June 2016

Community Health Assessment: Special Populations Report

ELKHORN LOGAN VALLEY PUBLIC HEALTH DEPARTMENT.
Mason McCain

Introduction

From the demographics section of the Elkhorn Logan Valley Public Health Department (ELVPHD) Community Health Assessment (CHA) report, population demographic information of the health district are further discussed in this report. This Special Populations Report will look into specific areas of health concern, or a health disparity, in selected demographic populations throughout the health district. A health disparity happens when a negative health outcome occurs much more in one subset of the population based upon race, age, sex, socioeconomic status, etc. The populations addressed in this report include the elderly, Hispanic minorities, and veterans, and this report will address health disparities that these populations face.

It is generally understood that the populations of most rural communities are aging due to large representation of the baby boomer generation. This is also caused by many young adults leaving rural areas for higher education and careers. According to the U.S. Census[1] numbers, the population of the ELVPHD health district has decreased by nearly 5% since 2000. Census numbers also show that the median age for all counties in the health district are above the state, meaning that the counties we serve are typically older than the state average. This is most prevalent in Burt County, where the median age is 47.0 according to census data. Respondents to the 2016 CHA survey are older on average than what is described in the census, so the study somewhat over-represents the elderly population. The health issues and needs of this population can be specifically studied by focusing on this population.

Census data also shows that the health district is becoming more diverse with increases in minority populations from 2000 to 2014[1]. As a percent of the population, the numbers of Hispanic minority persons in the area have increased from 6.4% of the population to 11.1% of the population in the same time period. According to census data, as a percent of each county, this population is highest in Madison County and lowest in Burt County.

Another special population of interest are veterans. Of those 18 and older, about 9% have veteran status[2]. The proportions of veterans are higher in Cuming and Burt Counties. The representation of veterans in the 2016 CHA survey are lower, coming in at about 3% of survey participants. So veterans were less likely to fill out the survey.

The problems facing these populations are complicated by the health provider landscape in our area. In Nebraska, 61 out of the 93 counties are State Designated Shortage Areas for family practice. Of the four counties served by ELVPHD, three of them are State-Designated Shortage Areas for family practice (Stanton, Cuming, and Burt). Stanton, Cuming, and the northern part of Burt Counties are State-Designated Shortage areas for general dentistry. All four counties are State-Designated Shortage Areas for Psychiatry and Mental Health (only 5 full counties in Nebraska are **not** State-Designated Shortage Areas for Psychiatry and Mental Health)[3]. All of the counties have geographic portions that are Federally

[1] U.S. Census Bureau. (2000, 2010, 2014). *Population Characteristics. ELVPHD District.*
[2] U.S. Census Bureau. (2010-2015). QuickFacts. Stanton, Cuming, Burt, and Madison Counties.
[3] Rural Health Advisory Commission DHHS-Nebraska Office of Rural Health. 2014. "State-Designated Shortage Area Family Practice."

Designated Primary Care Medically Underserved Areas, all of Stanton County falls under this category. Madison County has Federally Designated Medically Underserved Populations for Primary Care.[4]

Elderly Population

Census data shows that the elderly population (ages 65 and older) consists of anywhere between 15% in Stanton County and 23.9% in Burt County (15.6% in Madison County, and 21.5% in Cuming County).[2] Since the elderly population is a large portion of the population in our service area, it is important to understand and respond to their health concerns. This is especially the case when the fact that more elderly individuals (23%) have Fair-Poor general health than other age groups according to 2011-2014 Behavioral Risk Factor Surveillance System (BRFSS) data[5]. This means that they perceive their health to be either Fair or Poor (bottom two choices) on a scale of Poor, Fair, Good, Very Good, or Excellent. Those over age 65, however, are less likely to report mental health issues including Frequent mental distress, Ever being told they have depression, those currently taking medication or receiving treatment for a mental health condition, and those having symptoms of serious mental illness in the past 30 days.

In the 2016 CHA report, respondents were asked about seriousness of different health issues in their community. This question can be used to show how the health priorities of the elderly population differs from the health priorities of the population at large. From the results of this question, it is clear that residents aged 65 and over have a different opinion of the importance of some health issues. Health issues that respondents aged 65 and over prioritized included high blood pressure, diabetes, aging problems (arthritis, hearing/vision loss), stroke, and injuries resulting from falls. The most extreme cases where differences are seen for health issues among those aged 65 and over were in injuries resulting from falls and aging problems (arthritis, hearing/vision loss).

BRFSS demographic data for the health district shows that elderly populations are more likely to have been told that they have diabetes (18.4% for 65+ compared to 9.8% for ages 45-64). This same age group is more likely to have No leisure-time physical activity in the past 30 days than those 18-44 (30.3% compared to 20.9%), but this is not much different than those aged 45-64 where 29.3% say they get no leisure-time physical activity in the last 30 days[6].

Lack of physical activity can be a risk factor for high blood pressure, diabetes, among other health issues. Of respondents to the 2016 CHA survey that were over 60, nearly 54% of respondents had been told that they had high blood pressure (compared to only 24% of the general population in the 2016 CHA survey) and 51% had been told that they had high cholesterol (compared to 25% in the general population). Similar proportions are found when comparing elderly currently on medication for high cholesterol and high blood pressure to the general population. High blood pressure and high cholesterol can be risk factors for heart disease and other heart problem[7], which can lead to lower quality of life for elderly people in our communities.

---

[4] Office of Shortage Designations. 2012. *Federally Designated Primary Care medically Underserved Areas/Populations.* http://dhhs.ne.gov/publichealth/RuralHealth/Documents/HPSA%20MUA_MUP.pdf

[5] Behavioral Risk Factor Surveillance System (BRFSS). (2015). *BRFSS 2011-2014 Detailed Tables for Elkhorn Logan Valley.*

[6] Behavioral Risk Factor Surveillance System (BRFSS). (2015). *BRFSS 2011-2014 Detailed Tables for Elkhorn Logan Valley.*

[7] American Heart Association

According to 2010-2014 American Community Survey 5-Year Estimates all counties in the health department are at or above the state level of elderly individuals below the poverty level in the last 12 months. This means that more of those 65 and older in our health district are more likely to be considered living in poverty when compared to the state. The elderly poverty rate for Nebraska is 7.8% of those over 65 years old, while the rates for the health district counties are as follows: Burt 10.5%, Cuming 11.6%, Madison 7.9%, and Stanton 10.2%[8]. This measure can have implications on whether the elderly in our health district can afford some necessities such as nutritious food, transportation, and out-of-pocket medical or dental expenses not covered by Medicare.

That being said, according to the 2016 CHA survey, nearly 97% of respondents over 60 report that transportation is not a barrier to receiving health screenings or other health care services. Similarly, the 2016 Survey shows that over 75% of adults over 60 in the health district report that they do not use any kind of assistance programs including senior center meals, food pantries, medication assistance, and disability payments. Small proportions were reported for each of these (less than 5% with the exception of those eating senior center meals, 14%).

In the 2016 CHA survey, a little over half of those aged 60 and over report utilization of Medicare (52%, could not be broken down to those over 65 from the ELVPHD survey). Employer provided health insurance was utilized by 50%. Dental insurance was an area in the 2016 CHA survey where those aged 60 and over fared worse than the population overall. Only 50% of those aged 60 and over have dental insurance, while just over 75% of the general population have dental insurance.

Contributing Factors to Health Disparities: Elderly Populations

The aging population in the United States poses some great challenges to the health care field in the current time and near future. The problem is disproportionately larger in rural areas since rural areas contain a greater percentage of elderly individuals. In addition to this, as mentioned previously in this report, the ELVPHD health district consists of state and federally designated provider shortages.

Because of advances in medical technology and other factors, people have been living much longer. However, the longer people live, the more likely it is that they will utilize health care resources. Because of this, health care services are needed more and more. In rural-based populations this is problematic, because a greater proportion of the population is elderly, and rural areas are typically less likely to be fully staffed with easy-to-access health services.

The healthcare field itself is not immune to this aging workforce. According to a recent brief, nearly one out of four physicians in 2007 were 60 years or older.[9] Predominantly rural areas, like the one served by ELVPHD, will be hit hardest by the retirement of health care providers. This is because recruitment of providers to these areas is not easy.

---

[8] American Fact Finder. 2014. *Percent of People 65 Years and Over Below Poverty level in the Past 12 Months.*

[9] Heidkamp, Laurie and Maria Harrington. 2013. *The Aging Workforce: Challenges for the Health Care Industry Workforce.* Issue Brief of the NTAR Leadership Center, New Brunswick, NJ: National Technical Assistance and research Center to Promote Leadership for Increasing the Employment and Economic Independence of Adults with Disabilities.

Community Assets

Geriatric care should be a priority for the area. Multiple nursing homes are available in the health district for around the clock care, and home-health networks are being utilized as well. Obstacles to home-health care include increased distance and travel time due to the rural geography as well as low numbers of home health personnel in the area.

ELVPHD has its own programs supporting balance and fall prevention for aging people in the area (including Tai Chi and Stepping On classes). The elderly population in the health district are also served by area senior centers that provide activities, assistance, and referrals for elderly individuals. The Northeast Nebraska Area Agency on Aging is another resource that works with the elderly population in order to provide referrals, activities, and information.

In order to help ease the provider shortage, partnerships with local and Nebraska schools help to bring providers to this area for training. The Northern Nebraska Area Health Education Center works with many students to provide career education materials as well as professional shadowing appointments.

The CHA survey asked respondents about caregiving for persons aged 65 or older. Overall, 8.3% of respondents responded that they were the main person to care for someone 65 or older (this was down from 12.9% in the 2013 survey, but could be due to more representation of younger participants). About 70% of these caregivers were over age 55 themselves. Very few of these participants had ever attended a caregiver support group. In addition, 28.6% of those aged 60 or older have not thought about plans for long-term care.

Hispanic Minorities

Census data shows that the Hispanic population in the health district has been increasing since 2000. This population has increased from 6.4% of the population in 2000, to 11.1% in 2014. As a percent of the county population, Hispanic minorities are found most in Madison and Cuming Counties (14.2% and 9.6%, respectively). This population is not quite as prevalent in Stanton and Burt counties, representing 4.8% and 2.7% respectively[10]. The CHA report under-represents the Hispanic population of the health district, as only 4.5% of the respondents identified as Hispanic.

When comparing Hispanic minority health to the health district overall, Hispanic respondents are over twice as likely to report their general health as fair or poor (CHA survey participants: overall=7.4%, Hispanic=16.7%.Compared to BRFSS data: overall=40.6%, Hispanic= 16.5%). As described above, this means that they perceive their health to be either Fair or Poor (bottom two choices) on a scale of Poor, Fair, Good, Very Good, or Excellent.

The Hispanic population in the health district are over twice more likely than the general population to have ever been told that they have diabetes (21.4% compared to 8.7%) according to the 2011-2014 BRFSS data. The percentage of Hispanics that are overweight (BMI=25+) or obese (BMI=30+) are the same as those for the general population. A contributing factor to this is physical activity. BRFSS data shows that Hispanic minorities in the health district are nearly twice as likely to have no leisure-time physical activity in the past 30 days (43.1% compared to 26.1%). According to CHA data, nearly 26% of

[10] U.S. Census Bureau. 2010-2015. "QuickFacts." Stanton, Cuming, Burt, and Madison Counties.

Hispanics in the health district never get the recommended amounts of physical activity per week compared to 15% of the general population.

Hispanic minorities actually fair better or nearly the same in many health indicators, which mirrors national data. According to BRFSS data, Hispanic minorities in the health district are half as likely to currently have asthma (2.9% compared to 6.8% for the general population). Cigarette and tobacco use are also much lower than the general population according to BRFSS data, and the same according to CHA respondents. BRFSS data shows that while 19.4% of the general population uses cigarettes only 7.2% of the Hispanic population does. It also shows that 6.1% of the general population reported smokeless tobacco use, and Hispanic respondents reported 0% smokeless tobacco use. Alcohol consumption for Hispanic minorities were half that for the general population (this included any alcohol consumption in the past 30 days as well as binge drinking in the past 30 days).

Contributing Factors to Health Disparities: Hispanic Minorities

Unfortunately, Hispanic minorities are much less likely to have health insurance. Only 51.5% of Hispanic respondents aged 18-64 have health care coverage compared to 81.5% of the general population in the same age group. The CHA report over-reports the amount of Hispanic households where all members are covered by health insurance (overall=92%, Hispanic population=70.4%). This measure most likely contributes to nearly twice as many Hispanic respondents not being able to see a doctor because of cost in the last year (20.3% compared to 11.8%)[11]. Similarly, Hispanic respondents were half as likely to visit a dentist or a dental clinic in the past year (61.7% compared to 32.2%).

Factors contributing to low health insurance coverage and poor health outcomes in preventative health indicators are mainly socioeconomic. Social determinants of health include poverty, lack of formal education, racial discrimination, legal status, and a lack of access to helpful services. Others include poor diet, long work shifts, physical inactivity, and lack of financial resources for better nutrition and physical activity. Cultural beliefs and misinformation from and towards health care centers can also contribute to poor health outcomes in the area. Poverty levels of the Hispanic population in the health district are quite variable depending upon the county. Poverty levels are much higher in Cuming and Madison Counties, where they are 2-3 times the rate for the general population (33.5% compared to 11.8% in Cuming, and 31.4% compared to 15% in Madison). However, in Burt County the poverty rate for Hispanics is lower than the county average (7.4% compared to 9.3%). In Stanton County the rates are nearly the same at about 10%.[12]

Health literacy is an issue in the health district, with nearly 30% of the general population sometimes having issues understanding written health information[13]. CHA data shows that 40% of Hispanic respondents (compared to about 30% of overall) *Often* or *Sometimes* get help filling out forms, reading

[11] Behavioral Risk Factor Surveillance System (BRFSS). 2015. "BRFSS 2011-2014 Detailed Tables for Elkhorn Logan Valley."

[12] U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates. 2010-2014. Poverty Status in the Past 12 Months. Accessed Jun 2016. http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_S1701&prodType=table.

[13] Behavioral Risk Factor Surveillance System (BRFSS). 2015. "BRFSS 2011-2014 Detailed Tables for Elkhorn Logan Valley." Question “Written health information is always or nearly always easy to understand.”

prescription labels, insurance forms, and/or health education sheets. This issue is most likely complicated by language and cultural barriers.

Hispanic Minorities are actually quite healthy in many indicators when compared to the population overall. Where health disparities show up most are in preventative health care and diabetes (as noted above). This is most likely due to an inability of health care facilities and supporting agencies to fully connect with this population. This missed connection can have devastating effects on preventing disease and possibly even distrust of health care professionals. It is important, then, that health care agencies and facilitators in the area continue to address the needs of this population with an ideal of cultural competence. When asked about concerns about health care, Hispanic respondents cited cost barriers, inability to easily make appointments, or having to go to multiple appointments to achieve results. Also included were concerns with not receiving up-to-date health information.

Community Assets

Besides local hospitals and clinics, ELVPHD works with Minority Health Initiatives under the Nebraska DHHS in order to help address health disparities for the Hispanic and other populations in the health district. Some local resources utilized by Hispanic minorities include NENCAP (Northeast Nebraska Community Action Partnership) which has WIC programs, vaccination clinics, meal and housing programs, and much more. Along with the hospitals and clinics mentioned previously, Midtown Health Clinic is the only Federally Qualified Health Center in the health district and is located in Norfolk, the most populous community of the health district. This clinic utilizes bilingual staff to help reduce the language barrier to positive health outcomes.

Veteran Population

According to the U.S. Census QuickFacts, about 9.4% of the health district population are veterans. This is consistent with the state rate at about 9.9%[14]. CHA respondents, however, only made up about 3% of the respondent pool, which is not representative of the veteran population in the health district. Since veteran respondents were so few in the CHA survey the data received from looking specifically at veterans' responses are not as useful for reporting purposes. That being said, 16.2% of CHA respondents reported military service for someone in their household.

Although the unemployment rate for veterans in the health district is high compared to the civilian population (except in Stanton County), the percentage of veterans below poverty is the same or lower than the civilian population. Veterans in our service area are between 2-3 times more likely to be unemployed compared to the civilian population (except in Stanton County). On the bright side, however, veterans are less likely to have incomes below the poverty level in the last 12 months, especially in Madison and Stanton Counties.[15]

[14] U.S. Census Bureau. 2010-2015. "QuickFacts." Stanton, Cuming, Burt, and Madison Counties

[15] U.S. Census Bureau. 2010-2014. *American Community Survey 5-Year Estimates: Veteran Status.* American Fact Finder

Table 1: Veteran Unemployment and Poverty Status

		Un-employ-ment Rate	Below poverty in the past 12 months		Un-employ-ment Rate	Below poverty in the past 12 months		Un-employ-ment Rate	Below poverty in the past 12 months
Nebraska	Total	5.3%	11.3%	Veterans	5.2%	5.8%	Nonveterans	5.3%	11.9%
Burt County	Total	2.6%	9.7%	Veterans	7.3%	8.9%	Nonveterans	2.3%	9.8%
Cuming County	Total	2.6%	9.7%	Veterans	5.8%	9.4%	Nonveterans	2.3%	9.7%
Madison County	Total	3.3%	13.0%	Veterans	9.9%	3.9%	Nonveterans	3.0%	13.9%
Stanton County	Total	2.9%	8.9%	Veterans	0.6%	4.1%	Nonveterans	3.0%	9.4%

Source: U.S. Census Bureau. 2010-2014. *American Community Survey 5-Year Estimates: Veteran Status.* American Fact Finder

Veterans on average are much more likely to have a disability than the civilian population, most often due to traumatic events and experiences that are witnessed. In the state of Nebraska, Veterans are estimated to be twice as likely to have a disability compared to the civilian population. This proportion is consistent with the communities in the health district. Veterans in the health district are 2-3 times more likely to have a disability than the civilian population.[16] This observation is mirrored in the 2016 CHA survey. Only 10.3% of all respondents stated that they were limited in any way in any activities because of physical, mental, or emotional problems and/or disability compared to 27.2% of veteran respondents.

Contributing Factors to Health Disparities: Veterans

Although the U.S. Department of Veterans Affairs assists veterans in accessing health care and other services, not all veterans are registered to receive such assistance. Even those who are registered may not utilize the VA system all of the time due to other factors. Some other contributing factors that pose a challenge to veterans' health include simply not knowing what resources are available and a lack of support when first getting out of the military. Undiagnosed mental and physical illnesses including post-traumatic stress disorder and traumatic brain injuries are also issues that face veterans. There also seems to be a cultural gap between civilian and the veteran population when it comes to seeking care. Trust issues and communication barriers can occur with civilian providers who may not be knowledgeable of military culture, causing the patient-provider relationship to be disconnected.

Community Assets

Besides ELVPHD's VetSet programs and other services provided, there are many community partners and organizations that serve the veteran population of the health district. Local hospitals and clinics, the Department of Labor, local churches, NENCAP (Northeast Nebraska Community Action Partnership), and other agencies provide services for the general population and spend much time serving veterans as well. The Norfolk VA clinic, local Veterans of Foreign Wars (VFW) posts and American Legions, as well as County Veteran Service Officers provide resources for veterans as well.

[16] 2010-2014. *American Community Survey 5-Year Estimates: Veteran Status.* American Fact Finder.

Conclusion and Recommendations

The populations in this report represent only a few of the population groups in the ELVPHD health district. These populations are increasing, and they face challenges that require unique and individualized solutions. The elderly population is increasing, and it will be important for the health care field to expand and be able to attract new providers and caregivers to help care for these individuals. The Hispanic minority population has grown in recent years, and the ability of this population to obtain culturally and language appropriate preventative health services should be a focus for interacting with these individuals. Veterans in the health district deserve the attention of the healthcare system so that their specific mental and physical health related to traumatic events do not go underserved. This is in addition to the general health concerns that they share with the general population.

Coordinated efforts on the part of all community partners can help to alleviate these health disparities. More training and familiarity with geriatric services, a greater availability of translation services, opportunities for providers to learn Spanish, and trainings on military and veteran culture will help to equalize these health disparities. At Elkhorn Logan Valley Public Health Department we will continue to serve these populations and connect them to resources. A greater focus and understanding on cultural influences in health outcomes can help to improve health outcomes for not just the populations included in this report, but also the population of the health district overall.

References

American Fact Finder. 2014. *Percent of People 65 Years and Over Below Poverty level in the Past 12 Months.* http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_GCT1703.US05PR&prodType=table.

American Heart Association. 2014. *Why Blood Pressure Matters.* Accessed June 6, 2016. http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/WhyBloodPressureMatters/Why-Blood-Pressure-Matters_UCM_002051_Article.jsp#.V1W63rz2bIV.

Behavioral Risk Factor Surveillance System (BRFSS). 2015. "BRFSS 2011-2014 Detailed Tables for Elkhorn Logan Valley."

Heidkamp, Laurie Harrington and Maria. 2013. *The Aging Workforce: Challenges for the Health Care Industry Workforce.* Issue Brief of the NTAR Leadership Center, New Brunswick, NJ: National Technical Assistance and research Center to Promote Leadership for Increasing the Employment and Economic Independence of Adults with Disabilities.

Office of Shortage Designations. 2012. *Federally Designated Primary Care medically Underserved Areas/Populations.* http://dhhs.ne.gov/publichealth/RuralHealth/Documents/HPSA%20MUA_MUP.pdf.

Rural Health Advisory Commission DHHS-Nebraska Office of Rural Health. 2014. "State-Designated Shortage Area Family Practice."

U.S. Census Bureau. 2014. "2010-2014 American Community Survey 5-Year Estimates."

—. 2010-2014. *American Community Survey 5-Year Estimates: Veteran Status.* American Fact Finder.

U.S. Census Bureau. 2000, 2010, 2014. "Population Characteristics. ELVPHD District."

U.S. Census Bureau. 2010-2015. "QuickFacts." Stanton, Cuming, Burt, and Madison Counties.

U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates. 2010-2014. *Poverty Status in the Past 12 Months.* Accessed Jun 2016. http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_S1701&prodType=table.