DCHD DUVAL COUNTY HEALTH DEPARTMENT

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Center for Health Statistics Report

Access to Care

Access to Care: The National Challenge

A*ccess and use of health care* is defined by the Institute of Medicine as "the timely use of personal health services to achieve the best possible health outcome." The national challenge targets four major components of the health care system: clinical preventive care, primary care, emergency services, and long-term and rehabilitative care. These components represent the array of health services and care settings that address health promotion, disease prevention, and the diagnosis, treatment, management, and rehabilitation of disease, injury, and disability. Quality measures in this continuum serve as key indicators for improvement in access to high quality health care that eventually lead to improved prevention.

In the 21st century, efforts to improve Americans' health are shaped by the nation's trend of a population that is growing older and becoming more racially and ethnically diverse. A primary indicator that is used as a quality measure of access to care is insurance coverage. In 2004, 84% of the US population under 65 years of age had personal health insurance and 87% had a source of ongoing care.

Often people do not receive health care due to high insurance premiums and/or high out of pocket expenses. Of those uninsured under the age of 65, reasons for no health insurance include a job loss or change in employment (26.9%), change in marital status or death of a parent (2.8%), ineligible due to age or left school (6.2%), employer didn't offer or insurance company refused (14.1%), cost (53.3%), Medicaid stopped (10.0%) and other reasons (6.0%).[5] In

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Access to Care: Health Disparities at the Local Level

Limitations in access to care extend beyond basic causes, such as a shortage of health care providers or a lack of facilities. Individuals also may lack a usual source of care or may face other barriers to receiving services, such as financial barriers (having no health insurance or being underinsured), structural barriers (no facilities or health care professionals nearby), and personal barriers

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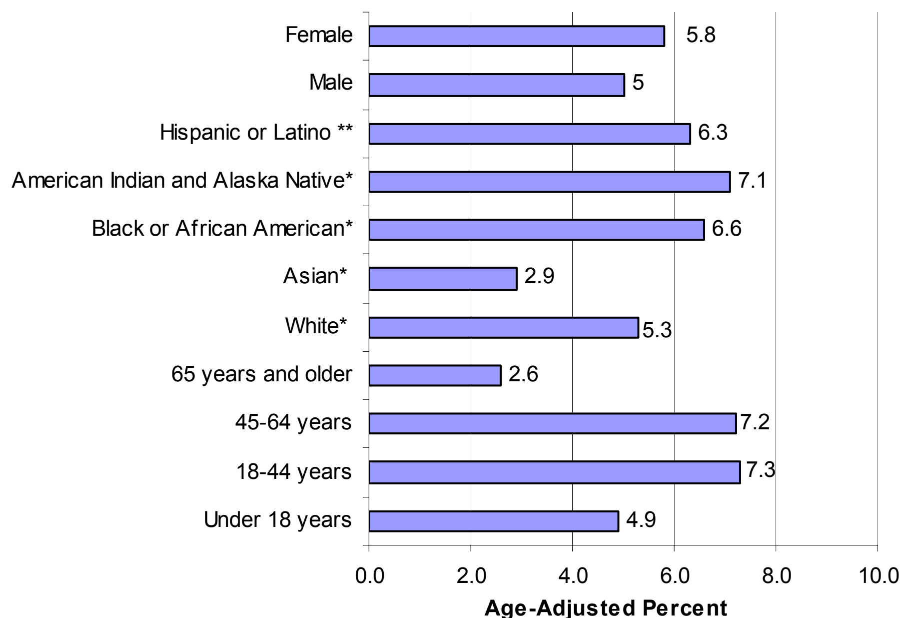
Figure 1 **Percentages of persons who did not recieve medical care in the past year due to cost, by race, gender and age, United States, 2004**



Data Source: National Health Interview Survey, 2004
*Persons who only indicated a single race group
Prepared by: DCHD, Institute for Health, Policy and Evaluation Research , September, 2006

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Jacksonville Access to Care Health Report Card

Objective #	Objective	U.S. (1998)	FL (2002)	Duval (2002)	2010 Target
1-1	Increase the proportion of persons with health insurance. (Percent)	83.0[1]	81.3[2]	89.2[2]	100
1-5	Increase the proportion of persons with a usual primary care provider. (Percent)	77.0[1]	76.1[2]	78.4[2]	85.0
1-6	Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family member. (Percent)	12[1]	8.7[2*]	6.1[2*]	7
1-9	Reduce hospitalization rates for three ambulatory-care-sensitive conditions -pediatric asthma, uncontrolled diabetes, and immunization-preventable pneumonia and influenza. (Rate per 10,000 population)				
1-9a	Pediatric Asthma (< 18 years)	23[1]	24.6[3] (2004)	14.5[3] (2004)	17.3
1-9b	Uncontrolled diabetes (18—64 years)	7.2[1]	8.1[3] (2004)	9.8[3] (2004)	5.4
1-9c	Immunization-preventable (> 65 years) pneumonia and Influenza	10.6[1]	3.0[3] (2004)	3.7[3] (2004)	8.0
1-12	Establish a single toll-free telephone number for access to poison control centers on a 24-hour basis throughout the United States. (Percent)	15	Florida has[4]	Florida has[4]	100

[1] Healthy People 2010, Data Source 2006
[2] Behavioral Risk Factor Surveillance System, 2002
[3] Agency for Health Care Administration, In-Patient Hospitalization, 2004
[4] Centers for Disease Control and Prevention, 2001
* Percent without access to needed medical care in the past 12 months

Data Report Card Overview

The Data Report presents an overall comparison of national, state, and local levels of access to care objectives. In relation to Florida and Duval County, limited data is available. Only five of the sixteen Healthy People 2010 objectives of access to care were available. The most recent information for access to care were obtained from the 2002 Florida Behavioral Risk Factor Surveillance System, 2002 Duval County BRFSS, Centers for Disease Control and Prevention CDC Wonder, and the Agency for Health Care Administration. In comparison of available data, Duval county has advanced towards progressively meeting 3 out of 4 of the health people 2010 objectives. For Objective 1-1, 89.2% of Duval County persons had health insurance coverage, 78.4% had a usual primary care provider (Objective 1-5), and 6.1% of families experienced difficulties or delays in obtaining health care (Objective 1-6). In comparison to national baseline data for reduced hospitalization rates among three ambulatory care sensitive conditions (1-9), only uncontrolled diabetes, with a rate of 9.8 per 10,000, did not meet the objective of 5.4 per 10,000 people for hospitalizations (Objective 1-9b).

FQHC-Health Access for the Uninsured and Underserved

Wally Plosky, Business Development Coordinator, DCHD Health Services

Over 13,000,000 individuals can access primary health care, even if they are uninsured or have limited incomes, thanks to FQHCs-Federally Qualified Health Centers. These local non-profit medical practices serve everyone in the community, and patients are charged based on what they can afford. FQHCs offer a "medical home" – a doctor to call your own.

The Office of Management and Budget (OMB) has selected FQHCs as the most effective federally supported health care program because of their quality of care, comprehensiveness of services, and cost benefit to the patient. In 2002, Congress approved a five year $1 billion expansion of FQHCs nationally, recognizing their positive impact on expanding access to quality primary care.

What sets FQHCs apart from other health care providers is how they are operated. These non-profit or public FQHCs are governed by boards of directors, the majority of whom are users of the medical services of the FQHC. This assures a connection with the community being served, as well as the primary care needs of the patients.

Of the 13 million FQHC patients served in 2005: 40.1% were uninsured, 91.1 % were below 200% of poverty, 63.5 % were racial or ethnic minorities, 726,813 were migrant or seasonal agricultural workers, and 703,023 were homeless clients. See Figures 2 and 3 for all age groups and ethnicities FQHCs serve.

FQHC services include:

- primary care (family medicine, pediatrics, internal medicine, OB-GYN) diagnostic laboratory and radiological services
- pharmaceutical services
- preventive services including screening for cancer and other diseases
- prenatal, perinatal services, well child services, and eye, ear and dental screening for children
- preventive and emergency dental services
- immunizations against vaccine-preventable diseases
- family planning services
- case management services
- services to assist the patients gain of financial support for health and social services
- referrals to other providers of medical and health-related services including substance abuse and mental health services
- services that enable patients to access health center services such as outreach, transportation and interpretive services
- education of patients and the community regarding the availability and appropriate use of health services

Jacksonville has two such FQHC clinics operated in partnership with the Duval County Health Department and the Agape Community Health Center. The main Agape clinic is located on Edgewood Avenue West in the Lake Forest area, and its newest clinic, the West Jacksonville Family Health Center, is located on King Street. Patients can see Pediatric and Family Practice doctors and ARNPs (nurse practitioners) and receive a bundle of comprehensive primary care services at both the Agape and West Jacksonville clinics. These FQHCs currently serve over 6,000 patients, and have capacity to offer over 18,000 clinical encounters annually.

(continued on page 6)

Figure 2

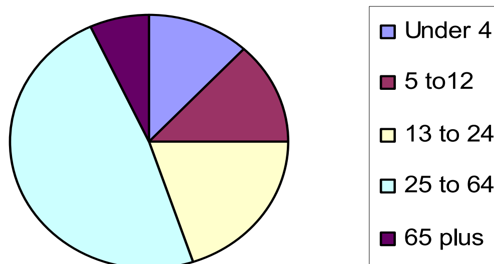
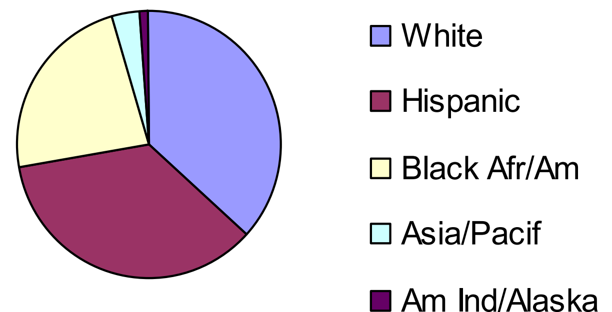


Figure 3



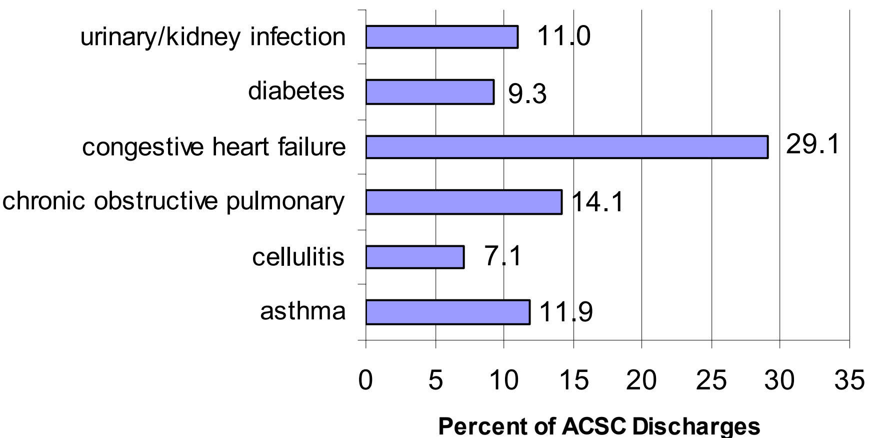
Source: Bureau of Primary Health Care, Uniform Data Set, 2004

Ambulatory Sensitive Conditions

Center for Health Statistics, Institute for Health, Policy and Evaluation Research

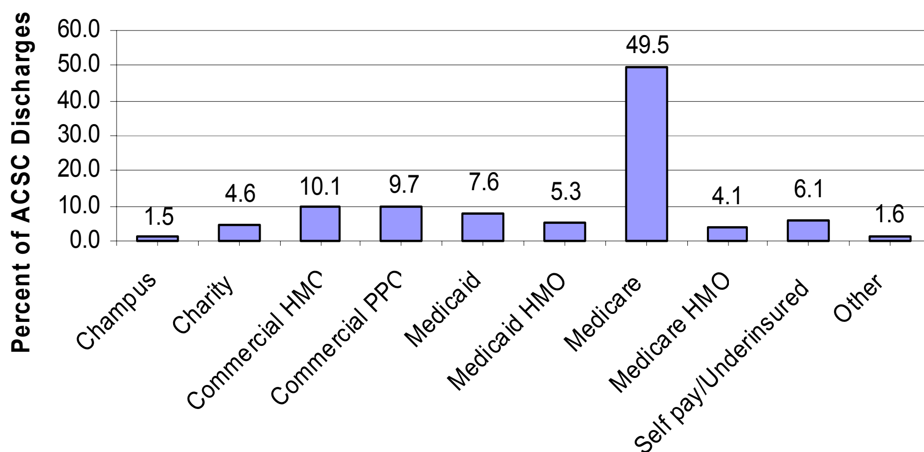
Prevention is the preferred approach for combating numerous health conditions, diseases, and deaths. Getting timely and adequate care for preventable conditions is often associated with access to care, cost, primary care, and education. Ambulatory Care Sensitive Conditions (ACSCs) are medical problems that are potentially preventable and do not require hospitalization with proper treatment and management of care, which are most often associated with access to care limitations. Hospital discharge data was reviewed for Duval County's major hospitals, including St. Vincent's Medical Center, Shands Jacksonville, Memorial Hospital, St. Luke's Hospital, Baptist Medical Center—Downtown, and Baptist Medical Center—Beaches. Specific data reviewed included Ambulatory Care Sensitive Conditions (ACSCs).

ACSCs make up 12% of all hospital discharges. Of the ACSC discharges, the highest percentages are congestive heart failure (29%), chronic obstructive pulmonary conditions (14%), asthma (12%), urinary/kidney infections (11%), diabetes (9.3%), and cellulitis (7% (see Figure 4)).



Source: FDOH, Agency for Health Care Administration, 2004
*Data only includes St. Vincent's, St. Luke's, Shands, Memorial, Baptist downtown and Baptist beaches.
Prepared by: DCHD, Institute for Health, Policy and Research Division, October 2006

As with many other health related conditions, disparities exist among ACSC conditions. The ACSCs for the black population represent 13% of all discharges among the black population compared to 6% for the white population. The most common ACSCs for the black population are congestive heart failure, asthma, and diabetes. For the white population, the most common ACSCs are chronic obstructive congestive heart failure, pulmonary, and urinary/kidney infections. For gender disparities, males represent 41% of all ACSC discharges while females represent the remaining 59% of all ACSC discharges.



Source: FDOH, Agency for Health Care Administration, 2004
*Data only includes St. Vincent's, St. Luke's, Shands, Memorial, Baptist downtown and Baptist beaches.
Prepared by: DCHD, Institute for Health, Policy and Research Division, October 2006

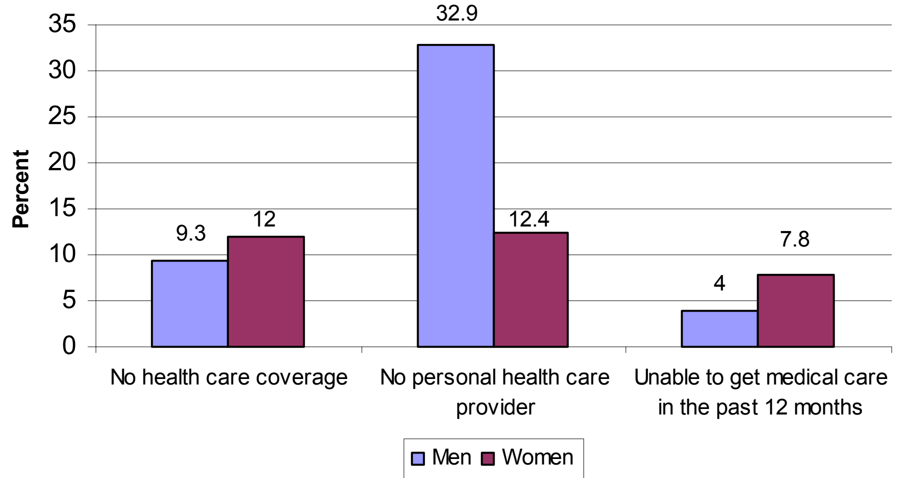
Data was also reviewed for payor type for all ACSCs. Those with the highest number of ACSCs across all hospitals in the study were Medicare recipients, making up 50% of all ACSCs. Other notable payor types included Commercial HMO and PPO, each with 10% of all ACSC discharges, and Medicaid

(continued on page 7)

Access to Care Disparities at the Local Level (continued from page 1)

(sexual orientation, cultural differences, language differences, not knowing what to do, or environmental challenges for people with disabilities). Hispanics, young adults, and uninsured persons are least likely to have a usual source of care or health insurance coverage. From 2000 to 2002 Hispanic women (19.8%) did not have a usual source of health care vs. Non-Hispanic White women (8.3%) and Non-Hispanic Black women (10.5%). In 2003, young adults 18-24 (30.1%), American Indian and Alaska Natives (35%), and Hispanics or Latinos (34.7%) had the highest prevalence of no insurance, a rate twice the national average.

Figure 6



Source: Behavioral Risk Factor Surveillance System
Prepared by: DCHD, Institute for Health, Policy and Research Division, September 2006

From 1999 to 2004, Duval County's (12.1% to 13.7%) prevalence of uninsured coverage remained low in comparison to the state of Florida (16.8% to 19.2%). Although uninsured rates of health care coverage were low in comparison to the state level, disparities were present at the local level. In 2002, more women than men had no health care coverage, 12% and 9.3% respectively. Likewise, more women, 7.8%, were unable to get medical care in the past 12 months than men with only 4%. However, women were 62% more likely to have a personal health care provider than men (See Figure 6). For Ambulatory-Care Sensitive conditions, black's were highest for pediatric asthma, uncontrollable diabetes and immunization preventable Pneumonia and Flu (See Figure 7). In 2000, in a predominant African American area of Duval County (Health Zone 1), the highest estimated uninsured percentage of 16.5% versus the county's percentage of 13.1% is revealed through Geographical Information Systems (GIS) mapping (see Figure 11 on page 8). In 2004, Health zone 1 rates were highest among pediatric asthma at 27.9 per 10,000 and uncontrolled diabetes at 23.8 per 10,000 (see Figures 8 and 9 on page 6).

Hospital inpatient care is greater among families of low income than among families whose income is at least twice the poverty level. In 2004, hospitalization rates for ambulatory-care sensitive conditions (ACSC) among Blacks were 22.0 per 10,000 for pediatric asthma and 17.8 per 10,000 for uncontrolled diabetes.

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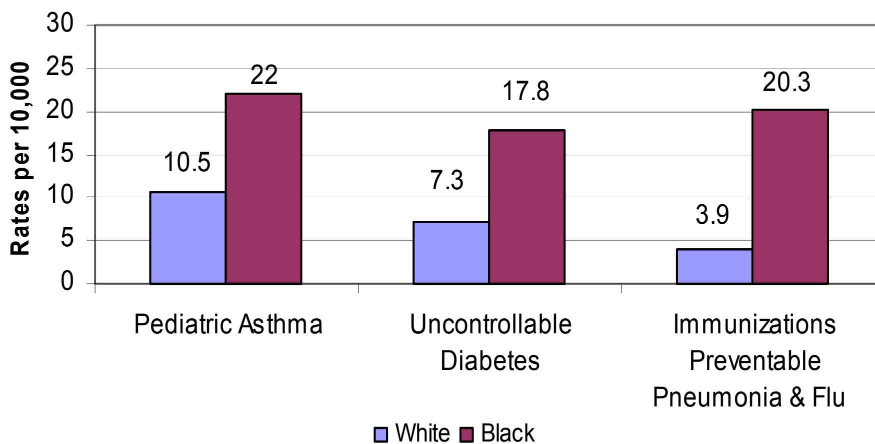
Figure 7



Source: FDOH, Agency for Health Care Administration, 2004
Prepared by: DCHD, Institute for Health, Policy and Research Division, September 2006

Access to Care Disparities at the Local Level (continued from page 5)

Disparities for usual access to care and health care insurance among age groups also exists at the local level. Adolescents under 17 years had the lowest prevalence (68.9%) of entry into prenatal care during the first trimester than any other age group 18 and above. According to the Florida's Health Insurance Study, from 1999 to 2004, the prevalence of uninsured children remained relatively low. The group most impacted were those 19 to 24 years, showing an increase from 19.5% to 31.7%.

Sources:
Healthy People 2010, US Department of Health and Human Services
Centers of Disease Control and Prevention, MMWR, Vital and Health Statistics 2006 vol. 368
AHCA, Florida Health Insurance Study, 2004

Figure 8

Pediatric Asthma Hospitalization Rates by Health Zone Duval County, 2004

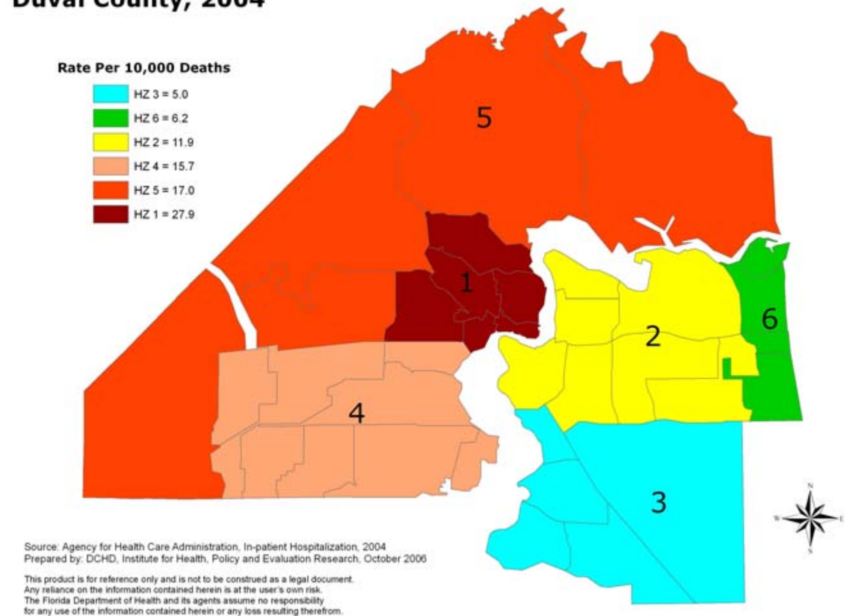
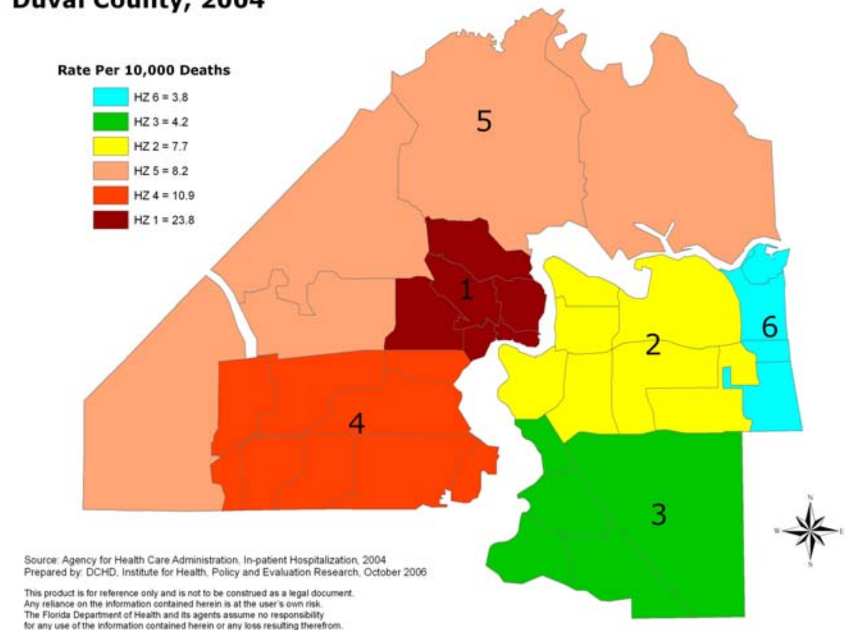


Figure 9

Uncontrolled Diabetes Hospitalization Rates by Health Zone Duval County, 2004



FQHC-Health Access for the Uninsured and Underserved (continued from page 3)

Agape offers a discounted "sliding" fee schedule that is based on income and family size. For example, a family of four making less than $40,000 annually would qualify for the Agape Sliding Fee Schedule. There are different rates for smaller or larger family units and for individuals. In 2005, sliding fee discounts amounted to over $210,000. Estimated sliding fee discounts for 2006 are $400,000.

The Duval County Health Department and its Agape Community Health Center FQHC are assessing health care access needs in other parts of Jacksonville, and are working with the health care safety net stakeholders to expand the number of FQHC clinics that can provide these valuable primary care services at affordable cost.

There is also another form of FQHC available for adults, the I.M. Sulzbacher Center, located on East Adams. Its services are more specialized and focus on clients with some of the most difficult health access barriers, especially the homeless. For more information on the Duval County FQHC's, go to http://www.dchd.net/agape.htm or http://www.dchd.net/westjax.htm.

Access to Care: The National Challenge

(continued from page 1)

2004, a high prevalence of no insurance existed among age groups 18-24 (30.1%) and 25-34 (25.4%) and among Hispanics or Latinos (34.7%) and American Indians or Alaska Native (35.0%). Cost was the main reason cited (more than 50%) why people do not have health insurance (see Figure 1 on page 1 for percentages by selected demographics). In 2004, Non Hispanic Whites were more likely to have Medicare and use preventative care through physician offices (78%), while Non Hispanic Blacks regardless of age and Hispanics were likely to have higher rates (≥ 38 per 100 visits) of visits to Emergency Departments and Outpatient Departments.[3,4]

Use of Emergency and Outpatient Departments are utilized most among the elderly, poor, or uninsured. This national trend of health disparities has been shown to affect the quality of services within health care systems. From 1994 through 2004, the number of Emergency Department visits increased from 93.4 million to 110.2 million visits annually (up by 18 percent).[3] Emergency Departments are under increasing pressure to provide care for more patients, resulting in crowding and ambulance diversions that place patients at risk for poor outcomes.[3]

The public health system can be an important factor in improved prevention because it can educate people about prevention and address the need to eliminate disparities by easing access to preventive services for people less able to use existing health services. This strategy is best illustrated through Healthy People 2010's example of factors for reducing the burden of heart disease and narrowing the gap in heart disease outcomes between different racial groups. Such factors include ensuring access to clinical preventive services, such as blood pressure and cholesterol screening; effective primary care to educate people about modifiable risk factors, such as smoking; effective chronic disease management, such as controlling hypertension; high-quality emergency services to improve outcomes of acute cardiac events; and access to rehabilitative and long-term care for heart disease patients.[2] For more information on access to care, visit the Healthy People 2010 website at http://www.healthypeople.gov/.

Sources:
1. Centers of Disease Control and Prevention, Trends in the Health of Americans 2005
2. Healthy people 2010, US Department of Health and Human Services
3. Centers of Disease Control and Prevention, National Hospital Ambulatory Medical Care Survey: 2004 Outpatient Department Summary vol. 373, 2006
4. Centers of Disease Control and Prevention, National Hospital Ambulatory Medical Care Survey: 2004 Emergency Department Summary vol. 372, 2006
5. Centers for Disease Control Prevention, Summary Health Statistics for the U.S. Population: National Health Interview Survey, 2004

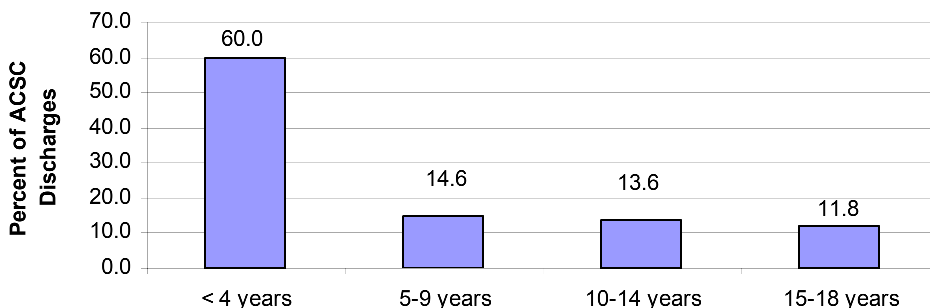
Ambulatory Sensitive Conditions

(continued from page 4)

recipients, with 8% of all ACSC discharges. One other notable payor type is those that self-pay or are underinsured, which make up 6 % of the ACSC discharges. See Figure 5 on page 4 for other for all payor types.

Young children and adolescents include 8% of all ACSC discharges (see Figure 10). Children < 4 years are hardest hit by these conditions, making up 60% of all ACSCs for ages 0-18. The most common conditions for this age group includes asthma, 33% of ACSCs in this age group, followed by cellulitis (13%). In addition, this group has the highest percent of self-pay or underinsured (4%) of all the adolescent age groups. For 5-9 year olds, asthma is also the leading ACSC (41%) for this age group followed by cellulitis (15%). For 10-14 year olds, the leading ACSC is diabetes (35%) followed by asthma (27%). For 15-18 year olds group, asthma and diabetes are equal with 22% each for ACSCs in this age category. For more information, visit the Agency for Healthcare Research & Quality at http://www.ahrq.gov/.

Figure 10



Source: FDOH, Agency for Health Care Administration, 2004
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Figure 11