Healthy People 2020: Who’s Leading the Leading Health Indicators?
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.
Who’s Leading the Leading Health Indicators?

Featured Speakers:

- **Karen B. DeSalvo, MD, MPH, MSc**
  Acting Assistant Secretary for Health, U.S. Department of Health and Human Services

- **Sarah Linde, MD, RADM, U.S. Public Health Service**
  Chief Public Health Officer, Health Resources and Services Administration

- **Marcia Pugh, DNP, MBA, HCM, RN**
  Grants, Research, Outreach of West AL Division Director, Tombigbee Healthcare Authority
Access to Health Services

Regular and reliable access to health services can affect a person’s health and well-being by:

- Preventing disease and disability
- Detecting and treating illnesses or other health conditions
- Increasing quality of life
- Reducing the likelihood of premature (early) death
- Increasing life expectancy
Access to Health Services

Percent of Persons under Age 65 with Health Insurance, 2003–2013

- HP2020 Target: 100
- Percent
  - 2003: 83.5
  - 2013: 83.3

Percent of Persons with a Usual Primary Care Provider, 2001–2011

- HP2020 Target: 83.9
- Percent
  - 2001: 77.5
  - 2011: 77.3

SOURCE: National Health Interview Survey (NHIS), CDC/NCHS.  
Obj. AHS-1.1

SOURCE: Medical Expenditure Panel Survey (MEPS), AHRQ.  
Obj. AHS-3
Access to Health Services in Rural America

- More than 7.8 million uninsured Americans live in rural areas

- As population density and proximity to an urban area decrease, uninsurance rate increases

- Americans living in rural areas are uninsured for longer periods of time
Residents in rural areas are less likely to visit a health care provider to receive appropriate preventive care.

People living in rural areas of the country are more likely to report a health status of “fair” or “poor”.

Residents in rural areas are more likely to:
- Be overweight or obese
- Have diabetes
- Have higher rates of heart disease
Healthy People 2020
Who’s Leading the Leading Health Indicators?

ACCESS: The HRSA Perspective

RADM Sarah Linde, MD
Chief Public Health Officer
Health Resources and Services Administration
U.S. Department of Health and Human Services
January 22, 2015
HRSA Mission

To improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs
HRSA Strategic Plan

1. Improve Access to Quality Health Care and Services
2. Strengthen the Health Workforce
3. Build Healthy Communities
4. Improve Health Equity
Subgoals under Goal 1: Improve Access

1. Ensure a medical home for populations served.
2. Expand oral health and behavioral health services and integrate into primary care settings.
3. Integrate primary care and public health.
4. Strengthen health systems to support the delivery of quality health services.
5. Increase outreach and enrollment into quality care.
6. Strengthen the financial soundness and viability of HRSA-funded health organizations.
7. Promote innovative and cost-efficient approaches to improve health.
Rural Access – Challenges and Barriers

Rural Americans are more likely

- To live below the poverty level
- To be uninsured
- To remain uninsured for longer
- To live in a Health Professions Shortage Area
- To report fair or poor health status
- To experience diabetes, obesity, and heart disease

Rural Americans are less likely

- To receive clinical preventive services
- To have employer-provided health insurance
- To be covered by Medicaid
HRSA and Rural Health

1. The FEDERAL Office of Rural Health Policy (ORHP)
2. Advises the Secretary of HHS
3. 62 million residents of rural communities
4. Policy
   a. Effects of Medicare and Medicaid on rural citizens’ access to care
   b. Viability of rural hospitals
   c. Availability of physicians and other health professionals
5. Programs
   a. Community Based
   b. Hospital Based
The Rural Health Safety Net

Direct Services
- 36 % of 9K health centers are located in rural communities
- Approximately 4K rural health clinics and 2K small rural hospitals
- Of 2K hospitals, 1,750 have fewer than 50 beds
- Telehealth

Workforce Programs
- The National Health Service Corps (NHSC)
- Teaching Health Centers
- Rural Training Tracks

Community Based Programs
- Network Planning Grants
- Network Development Grants
- Delta States
Subgoals under Goal 1: Improve Access

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1. Ensure a medical home

http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html
2. Expand oral and behavioral health and integrate into primary care settings


http://www.hrsa.gov/publichealth/guidelines/BehavioralHealth/index.html
3. Integrate primary care and public health

http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx

http://www.astho.org/Programs/Access/Primary-Care-and-Public-Health-Integration/
4. Strengthen health systems to support delivery of quality health services

- Rural Health Network Development Program
- Rural Health Network Development Planning Program
- Evidence-Based Tele-Emergency Network Program
- Telehealth Resources Centers
- Radiation Exposure Screening and Education Program
- Rural Access to Emergency Devices Program
- Public Access to Defibrillation Demonstration Project
- Healthy Start Program
- Health Center Program

http://www.hrsa.gov/about/news/pressreleases/140926ruralhealth.html
5. Increase outreach and enrollment into quality care

“There are unique challenges in rural areas in getting people signed up for health insurance coverage....Issues such as a lack of Internet connectivity or long travel times for those who can assist with enrollment make it especially important that there is a targeted outreach in rural areas.”

http://www.hrsa.gov/about/news/pressreleases/141010ruraloutreach.html
6. Strengthen the financial soundness and viability of HRSA-funded health organizations

Awards Management Tutorial

Program Integrity

Grants Management Technical Assistance

Ins and Outs of Lobbying for HRSA Grantees

Quarterly Conference Calls

http://www.hrsa.gov/grants/manage/index.html
7. Promote innovative and cost-efficient approaches to improve health

The Affordable Care Act- What it Means for Rural America

- Subsidized insurance coverage
- Increase competition in the insurance market
  - Lower cost
  - Compare options
- Access to Preventive Services with no cost sharing
- Ages 19-26 can remain on parents’ plans
- No lifetime or annual limits
- No denials for pre-existing conditions

7. Promote innovative and cost-efficient approaches to improve health

Delta States Rural Network Development Grant Program

**Purpose**
Fund organizations in the eight Delta States
Address unmet local health care needs

**Eligible entities**
Public or non-profit entities in eligible rural Delta county/parish; and
Located in a Rural County or Eligible Rural Census Tract in an urban county

**Focus areas**
Prevention, treatment and management of cardiovascular disease, obesity and diabetes
Resources
Rural Assistance Center
Access to Capital
Health Information Technology
Workforce
Geospatial Data Warehouse
Community and Hospital Resources
Minority Health
Policy and Research

http://www.hrsa.gov/ruralhealth/resources/index.html
“The health of the individual is almost inseparable from the health of the larger community. And the health of each community and territory determines the overall health status of the Nation”

Tombigbee Healthcare Authority

Access to Health Services
Access to Health Services

Alabama health disparities exist due to:

- High Unemployment Rates
- High Poverty Rates
- Lack of Transportation
- Limited access to computers & Internet
- Lack of insurance coverage
- Low literacy issues
In the Alabama Delta, these factors lead to unmet health needs, particularly related to diabetes prevention and management among the African American population.

Alabama is ranked third in the United States for percentage of adults with diabetes. (Alabama Department of Public Health, Diabetes in Alabama Report, 2010).

Alabama’s rate increased from 11.1% in 2010 to 11.8% in 2011. (Kaiser Health Status Report)
Diabetes is related to many other health conditions. Of adults with diabetes:

- 71% have hypertension
- 65% have a blood cholesterol > 100 mg/dl
- They have a 1.7 times higher cardiovascular death rate
- 44% have diabetes as the primary cause of kidney failure (2011)

(National Diabetes Statistics Report, 2014)
Improving overall community health is a goal of the Tombigbee Healthcare Authority. The Authority:

- Utilizes a mobile health van (Healthcare on Wheels) to provide health screenings and referrals to health care providers in the rural community.

- Provides Health insurance enrollment navigation assistance throughout the Delta region.
Tombigbee Healthcare Authority

- Provides community access to Preventive Health Services in schools, churches, community centers, homes and other community outlets.

- Maintains the Delta Rural Access Program (DRAP) which provides
  - Preventive services for those at risk of developing chronic health conditions
  - Increased access to prescription drugs for residents in the Delta region.
  - Provide diabetes education classes.
Access to Health Services

Mobile Health Van
Healthcare on Wheels Program
Access to Health Services

• Provide Health insurance enrollment navigation assistance throughout the Delta region.
Access to Health Services

Diabetes Prevention and Management Education Classes done using the National Diabetes Education Program (NDEP)

*Power to Prevent: A Family Approach to Diabetes Prevention*
Access to Health Services

What is Power to Prevent?

- A 12 session; 3 month class period
- A 3 month follow-up period
- Classes cover all aspects of diabetes management and healthy lifestyle
- Classes include health screenings
- Classes include hands-on demonstrations.
Access to Health Services

Why Power to Prevent?

• It is an evidence based program.
• It is specific to our target population - African Americans.
• Research shows it to be a very useful educational tool for teaching individuals affected by or at high risk for diabetes in group settings.

Access to Health Services

Recruitment

- Attend church programs and community activities provided by businesses, schools and cities.
- Broadcast using television bulletin boards
- Use community buildings to provide classes – courthouses, libraries, church activity centers
- Network with county and city officials for incentives.
DRAP Program Success

Physical Measurement Changes - Means

- Weight: Initial: 199.4, 3 months: 196.4, 6 months: 196.2
- Systolic Blood Pressure: Initial: 138.2, 3 months: 134.2, 6 months: 136.6
- Diastolic Blood Pressure: Initial: 80.2, 3 months: 79.2, 6 months: 76.2
- Body Mass Index: Initial: 33.9, 3 months: 33.3, 6 months: 32.7
- Cholesterol: Initial: 168, 3 months: 162.8

Initial: Light blue, 3 months: Light blue, 6 months: Dark blue
DRAP Program Success

Decisions on Eating

- Eat anything I want: 39.1% (Initial), 10.6% (6 months)
- Avoid sweets/sugar: 38.9% (Initial), 51.3% (6 months)
- Limit amount of fat: 29.8% (Initial), 54.8% (6 months)
- Count carbohydrates: 17.2% (Initial), 28.2% (6 months)
- Count calories: 16% (Initial), 38.4% (6 months)
DRAP Program Success

Physical Activity Changes - %

- No Activity
  - Initial: 46.7
  - 3 months: 30.9
  - 6 months: 26.4

- Light Activity
  - Initial: 22.8
  - 3 months: 31.4
  - 6 months: 23.4

- Moderate Activity
  - Initial: 26.6
  - 3 months: 32.8
  - 6 months: 39.3

- Vigorous Activity
  - Initial: 3.8
  - 3 months: 4.9
  - 6 months: 10.9
DRAP Program Success

Emotion - Related to Lessons - %

- Aware of unhealthy habits done when feeling bad: Pre Test-Strongly Agree/Agree: 82.2%, Post Test-Strongly Agree/Agree: 98.3%
- Aware negative feelings lead to poor eating habits: Pre Test-Strongly Agree/Agree: 73.3%, Post Test-Strongly Agree/Agree: 98.3%
- Feel eating properly can improve mood: Pre Test-Strongly Agree/Agree: 72.4%, Post Test-Strongly Agree/Agree: 96.1%
DRAP Success Stories

• The attendee who did not drink water prior to attending classes increased her intake to 64 ounces a day in 6 months.

• The wife who was able to get her spouse to start exercising. Together they lost 15 pounds in 6 months.

• The attendee who was able to decrease her total blood cholesterol from 300 to 215 in 6 months.
Access to Health Services

1. Increase the services provided on the mobile health van.

2. Increase community medical insurance assistance sites in the Delta counties.

3. Increase community awareness about diabetes prevention.
Marcia A. Pugh, DNP, MBA, HCM, RN  
Program Director  
Telephone: 334-287-2447  
Email: mapugh@bwwmh.com

Christina Carr, MSCE, BSPYSY  
Program Manager  
Telephone: 334-287-2675  
Email: ccarr@bwwmh.com
Roundtable Discussion

Please take a moment to fill out our brief survey.
Continuing Education Credits Available

- 1 credit hour available from APHA in Medicine, Nursing, or Health Education
- Must complete online evaluation
  - Will receive via email within 48 hours
- If not logged in to webinar with your own name, send email to healthypeople@norc.org within 24 hours after webinar
Please join us as we review select Healthy People 2020 objectives in the Social Determinants of Health and Lesbian, Gay, Bisexual and Transgender Health topic areas.

February 5, 2015

Hear from a community-based organization that is working to improve outcomes in the community.

To register, visit: www.healthypeople.gov
Affordable Care Act Resources

- https://www.healthcare.gov/
- https://localhelp.healthcare.gov/

Get personal help applying for health coverage
2015 Healthy Aging Summit Registration is Open!
- July 27-28, 2015 in Washington, DC
- State of the Science meeting
- Social Determinants of Health Framework

ODPHP encourages all sectors to submit abstracts online through 11:59 p.m. EST, Monday, February 2

To get the most current information visit www.2015HealthyAgingSummit.org and follow us @gohealthypeople #HealthyAging2015
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