HRSA Priorities
HCH Clinicians’ Network Membership Breakfast
May 23, 2019

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

Vision: Healthy Communities, Healthy People
• 299 health centers receive section 330h funding (22% of all health centers)
• 5% of all health center patients are homeless (unchanged 2015-2017)

Source: Uniform Data System, 2015-2017
### HRSA Clinical Priorities

- Health Center Workforce
- Care Integration
- Substance Use Disorder and the Opioid Crisis
- Diabetes Prevention and Control
- Ending the HIV Epidemic
- Telehealth
- Intimate Partner Violence and Human Trafficking
- Value-Based Care
Enhancing Communication:
Primary Health Care Digest

October 17, 2017
A Message from Jim Macrae, BPHC Associate Administrator
At its core, the Health Center Program is about community. We are a vast yet close community of health centers, and so when one health center is affected by a natural disaster, we come together to offer our thoughts of support. From the health centers along the Gulf Coast and in the U.S. Virgin Islands and Puerto Rico affected by the hurricanes to those in Las Vegas affected by the shooting to our health center colleagues in the west and California affected by wildfires, we support you, and support your efforts to provide services for your community.

Uniform Data System (UDS) Performance Data Collection Environment (PDCE) Now Open
As part of efforts to modernize UDS, HRSA is pleased to announce the availability of new functionality in its Electronic Handbooks (EHB) that allows health centers to access the UDS reporting environment earlier.

The aim is to reduce reporting burden, improve data quality and usage, and better reflect the impact of the Health Center Program.

The PDCE allows health centers to enter and validate any available/partial

Special Edition Digest:
Workforce Engagement and Well-being

Sign Up:
bphc.hrsa.gov
Screening for Behavioral Health Conditions

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

<table>
<thead>
<tr>
<th>Year</th>
<th>National</th>
<th>HCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>457,132</td>
<td>29,679</td>
</tr>
<tr>
<td>2016</td>
<td>716,677</td>
<td>41,479</td>
</tr>
<tr>
<td>2017</td>
<td>1,017,249</td>
<td>53,265</td>
</tr>
</tbody>
</table>

Depression Screening & Follow-up 2015 - 2017

<table>
<thead>
<tr>
<th>Year</th>
<th>National</th>
<th>HCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>50.61%</td>
<td>50.61%</td>
</tr>
<tr>
<td>2016</td>
<td>60.34%</td>
<td>58.60%</td>
</tr>
<tr>
<td>2017</td>
<td>66.15%</td>
<td>64.65%</td>
</tr>
</tbody>
</table>

Source: Uniform Data System, 2015-2017
Increasing Access to Medication-Assisted Treatment

National

- Definition of MAT providers expanded to include physician assistants and certified nurse practitioners in 2017.

Source: Uniform Data System (UDS), 2017 - Table Other Data Elements. UDS 2016 Health Information Technology (HIT) Information.
Medication-Assisted Treatment: HCH

All health centers = 65% ^

All health centers = 75% ^

All health centers = 26% ^

*Definition of MAT providers expanded to include physician assistants and certified nurse practitioners in 2017.
Source: Uniform Data System (UDS), 2017 - Table Other Data Elements. UDS 2016 Health Information Technology (HIT) Information.
## Access to Comprehensive Care: National

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Number of Sites</td>
<td>9,829</td>
<td>10,415</td>
<td>11,057</td>
<td>^ 12%</td>
</tr>
<tr>
<td>Total Health Center Patients</td>
<td>24,295,946</td>
<td>25,860,296</td>
<td>27,174,372</td>
<td>^ 12%</td>
</tr>
<tr>
<td>Medical</td>
<td>20,616,149</td>
<td>21,880,295</td>
<td>22,866,468</td>
<td>^ 11%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1,737,060</td>
<td>2,071,326</td>
<td>2,266,902</td>
<td>^ 31%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1,491,926</td>
<td>1,788,577</td>
<td>2,049,194</td>
<td>^ 37%</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>117,043</td>
<td>141,569</td>
<td>168,508</td>
<td>^ 44%</td>
</tr>
</tbody>
</table>

Source: Uniform Data System, 2015-2017. 2016 was the first year telehealth data was collected.
# Access to Comprehensive Care: HCH

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</thead>
<tbody>
<tr>
<td>Number of Health Centers</td>
<td>295</td>
<td>295</td>
<td>299</td>
<td>^1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Health Center Patients</td>
<td>890,283</td>
<td>934,174</td>
<td>1,008,648</td>
<td>^13%</td>
</tr>
<tr>
<td>Medical</td>
<td>720,933</td>
<td>758,187</td>
<td>822,358</td>
<td>^14%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>84,975</td>
<td>87,495</td>
<td>94,505</td>
<td>^11%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>139,777</td>
<td>161,229</td>
<td>177,635</td>
<td>^27%</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>40,591</td>
<td>40,592</td>
<td>45,058</td>
<td>^11%</td>
</tr>
</tbody>
</table>

# Diabetes by the Numbers

<table>
<thead>
<tr>
<th></th>
<th>UDS National Average</th>
<th>HCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Medical Patients with Diabetes*</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Percentage of Patients with Poorly Controlled Diabetes (Hemoglobin A1c &gt;9%)</td>
<td>33%</td>
<td>34%</td>
</tr>
</tbody>
</table>

*Data calculated from UDS Table 7 and Table 5
Futures Without Violence Virtual Toolkit
https://ipvhealthpartners.org/

A Domestic Violence Toolkit

Steps for health settings to address intimate partner violence:

1. Build partnerships between health centers and local domestic violence (DV)/sexual assault (SA) programs.
2. Prepare your practice by implementing a new or updated DV/SA policy to identify and respond to survivors in partnership or community-based DV/SA programs, and promote prevention.
3. Adopt the evidence-based intervention to educate all patients about the connection between IPV and their health and engage them in strategies to promote wellness and safety.
4. Train providers and all staff on the impact of DV/SA on health outcomes, and how to assess and respond in collaboration with community-based DV/SA programs.
5. Evaluate and sustain your progress as part of continuous quality improvement.
Moving to Value Based Care: HRSA Approach

Components

- Comprehensive, integrated, patient-centered care
- Quality improvement; learning health system
- Operational excellence
- Health IT, population health management
- Addressing social risk factors
- Value based payments

Activities

- Quality Measurement/QI Awards
- Diabetes Quality Improvement Initiative
- Primary Care Associations
- Health Center Controlled Networks
- TA and Training National Cooperative Agreements – Health IT, workforce, special populations, payment reform, social risk factors
- Federal Partners – CMS, CMMI
Health Center Program Resources

- **Website:** [https://bphc.hrsa.gov/](https://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 on the Health Center Program
- **Health Center Program Support:** [https://bphccommunications.secure.force.com/ContactBPHC/BPHC_Contact_Form](https://bphccommunications.secure.force.com/ContactBPHC/BPHC_Contact_Form)
  - EHBs questions/issues
  - FTCA inquiries
- **FTCA Resources: [https://bphc.hrsa.gov/ftca/index.html](https://bphc.hrsa.gov/ftca/index.html)**
- **UDS Resources: [https://bphc.hrsa.gov/datareporting/reporting/](https://bphc.hrsa.gov/datareporting/reporting/)**
- **National Cooperative Agreements & Primary Care Associations:** [https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/](https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/)
- **Quality Improvement Resources:** [https://bphc.hrsa.gov/qualityimprovement/index.html](https://bphc.hrsa.gov/qualityimprovement/index.html)