

# **Health Care Access in Adams County, Illinois**

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# Executive Summary

## Background

In the Summer of 2005, the Adams County Health Care Access Planning Committee began the assessment phase for a health care access planning project. For this assessment, the Adams County Health Department engaged The Medical Foundation (TMF), a non-profit organization with expertise in community assessment, planning and health promotion, to assess the issues affecting access to healthcare in Adams County, Illinois.

This report provides information on a two pronged approach to assessing the issues affecting access to healthcare in Adams County focusing specifically on “safety net<sup>1</sup>” services and the population most likely to utilize those services. The first element of the assessment consisted of qualitative data collection through a series of interviews and focus groups with members of the community and with health care and social service providers. The second element was an investigation of the variables known to predict or affect utilization of safety net services and the status of the Adams County population on those variables. This Executive Summary provides a brief discussion of the primary findings of the work. The full details of the study are included in the body of the report.

## Qualitative Analysis

The qualitative data collection was conducted through interviews and focus groups with providers and consumers. Potential participants were identified by members of the Adams County Health Care Access Planning Committee and invited to participate in either a focus group or interview. All interviews were conducted by trained facilitators from TMF.

### *Purpose of the Focus Groups and Interviews*

The objectives of the interviews and focus groups with medical and social service providers were to hear:

- How providers currently accommodated/can't accommodate the needs of the target population
- Perceptions of how the health care system works for the target population
- Barriers to appropriate use of the system by patients and provision of services by providers
- Ideas on how to increase appropriate

The objectives of the interviews and focus groups with consumers were to hear:

- Descriptions of health care services they need/want
- Perceptions of the health care system available to them
- Successes in obtaining needed/wanted services
- Identification of barriers to services they need/want
- Ideas on how to improve the system available to them

### *Wants/Needs*

Providers and consumers agreed that the target population wanted and needed a variety of components in the health care system, including:

- Affordable, quality care

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<sup>1</sup> Safety net services are those provided to low income, uninsured and otherwise vulnerable individuals.

- Access to primary care providers
- Access to specialists
- Affordable Pharmaceuticals
- Access to behavioral and mental health services

### *Barriers*

Providers and consumers cited multiple barriers to accessing health care services. The identified barriers include:

- Lack of transportation
- Lack of financial resources
- Limited availability of services, especially outside of the City of Quincy, Illinois

In addition, providers perceived a lack of education on and awareness of availability services and knowledge of how to access the health care system on behalf of the consumers. While consumers cited a lack of employer sponsored health insurance options, a feeling of being stigmatized because they received Medicaid or did not have any health insurance options, a lack of providers having evening or weekend hours, and existing debts to providers.

### *Current Strategies to Meet Consumer Needs*

Individual providers are utilizing a variety of strategies to increase access to services including appointments identified for acute care, increasing the utilization of nurse practitioners and coordinating and collaborating with social service organizations. In addition, there are established programs in the community specifically addressing the needs of the target population. These include Blessing Hospital's Community Outreach Clinic, the Adams County Dental Clinic, Catholic Charities' Med Assist, and the East Adams Clinic.

### Quantitative Analysis

The Behavioral Model of health services utilization (Anderson 1968, 1995) was used as the conceptual model to guide the investigation of access to health care in Adams County. This model conceptualizes the factors affecting utilization of health services as falling into three broad categories: predisposing, enabling and need factors. Predisposing factors include demographic and social variables and the beliefs of individuals. Enabling factors are those factors that "facilitate or impede use of services" (Davidson, et al 2004, p.22). Need factors include perceived need (i.e. perception of need on the part of the individual) and evaluated need (i.e. the degree to which an individual's specific health condition would be recognized as a condition in need of medical care). These individual level factors have been extensively studied over many years and have been shown to account for approximately a quarter of the variance in utilization (Davidson, et al 2004).

Recent theory development has attempted to extend the behavioral model beyond the individual level of measurement and explanation to include community or contextual level factors. In addition to individual level variables, community characteristics such as safety net population characteristics, low income population support, health care market factors, safety net support and safety net services have been utilized to explained access outcomes. The hypothesis is that together the individual level and community characteristics might explain more of the variance in health care access outcomes than individual factors alone.

Several researchers have investigated how these individual and community level variables affect access outcomes. Two of the most commonly studied access outcomes are: 1) whether or not the individual had a usual source of care and 2) whether or not the individual had visited the doctor at least once in the previous 12 months.

To identify areas of need or possible areas of focus for improving access, this report provides descriptive data on the individual and community level variables available at the county level; estimates of the two access variables; and comparison data at the state or national level where available. The outcome variables of usual source of care and doctor visit in last 12 months are supplemented by five other outcomes thought to be affected by access to care including emergency room visits for primary care, immunization rates, ambulatory care sensitive conditions, teen birth percent and adequate prenatal care.

Variables which were found to be significant predictors of access and on which the Adams County value was worse than the comparison data, suggest an area for more research and/or intervention to improve access. These areas include education level; household income; health insurance coverage; having a usual source of care; proportion of population < 100% of the federal poverty level; the proportion of physicians providing primary care; and six of the seven outcome variables studied, including usual source of care, doctor visit in the past 12 months, emergency room visits for primary care, ambulatory care, immunization rates, ambulatory care sensitive conditions, and teen births percent. Interventions focused on improving one or more of these factors might improve access to care and overall population health.

The present report is only descriptive, providing a cross-sectional analysis of the Adams County population on the variables in question and comments and perceptions from providers and consumers. Investigation of how the Adams County level on each variable actually affects access would require an inferential analysis which is beyond the scope of this document.

In addition, no attempt was made to disaggregate the data by other variables that could be important such as race. It could be that aggregate values mask significant differences by race, class or socioeconomic status. Investigation of these possibilities is recommended.

## Recommendations

As a result of the quantitative and qualitative data collection and analysis, several areas of focus have been identified:

- Address the issue of feelings of stigmatization on the part of consumers
- Increase and improve coordination of care through case coordination of care through case coordination, electronic medical records and a resource and referral system
- Provide varied opportunities for payment
- Increase health education and information opportunities for consumers
- Provide broader assistance and information on available programs and services and accessing the health care system
- Expand the number and type of providers taking Medicaid
- Expand the number and type of providers for the uninsured

- Conduct research on whether there are significant differences on the predictor and outcome variables for various sub-populations (i.e. by race, education, etc.)
- For more research and/or interventions to improve access, investigate the variables found to be significant and which the Adams County value was works than the comparison, including both predictor and outcome variables. These variables include:
  - Increase the percentage of persons with more than a high school education
  - Increase household income
  - Improve access to health insurance coverage
  - Increase the percentage of persons with a usual source of care
  - Reduce the proportion of population below 100% of the federal poverty level
  - Increase the proportion of physicians providing primary care
  - Increase the percentage of persons having visited the doctor in the past 12 months
  - Reduce emergency room visits for primary care
  - Reduce the incidence of visits for ambulatory care sensitive conditions
  - Improve immunization rates
  - Reduce the percentage of teen births

## Summary of Qualitative Data from Interviews and Focus Groups

## **Background**

To provide opportunities for community members to take part in this study, qualitative data was collected through interviews and focus groups with providers and consumers. Potential participants were identified by members of the Adams County Health Care Access Planning Committee and invited to participate in either a focus group or interview. All interviews and focus groups were conducted by trained facilitators from The Medical Foundation. Each interview was conducted in thirty to forty-five minutes, while each focus group was conducted in ninety minutes. A complete list of focus group and interview participants may be found in Appendix B.

### *Providers*

The objectives of the interviews and focus groups with medical and social service providers were to hear:

- How providers currently accommodate/can't accommodate the needs of the target population
- Perceptions of how the healthcare system works for the target population
- Barriers to appropriate use of the system by patients and provision of services by providers
- Ideas on how to increase appropriate access

Thirty-one providers took part through fifteen interviews and two focus groups. A copy of the provider focus group and interview guide may be found in Appendix C.

### *Consumers*

The objectives of the interviews and focus groups with consumers were to hear:

- A description of healthcare services they need/want
- Perception of the healthcare system available to them
- Success in obtaining needed/wanted services
- Identification of barriers to services they need/want
- Ideas on how to improve the system available to them

Fifteen consumers took part through eleven interviews and two focus groups. A copy of the consumer focus group and interview guide may be found in Appendix D.

### *Type of Health Care Services Wanted and Needed*

*“Friendly, courteous, non-judgmental providers and office staff.”* – consumer

*“A place to go where they [the consumer] can get into and get things resolved before they become an inpatient.”* – health care provider

Providers and consumers agreed that the target population wanted and needed a variety of components in the health care system, including:

- Affordable, quality care
- Access to primary care providers
- Access to specialists
- Affordable pharmaceuticals
- Access to behavioral and mental health services

Providers specifically noted consumers wanting and needing affordable, quality, patient centered health care that had characteristics of being efficient and personal. This care was mentioned in the context of consumers needing improved access to primary care providers for prevention, chronic and acute care and specialists. Individual participants’ comments included “a place to go where they [the consumer] can get in and get things resolved before they become an inpatient” and “individuals come into the emergency room because care for a wound has been put off and they now require IV antibiotics, possible surgery and special dressings.” Providers also commented on the need for improved access to dental care for adults, more effective health education and information opportunities, and greater access to affordable durable medical equipment and supplies.

Consumers expressed additional wants and needs for greater access to and resources for health and dental insurance, “friendly, courteous, non-judgmental providers”, greater financial resources on the individual and community level to cover services and co-pays, assistance in completing paperwork, prevention and treatment strategies that are simple, easy to understand and affordable, and services located outside of Quincy.

### *Current Strategies to Meet Consumer Needs and Care Consumers Say is Available*

*“Many of my patients could not get anything without Med Assist.”* – health care provider

*“Only things we can pay for.”* – consumer

Individual providers are utilizing a variety of strategies to increase access to services including appointments identified for acute care, increasing the utilization of nurse practitioners and coordinating and collaborating with social service organizations. In addition, there are established programs in the

community specifically addressing the needs of the target population. These include Blessing Hospital's Community Outreach Clinic, the Adams County Dental Clinic, Catholic Charities' Med Assist, and the East Adams Clinic. Providers also noted that each of these programs has limits to the services provided, hours of availability, and eligibility for services and most have waiting lists for services.

Consumers noted various limits on what is available because of eligibility requirements, hours of operation, and a lack of financial resources to pay for services. One consumer noted, "if you have insurance there are no limits in what you have access to."

### *Gaps in Services Identified by Providers*

*"Many providers are not accepting Medicaid."* – social service provider

*"Providers accepting Medicaid are swamped."* – health care provider

Providers were asked to identify the gaps in health care services. Their responses included:

- Lack of dental services
- Lack of specialists accepting Medicaid
- Lack of affordable insurance and services for adults
- Lack of insurance coverage and programs to cover hearing aides, glasses, orthodontics
- Lack of access to pharmaceuticals

### *Barriers to Accessing Health Care Services*

*"There is nothing more embarrassing than being called by the receptionist regarding how you are going to pay for your bill while you are waiting to be seen by the doctor."* – consumer

*"I work two jobs and neither of them offer health insurance."* - consumer

Providers and consumers cited multiple barriers to accessing health care services. The identified barriers include:

- Lack of transportation
- Lack of financial resources
- Limited availability of services, especially outside of Quincy

In addition, providers perceived a lack of education on and awareness of available services and knowledge of how to access the health care system on behalf of the consumers. While consumers identified additional barriers including a lack of employer sponsored health insurance options, a feeling

of being stigmatized because they received Medicaid or did not have any health insurance options, a limited number of providers who have evening or weekend hours, and existing debts to providers.

### *Barriers to Delivering Services*

*“We can’t do much for them [the consumer] if they don’t or can’t show up for appointments.”* – health care provider

Providers were asked to discuss barriers that prevented them from delivering services to the consumer. Specifically, they mentioned a tightening of eligibility requirements for services that limited what services can be provided and to whom, a long wait for reimbursement from the State of Illinois for services provided to the Medicaid population, a lack of resources to provide free or subsidized care to consumers, and a lack of coordination and awareness of the services that are available among providers. In some instances, the individual behaviors (exacerbated by economic issues) of particular consumers were noted as barriers. Examples include missed appointments, inability to set up timely follow up appointments, and challenges contacting individual consumers via telephone or the mail.

### *Successes in Accessing and Obtaining Health Care*

*“Everything we need is at the East Adams Clinic.”* - consumer

Providers and consumers noted several programs/organizations that are successful in assisting consumers in accessing and obtaining health care. These are the Adams County Dental Clinic (specifically for children), Blessing Hospital’s Community Outreach Clinic, Transitions, the East Adams Clinic, and the Quincy Area Partnership for Unmet Needs. In addition both groups of respondents noted the importance of developing relationships with providers, including pharmacists, to increase the possibility for success in obtaining services.

### *Rating of Health Care and Social Services*

*“It all depends if you have insurance or financial resources or not.”* – social service provider

*“For me and my kids it is excellent. For my husband it is poor. He does not have any insurance.”* - consumer

Both providers and consumers were asked to rate the current health care services being provided. Health care providers rated the services very good to excellent if the individual has financial resources, private health insurance or Medicaid and an established positive relationship with the provider. An

adequate rating was noted if the individual has Medicaid, does not have financial resources or does not have Medicaid.

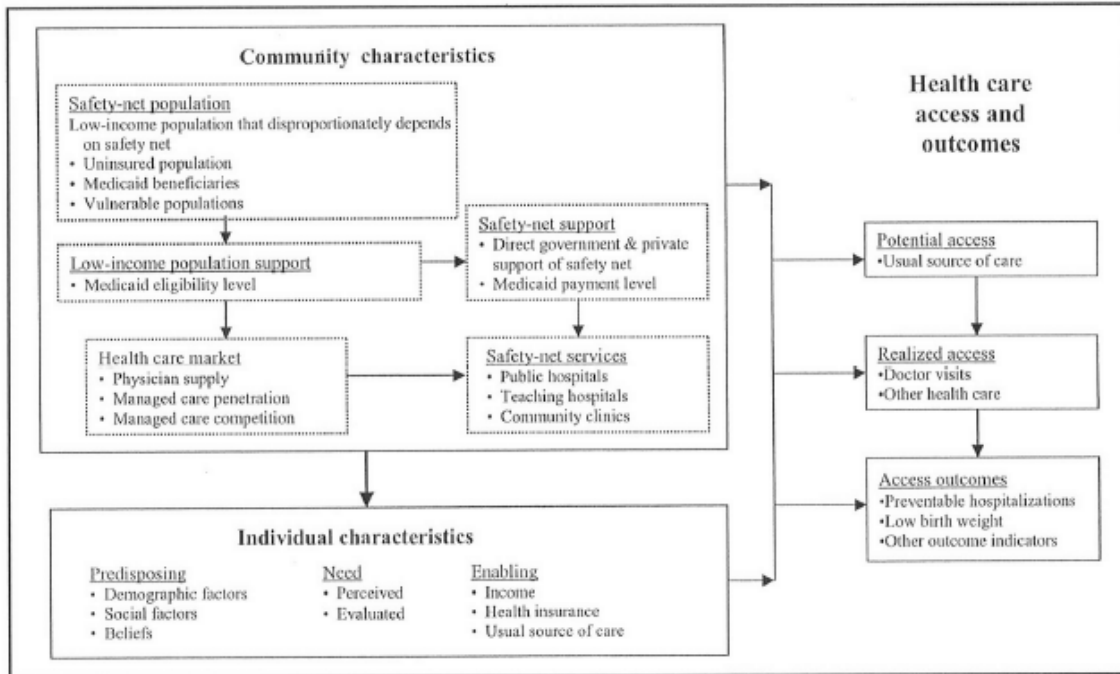
Social service providers and consumers rated the existing services good to excellent if the individual has financial resources, private health insurance or Medicaid and an established positive relationship with the provider. A poor to adequate rating was noted if the individual has Medicaid, does not have financial resources or does not have Medicaid.

Variables Affecting Access to Health Care Services for the  
Safety Net Population: Adams County, Illinois 2005

## **Background**

For a number of years the most widely used and fully studied model for conceptualizing the use of health services has been the Behavioral Model of health services utilization, also referred to as the Anderson Model (Anderson 1968, 1995). This model conceptualizes the factors affecting utilization of health services as falling into three broad categories: predisposing, enabling and need factors. Predisposing factors include demographic and social variables and the beliefs of individuals. Enabling factors are those factors that “facilitate or impede use of services” (Davidson, et al 2004, p. 22). Need factors include perceived need (i.e. perception of need on the part of the individual) and evaluated need (i.e. the degree to which an individual’s specific health condition would be recognized as a condition in need of medical care). These individual level factors have been extensively studied over many years and have been shown to account for approximately a quarter of the variance in utilization (Davidson, et al 2004).

Recent theory development has attempted to extend the behavioral model beyond the individual level of measurement and explanation to include community or contextual level factors. Davidson et al provide a theoretical framework that includes, in addition to individual level variables, community characteristics grouped into 5 broad categories including safety net population characteristics, low income population support, health care market factors, safety net supports and safety net services. They speculate that together the individual level and community characteristics might explain more of the variance in health care access outcomes such as potential access, realized access and access outcomes, than individual level variables alone. Potential access is defined as having a usual source of care. Realized access is defined as having actually used the services of a physician or other health care provider. Access outcomes include prevention of unnecessary hospitalizations, low birth weight and other preventable and undesirable health outcomes. The model explicated by Davidson suggests an array of community level variables in addition to the traditional individual level variables of demographics. Figure 1 provides a graphic depiction of the framework.



**Figure 1. Conceptual framework for evaluating safety net and other community-level factors on access and access outcomes.**

(Adapted from Davidson, et al 2004)

Brown utilized the Davidson framework in an empirical study that investigated the effect of individual and community level variables on two access outcomes: 1) whether or not the individual had a usual source of care and 2) whether or not the individual had visited the doctor at least once in the previous 12 months. The study population was low income individuals (less than 250% of the federal poverty level) in 54 metropolitan statistical areas. The authors provide descriptive statistics for the individual and community level variables and ranges for the two access variables by metropolitan statistical area (MSA). In addition, they developed multivariate models that estimated the effect of each of the independent variables on the probability of having a regular source of care and having seen the doctor at least once in the prior 12 months.

Together the Anderson/Davidson framework and the results from the Brown study provide a guide for investigating the individual and community level variables that could affect access to health care for the low income (or safety net) population in Adams County. This report provides descriptive data on the individual and community level variables available at the county level; estimates of the two access variables suggested by

the Brown study; and comparison data at the state or national level where available. In addition, information will be provided on the findings regarding the effect of individual and community level variables on the access variables from the Brown study. While this study was conducted on populations from a more urban setting than Adams County, the findings can nevertheless, provide some sense of the affect we might expect these variables to have on access.

The multivariate models estimated in the Brown study are disaggregated by insurance status (insured and uninsured). For the local data it is not possible to replicate this disaggregation given the existing data sources. Similarly, the Brown study looked only at the percentage of the population below 250% of the federal poverty level and existing data sources do not allow disaggregation of the local data in this manner.

A study released quite recently conducted by Litaker, Koroukian and Love (2005), utilizes the Anderson framework in a manner similar to the work by Davidson and Brown. This study includes some additional variables to operationalize the predisposing, enabling and need variables and the community or contextual variables and investigated the effect of these variables on the outcome variable of *usual source of care* by estimating a multivariate model. The Litaker study has the added advantage, from the point of view of the present investigation of the Adams County population, of having used a randomly selected sample from Ohio that included urban, suburban and rural settings. Variables from the Litaker study that were not included in Brown are included in the present study and described below.

The present report is only descriptive, providing a cross sectional analysis of the Adams County population on the variables in question. Investigation of how the Adams County level on each variable actually affects access would require an inferential analysis which is beyond the scope of this document.

## **Methods**

### *Variables*

Because our purpose is to investigate the Adams County level on each variable and, where possible, to investigate the difference between the Adams County value and some comparison value (i.e. state or national) the variables included in the Davidson model that can only be estimated at the state level were omitted. For the sake of parsimony only

those variables from the Litaker study that were found to be significant in the final multivariate model are included in this review. The outcome variables of usual source of care and doctor visit in last 12 months are supplemented by five other outcomes thought to be affected by access to care. Table 2 depicts the variables included in the present study.

**Table 2: Variables**

<b>Level (factor)</b>	<b>Variable Name</b>
<b>Individual (Predisposing) factors</b>	
	Age
	Gender
	Race/Ethnicity
	Education
	Marital Status
	Recent immigrant
<b>Individual (Enabling) factors</b>	
	Household income/Poverty level
	Health Insurance
	Usual source of care
<b>Individual (Need) factors</b>	
	Health status
	SF-12 mental component sub-scale
	Treated for any chronic conditions
<b>Community/Contextual factors</b>	
	Proportion of population < 100% FPL
	Percent Medicaid
	Percent single female households
	AIDS incidence rate
	Physician supply
	Hospital beds per capita
	Rural Urban Continuum codes
	Percentage of physicians in county engaged in primary practice
<b>Outcome Variables</b>	
	Usual Source of Care
	Doctor Visit
	ER Visits for Primary Care
	Ambulatory Care Sensitive Conditions
	Immunization Rates
	Teen birth percent
	Adequate Prenatal Care

## Results

This section provides a description of how each of the variables included in the Brown study were found to affect the two outcome variables under the heading *How Variable Affects Access*. Not all of the variables included in the Davidson framework were included in the Brown study. From the Litaker study only those variables found to be significant in the final multivariate model are included in the present study.

The Adams County values are included where available along with comparison data whenever possible. Table 3 provides a summary of the findings. Each variable found to have a significant effect on the probability of having a usual source of care or having visited a physician in the past 12 months in the Brown study or on having a usual source of care in the Litaker study, is signified by an X in the appropriate (second or third) column. Each variable on which the Adams County value was worse than the comparison data is similarly signified by an X in the fourth column.

Finally, an X in the Possible Focus Area column signifies that the variable was found by Brown and/or Litaker to be a significant predictor of access and on which the Adams County value was worse than the comparison data, suggesting an area for more research and/or intervention. This table provides a “snapshot” of the findings that are discussed in more detail in the subsequent text.

**Table 3: Significance of Variables**

Variable	Significant Finding from Brown and/or Litaker		Adams County Worse Than Comparison	Possible Focus Area
	Source of Care	Seen Provider		
<b>Individual (Predisposing) factors</b>				
Age	X			
Gender	X	X		
Race/Ethnicity				
Black	X			
Asian		X		
Other	X			
Education	X		X	X
Marital Status	X			
Recent immigrant	X			
<b>Individual (Enabling) factors</b>				
Household income/Poverty level	X		X	X
Health Insurance	X	X	X	X
Usual source of care	NA	X	X	X
<b>Individual (Need) factors</b>				
Health status (low)	X	X	X	X
SF-12 mental component sub-scale	X	NA	NA	
Treated for any chronic conditions	X	NA	NA	
<b>Community/contextual factors</b>				
Proportion of population < 100%FPL	X	NA	X	X
Rural Urban Continuum Code <sup>1</sup>	X	NA		
Proportion of physicians in primary care (for each 5% increase)	X	NA	X	X
<b>Outcome Variables</b>				
Usual Source of Care			X	X
Doctor Visit			X	X
ER Visits for Primary Care			X	X
Ambulatory Care Sensitive Conditions			X	X
Immunization Rates			X	X
Teen Birth percent			X	X
Adequate Prenatal Care				

1: More rural less likely to report no usual source of care; 2: Not available or Not applicable

## Age

### How Variable Affects Access

Brown compared the 19 to 39 age group to the 40 to 64 year old age group and found 19 to 39 year old adults had significantly lower probability of having a usual source of care (OR uninsured = .819; OR insured = .670). There was no significant difference in the probability of visiting a physician in the last 12 months for either group (OR uninsured = 1.041; OR insured = .914). A similar finding was reported in the Litaker study with older persons being less likely to report no usual source of care.

### Adams County and Comparison Values

The population distribution for the total Adams County population is given in Table 4. The closest approximation to the age groups used in the Brown study is to aggregate persons 20 to 44 and 45 and older, these data are given in Table 5. Adams County has a lower percentage of persons in the 20 to 44 age group than in the state as a whole.

**Table 4: Total Population Distribution Adams County and Illinois**

	Adams County		Illinois	
	N	%	N	%
<b>Under 5 years</b>	4,202	6.2	876,549	7.1
<b>5 to 9 years</b>	4,717	6.9	929,858	7.5
<b>10 to 14 years</b>	5,018	7.3	905,097	7.3
<b>15 to 19 years</b>	5,112	7.5	894,002	7.2
<b>20 to 24 years</b>	3,939	5.8	850,843	6.9
<b>25 to 34 years</b>	7,973	11.7	1,811,674	14.6
<b>35 to 44 years</b>	10,028	14.7	1,983,870	16.0
<b>45 to 54 years</b>	8,895	13.0	1,626,742	13.1
<b>55 to 59 years</b>	3,455	5.1	577,747	4.7
<b>60 to 64 years</b>	2,913	4.3	462,886	3.7
<b>65 to 74 years</b>	5,598	8.2	772,247	6.2
<b>75 to 84 years</b>	4,511	6.6	535,747	4.3
<b>85 and over</b>	1,916	2.8	192,031	1.5

Census 2000

**Table 5: Population Distribution for 20 to 44 and 45 and Over Adams County and Illinois**

	Adams County		Illinois	
	N	%	N	%
<b>20 to 44</b>	21,940	32.1	4,646,387	37.4
<b>45 and over</b>	27,288	40.0	4,167,400	33.6

Census 2000

### *Gender*

#### How Variable Affects Access

Both insured and uninsured females were found to have significantly higher probabilities of having a usual source of care compared to males (OR uninsured = 1.768; OR insured = 1.896) and for having visited a physician in the last 12 months (OR uninsured = 2.316; OR insured = 2.138). Similar to the Brown finding, Litaker reported males were more likely to report having no usual source of care.

#### Adams County and Comparison Values

Adams County has a gender distribution that is nearly identical to the Illinois distribution with just slightly more females than in the state.

**Table 6: Gender Distribution**

	Adams County		Illinois	
	N	%	N	%
<b>Male</b>	32,846	48.1	6,080,336	49.0
<b>Female</b>	35,431	51.9	6,338,957	51.0

Census 2000

## *Ethnicity/Race*

### How Variable Affects Access

Brown et al compared Latinos, African Americans, Asians and Others to non-Latino Whites on both outcome variables. No significant differences were found for the uninsured population on the usual source of care outcome variable. For persons with insurance, African Americans and Others were found to have significantly higher probability of having a usual source of care (OR African American = 1.508; OR Other = 4.659). The only significant finding for physician visit in the past 12 months, was for Asians with insurance who had a significantly lower probability (OR = .677). Race was not found to be significant in the Litaker study.

### Adams County and Comparison Values

The Adams County population is predominately white as shown in Table 7 with other racial groups making up less than 5% of the total population compared to almost 20% in the state.

**Table 7: Racial Distribution (Ethnicity)**

	<b>Adams County</b>	<b>Illinois</b>
	<b>%</b>	<b>%</b>
<b>White</b>	95.1	73.5
<b>Black or African American</b>	3.1	15.1
<b>American Indian/Alaskan Native</b>	.2	.2
<b>Asian</b>	.4	3.4
<b>Native Hawaiian/Pacific Islander</b>	0	0
<b>Other</b>	.3	5.8
<b>Two or more races</b>	1.0	1.9
<b>(Hispanic or Latino any race)</b>	.8	12.3

IPLAN/CENSUS 2000

## *Education*

### How Variable Affects Access

No significant differences were found on the usual source of care variable when comparing those who were not high school graduates to high school graduates and to those with education beyond high school in either the insured or uninsured populations. Those with less than high school education did have significantly lower probabilities of having seen a physician in the past 12 months in both populations (OR uninsured = .756; OR insured = .698) as did high school graduates in the insured population (OR insured = .811).

The Litaker study found that persons with less than a high school education were significantly more likely to report no usual source of care when compared to persons without a high school education.

### Adams County and Comparison Values

Adams County has a slightly higher percentage of the population with a high school degree or higher compared to the Illinois percentage and a lower percentage of individuals with a four year degree or more, as shown in Table 8.

**Table 8: Education**

	<b>Adams County</b>	<b>Illinois</b>
	<b>%</b>	<b>%</b>
<b>HS or Higher</b>	83.7	81.4
<b>Bachelors or higher</b>	17.6	26.1

Census 2000

*Marital status*

How Variable Affects Access

Married persons in the insured category were found to have significantly higher probability of having a usual source of care (OR = 1.405). No differences were found when comparing married to non-married persons regarding probability of visiting a physician. The Litaker study found that persons who were not currently married or coupled were more likely to report no usual source of care.

Adams County and Comparison Values

Adams County has higher percentages of married person for both males and females than for the state.

**Table 9: Marital Status (population 15 and older Now Married)**

	Adams County		Illinois	
	Males %	Females %	Males %	Females %
<b>Married</b>	61.8	54.8	56.1	51.3

Census 2000

*Recent immigrant*

How Variable Affects Access

Recent immigrants (less than 5 years in US) were found to have significantly lower probabilities of having a usual source of care in both insurance categories (OR uninsured = .527; OR insured = .527). Insured individuals who were recent immigrants were less likely to have seen a physician in the past 12 months (OR= .677).

Adams County and Comparison Values

No data is available on recent immigration status of the Adams County population. As shown in Table 10, Adams County has a very low percentage of foreign born individuals. Another variable that could provide information on how recently a person has migrated to the US is speaking a language other than English at home. Adams

County does have a surprisingly high percentage of persons that speak another language other than English at home (2.5%) given the racial and ethnic distribution (reported above).

**Table 10: Percent Foreign born**

	<b>Adams County</b>	<b>Illinois</b>
	<b>%</b>	<b>%</b>
<b>Foreign born</b>	.8	12.3

Census 2000

*Household income/Poverty level*

How Variable Affects Access

When comparing the 3 income categories of < 50% FPL, 51% to 100% FPL and 101% to 150% FPL to the reference category of 151% to 250% of the FPL, Brown found only one significant difference, with those in the 101% to 150% category who were insured showing a lower probability of usual source of care (OR = .748). For having visited a physician, persons below 50% of FPL and uninsured had significantly higher probability of a visit in the past 12 months (OR = 1.323). Litaker found the poor (less than 100% FPL) and near poor (100% - 200% FPL) were significantly more likely to report not having a usual source of care.

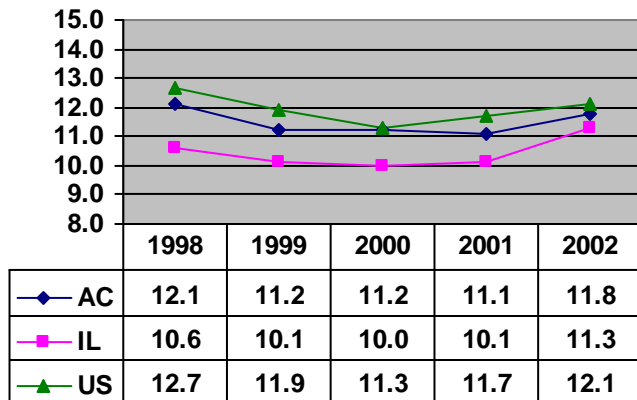
Adams County and Comparison Values

Figure 2 shows that the Adams County percentage of the population below 100% of the poverty level is slightly higher than the Illinois and slightly under the US percentage.

Figure 2: Percentage of the total population living below the federal poverty level

Description: Percentage of the population all ages living below the federal poverty level

Data Source: US Census Small Area Income & Poverty Estimates  
<http://www.census.gov/cgi-bin/saipo/saipo.cgi>



### *Health Insurance*

#### How Variable Affects Access

No significant differences were found on the usual source of care variable when comparing those who did not have health insurance and those who had Medicaid to the reference group of those who had private insurance or Medicare. Medicaid recipients were found to have a higher probability of having seen a physician in the past 12 months (OR = 1.284). Litaker found that those who were continuously uninsured or insured only some of the time (more than 5 week but less than 52 weeks) in the prior 12 months were more likely to report having no usual source of care.

#### Adams County and Comparison Values

As shown in Figure 3, Adams County has a lower percentage of persons without health insurance than other rural Illinois counties or Illinois as a whole. The percentage of the total population enrolled in Medicaid is given in Table 3.1.

Figure 3: Percentage of adults without health insurance

Description: Percentage of respondents answering No to the BRFSS question, “Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare”?

Data Source: Behavioral Risk Factor Surveillance System, Illinois Department of Public Health

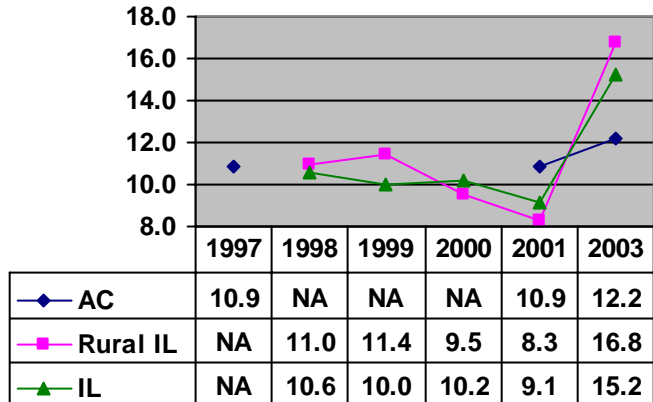
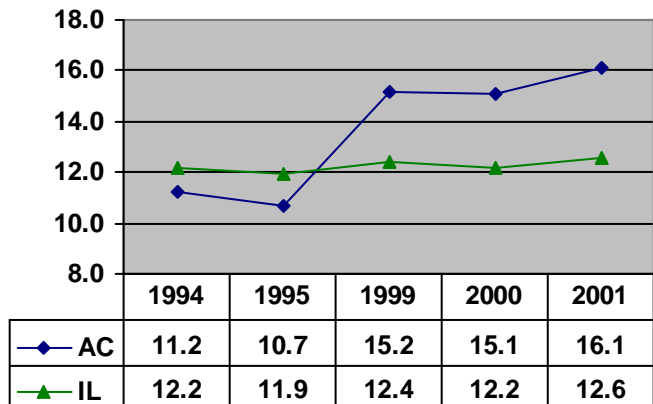


Figure 3.1: Percentage of population enrolled in Medicaid

Description: Actual percent of Medicaid enrollees for total population.

Data Source: IPLAN Data System, Illinois Department of Public Health



### *Usual Source of Care*

#### How Variable Affects Access

Individuals who had a usual source of care were found to have a much higher probability of having seen a physician in the past 12 months no matter their insurance status (OR uninsured = 2.586; OR insured = 3.127).

Adams County and Comparison Values

The 2004 BRFSS survey asked the question “Do you have a usual person as a health care provider” in Adams County. Respondents were categorized as “At Risk” or “Not at Risk”. For the Rural Strata in Illinois and for Illinois in total, the survey included the question “Do you have one person you think of as your personal doctor”. Responses were Yes and No. Adams County, Rural Strata and Illinois percentages are included below. Adams County has a percentage nearly identical to other rural counties in Illinois and 3.3 percentage points below the Illinois percentage.

**Table 11: Usual Source of Care/Personal Doctor**

	<b>Adams County</b>	<b>Rural</b>	<b>Illinois</b>
	<b>%</b>	<b>%</b>	<b>%</b>
<b>At Risk/No Dr.</b>	14.9	14.4	18.2

BRFSS 2004

*Health Status*

How Variable Affects Access

Persons with low health status were found to be more likely to have a usual source of care (OR uninsured = 1.477; OR insured = 1.804) and to have visited a physician in the past 12 months (OR uninsured = 2.664; OR insured = 3.190) regardless of insurance status.

Adams County and Comparison Values

The percentage of the population in Adams County reporting poor health is given in Table 12. Adams County had a slightly higher percentage than the state in 1997/98 but was lower in 2001 and 2004.

**Table 12: Percent Reporting Poor Health**

	<b>Adams County</b>	<b>Illinois</b>
	<b>%</b>	<b>%</b>
<b>2004</b>	3.4	4.1
<b>2001</b>	1.4	3.1
<b>1997/1998</b>	3.0	2.6

BRFSS 2004

*SF-12 mental component sub-scale*

How Variable Affects Access

The Litaker study used scores on both the mental and physical sub-scales of the SF 12 as a measure of need. Although Litaker found a significant result for the SF 12 mental subscale the authors suggest that the difference is probably not clinically significant.

Adams County and Comparison Values

No data sources exist at the county level for outcomes on the SF 12.

*Treated for any chronic conditions*

How Variable Affects Access

Litaker conceptualized having been treated for a chronic condition as a need variable and found that those who reported less treatment for chronic conditions also reported being less likely to have a usual source of care.

Adams County and Comparison Values

No data sources exist at the county level outcomes for likelihood of treatment for chronic disease.

*Percent low income*

How Variable Affects Access

See above

Adams County and Comparison Values

See above

*Rural Urban Continuum Codes*

How Variable Affects Access

The Rural Urban Continuum Codes are a system for classifying counties from the most urban to the most rural. There are nine categories with higher numbers denoting greater rurality (see Table 13). Litaker found that persons in progressively more rural counties were less likely to report no usual source of care.

Adams County and Comparison Values

Although there is really nothing to be “done” about the rurality issue, the classification for Adams County and other surrounding counties are: Adams 5; Brown 9; Pike 7; Lewis 7 and Clark 9.

**Table 13: Rural Urban Continuum Codes**

<b>Code</b>	<b>Description</b>
Metro counties:	
1	Counties in metro areas of 1 million population or more
2	Counties in metro areas of 250,000 to 1 million population
3	Counties in metro areas of fewer than 250,000 population
Nonmetro counties:	
4	Urban population of 20,000 or more, adjacent to a metro area
5	Urban population of 20,000 or more, not adjacent to a metro area
6	Urban population of 2,500 to 19,999, adjacent to a metro area
7	Urban population of 2,500 to 19,999, not adjacent to a metro area
8	Completely rural or less than 2,500 urban population, adjacent to a metro area
9	Completely rural or less than 2,500 urban population, not adjacent to a metro area

### *Percent Physicians in Primary Care*

#### How Variable Affects Access

A very interesting finding of the Litaker study is that while the total supply of physicians was unrelated to the likelihood of having a usual source of care, the percentage of physicians engaged in primary care in a county was significantly related. Persons living in counties with higher proportions of primary care physicians were less likely to report no usual source of care.

#### Adams County and Comparison Values

There are 47 physicians practicing family or general medicine in Adams County out of a total of 198 (AMA Physician Masterfile). This represents 23.7% of the total practicing physicians. In a 2003 report the General Accounting Office suggests the percentage of generalists (physicians whose primary specialty is family practice, general practice, general internal medicine, or general pediatrics) is about one third of the total physician supply on a national basis. The same report shows about 41% of all physicians are generalists in counties of the same urban influence code category as Adams. There are 74 physicians practicing in the categories used in the GAO report, yielding a percentage of 37.3%. By either measure, the percentage of physicians engaged in primary care or generalist practice appears to be lower than the national average.

Data from the Agency for Health Research and Quality shows the rates per 100,000 population for pediatricians, primary care physicians, OB/GYN, specialists and surgical specialists are all higher for Adams County than for Illinois and the US in general.

## Outcome Variables

### *Usual Source of Care*

See above

### *Doctor Visit*

This is one of the outcome variables providing a measure of “realized” access. The Brown study used “No visit in the last 12 months” as the measure. The BRFSS survey in 2003 for Adams County included the measure “Saw health professional in past 12 months”, however the Rural and Illinois total data do not include a similar measure for comparison. The Adams County values are: 79.4% Yes; 20.6% No.

For 1997 and 1998 the IPLAN dataset contains the measure, “No medical physical in the past 2 years”. Adams County has a slightly higher percentage of individuals reporting no medical physical in the past two years when compared to the state.

**Table 14: No Medical Physical in Last 2 Years**

	Adams County	Illinois
	%	%
1998	16.2	15.8
1997	18.1	16.7

IPLAN Data System

### *ER visits for primary care*

For Fiscal year 2004, there were 22,626 episodes of primary care delivered at Blessing Emergency Room (Blessing Hospital). Converted to a population measure, this represents a rate of 331.39 episodes per 1000 population. No comparison measure has been identified for this rate. Data from the Agency for Healthcare Research and Quality

shows Adams County has a rate for Emergency Department visits per 1000 population that is higher than the state rate, 491.33 and 421.02, respectively.

*Ambulatory Care Sensitive Conditions<sup>2</sup>*

The rates per 10,000 population for seven ambulatory sensitive care conditions (ACSC) in Adams County and in Illinois are presented in Table 15. The Adams County rates are higher than the state rate for 6 of the 7 conditions.

Data from the Agency for Healthcare Research and Quality shows that age and sex adjusted rates of hospitalization for preventable conditions are lower for Adams County than for Illinois or the US (see Table 15.1).

**Table 15: Ambulatory Sensitive Care Conditions Adams County Residents 1998-2000**

	Adams County		Illinois	
	N	Rate per 10,000	N	Rate per 10,000
<b>Congestive Heart Failure</b>	1910	93.8	256,690	68.9/
<b>Bacterial Pneumonia</b>	1645	80.8	187,179	50.2
<b>Kidney/urinary infection</b>	980	48.1	127,609	34.3
<b>Dehydration</b>	881	43.3	128,402	34.5
<b>Diabetes C</b>	629	30.9	94,481	25.4
<b>COPD*</b>	635	31.2	74,096	19.9
<b>Hypertension</b>	714	35.1	144,799	38.9
<b>Total</b>	7394	363.2	1,302,590	272.0

\*Chronic Obstructive Pulmonary Disease

Blessing Hospital Community Health Data

<sup>2</sup> It is unclear whether this data is age-adjusted.

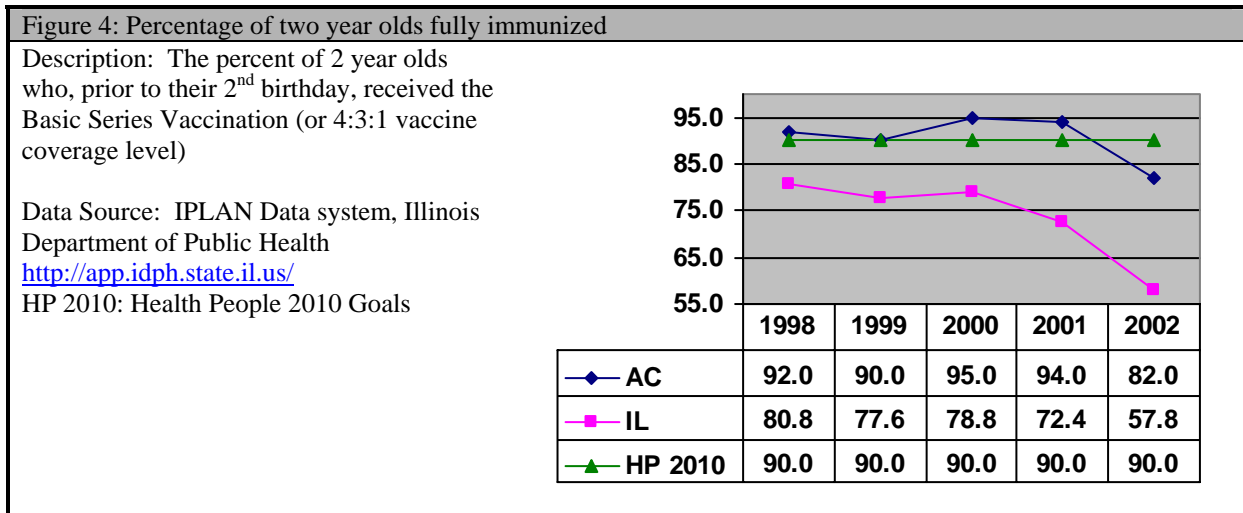
**Table 15.1: Rate of Preventable Hospitalizations per 1000 Population (Adjusted for Age and Sex)**

	Adams County	Illinois	US
Age category			
<b>0-17</b>	6.80	9.13	11.13
<b>18-39</b>	6.71	7.15	7.65
<b>40-64</b>	20.37	20.17	21.48

AHRQ

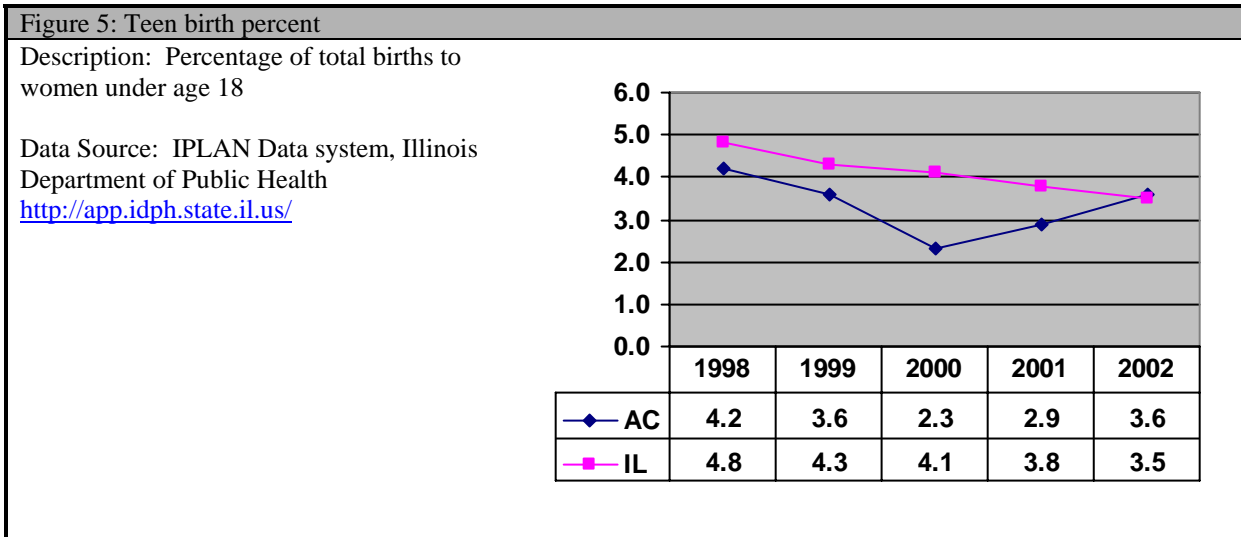
*Immunizations*

The percentages of 2 year olds with full Basic Series vaccination in Adams County and Illinois along with the Healthy People 2010 goal for vaccine coverage are given in Figure 4. The Adams County rate is better than the Illinois rate but still slightly below the Healthy People 2010 goal of 90%.



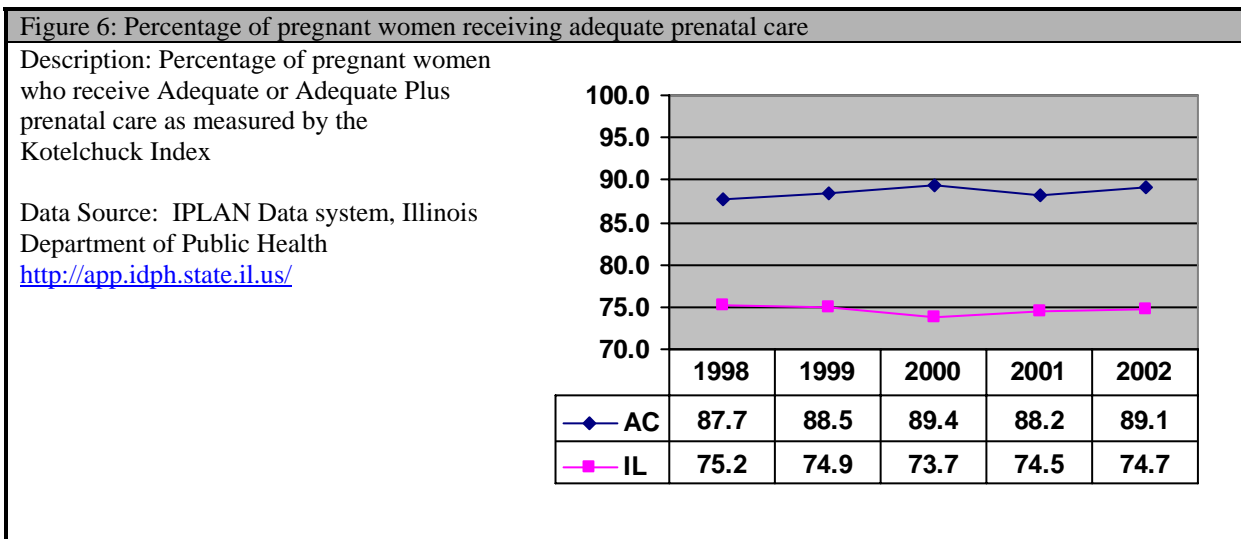
*Teen births*

The percentages of births to women under age 18 in Adams County and Illinois are given in Figure 5. The Adams County rate has been lower than the state rate in recent years, however in 2003 the rates were virtually identical.



*Adequate prenatal care*

The percentage of pregnant women receiving adequate prenatal care for Adams County and Illinois are given in Figure 6. The Adams County percentages have consistently been higher than the Illinois percentages for the recent past.



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## Appendix A

### Focus Group and Interview Participants

## Focus Group and Interview Participants

Tena Awerkamp – Blessing Hospital  
Nancy Bluhm – Adams County Health Department  
Geri Buss – Blessing Hospital  
Diane Campbell – Illinois Department of Human Services  
William Cary – Community Member  
Linda Demming – Community Member  
Mary Ann Doellman – Quincy Catholic Charities  
Brenda Derrick – University of Illinois Extension  
Janet Enroth – Quincy Public Schools  
Loretta Feldkamp – Quincy Medical Group  
Marla Ferguson – Quanada  
Gina Genebacher – Blessing Physician Services  
Melody Hackett – Community Member  
Kathy Harmon – Quincy Medical Group  
Chuck Johnson – Newman Clinic  
Jerry Kruse – SIU Family Practice  
Ruth Liesen – Adams County Dental Clinic  
Patty Lieurance – Illinois Department of Human Services  
Marissa Logsdon – Community Member  
Viola Majors - Community Member  
Jeannie Martin – Quincy Public Schools  
Gail McCauslin – West Central Illinois Area Agency on Aging  
Marlene McEwen – The Salvation Army  
Denise Mewes – Community Member  
Gary Meyer – Community Member  
Thomas Miller – SIU Family Practice  
Mark Motley – Community Member  
Debbie Mountain – Blessing Physician Services  
Elizabeth Payne – Community Member  
Teddy Pendleton – Community Member  
Debra Phillips – SIU Quincy Family Practice  
Alan Richardson – Quincy Medical Group  
Nicole Robbins – Community Member  
Claire Robinson – United Way of Adams County  
Mary Kay Ryan – Blessing Hospital  
Donna Sanders – Quincy Public Schools  
Mark Schmitz - Transitions  
Elaine Selsor – Community Member  
John Skeinkeller – Community Member  
Kurt Stuckman – Quincy Catholic Charities  
Gary Taute – Community Member  
Cathy Walsh – Community Member

Cheryl Waterman – United Way of Adams County  
Michele Young – University of Illinois Extension  
Rich Zeidler - Transitions

## Appendix B

### Provider Focus Group and Interview Guide

## PROVIDER ASSESSMENT

**Purpose:** To assess the organization, impact, and challenges of the health care delivery system in Adams County – particularly among the Medicaid, uninsured and underinsured populations

- Objective:** Hear from providers on:
- Perception of how system works for target population
  - Barriers to appropriate use of system by patients and provision of services by providers
  - How providers currently accommodate/can't accommodate needs of target population
  - Ideas on how to increase appropriate access

**Questions:**

- 1) Please describe the kind of health care/social services your patients/clients:
  - A. Want
  - B. Need
- 2) How are you able to accommodate (meet) those needs/wants?
- 3) Where are the gaps?
- 4) What barriers prevent your patients/clients from accessing and obtaining the health care/social services they need/want? Please describe.
- 5) What barriers prevent you from delivering the health care/social services your patients/clients may need/want? Please describe.
- 6) What kind(s) of success has your patient/client had in accessing and obtaining the health care/ social services they need/want?
- 7) In general, how would you rate the health care/ social services your patient/client currently receives? (Excellent/Very Good/Good/Adequate/Poor) Why?
- 8) Do you have any ideas on how to improve access to the health care/social services available to your patient/client?
- 9) Are there other comments/thoughts you may wish to share on this topic?

## Appendix C

### Consumer Focus Group and Interview Guide

## CONSUMER ASSESSMENT

**Purpose:** To assess the organization, impact, and challenges of the health care delivery system in Adams County – particularly among the Medicaid, uninsured and underinsured populations

- Objective:** Hear directly from consumers on their:
- Description of healthcare services they need/want
  - Description of healthcare services they don't need/want
  - Perception of the healthcare system that is available to them
  - Success in obtaining needed/wanted services
  - Opinions about why they may not get the services they need/want
  - Ideas on how to improve the system available to them

### Questions:

- 1) Please describe the kind of health care services you
  - A. Want
  - B. Need
- 2) What kind of health care is currently available to you/your family?
- 3) How do you learn/find out about the health care available to you/your family?
- 4) Have you seen a health care professional in the past 12 months? Why? Why not?
- 5) Do you have one person that you think of as your personal health care provider?
- 6) What kind(s) of success have you had in accessing and obtaining the healthcare you need/want?
- 7) What barriers prevent you from accessing and obtaining the healthcare services you need/want? Please describe.
- 8) How would you rate the healthcare you currently receive? (Excellent/Very Good/Good/Adequate/Poor) Why?
- 9) Do you have any ideas on how to improve the health care available to you/your family?
- 10) Are there other comments/thoughts you may wish to share on this topic?

## Appendix D

### Themes from Qualitative Data Collection

**From Providers (n = 31) (15 Interviews and 2 Focus Groups)**

**1) Please describe the kind of health care/social services your patients/clients: A. Want B. Need**

**1A. Want:**

- Affordable, quality care (5 respondents)
  - Efficient service
  - Personal service
  - Patient centered care
- Health education and health information (5)
- Access to acute care (4)
  - In general, consumers/clients end up in ER
  - Wound Care (individuals come into the ER because care for a wound has been put off and they now require IV antibiotics, possible surgery, and special dressings)
- Behavioral and mental health services (3)
- Affordable pharmaceuticals (2)
  - Hypertension
  - Cholesterol
  - Diabetes
- Patients want to be seen in a timely manner by the health care professional (time from call to appointment) (2)
- Recommendations/Medications the consumer can afford to implement
  - “Why go if you know you won’t be able to afford the antibiotics” – social service provider
- Engage consumers in decision making
  - More options in care
  - “They are told what they are going to get, they need to have a voice in their health care options” – social service provider
- Transportation to and from services
- Additional financial support to pay for medical bills/medication
- To see a physician for the visit not the nurse

**From Consumers (n = 15) (11 Interviews and 2 Focus Groups)**

**1) Please describe the kind of health care services you: A. Want, B. Need**

**1A. Want:**

- Health Insurance (2 respondents)
- Child psychologist – “I’d like a child psychologist that could diagnose more than behavioral disorders. A psychologist who could diagnose developmental and mental health issues.”
- Affordable pharmaceuticals/medications
- Dental Insurance
- Assistance in completing paperwork
  - “I would like to sit down with people who have the experience in understanding the drug companies. I have high blood pressure, pain, diarrhea, and panic attacks. The applications are greek to me.”
- Access to affordable rehabilitation services outside of Quincy
- A simple routine for exercise/ Access to exercise equipment
- An exercise support group
- Culturally competent providers
- More information on what services are available
- Friendly, courteous, non-judgmental “providers” (e.g. receptionist, billing office)
- “I will take whatever I can get to help me.” – rural community member
- Coverage for unplanned hospitalizations

**B. Need:**

- Access to Primary Care Providers (for prevention, chronic and acute care) (5)
  - “A place to go where they can get into and get things resolved before they become an inpatient.” – nurse
  - Pediatricians
  - Internal medicine
  - Nurses
  - Pharmaceuticals
- Access to Specialists (5)
  - Need more than one visit, need obligation to take patient
- Access to dental care, prevention and emergency care (5)
- Health education (5)
  - Nutrition
  - Physical activity
  - Oral hygiene
  - Other health information
- Durable medical equipment and supplies (2)
- A wellness center addressing mind, body and spirit
- Sites for services that are close to where people live and work

**B. Need**

- Financial resources to cover services and co-pays
- Allergist – have
- More Pediatricians – have
- More Family Practice – have
- Neurological Specialists
- Affordable, Quality health care
- Opportunities and time to develop a trusting relationship with my providers
- Pediatric sickle cell anemia testing
- Culturally competent providers and front desk staff
- Greater outreach to the minority communities

**2) How are you able to accommodate (meet) those wants/needs?**

- Community Outreach Clinic
  - Waiting list
  - Only open 3 hours per week
  - Expanding clinic in the Fall?
- Blessing Homecare
- Blessing Charity Care
- Referrals back to physician or nurse to see if they can access samples of pharmaceuticals
- Salvation Army
  - Assists in paying for 30 day supply while client is waiting for Medassist
- Transitions – has expertise
- Quanada – develops relationship with individual doctors
- Senior Center – One stop shop, partners with other agencies to bring services into center
- Medassist
- Kids Care
- Blessing Developing treat and release piece of Emergency Room
- East Adams Clinic
  - Brought pharmacy into clinic
  - Brought physical therapy onsite
  - Brought testing onsite
- Coordinating with other providers to improve access to services
  - EAC works with Timberpoint Nursing Home to provide transportation into Quincy
- Refer to other health care and social service organizations
- Catholic Charities – Medassist
- Salvation Army
- Transitions
- Two Rivers
- Blessing Hospital Emergency Room
- Setting aside acute care slots in each day
- Developing larger role for nurse practitioners

**2) What kind of health care is currently available to you/your family?**

- Limited coverage for pharmaceuticals through Medassist
- “I just got the card, because two doctors say my husband can go to work, but his employer says he can’t go to work. My husband has had insurance. We have no family plan.” - Quincy community member
- “Enough. I have health insurance.” – Quincy community member
- “Only things we can pay for.” – Rural community member
- “Nothing, if I don’t pay for it.” – Quincy community member

### 3) Where are the gaps?

- Lack of dental services, for adults (5)
- Lack of specialists in area who take the medical card (4)
  - Orthopedic
  - Child psychiatrists
  - Cardiologist
  - Dermatology
  - Urology
- Lack of affordable insurance and services for adults who are (5)
  - self-employed or the working poor
  - 18 to 65 years old, men or individuals without dependents
- Lack of insurance coverage or programs that cover all or part of (3)
  - Hearing Aids
  - Glasses
  - Orthodontics
- Lack of access to pharmaceuticals (2)
  - Difficult to get meds if patient has no coverage and being discharged
  - Recently released prison population
- Durable medical equipment and supplies are not covered by insurance or some assistance programs (2)
- Lack of preventive care
- Have Medicare or Medical card but benefits structures are not useful
- Lack of services for the adult developmentally disabled with public guardian
- Finding provider who will take medical card
- Afterschool services for children with disabilities
- No dental hygiene training program in area
- Mental health services for un and under insured
- Lack of accurate information on who takes the card
- Shrinking eligibility, category 97 gone – cut in programs or eligibility restrictions
- Health education and prevention “if we can get a hold of these people earlier we could prevent some of this later in life” - nurse
- Lack of care from a consistent provider
- Culturally competent services

**4) What barriers prevent your patients/clients from accessing and obtaining the healthcare/social services they need/want? Please describe.**

- Limited availability of services (5)
  - Lack of providers taking the medical card
  - Lack of specialists taking the medical card and located in Adams County
- Money, to pay co-pay or for services and pharmaceuticals (5)
- Transportation (4)
- Education and awareness on what is available (3)
- Knowledge of how to access the system (3)
- Insurance (2)
- Stigma (2)
- Awareness and skills to make the phone calls to the various resource providers to make and change appointments
- Coordination among various parts of the system
- Other personal/familial issues are a higher priority
- Paperwork
- Long waiting time
  - Time on waiting list
  - Time from the making of the appointment and the actual appointment
  - Time for prior approval of services
- Health Beliefs
- Previous poor experiences
- Addictions
- Chronic Pain

**7) What barriers prevent you from accessing and obtaining the healthcare you need/want?**

- Lack of financial resources (3)
- Lack of transportation (2)
- Lack of providers in Quincy
- Appointments are during day
- Having unpaid bills with providers
  - “There is nothing more embarrassing than being called by the receptionist regarding how you are going to pay for your bill while you are waiting to be seen by the doctor. They want you to see accounting first.”
  - “We are almost \$3,000 in the hole at Blessing and the folks there will come after you.”
- Stigma – having the medical card
  - “The receptionists are kind of nasty, they make assumptions.” – Quincy community member
- Geography
  - Not wanting to go into Quincy
  - Not wanting to go to opposite side of town
- Lack of engagement of consumer in decision making

**5) What barriers prevent you from delivering the health care/social services your patients/clients may need/want? Please describe.**

- Tightening of the eligibility requirements for medical card and services (4)
- State slow in reimbursement (3)
- Lack of coordination and awareness among providers (3)
- Good vac dressings for wound care are not covered by public aid
- Transitions has capped resources from the state
  - Has begun rationing resources
  - Short stays
  - Long waiting lists
- Lack of team approach and collaboration
  - “I don’t see health care providers working together in Quincy” – health care provider
- Two class system for mental health - those with card and those who pay fee for services
- Hospitals writing off bad debt
- Category 97 gone
- Consumers not completing treatment in a timely manner
- Need for specialists
- Missed appointment, no shows
- Sense of hopelessness and frustration on the part of the consumer
- Transient population
  - Changing addresses and phone numbers
- Cycle of poverty
  - seeing third and fourth generation, “This is a way of life for them.”
- Focus in physicians office to treating chronic illness, limited room for acute care
- Lack of specialist taking medical card and located in Adams County
- Being overwhelmed with conditions of the consumer and the system in general
- “There are not enough hours in a day to see all those who need or want to be seen and still provide quality care.” - physician

**6) What kind(s) of success has your patient/client had in accessing and obtaining the health care/social services they need/want?**

- Adams County Health Department Dental Clinic (2)
- Transitions (2)
- Unmet Needs Committee (2)
- Community Outreach Clinic (2)
- Blessings episodic medication fund
- Medassist
- SIU/Quincy Family Practice
- Relationships with providers

**6) What kind(s) of success have you had in accessing and obtaining the health care you need/want?**

- “I have had really good success. The providers provide good services. If they can’t help me, I get a referral, I have a medical card for my kids.” - parent
- Some pharmacies allowing clients to get only the amount they can pay for at the time. “Sometimes at Walgreens, I can get half a prescription filled.”
- None
- “Everything we need is at the East Adams Clinic.” – rural community member

**7) In general, how would you rate the health care/social services your patient/client currently receives (Excellent/Very Good/Good/Adequate/Poor)? Why?**

Of the services in general

- Excellent
  - “If you have the means” – social service provider
  - “The care is excellent. It is the access that is the problem.” – health care provider
- Very Good
  - “Once you have established yourself and are in the door.” – health care provider
  - “Very good to excellent for 95% of the population. It is the 5% that it is a disaster for. They just do not know what to do.” – social service provider
- Good
  - “Lucky to have SIU/QFP, progressive health department and Blessing hospital” – social service provider
- Adequate
  - “Because of medical card restrictions” – health care provider
  - “Because they can always get something in the emergency room” – social service provider
- Poor
  - “We can’t find doctors to see our clients. They have to search outside of town and many of them do not have transportation.” – social service provider
  - “If you do not have the means” – social service provider
  - “If you get services in the ER but don’t have follow up.” – social service provider

**8) How would you rate the healthcare you currently receive (Excellent/Very Good/Good/Adequate/Poor)? Why?**

- Excellent (5)
  - “For me and my kids it is excellent. My doctor is straight forward. My kids’ doctor calls me at home to see how my kids are doing...As long as

my kids are happy, I am happy.” – parent

- “Having a pharmacy at the clinic (EAC), has been a big help.” – rural community member
- “Quincy Family Practice doctors take their time. They are always up-to-date. I am confident in their skills.” – Quincy community member
- Good (6)
- Adequate (2)
  - “I don’t have to wait long at Quincy Family Practice.” – Quincy community member
- Poor (2)
  - “Doctors will only provide what insurance covers, which may not be what we need.” – Quincy community member

Of specific services, organizations, agencies -

- Blessing Hospital
  - Excellent – “because we don’t worry about whether the patient is paying or not”
- Outside of Blessing Hospital
  - Poor – “especially for those without insurance”
- East Adams Clinic
  - Very Good!
- Quincy Medical Group
  - “dedicated doctors who strive to provide quality care.” – medical provider

**8) Do you have any ideas on how to improve access to the health care/social services available to your patient/client?**

- More managed care programs with emphasis on prevention with rewards for leading a healthy lifestyle
- Need for case coordination
- More nurse practitioners
- Legislation - improved government funding
- Create more public awareness in the need for access to care
- More education for consumer and providers on available services
- Bring more providers together to develop, discuss and implement strategies
- Establish “treat and release” at Blessing
- Get more providers outside of Blessing and Quincy Medical Group
- Add specialists to Community Outreach Clinic
- Dental hygiene program
- Make more funds available for working poor
- Investigate possibility for programs and services with Kroc Center
- Early prevention and education for young people
- Creation of a community health record
- Creation of financial database to lessen burden of paperwork.
- Expand Community Outreach Clinic
- Community based resource and referral system

**9) Do you have any ideas on how to improve the health care available to you/your family?**

- Expand affordable insurance options for those who are employed but do not have access to employer provided health insurance (2)
- Federally Qualified Health Center
- Expand the eligibility for the medical card
- Expand the number of providers who take the medical card
- Expand the list of pharmaceuticals covered by the medical card
- Improve health care for children
- Consider more sliding fee scale services and payment plan options
- Address the growing two class system of providing and accessing health care.
- “Would like to see Quincy Medical Group and Blessing change the way they collect their money.” – rural community member
- Expand dental coverage
  - “Why do the dentists feel like they are so different from the doctors?” Quincy community member
  - “The doctors take their share of the card, why can’t the dentists?” – Quincy community member
- Work with front office staff to change the way they treat consumers
- Provide more health information/education
- Provide more information on the available services

**9) Are there other comments/thoughts you may wish to share on this topic?**

- Quincy Medical Group
  - not accepting medical card
- SIU/Quincy Family Practice
  - “swamped”
  - “even employees can’t get in”
- Blessing Emergency Room
  - High usage
- Dentist
  - Not accepting medical card
- Medassist
  - Works well but new 30 day wait
- Tightened eligibility for medical card and other services
- Changes in the agricultural economy have limited financial resources available to rural community members
- “There is some infrastructure in the community but a lack of funding may bring about a loss of the existing infrastructure”
- Biggest cost to providing medical care services is cost of staff, not cost of malpractice insurance. Staff used to complete insurance forms and other paperwork.
- Quincy and Adams County serves region that includes Missouri but many providers do not take Missouri Medicaid

**10) Are there other comments/thoughts you wish to share on this topic?**

- “Quincy provides more for adults than children. The children need medical attention.” – parent
- “Dental care is an important issue. My kids get excellent care at the Adams County Dental Clinic.” – parent
- “We just can’t afford it (health care).” – rural community member

**3) How do you learn/find out about the health care available to you/ your family?**

- Word of mouth
- From my primary care provider
- “I go find what I need.” – parent
- Internet

**4) Have you seen a health care professional in the past 12 months?**

- Yes (12)
- No (3)

**5) Do you have one person that you think of as your personal health care provider?**

- Yes (12)
- No (3)

Appendix E  
Adams County  
Socio-demographics Summary

**Adams County  
Socio-demographics Summary**

**Population**

<b>General Characteristics</b>	<b>Adams</b>		<b>IL</b>	<b>U.S.</b>
	<b>Number</b>	<b>Percent</b>		
Total population	68,277			
Male	32,846	48.1	49.1	49.1
Female	35,431	51.9	50.9	50.9
Median age (years)	38.3	(X)	34.7	35.3
Under 5 years	4,202	6.2	7.1	6.8
18 years and over	51,276	75.1	73.9	74.3
65 years and over	12,025		12.1	12.4

**Race**

	<b>Adams</b>		<b>IL</b>	<b>U.S.</b>
	<b>Number</b>	<b>Percent</b>		
One race	67,627	99.0	98.1	97.6
White	64,932	95.1	73.5	75.1
Black or African American	2,094	3.1	15.1	12.3
American Indian and Alaska Native	109	0.2	.2	0.9
Asian	272	0.4	3.4	3.6
Native Hawaiian and Other Pacific Islander	8	0.0	0	0.1
Some other race	212	0.3	5.8	5.5
Two or more races	650	1.0	1.9	2.4
Hispanic or Latino (of any race)	567	.8	12.3	12.5

**Social Characteristics**

	<b>Adams</b>		<b>IL</b>	<b>U.S.</b>
	<b>Number</b>	<b>Percent</b>		
Population 25 years and over	45,101			
High school graduate or higher	37,756	83.7	81.4	80.4
Bachelor's degree or higher	7,948	17.6	26.1	24.4
Disability status (population 5 years and over)	10,560	17.0	11.0	19.3
Foreign born	554	0.8	17.6	11.1
Male, Now married, except separated (population 15 and over)	15,934	61.8	56.1	56.7
Female, Now married, except separated (population 15 and over)	15,630	54.8	51.3	52.1
Speak language other than English at home (population 5 and over)	1,632	2.5	19.2	17.9

**Economic Characteristics**

	<b>Adams</b>		<b>IL</b>	<b>U.S.</b>
	<b>Number</b>	<b>Percent</b>		
In labor force (population 16 years and over)	35,122	65.8	65.4	63.9
Median household income in 1999 (dollars)	34,784	(X)	46590	41,994
Median family income in 1999 (dollars)	44,133	(X)	55545	50,046
Per capita income in 1999 (dollars)	17,894	(X)	23104	21,587
Families below poverty level	1,347	7.4	7.8	9.2
Individuals below poverty level	6,558	10.0	10.7	12.4
Enrolled in Medicaid (2001)	10894	16.1	12.6	na
Under 21	5947	35.0 <sup>1</sup>	27.9 <sup>1</sup>	na
No health insurance (2003)	6177	12.2	15.2	na
Employed but no health insurance (% of total uninsured)	3830	62.0	64.4	na
Under age 18 no health insurance (% of total population <18)	1143	7.1	9.8	na

Source: US Census; IPLAN data system; Small Area Health Insurance Estimates  
1: Author's calculation using population under 18 as denominator

