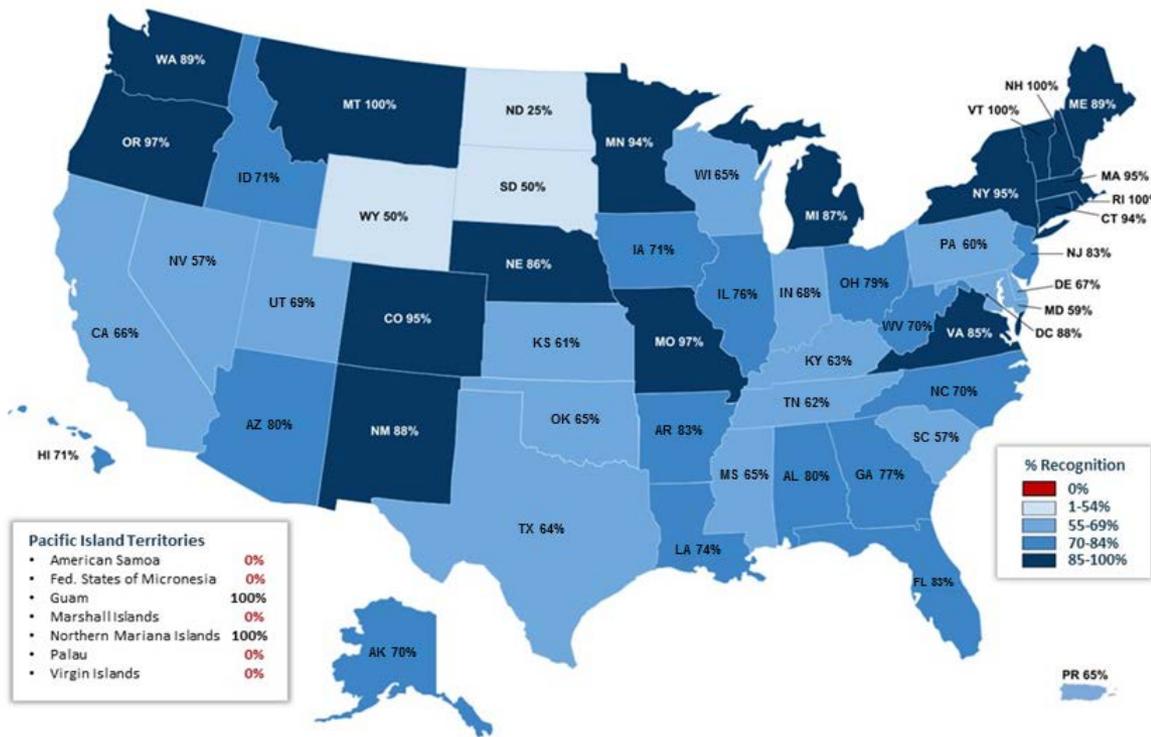
Category	2015	2016	2017	Δ 2015-2017
Number of Sites	9,829	10,415	11,057	^ 12%
Health Centers using Telehealth	--	523	600	--
Total Health Center Patients	24,295,946	25,860,296	27,174,372	^ 12%
Medical	20,616,149	21,880,295	22,866,468	^ 11%
Dental	5,192,846	5,656,190	6,116,732	^ 18%
Mental Health	1,491,926	1,788,577	2,049,194	^ 37%
Substance Use Disorder	117,043	141,569	168,508	^ 44%
Vision	501,647	599,314	670,973	^ 34%
Enabling	2,388,722	2,482,751	2,549,897	^ 7%

Source: Uniform Data System, 2017. 2016 was the first year telehealth data was collected.

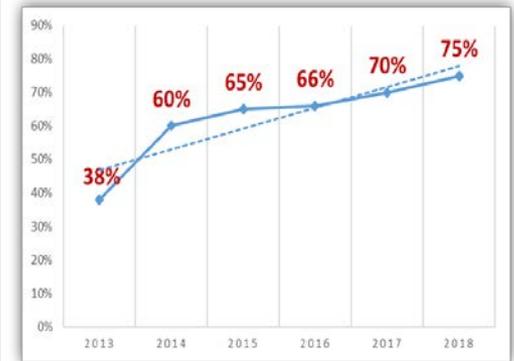


Patient-Centered Medical Home Recognition

National Patient-Centered Medical Home (PCMH) Recognition in Health Centers (75% as of July 1, 2018)



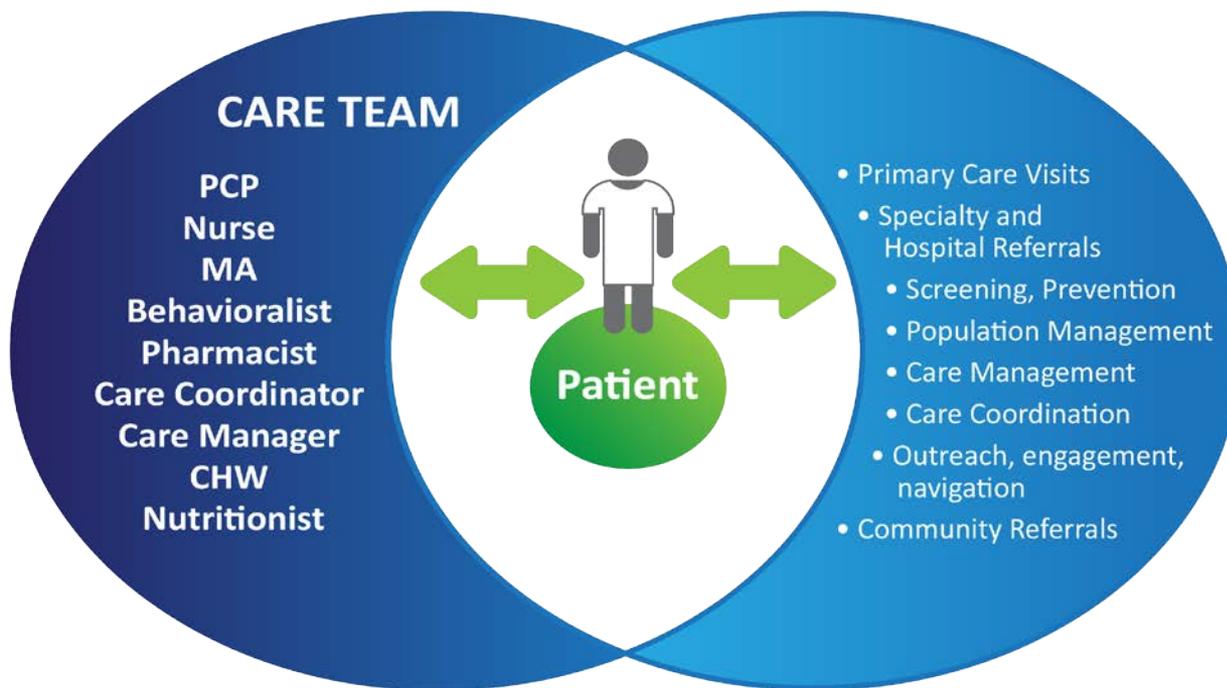
Percentage of Health Centers with PCMH Recognition



Source: HRSA Accreditation and Patient-Centered Medical Home Report, 2018



PCMH: Pro-Active Multidisciplinary Team-based Care

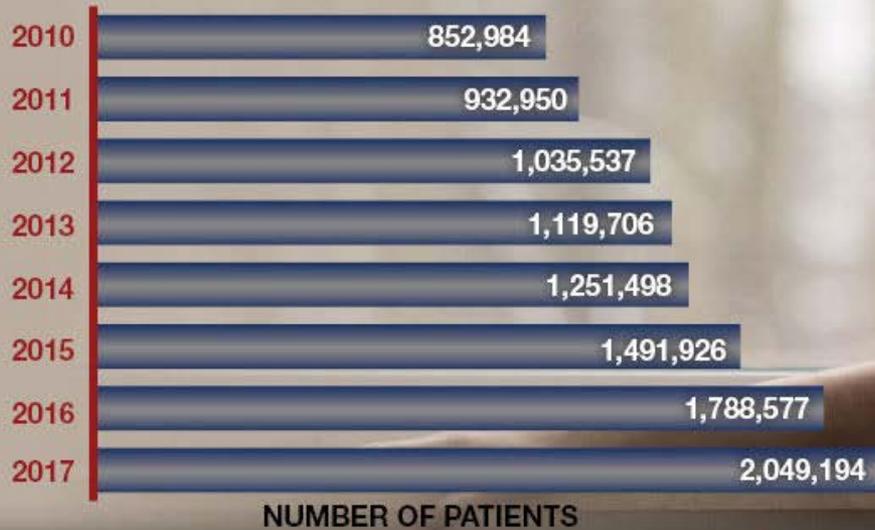


Source: UMass Medical School, 2016



Integrating Behavioral Health and Primary Care

Nearly **90%** of HRSA-funded health centers provide mental health services.

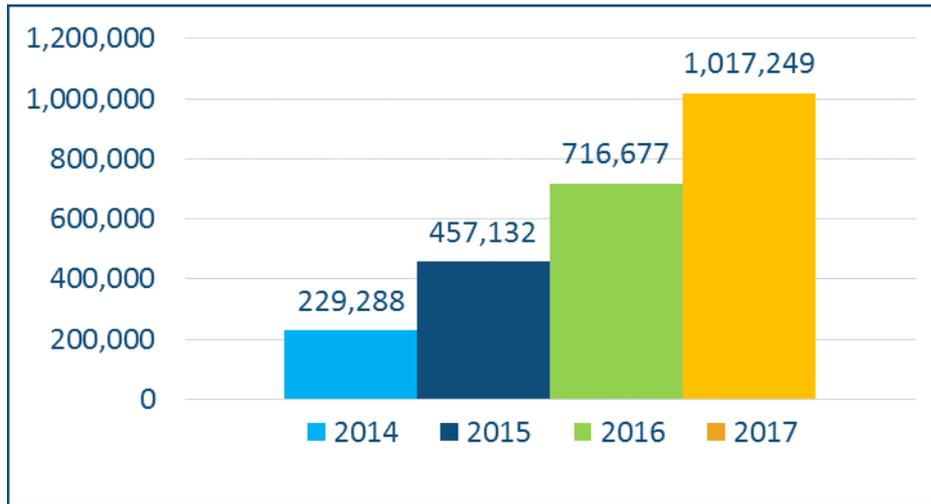


Source: Uniform Data System, 2010-2017

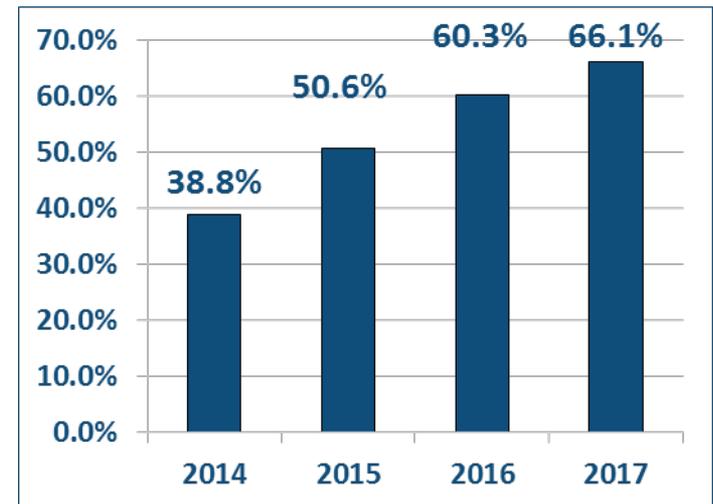


Screening for Behavioral Health Conditions

Patients Who Received Screening, Brief Intervention, and Referral to Treatment (SBIRT)



Depression Screening & Follow-up 2014-2017

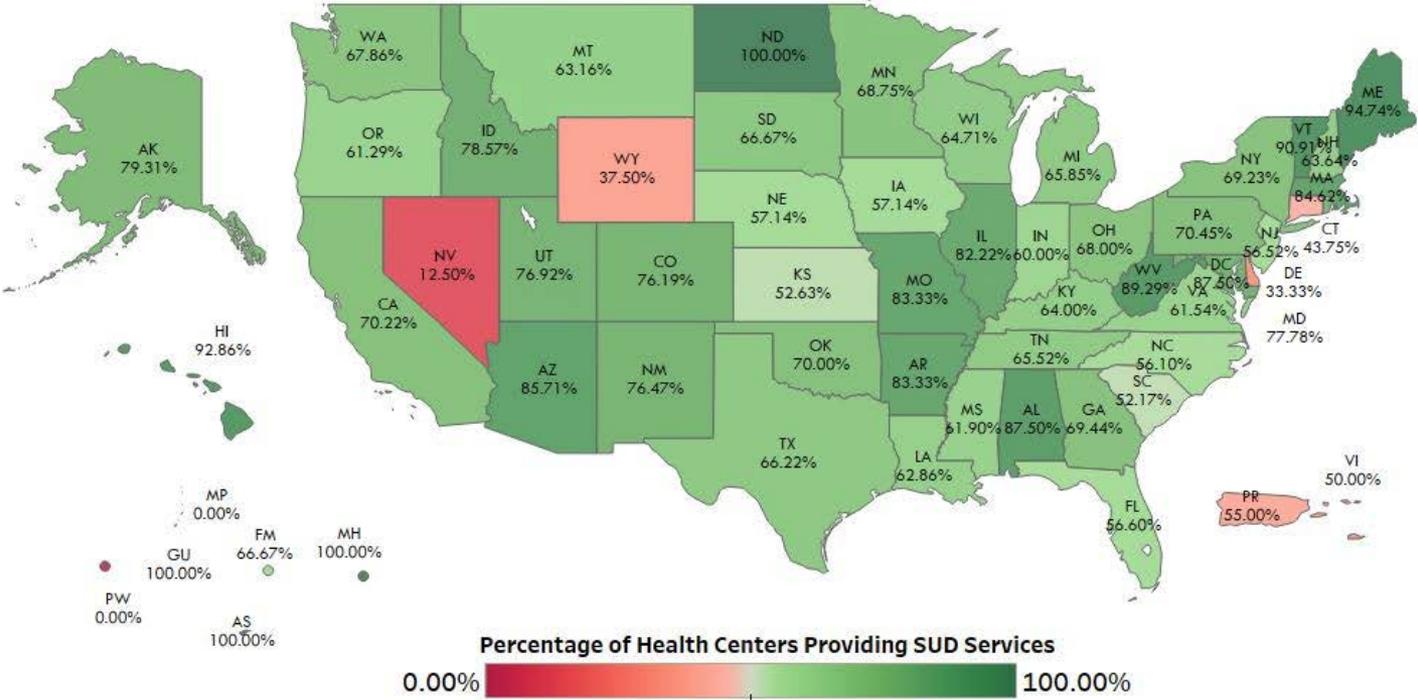


Source: Uniform Data System, 2017



Substance Use Disorder (SUD) Services

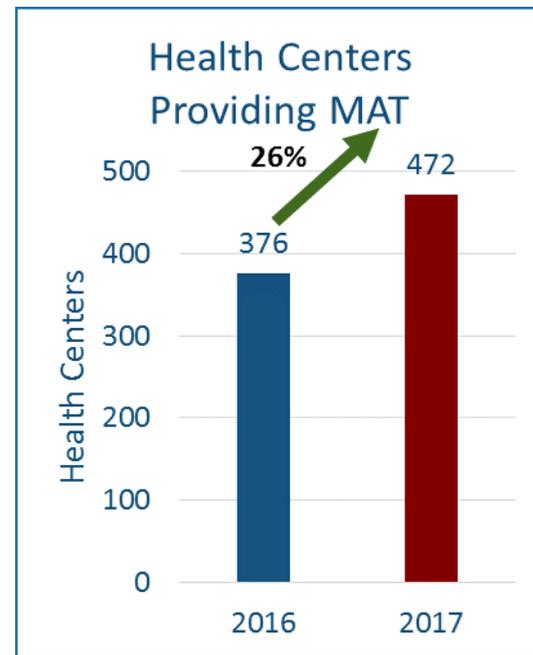
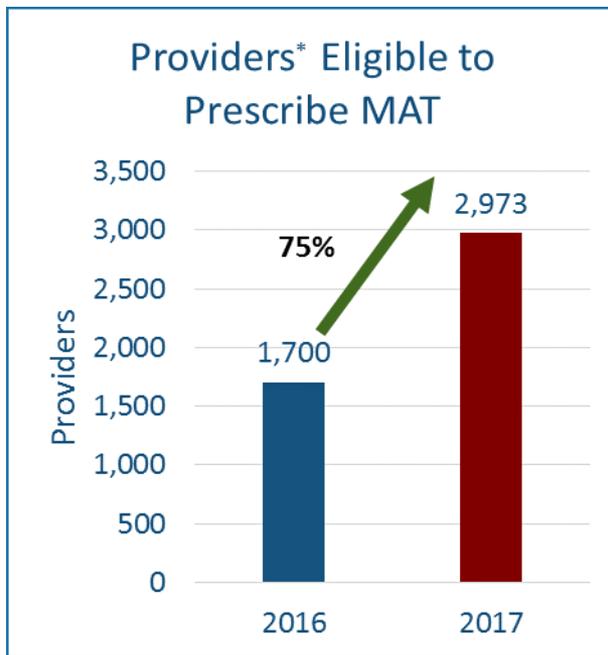
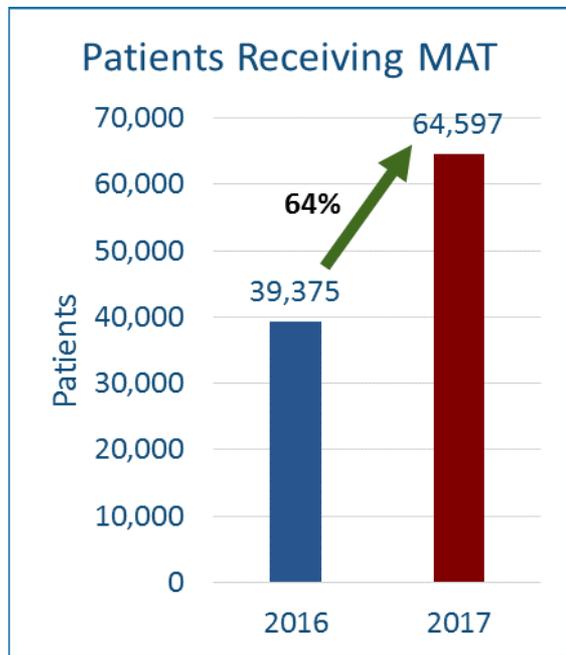
70% of Health Centers Offer SUD Services



Source: Uniform Data System, 2017



Increasing Access to Medication-Assisted Treatment



*Definition of MAT providers expanded to include physician assistances, certified nurse practitioners in 2017

Source: Uniform Data System (UDS) - Table Other Data Elements 2017. UDS 2016 Health Information Technology (HIT) Information.



Advancing Quality in Chronic Disease Management

Controlling High Blood Pressure and Diabetes

Health center patients with controlled hypertension



Health center patients with HbA1c \leq 9%



HIV Care Integration



↑ HIV testing by 27% to 1.8 million patients

84.5% of HIV patients were linked to care

Served 165,745 HIV patients over 616,392 visits

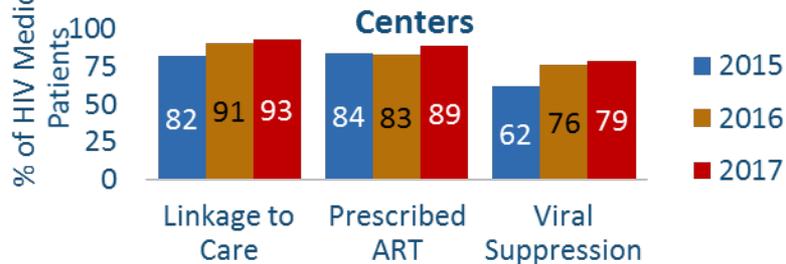


Partnerships for Care (P4C)

Demonstration Project, 2014-2017

Goal: Expand the provision of HIV prevention and care services within communities disproportionately impacted by HIV.

HIV Care Continuum at 22 P4C Health Centers



Southeast Practice Transformation Expansion Project (SEPTEP), 2017-2018

Goal: Advance HIV testing, linkage to care, and prevention at HRSA-funded health centers in the Southeast United States (Region 4), which has the nation's highest rates of HIV diagnoses.

Source: HRSA Electronic Handbooks

HRSA Health Center Program HIV and Primary Care: <https://bphc.hrsa.gov/qualityimprovement/clinicalquality/hivprimarycare.html>



Oral Health Integration



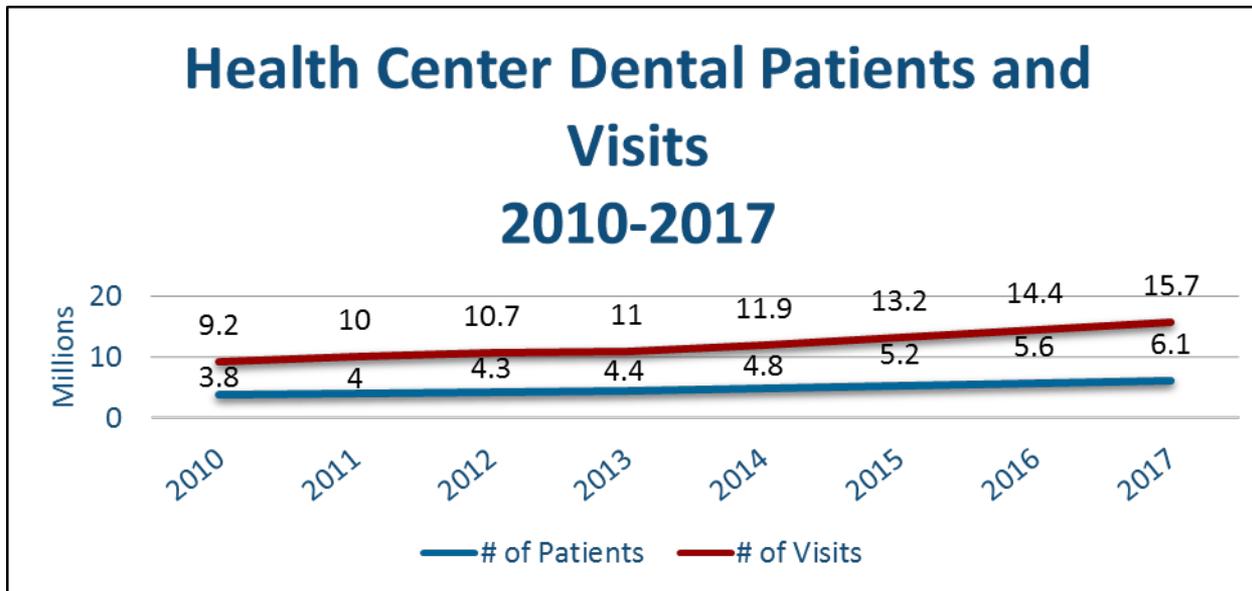
50.7% of children ages 6-9 years with elevated caries risk received dental sealants



↑ dental patients by 8% to 6.1 million



↑ dental workforce by 10%:
4,882 dentists (FTE)
2,498 dental hygienists (FTE)



Source: Uniform Data System, 2017



Primary Care Integration

**Multidisciplinary Team Includes Medical, Behavioral & Oral Health Providers:
Bidirectional Referrals & Warm Handoffs**

Dental

- Screen for oral health conditions suggestive of diabetes
- Manage oral health complications of diabetes and promote patient self management
- Screen for depression/behavioral health indicators
- Contribute to routine health screening: BP, BMI, etc.

Medical / Behavioral Health

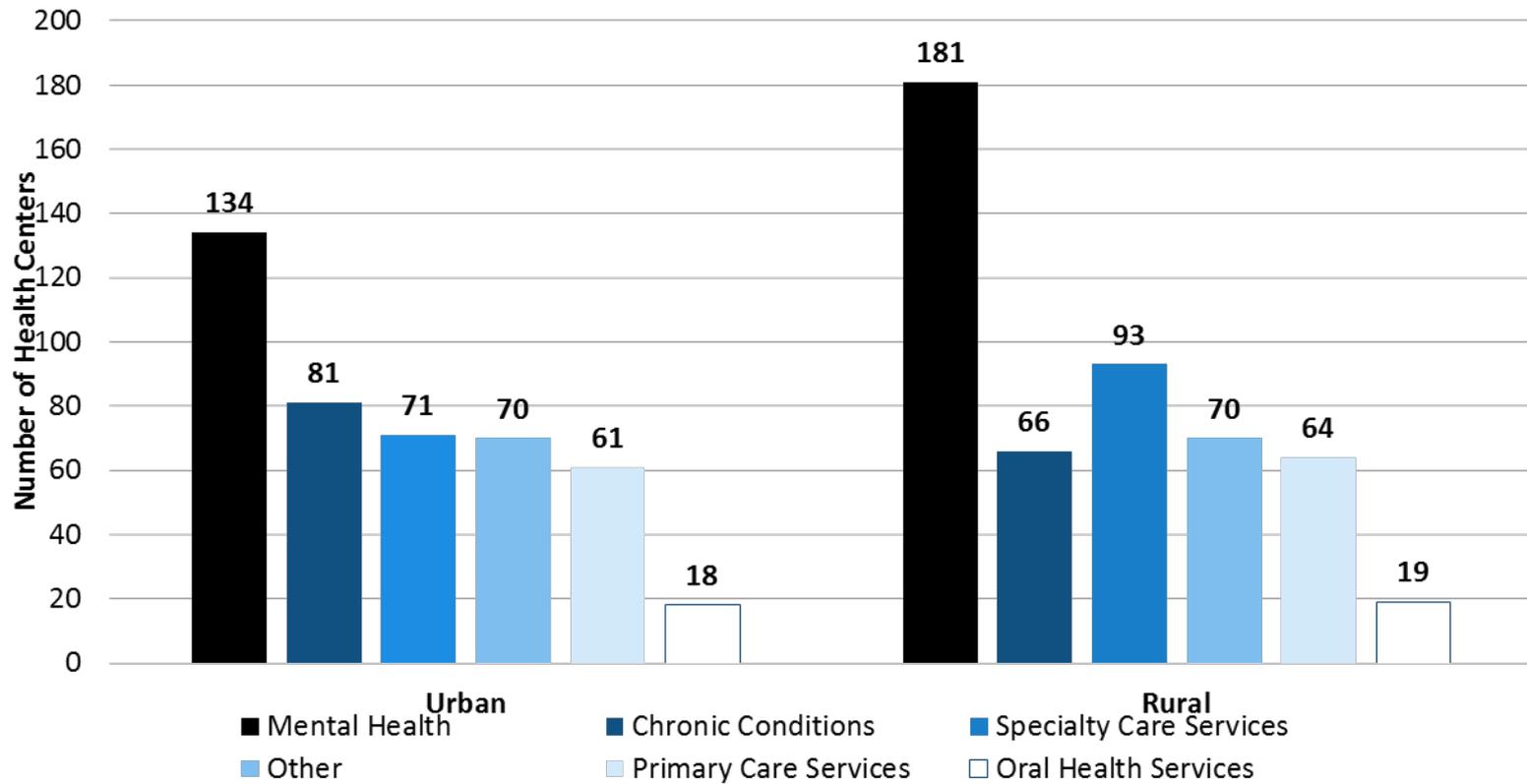
- Screen using dental questionnaire
- Refer for routine dental care
- Apply fluoride varnish

No Wrong Door



Use of Telehealth Services in Health Centers

44% of Health Centers Use Telehealth; 53% for Mental Health Care



Health Center Program Resources

- Website: 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: hrsa.gov/about/contact/bphc
 - FTCA inquiries
 - HRSA Electronic Handbooks (EHBs) questions/issues
- National Cooperative Agreements & Primary Care Associations: bphc.hrsa.gov/qualityimprovement/strategicpartnerships



Thank You!

Judith Steinberg, MD, MPH

Chief Medical Officer

Bureau of Primary Health Care (BPHC)

Health Resources and Services Administration (HRSA)



bphccmo@hrsa.gov



301-594-4110

www.bphc.hrsa.gov



Sign up for the *Primary Health Care Digest*





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To learn more about our agency, visit

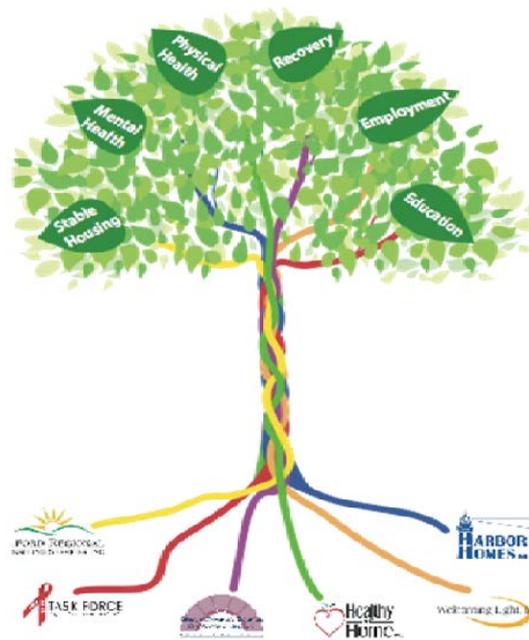
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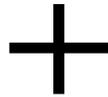
Partnership For Successful Living (PSL)

Increasing Access to Healthcare
Through a Unique Approach

The Partnership Formula: Housing + Services = SUCCESS

Housing

- Permanent Supportive Housing
- Transitional Housing
- Emergency Housing
- Affordable Housing for Individuals and/or Families with Disabilities
- Affordable Low to Moderate Income Housing
- More than 1,050 units of housing
- Serving approximately 2,000 clients



Services

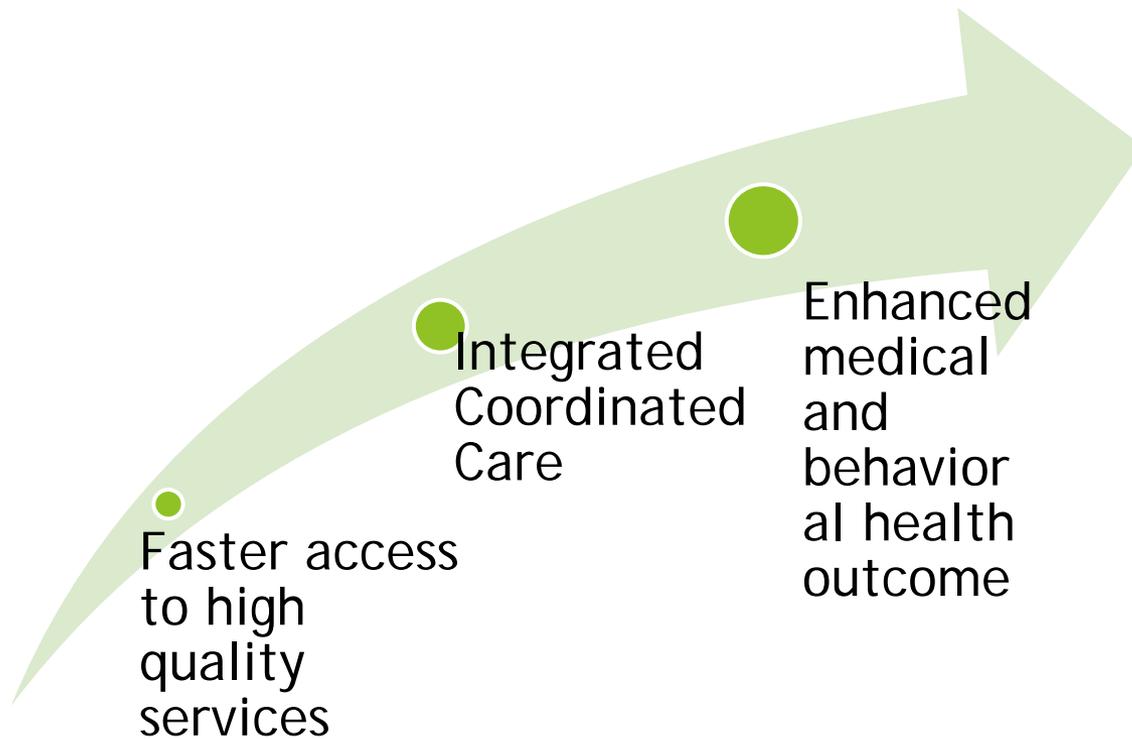
- Federally Qualified Health Care Center
- Serves as a primary care provider and health care home
- Mobile integrated services
- Behavioral health care
- Dental care
- Substance use disorder treatment
- On-site 340B pharmacy
- Resource coordination and client advocacy
- Medical Case Management
- Supportive Services and Prevention
- Serving over 3,000 patients annually

Who We Serve

Our agencies primarily serve :

- Homeless persons especially those with behavioral health challenges
- Veterans
- Pregnant and post-partum women and their children
- Frail Elderly
- Individuals with Hepatitis C and HIV
- Individuals with both chronic and acute medical conditions requiring in-home and outpatient health care
- Low-to-moderate income individuals and families in need of affordable housing, education, and employment

Impact to PSL Clients



Nashua Safe Stations



Nashua Fire Rescue

“Nashua Fire Rescue is proud to be a partner in this initiative by providing a gateway to recovery services in the Greater Nashua Region. This program fits nicely with our mission;

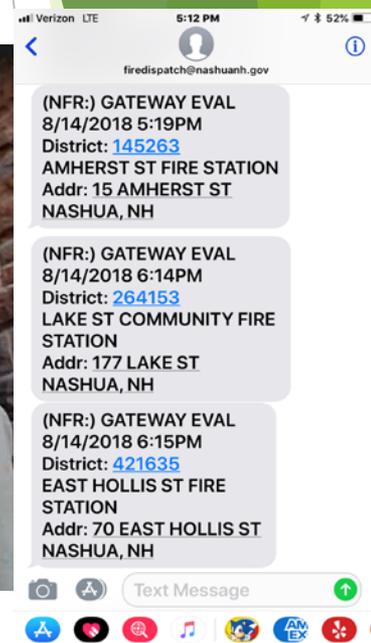
To create a safe and vibrant community through risk reduction, preparedness, and a proactive all hazards response plan”.

Fire Chief Brian Rhodes

STEP 1

At any time of the day or night, an individual seeking recovery and treatment for a substance use disorder can ask for assistance at any of the seven Nashua fire stations "Safe Stations".

Safe Stations is a stigma free access point without fear of incarceration, judgement or repercussion.



STEP 2

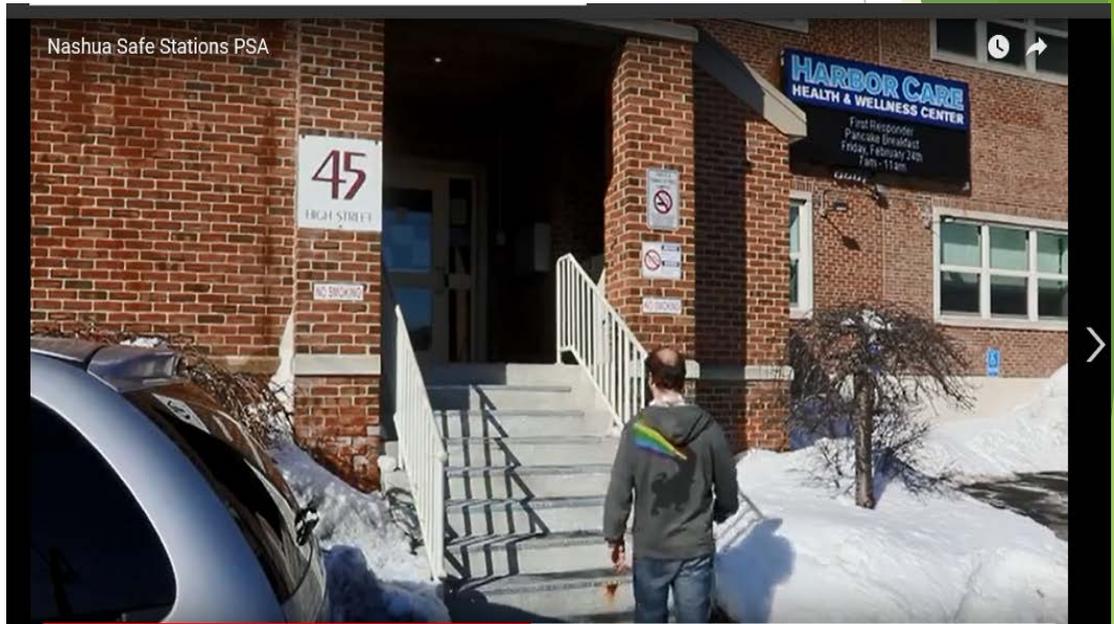
Fire personnel complete an immediate medical assessment to determine if emergency medical care is needed.

Fire calls Dispatch, AMR (American Medical Response) and PSL/HHI.



STEP 3

Within 10 minutes, a Harbor Homes trained peer recovery support provider responds with compassion in person to assess the participant, and transports to the appropriate location.



Common characteristics of a Safe Stations Client

- Early 30's
- Males (a 2:1 ratio)
- History of significant psychological, physical and sexual trauma
- Hepatitis/HIV due to injection drug use (at least one-fifth of the clientele)
- The term polysubstance use hardly does justice to the level of SUD we see
with clients; some start using substances at age 9
- Extensive criminal justice involvement
- Succeed only after several times
- Accompanied by loved ones to the fire stations
- Despondent - They feel that they have lost everything of value in their life

What is Medical Respite?

Medical respite care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital. Medical respite care shortens hospital lengths of stay, reduces readmissions, and improves outcomes. It is often used interchangeably with “recuperative care”, a term defined by the Health Resources and Services Administration.

This is where our Safe Station clients go through withdrawal management (detox)

<https://www.nhchc.org/wp-content/uploads/2017/07/policy-brief-respite-financing.pdf>



Primary care is the glue that binds and allows a launch into MAT – one of the most promising practices

Medical Respite (FQHC) patients accessing other PSL services

- **72** respite patients were served by PSL **housing** programs
- **249** respite patients participated in **Medication Assisted Treatment (MAT)** program at Harbor Care Health & Wellness Center
- **237** respite patients went into **residential treatment** after medical detox
- **34** respite patients went into **specialized services for pregnant and parenting women**

Medical Respite (FQHC) patients accessing other PSL services (continued)

- **51** respite patients were served in our **Dental** program
- **133** respite patients participated in PSL's **intensive outpatient/partial hospitalization program**
- **399** respite patients had no insurance, which led to **198** safe station appointments by to establish eligibility and enroll in coverage in the Health Insurance Marketplace
- **1,407** Safe Station participants received Licensed Alcohol **Drug Counselor Assessments**

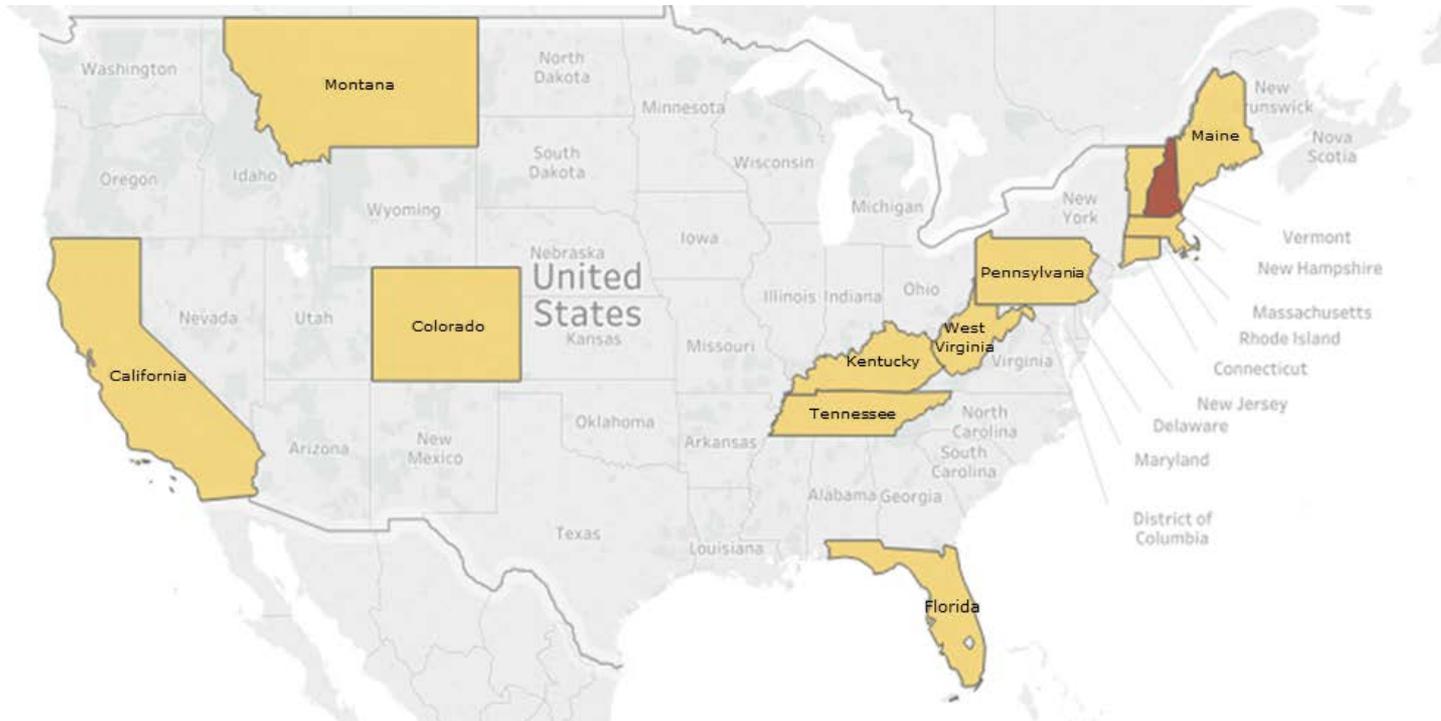
The Partnership and Safe Station Collaboration Impact – Nashua, NH



Nashua Opioid Crisis Summary

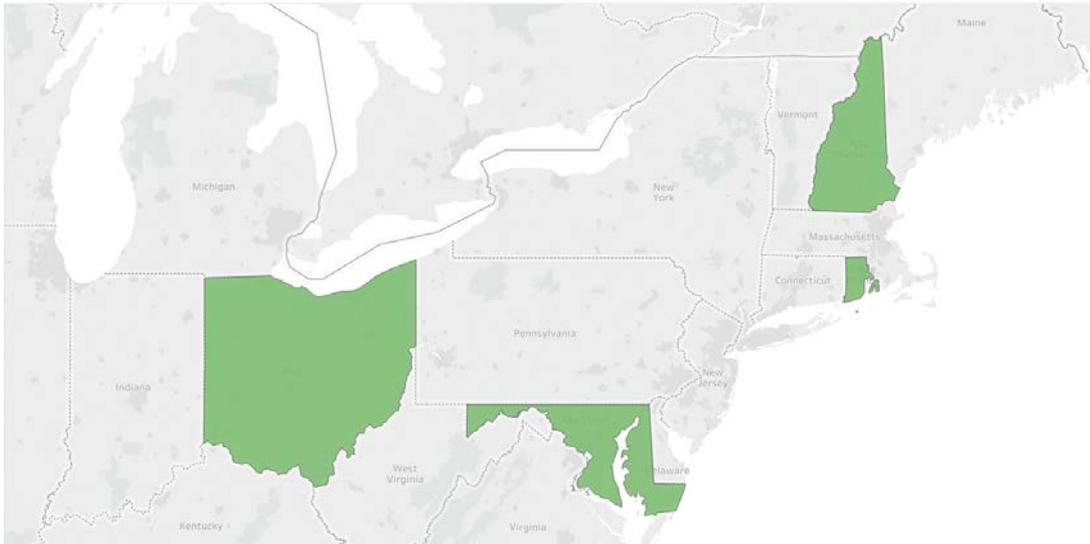
Line	Gateway to Recovery Statistics	2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Overall
1	Number of Walk-In Requests for Safe Station:	51	222	306	388	384	314	278	289		2,232
2	Number of Participants Taken to Substance Missuse Treatment Facility:	45	183	271	340	358	292	245	259		1,993
3	Number of Participants Taken to a Hospital Emergency Department:	5	35	33	40	22	21	32	28		216
4	SJH	0	15	17	24	9	10	16	10		101
5	SNHMC	5	20	16	16	13	11	16	18		115
6	Percent of Participant Requiring Transport to Hospital ED:	10%	16%	11%	10%	6%	7%	12%	10%		10%
7	Average Number of Minutes AMR / Fire Companies "Not Available":	14.3	12.0	12.1	10.7	10.2	9.9	8.9	8.6		10.4

Communities served by the Nashua Safe Stations Program



Other States Who have followed the Nashua Safe Station Model.

Sheet 1



States in the USA with Safe Stations:

- New Hampshire
- Maryland
- Rhode Island
- Ohio

Results Of Connectivity

- ▶ **13% reduction in emergency room visits** for primary SUD related overdose over a period of 5 months (2017 vs 2016)
- ▶ **36% decrease in fatal overdoses** compared to a similar period of 365 days (data as of 9/14/2018)
- ▶ **10% decrease in total overdoses** compared to a similar period of 365 days (data as of 9/14/2018)
- ▶ **74% less likely to fatally overdose after utilizing** Nashua Safe Stations as compared to before utilizing Nashua Safe Stations (source DPHCS Community Services Department-City of Nashua; Nov 2016 to July 25, 2018)
- ▶ **71% less likely to non-fatally overdose** after utilizing Nashua Safe Stations as compared to before utilizing Nashua Safe Stations (source DPHCS Community Services Department-City of Nashua; Nov 2016 to July 19, 2018)

Office of New Hampshire

Chief Medical Examiner Statistics

Annual Drug Deaths by Year



Drug Deaths by Year

2011	201
2012	163
2013	192
2014	332
2015	439
2016	485
2017	488
2018	190

Top Lessons Learned



1. Safety, immediacy and certainty of access matters.
2. Make sure you have First Responder buy-in.
3. Allocate funding for data collection.
4. Connect with a primary care provider – it's a critical component.
5. Hold regular meetings with stakeholders to allow for collective brainstorming.
6. Be alert about financial pressures.
7. Be ready to have the program evolve based on community needs.
8. Be prepared for compassion fatigue and have an action plan in place for when this happens.
9. Don't get disheartened by clients leaving Against Medical Advice.

Contact Information

Peter Kelleher at 603-882-3616 or p.kelleher@nhpartnership.org,
www.nhpartnership.org

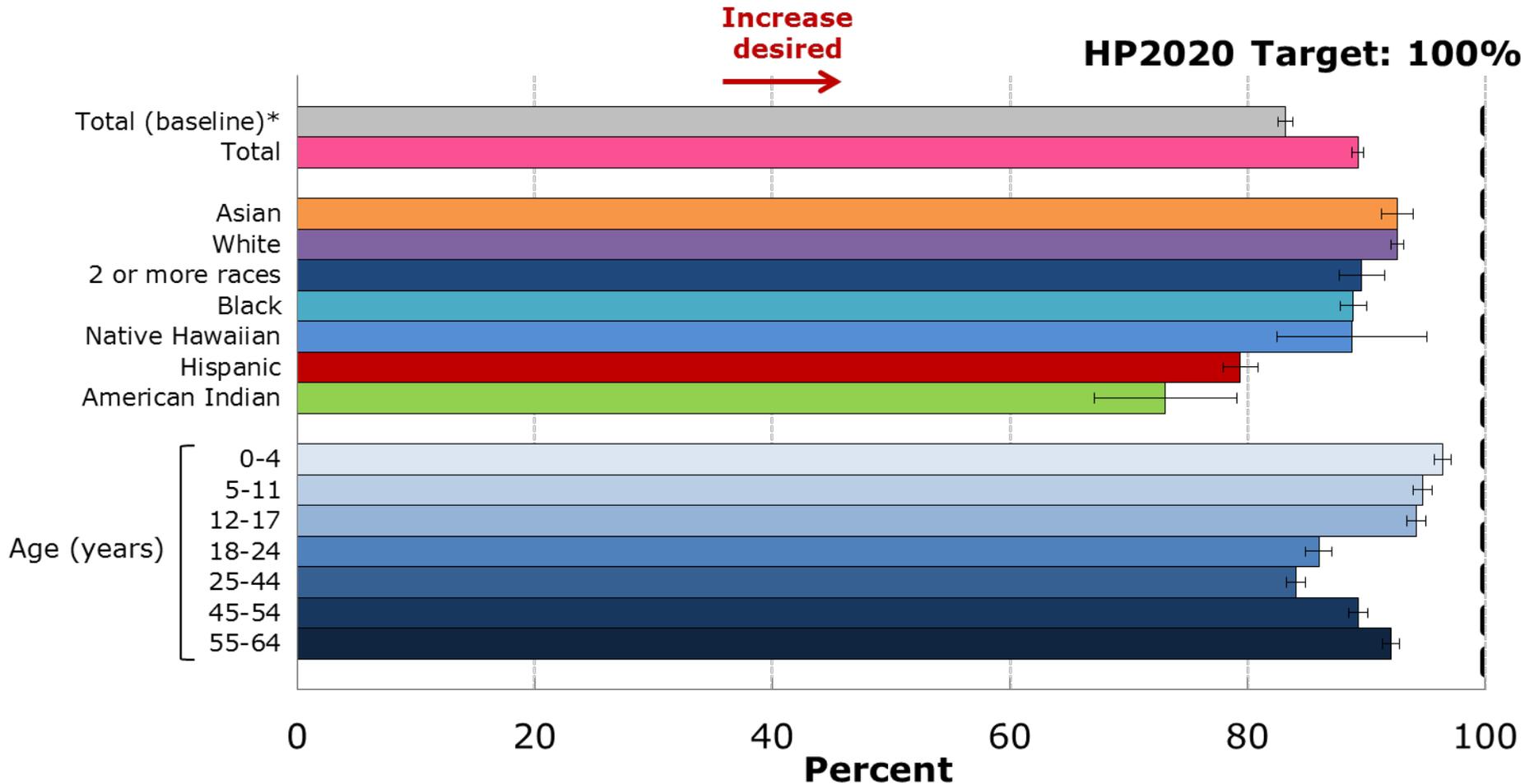
or

Chief Rhodes at 603-594-3651 or brianr@nashuanh.gov

Roundtable Discussion



Persons Under 65 Years with Health (Medical) Insurance, 2017



NOTES: — is 95% confidence interval. * Baseline: 2008. Black and White exclude persons of Hispanic origin. Persons of Hispanic origin may be of any race. American Indian includes Alaska Native. Native Hawaiian includes Other Pacific Islander. Respondents were asked to select one or more races. Single race categories are for persons who reported only one racial group.

SOURCE: National Health Interview Survey (NHIS), CDC/NCHS.

Obj. AHS-1.1

A library of stories highlight ways organizations across the country are implementing Healthy People 2020

Stories from the Field

Want to know what others are doing to improve the health of their communities? Explore our *Stories from the Field* to see how communities across the Nation are implementing Healthy People 2020. You can also [share your story!](#)

Explore the map below or filter to view stories by the related topic area or Leading Health Indicator.

Sort By: Viewing 80 results

Topic Area	Organization Name	Organization Type	Date Posted	Program State
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Filter By: Showing All Topic Areas Show LHI Only [Reset Filters](#) [Update](#)



Healthy People 2020 in Action

 Who's Leading the Leading Health Indicators? series  Stories from the Field

Healthy People in Action



Law and Health Policy

From Policy to Plate: Increasing fruit and vegetable intake through accessibility, affordability, and demand

Thursday, September 27, 2018 | 1pm ET

Join us to learn about the impact of health laws and policies on increasing fruit and vegetable intake and making food accessible and affordable.

This is the first in a series of webinars about the role of law and policy in helping to achieve Healthy People 2020 objectives.

- To register visit: healthypeople.gov



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Healthy People
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