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2016 Community Health Assessment: Access to Care Report

ELKHORN LOGAN VALLEY PUBLIC HEALTH DEPARTMENT

Mason McCain

Introduction

In order to prevent and treat disease, disability, or other negative health outcomes, people first have to be able to access health care. Unfortunately, access to health care is not as simple as going to the clinic. There are many factors that can stop or postpone someone from obtaining the healthcare that they want or need. Some factors include, but are not limited to, health insurance status, distance to care, perceived quality of available care, trust in health care providers or the health care system, poverty, language barriers, inability to pay, as well as other cultural and socioeconomic factors. It is good to keep in mind that access to nutritious foods and safe exercise facilities do impact one's ability to healthy living. However, this report will deal more specifically with the ability to access health care facilities and services.

Specifically, this report will assess the population's health insurance status, frequency of clinic/hospital visits, ability to pay for health-related services, barriers to receiving health care, etc. When asked about reasons that have stopped respondents from receiving or accessing health care services or screenings, 12.5% didn't know what kind of screening to get or when, 21.3% stated that their doctor hadn't recommended a health screening, 15.1% stated that their deductible or co-payment was too high, and 10.5% could not pay for health screenings or services. These answers suggest that a good number of patients were simply not knowledgeable about health screenings or when to get health services. This can be an area to target for further education for patients. These responses also suggest that the cost or inability to pay for health services is a factor contributing to the access of health services and screenings.

Local Healthcare Infrastructure

As discussed in other reports from the 2016 CHA data, many portions of the ELVPHD health district include some kind of health provider shortage. 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)[1]. All of the counties have geographic portions that are Federally 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.[2]

This shortage problem has effects on the ability for patients to access health services. For example, it limits the amount and variability of providers that a patient can see. This becomes a problem when patient-provider personalities do not match, or when sensitive matters are discussed and the patient seeks care from a certain type of provider (for example, gynecological exams). To help ease this provider shortage problem, Physician's Assistants and Nurse Practitioners (APRN) are utilized in many primary care clinics in the health district. In addition, since specialists are not very prominent in this area (especially with behavioral health) it is often the case that patients needing specialized care have to

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

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

utilize generalists in their place. This can not only put a stress on generalists by having to become more familiar with specialty areas, but also contributes to the primary care shortage since these patients are using time slots originally designated for general health care appointments. Further exploration of this topic is needed to determine this effect for our health district.

In addition to these clinics and hospitals, the ELVPHD health district also contains one FQHC (Federally Qualified Health Center), Midtown Health Center in Norfolk. This FQHC provides care including primary medical and dental care on a sliding fee scale. This clinic also provides disease and healthy lifestyle education. There is one facility in the service area classified as an urgent care which is located in Norfolk and open 7 days a week. In addition, there are several other medical clinics which have extended weekday hours and/or limited weekend hours of operation.

According to the 2016 CHA survey, 59.7% receive most of their medical care from a primary care provider (medical doctor, M.D.), 14.1% receive care from other medical doctors (OB/GYN, pulmonologists, cardiologists, etc.), 3.1% receive care from a non-medical doctor (ex: Chiropractor), and 17.7% receive care from other medical practitioners (physician assistant, P.A., or nurse practitioner, APRN). Of the total respondents, 5.5% stated that they did not seek medical care.

About seventeen (17) EMS services are based in the ELVPHD health district, with more that are outside of the health district but are still utilized when necessary.[3] Only one of which is has non-volunteer EMS services. These services are spread evenly throughout the district and utilize both professional and volunteer units. According to internal ELVPHD records, there are 26 dental clinics in the health district, mostly concentrated towards the west end of the district. Pharmacies are also mostly concentrated in the western part of the health district, totaling about 19 across the 4 counties. About nine (9) physical therapy locations are throughout the health district.[3]

Barriers to Receipt of Care

Hospital/Clinic Use

The ELVPHD health district contains three hospitals including Faith Regional Health Services in Norfolk, St. Francis Memorial Hospital in West Point, and Oakland Mercy Hospital in Oakland. Other clinics in the area are run through these hospitals, hospitals in neighboring health districts, and independently. Much of access to healthcare is having a hospital or clinic that has convenient availability for patients. Patient perception, then, is important in this measure, as it is their perspective based on their own schedules that can contribute to whether health care is accessible or not. Having few clinic hours or having clinic hours during normal business hours can reduce the access for many working-class patients. Clinic hours that do not allow for those working day jobs are problematic since many people are reluctant or unable to take time off from work. When chronic or frequent rehabilitation services are needed, a lot of work may have to be missed.

All three hospitals in the area have 24-hour emergency care availability. Typical clinic hours for family medical clinics in the area are 8:00 a.m. to 5:00 p.m., and specialist visits at clinics can be anywhere from weekly to only once monthly. This is due to the need for specialists to travel great distances sometimes to visit clinics, due to low amounts of specialists in rural parts of Nebraska. According to the 2016 CHA

[3] According to internal ELVPHD records

survey, 6.4% (about one in twenty) of respondents note that they don't have time to get a health screening or other services.

One way to measure access is to simply ask about recent visits. In the 2016 Survey, 74.4% of respondents stated that they had visited a primary care provider in the last year. About the same (73.1%) stated that they had been to the dentist in the last year. The study may over-represent those who access care more often when compared to BRFSS data. BRFSS data shows that 59% of people had a routine checkup in the past year, and 61.7% had visited a dentist or a dental clinic in the past year.[4]

According to the 2016 CHA, 87.8% of respondents receive medical care from a medical clinic, 4.7% receive medical care from an Urgent Care, 2.2% from a sliding-fee or reduced fee clinic, 1.9% from the hospital/emergency room, and the remaining 5.2% were spread across Tribal Health Clinics, Veterans Clinics/Hospitals.

One question in the 2016 CHA asked about reasons for using any of the local hospitals. From this, it is clear that the best indicator of where patients seek medical care in this area is how close and convenient the hospital is. This was by far the most selected reason coming in at 65%. This was followed by physician referral at 36% and quality of care at 33%.

Health Insurance Coverage

The health insurance coverage of the health district can be a reason for a lack of access to health care and services. Health insurance can help to reduce the out-of-pocket costs for medical visits, equipment, and medications. Without it, some people choose to delay seeking healthcare. Others forego it altogether. Some find care, but are unable to pay for their medications.

According to the 2016 CHA survey, 92% of respondents replied that all members of their household were covered by health insurance. Another 6.1% stated that some members of their household were covered, leaving only 1.9% that replied that none of the members of their household were covered by health insurance. Depending on what survey is used, the percent of the health district population lacking health insurance varies from 10-12% (according to U.S. Census QuickFacts; by county)[5] to 18.5% (according to BRFSS data). Related to this, 11.8% of the health district needed to see a doctor but could not due to cost in the past year.[6]

It is most common for people in the ELVPHD health district to utilize an employer provided health plan; 77.1% of households responded that they used this type of coverage. Private plans were utilized by 18.2% of participants, Medicare by 14.3%, Medicaid/Medical Assistance by 12.7%, and Medicare Part D by 10.8%. Indian Health Services, VA Insurance, and Long Term Care Insurance all utilized by about 5% or less of respondents.[7] About 75% of survey respondents stated that they have dental insurance.

[4] Behavioral Risk Factor Surveillance System (BRFSS). 2015. "BRFSS 2011-2014 Detailed Tables for Elkhorn Logan Valley."
[5] U.S. Census Bureau. 2010-2015. "QuickFacts." Stanton, Cuming, Burt, and Madison Counties.
[6] Behavioral Risk Factor Surveillance System (BRFSS). 2015. "BRFSS 2011-2014 Detailed Tables for Elkhorn Logan Valley."
[7] This question allowed for multiple responses to allow for individuals to select more than one type of coverage.

Access to Preventative Screening

The 2016 CHA survey asked respondents about their barriers to health screenings and other health care services. Included in this were options for doctor recommendations, the ability to pay for, health insurance coverage for, and knowledge about health screenings. This question allowed for multiple options to be chosen. About 21.3% of respondents stated that their doctor has not recommended a health screening. In addition, 12.5% of respondents stated that they didn't know what kind of screening they needed, or when to get it, and 3.5% didn't know where to go for one. About 10.5% of respondents stated that they can't pay for health screenings or services. This is probably related to the amount of uninsured in the area, but also with those who's health insurance doesn't cover health screenings (6%), and those who deem their deductible or co-payment to be too high (15.1%).

Health Care Travel

In some rural areas, travel to health care can be a challenge. Between long distances, challenging geography, or the lack of public transportation for those without licenses (particularly the elderly), simply getting to health services can be an issue. Luckily, ELVPHD's service area does not contain any mountainous or other particularly difficult geography, which makes traveling across the four-county-long service area relatively unchallenging. The four counties stretch to be over one hundred miles in length, and can take nearly two hours to travel the distance of the service area by car. With three hospitals spread throughout the counties and multiple clinic locations, driving distances are kept relatively low.

That beings said, travel during the winter months can sometimes pose a challenge. Depending on yearly snowfall, winter conditions can make travel difficult and dangerous. With a sizeable portion of individuals living off of main highways and outside of towns, travel can be delayed for days after decent snowfall. There is some variability in how well roads are maintained during the winter months, with some of the main highways being cleared off very well and some roads not able to receive as much attention. This area also lacks in public transportation. Many of the smaller communities do not have bus or taxi transport, and this can be a barrier for those without licenses. The problem is less severe when people want to travel within their own community, as walking distance is less of a factor in small towns. However, when traveling from town to town this becomes an issue.

The 2016 CHA asked how far, in miles, respondents travel one-way for different types of health professionals or services. The average distance of travel for primary care health professionals was 10.7 miles and dental health care was 9.2 miles. Participants normally traveled further for specialty care including mental health (13.4 miles), pediatrician (15.9 miles), cardiology (17.6 miles), and orthopedics at the top of the list at 20.4 miles.

Not surprisingly, the distance of travel for each type of care increases when only participants from the more predominantly rural Burt, Cuming, and Stanton Counties are included. These participants have to travel, on average, 5.3 more miles to reach each type of care when compared against the average of all survey respondents. The difference is less noticeable for those seeking a primary health care professional or orthopedics (both 2.7 miles farther). The distance is much more noticeable for those trying to seek obstetrics and gynecology (8.8 miles farther) and oncology/cancer services (9.8 miles farther). Breaking down this data further by county reveals what may also be expected; residents of Burt, Cuming, and Stanton counties travel on average 11.2 miles further (one-way) than residents of Madison County. None of the provider categories for Madison County have a higher average travel time

than averages for Burt, Cuming, or Stanton Counties, as seen in Table 1.[8] Remember that these distances are one-way, so this can add up to some increased driving times.

Table 1: Average distance, in miles, traveled for the following health professionals/services. (Write-in/open response) N=1204

	Madison Average	Burt Average	Cuming Average	Stanton Average	Avg Burt, Cuming, and Stanton	Total Response Average
Primary Care Health Professional	6.53	17.38	12.21	13.28	13.41	10.69
Cardiology/Heart	9.02	25.76	25.94	20.06	24.42	17.59
Orthopedics/Orthopedic surgeon	14.92	27.95	22.97	18.76	23.12	20.41
Urology	8.91	20.91	20.81	23.78	21.56	16.19
Obstetrics/Gynecology	9.17	31.30	24.72	20.37	24.60	15.85
Pediatrician	6.65	21.79	23.49	13.98	19.85	13.18
General Surgery	8.83	23.53	16.45	20.16	18.91	14.53
Oncology/Cancer	9.44	27.91	31.33	24.55	28.76	18.98
Mental Health	8.38	22.60	17.52	20.02	19.28	13.43
Dental Health	6.65	22.94	18.94	14.96	18.57	12.71
Prescriptions/Pharmacy	4.52	13.58	11.51	13.83	12.48	9.16
Other	22.53	9.64	27.38	32.21	24.98	23.44

That being said, only 2.2% of all 2016 CHA survey respondents stated that transportation was a barrier to receiving health screenings or other health care services. Remembering the preference for close or convenient care from the "Hospital/Clinic Use" section above, this makes sense that the travel distances are low despite some provider shortages, and helps reduce transportation as a barrier to care.

Access to Women's Health

According to the 2016 CHA survey, when seeking women's health services 47.7% of women visit an Obstetrician/gynecologist[9]. Another 37% of women utilize their primary care provider (medical doctor) as their women's health provider, and 9.4% utilize other medical practitioners (including physician assistants and nurse practitioners). Of these respondents, 4.8% stated that they did not seek women's health services.

Access to pregnancy and childbirth care and classes are also important indicators for women's health. When asked about what type of provider they visited for prenatal care during their most recent pregnancy, about 89% of 2016 CHA respondents stated that they saw an OB/GYN for prenatal care. Respondents were allowed to select multiple responses, and about 44% saw a primary care provider instead of or in addition to an OB/GYN. The same question asked about childbirth and newborn classes for the most recent pregnancy. About 29% of women took some kind of child birth education class, 30%

[8] County averages for analysis in this paragraph excluded the "Other" response. Respondents from outside of these four counties are included in the "Total Response Average" column.

[9] Question read "Where do you go for routine women's health services?" with the response selected here reading "Other Medical Doctor (Obstetrician/Gynecologist)" as opposed to primary care provider, non-medical doctors, and other medical practitioners.

of women attended a breastfeeding class, and 36% of women attended classes on how to care for their new baby.

Access to Child Health Care

Respondents to the 2016 CHA survey were also asked about receiving healthcare for their children, the responses of those who stated that they had children under the age of 18 living in their home are included below. About 65% of parents stated that their child/ren receive medical care from a primary care provider (medical doctor), and 21.1% more said that they received care from another medical doctor (pediatrician). Other medical practitioners (including physician assistants and nurse practitioners) were utilized for child health care by 11.7% of parents in this survey. Only 1% of parents responded that they did not seek medical care for their child/ren.

According to the U.S. Census Bureau, 5.6% of children and adolescents under the age of 18 in the state of Nebraska are uninsured. The health insurance rates for children and adolescents in the health district are comparable. The rate is only slightly lower in Burt County at 3.9%, nearly the same in Cuming County at 5.8%, and only slightly higher in Madison and Stanton Counties at 6.8% and 6.9%, respectively.

When asked about how often they take their children for well child check-ups, 96% of those households with children aged birth to 36 months stated that all of their children in this age range have received well child check-ups as recommended by their primary care provider. As children get older, however, the frequency of physical check-ups reduces. Only 77.6% of households with children aged 3 or older report that all of these children received a physical check-up in the last year. About 7% of relevant households stated that none of their children aged 3 and older had received a physical check-up in the past year.

Children's dental check-ups were similar, with about 75% of relevant households stating that all children aged 1 and older had dental check-ups in the past year. However, only about 35% of relevant households stated that their children aged 1 and older received their first dental check-up before his/her first birthday or when the first tooth appears. About 17% the total respondents stated that their dentists doesn't recommend dental appointments before one year of age.[10]

Access to Health Care in the Workplace

As described above in the health insurance section of this report, 77.1% of households in the 2016 CHA utilize an employer provided health insurance plan. According to the U.S. Census Bureau, 54% of the population utilizes employment-based health insurance, and only 48% rely on employment-based health insurance alone (without any other assistance or coverage).[11]

The 2016 CHA survey asked participants about work-based wellness programs. About 61.2% of respondents stated that their place of employment did have a wellness program that encouraged them to be healthy. Nearly 21% did not, 14.3% did not work outside the home, and 3.6% did not know if such a program existed in their place of employment. This is encouraging that a lot of businesses encourage

[10] The American Academy of Pediatric Dentistry recommends the first check-up to be when the first tooth appears, or no later than the first birthday. http://www.aapd.org/resources/frequently_asked_questions/#311

[11] U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates. 2015. *Health Insurance Coverage Status.* Accessed Jun 2016. http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_S2701&prodType=table.

health and wellness. However, only 43% of participants stated that their place of employment (or school) have access to healthy vending options.[12] About 22.7% stated that their place of employment did not have healthy vending options, 16.4% stated that no vending options were available at their job, and 3.5% did not know.

Data Collection for Access to Care

Efforts to collect data on the ability of the health district population to access health care is an essential public health service provided by ELVPHD. In order to know what specific barriers are in place for the population and subpopulations, we have to survey our constituents. Daily interactions with partners and the public are also a great way to be made aware of barriers to health care.

Beginning in 2013, every three years ELVPHD partners with local hospitals to complete the Community Health Survey. This consists of an extended questionnaire regarding health behaviors, illnesses, access to health barriers, environmental, and population statistics among others. In this most current process, data was shared in two focus groups mainly consisting of community partners; one in West Point and one in Norfolk. These focus groups were used to present 2016 Survey findings and ask for input on CHIP priority areas. New CHIP priority areas were suggested and discussed in smaller groups, participation in these smaller group discussions were voluntarily chosen. Access to Care was a specific small group discussion in each focus group, and input from these discussions is included in the 2016 version of the CHIP.

Select ELVPHD programs also look into the accessibility of health care using program-specific surveys and questionnaires. Some of these examples include questions about whether Operation Heart to Heart project participants have access to a medical home. Another example includes the Smile in Style program asking parents of their students about family access to a dental home. The VetSet program also asks about the needs of rural veterans in this area with regards to health care, mental health services, and substance abuse programs as well as other social services. Program participant's ability to access care is considered for these selected programs so that appropriate referrals and/or educational instruction can be tailored to client's needs

ELVPHD also utilizes other local, state, and national databases for comparisons and trends. We frequently utilize BRFSS (Behavioral Risk Factor Surveillance Survey) data, U.S. Census Data, Healthy People 2020 goals, County Health Rankings, and many other sources.

Conclusions and Recommendations

In addition to the recommendations included in the pages above, it is important that ELVPHD and partners work to reverse the provider shortages in this area and also in many places of rural Nebraska. Another goal that will help reduce the barriers to care will include education for the public on the importance of preventative screening, the health benefits of regular health care access, as well as the availability of various services in the health district. Increasing costs for medical services are also a barrier to access, and one area that should be addressed is the amount of the population that are unable to receive care because of cost. This is especially important when the preference for close and

[12] Healthy vending options were listed as examples in the question: "milk, 100% fruit juice, water, granola bars, cheese, nuts, etc."

convenient healthcare is as prevalent as it is in this area. Having quality, affordable, close, and therefore accessible healthcare should be the goal of every community. Increasing access to healthy foods, wellness information, and physical activity opportunities would also benefit the public who are concerned about time and funds to do so outside of work.

Within our health department there are certain populations that have unequal access to health services. This is not just the case here, but throughout the entire nation and even the world. Minority populations especially often suffer from a lack of access to healthcare and health services. Those in poverty and lacking financial resources also face extreme barriers to receiving care.

Continuing to offer quality and compassionate care to the people of this health district is the single most important goal for the healthcare system and its affiliates. In doing this, we can assist the population in overcoming these barriers in order to work toward the vision of ELVPHD; “Healthy people living in healthy communities.”

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