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MAPPing Healthcare of the Physically Disabled in Rockbridge County, VA

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A Community Based Research Project

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Introduction:

MAPP Assessment of Health:

The following study was completed in conjunction with the Rockbridge Area Free Clinic's assessment of the access to and quality of health care for the disadvantaged residents of Rockbridge County, Virginia. The study was completed under the guidelines of MAPP – Mobilization for Action through Planning and Partnership. This portion of the assessment focused on a specific group - persons with physically disabilities.

Despite the severity of their conditions, the needs of the disabled populations are not distinct from the general community. The findings and recommendations generated by this study have beneficial implications for the broader community – specifically the growing elderly population, the underinsured, and those for whom poverty hinders mobility. For instance, many of the issues identified, such as insufficient dental care and transportation, plague the disadvantaged community as a whole. Focusing on the disabled provides not only a distinct high-needs population, but one whose defining characterization links human capabilities with medical conditions and for whom society has accepted the responsibility to eliminate barriers and provide healthcare. Furthermore, under the Patient Protection and Affordable Care Act there is likely to be a significant increase in the number enrolled in Medicare. Thus the data gathered in this study of adults with physical disabilities, the majority of whom have Medicare and/or Medicaid, can provide valuable indications as to how the local healthcare system will respond to such an increase.

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Disability - Definition and Scope:

The World Health Organization (WHO) and International Classification of Function, Disability and Health (ICF) define *disability* as "an umbrella term, covering impairments, activity limitations, and participation restrictions."[1] These components reflect both the medical and social implications of the condition. *Impairments* are maladies "in body function or structure" and are classified as physical, sensory, cognitive and/or developmental. *Activity limitations* are the difficulties experienced by the "individual in executing a task or action," while *participation restrictions* impede "involvement in life situations,"[2] Disabilities are relative to the individual's society or environment, and therefore not solely a medical phenomenon. Thus a study focused on disabilities welcomes not only an analysis of health and non-health sector factors in treating patients' medical condition, but discussion of these factors effectiveness in offering that individual a maximum range of functions or capabilities in life.

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Disabilities vary in magnitude or severity and the underlying causes are extremely diverse. WHO estimates that over a billion people and about 15% of the world's population lives with some form of disability, while 110 to 190 million (2.2 to 3.8%) persons 15 years and older experience "significant difficulty functioning."[3] These numbers are increasing due to population aging and growing incidence of chronic disease – global trends which are visible

[1] "Disabilities", World Health Organization 2012, accessed April 7, 2012, http://www.who.int/topics/disabilities/en/
[2] ibid
[3] "Disability and Health Fact Sheet", WHO 2012, accessed April 7, 2012, http://www.who.int/mediacentre/factsheets/fs352/en/index.html

within Rockbridge County, VA.

This study focuses on disabilities resulting from physical impairments which produce significantly activity limitations. This focus is similar to the federal disability definition of *orthopedic impairment*: "a severe orthopedic impairment that adversely affects performance. The term includes impairments caused by a congenital anomaly, disease (e.g., poliomyelitis, bone tuberculosis), and …from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contractures)."[4] The decision to narrow the study's focus was motivated in part by the disabled persons' ability to consent and participate in the study's proceedings. Congruently, the following results primarily represent physically disabled adults as all study participants were persons 18 years of older. However due to concomitant impairments or *multiple disabilities* and the similarity of healthcare needs and barriers experienced by all of the community's disabled, much of the following discussion has a broader applicability than solely that of the immediate population studied.

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Disability – Health needs, risks and barriers:

Especially in the instance of severe disability, there is a risk of fixating upon the condition primarily responsible for the disability when determining the person's needs or assessing healthcare delivery. In addition to the needs generated by the primary condition, the disabled population shares the same general health needs as the overall population. Unfortunately these needs are often overlooked as preventative care measures, such as "health promotion and

[4] "Federal Disability Definitions" accessed April 8, 2012 http://www.ctc.ca.gov/credentials/CREDS/federal-disability-definitions.pdf

prevention activates seldom target people with disabilities."[5] Even in developed countries, disabled adolescences are infrequently targeted by health education campaign and, as adults, are less likely to have their weight checked. Similarly, disabled women receive fewer breasts and cervical cancer screenings. This group also experiences increased vulnerability to preventable and predictable secondary conditions (e.g. pressure ulcers, urinary tract infections, osteoporosis), age-related conditions due to premature aging, co-morbid conditions, health risk behaviors (e.g. poor diet, physical inactivity) and lower life expectancy.[6]

Disability introduces a range of barriers to accessing existing health care facilities. Unique equipment, specialized facilities and transportation to the facility pose physical barriers, in addition to scarcity of resources, limited availability of services and inadequate skills or knowledge of health professions. In fact, "people with disabilities were more than twice as likely to report finding health care provider skills inadequate to meet their needs, four times more likely to report being treated badly and nearly three times more likely to report being denied care."[7] Among other goals, this study will attempt to determine to what extent, if at all, such trends are present in Rockbridge Co.

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[5] "Disability and Health Fact Sheet", WHO 2012, accessed April 7, 2012, http://www.who.int/mediacentre/factsheets/fs352/en/index.html
[6] ibid
[7] ibiid

Rockbridge County, Virginia:

Demographic of Disabled Population:

According the US Census Bureau's "2008-2010 American Community Survey 3-year Estimate" in Rockbridge County, Virginia, 16.3% of the non-institutionalized population 5 years of age or older or approximately 3,431 persons have disabilities (Table 1).[8] Persons with physical disabilities represent a substantial subset of these estimates. The categories of ambulatory difficulty, self-care difficulty and independent living difficulty[9] encompass the focus or target population of this study, the physically disabled. It should be noted than an individual with multiple disabilities can be counted in multiple categories. Thus the number of physically disabled can only be approximated given these figures. However, even without a fully comprehensive measure, the number of physically disabled person residing in Rockbridge County is not insignificant, especially when differentiated by age group, as presented in Figure 1. The red box in Figure 1 highlights groups containing the physically disabled. Of the Rockbridge Co. residents 18 to 64 years of age, 7.1% have ambulatory difficulties. Given the number margin of error the actual value be

Table 1: Data from US Census Bureau, 2008-2010 American Community Survey 3-year Estimate	Rockbridge County	
	With a disability	
	Estimate	Margin of Error
Population 5 to 17 years	**151**	**+/-131**
With a hearing difficulty	29	+/-48
With a vision difficulty	0	+/-165
With a cognitive difficulty	151	+/-131
With an ambulatory difficulty	0	+/-165
With a self-care difficulty	0	+/-165
Population 18 to 64 years	**1,822**	**+/-403**
With a hearing difficulty	399	+/-195
With a vision difficulty	306	+/-163
With a cognitive difficulty	1,068	+/-332
With an ambulatory difficulty	957	+/-302
With a self-care difficulty	295	+/-186
With independent living difficulty	820	+/-310
Population 65 years and over	**1,458**	**+/-281**
With a hearing difficulty	784	+/-193
With a vision difficulty	177	+/-91
With a cognitive difficulty	360	+/-157
With an ambulatory difficulty	897	+/-195
With a self-care difficulty	387	+/-209
With independent living difficulty	609	+/-203

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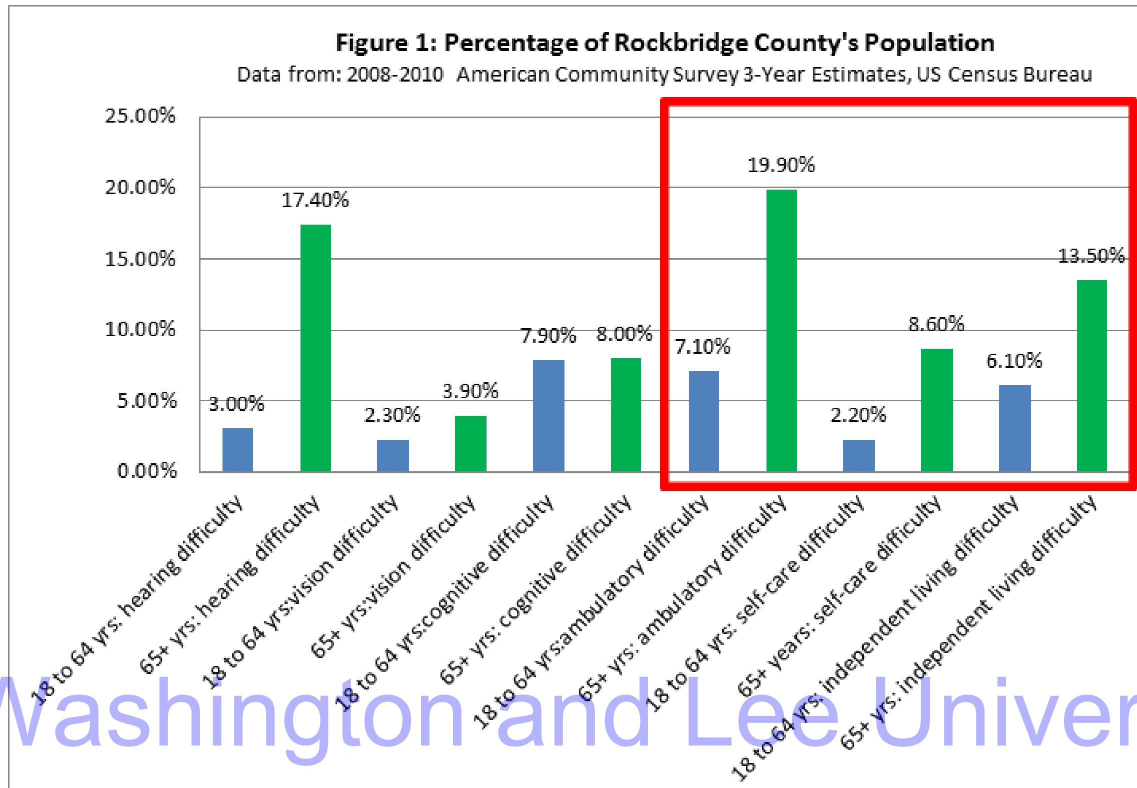
[8] American FactFinder. 2012. US Census Bureau. accessed April 2, 2012 http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?ref=geo&refresh=t#none

[9] It is interesting to note that the question used to access independent living disability directly references the concept of access to medical care: "Because of a physical, mental, or emotional condition, does this person have difficulty doing errands alone such as *visiting a doctor's office* or shopping?"

as high as 9.3% of the county's total population.[10] As could be expected given the onset of



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disability due to aging or age-associated diseases, all three measures indicating physical disability were highest among the population 65 years or older. In fact, 19.9% of the county residents older than 65 years of age have ambulatory difficulties. Again, given the margin of error, this number may be as high as 24.4%.[11] In all instances the percentages for Rockbridge County exceed or were not significantly different from the national average. Nationally 6.9 % of the adult population has ambulatory difficulties, 2.6% has self-care difficulties, and 5.5% report independent living difficulties. These numbers indicate the

[10] American FactFinder. 2012. US Census Bureau. accessed April 2, 2012 http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?ref=geo&refresh=t#none
[11] ibid

need and relevance of the studying access to care and quality of care experienced by the physically disabled residents of Rockbridge County.

Table 2	Rockbridge County			
Data from US Census Bureau, 2008-2010 American Community Survey 3-year Estimate	With a disability		Percent with a disability	
	Estimate	Margin of Error	Estimate	Margin of Error
SEX				
Male	1,689	+/-316	15.6%	+/-2.9
Female	1,768	+/-386	15.4%	+/-3.5
RACE AND HISPANIC OR LATINO ORIGIN				
White alone	3,197	+/-502	15.2%	+/-2.4
Black or African American alone	247	+/-118	34.1%	+/-16.2
Hispanic or Latino (of any race)	N	N	N	N
American Indian, Alaska Native alone	N	N	N	N
Asian alone	N	N	N	N
Native Hawaiian, Pacific Islander	N	N	N	N

In continuing the overview of population data, the number of persons in Rockbridge County within the broad category of disability was examined by gender and race (Table 2). Disabilities were equally distributed between males and females in both the number and percentage of the population. Although a far greater number of white residents (≈3,197 persons) had disabilities when compared to African Americans (≈247persons), African Americans bear a disproportionate share of disabilities (34.1%) compared to their white counterparts (15.2%). The intersectionality of disability and race is important to note given the potential for race-related vulnerability often observed in studies of access to and quality of health services and especially prevalent among the lower socioeconomic brackets.

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Community Health Survey – Current Usage:

In accordance with the MAPP guidelines for assessing community health, a survey regarding current and predicted-future utilization of healthcare services was administered throughout Rockbridge County (Appendix). At the time of writing this report, the survey was ongoing. The results discussed in this paper were those gathered between February and April 6, 2012 (n=157). Responses given by physically disable persons, all of whom are at least partially reliant on wheelchairs, (n=16) were recorded in two data sets, one containing only responses from physically disabled persons (labeled in the following as "disabled" for brevities sake) , and second within the total community response. The data labeled as "total" or the "general community," includes data from disabled participants. Therefore, the difference between the disabled and total responses is stronger than presented in the following statistics. It is also important to reiterate that all participants were adults. One of the surveys included among the physically disabled was provided by a parent of a physically disabled child and so reflects the needs of all members of the family. Survey participants reflected the diversity of localities within Rockbridge County. Figure 2 displays the array of residences for the physically disabled participants.

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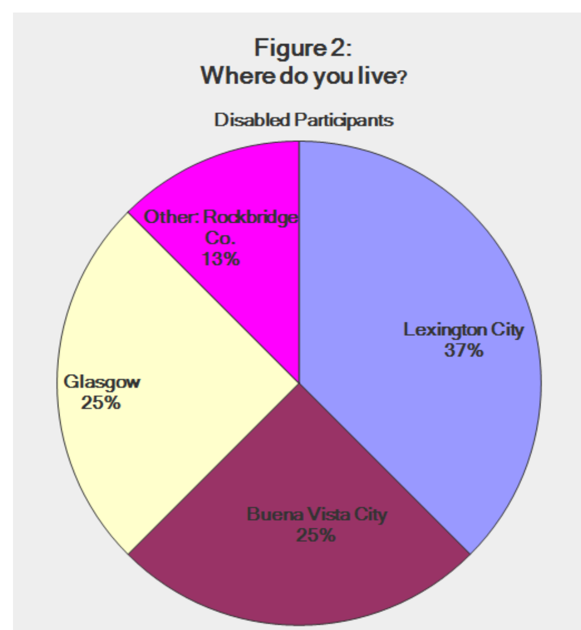
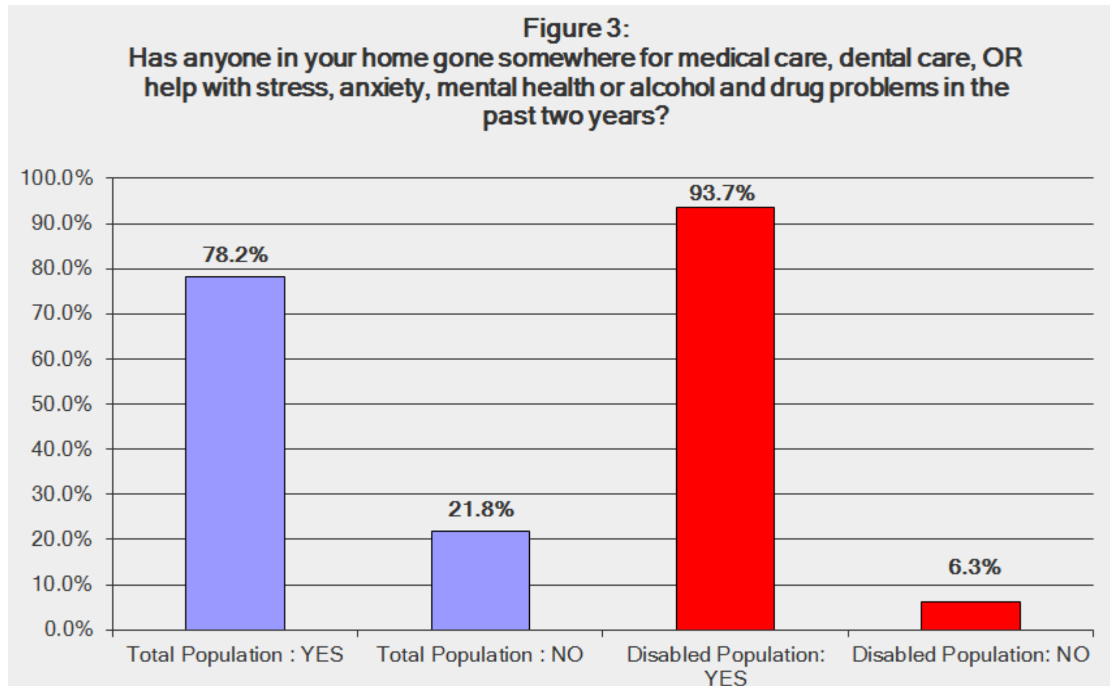
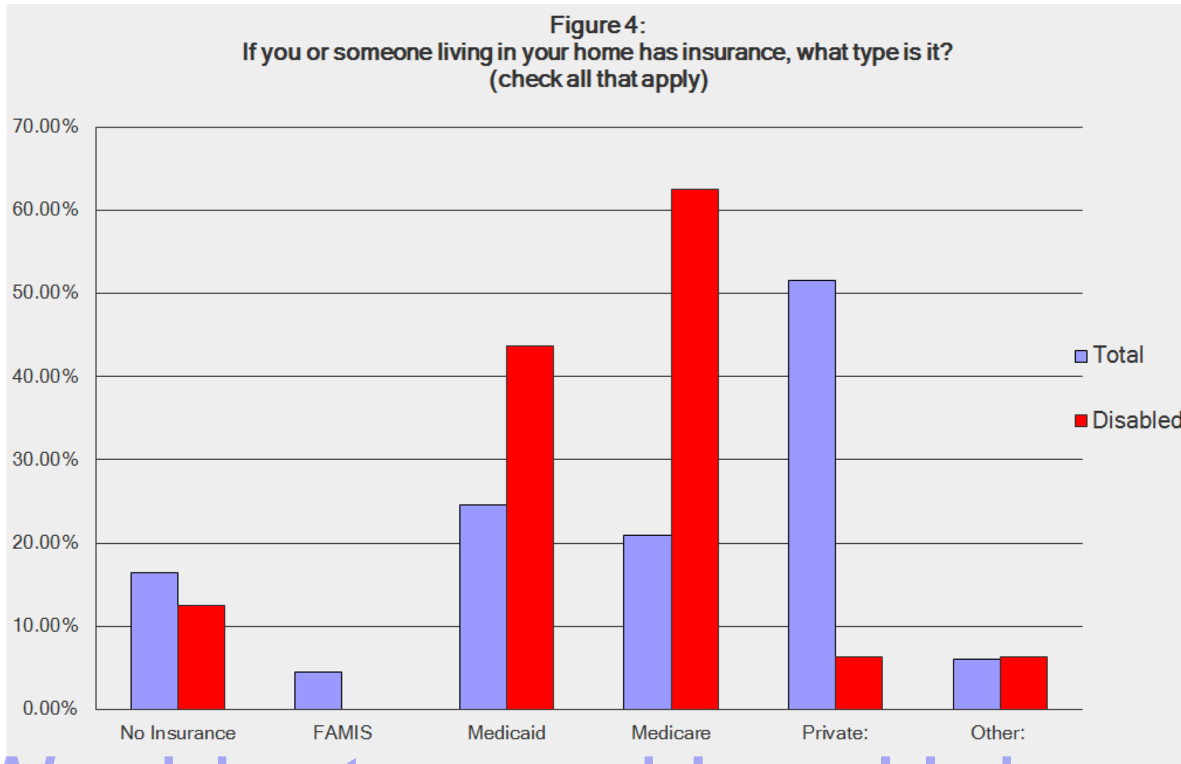




The survey's first question ascertained if the participant or member of the participant's household had utilized any component(s) of healthcare within Washington and Lee University the last two years (Figure 3). The percentage of persons who received medical care, dental care or help with stress anxiety, mental health, or alcohol and drugs was higher for physically disabled persons (93.7%) than the total surveyed population (78.2%). This is congruent with the idea that disabled persons have higher health needs. Additionally, this may also reflect that health insurance increases the likelihood of seeking care, as most disabled persons are eligible for Medicare and/or Medicaid. Only 12.5% of physically disabled persons surveyed reported lacking insurance, and this percentage may in fact be closer to 6.26% focus group commentary revealed the uninsured person to be the parent of a disabled child who was insured (Figure 4). In either case, the number of uninsured persons is lower than the 16.4% observed for

the total population surveyed.



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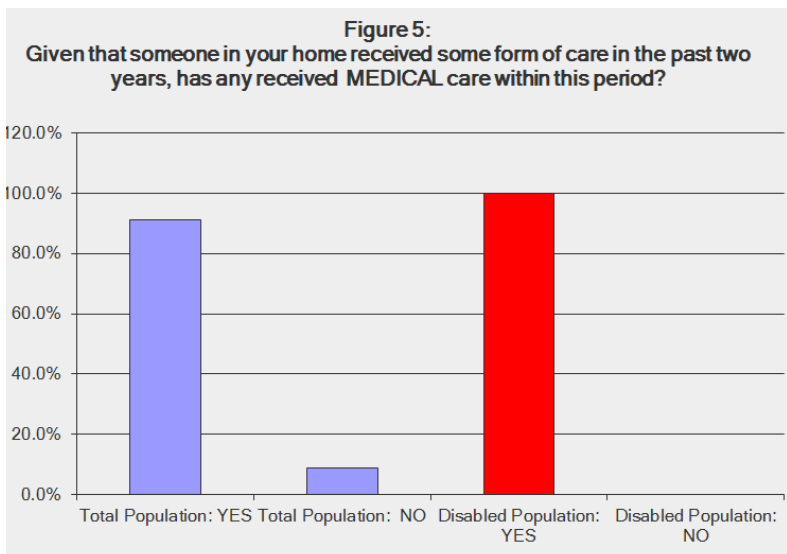
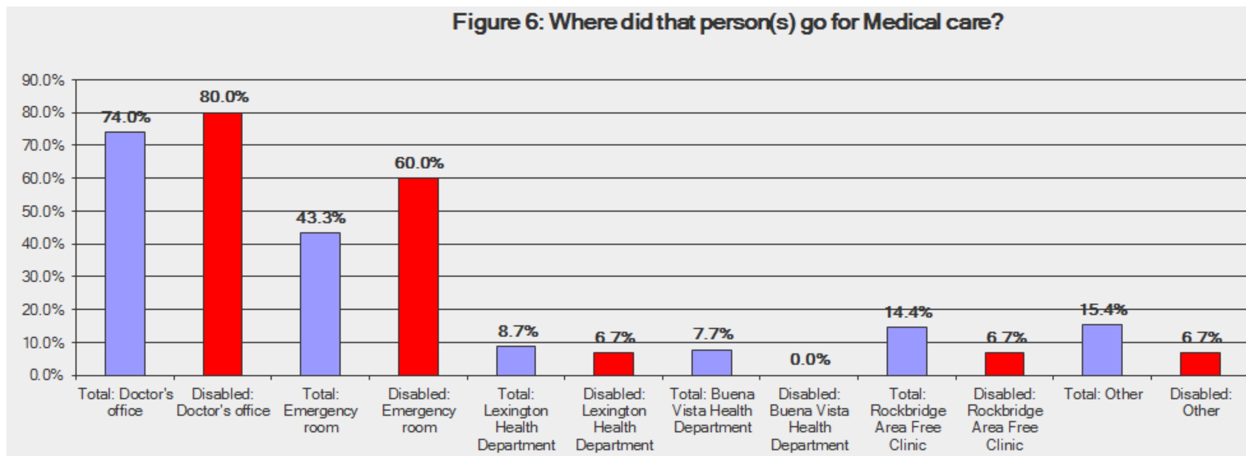
As displayed in Figure 4, public health insurance, Medicare and Medicaid, provide for the healthcare of the majority of physically disabled persons surveyed. In fact only one person, whose income was significantly higher, possessed private insurance.



Similarly, of the physically disabled participants who responded "Yes" to receiving some form of care within the last two years (Figure 3) 100% had received **medical care** in the last two years, versus 91.1%

for total participants (Figure 5). Again these findings emphasize the existence of considerable health needs, specifically those of a medical nature, as well as access to existing medical services. Although this deviation between the physically disabled and the total populations was relatively small, there was a pronounced difference in the medical services utilized (Figure 6).



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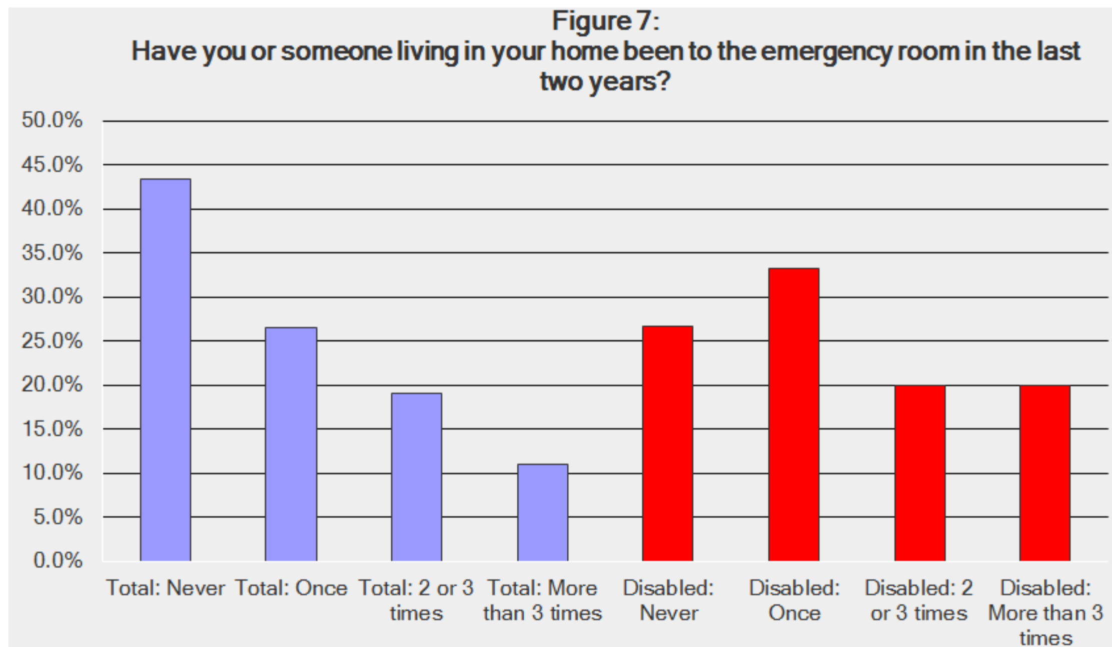
Physically disabled persons were more like to receive medical care at a doctor's office than the total community, and less likely to receive care at a health department or the Rockbridge Area Free Clinic. The statistic reflects the difference of health insurance status discussed above, as well as a possible difference in severity of condition. Furthermore, while less than half (43%) of the total community received care from the Emergency Room at Carilion Stonewall Jackson Hospital,[12] 60% of disabled persons were treated in the ER. Such finds indicate the need to investigate possible overutilization of the ER, which is concerning, costly nationwide trend in healthcare.

Additionally findings supported the possibility of ER overutilization or at

[12] Stonewall Jackson was the only ER explicitly mentioned by survey participants;, however, no all participants provided the location where they received cared.

very least heavy utilization. Not only were the physically disabled more likely to receive medical care in the ER, they received care in the ER more frequently.



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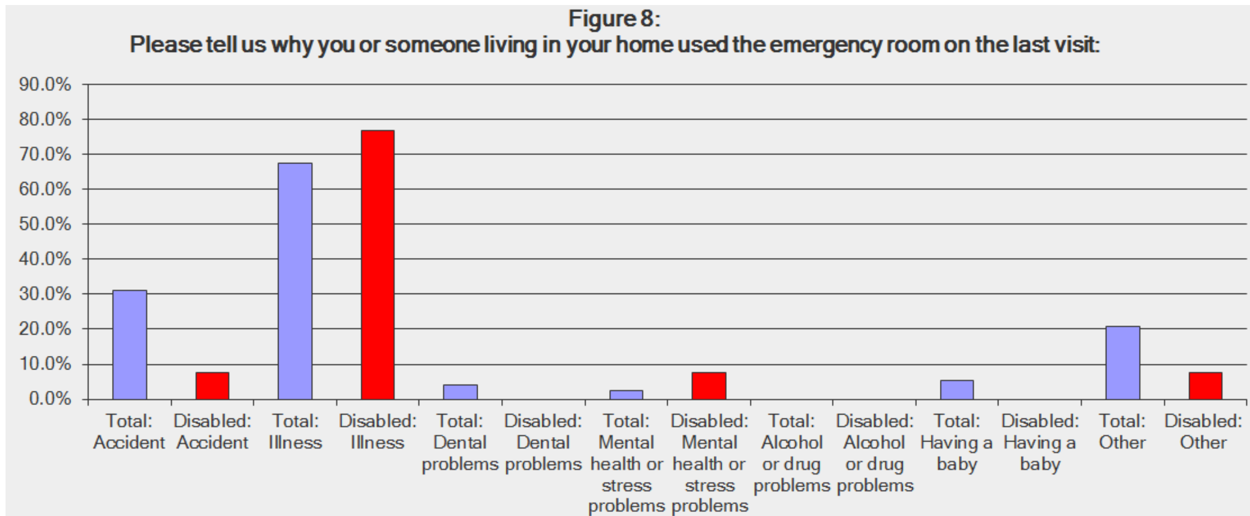
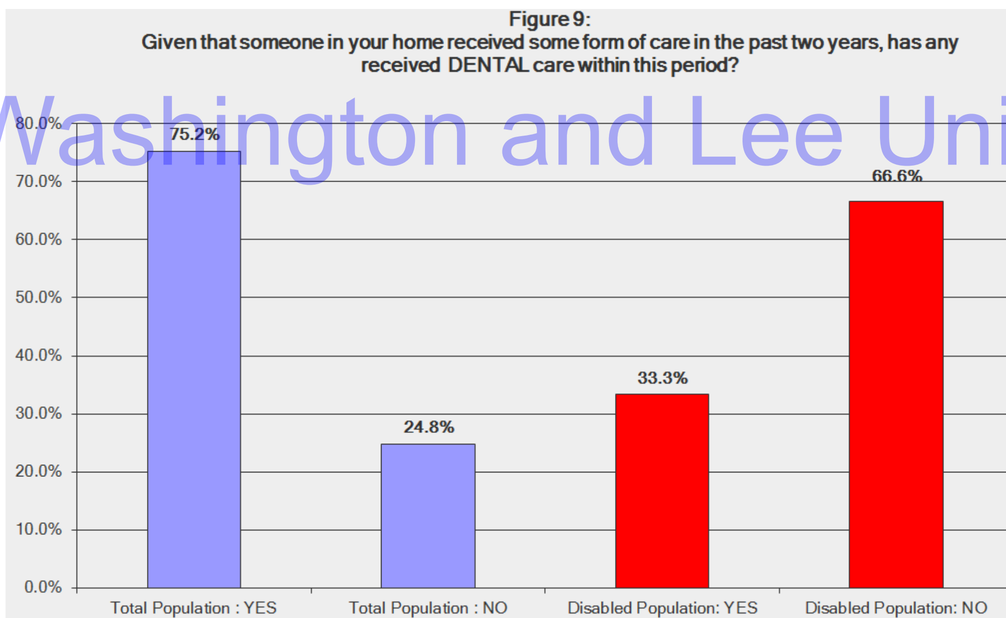
According to the findings presented in Figure 7, this trend was observed over all the visit-frequencies measured. At the strongest point of difference, physically disable persons were twice as likely as the total population to have received medical care in the ER more than 3 times within the past two years. Additionally the reason for using the ER for disabled persons, shown in Figure 8, was almost exclusively (76.9%) "illness." "Breathing problems" represents the "other" 7.7%. These findings raise questions regarding the preventability of these illnesses, whether a primary care physician would have been a more appropriate source of care or if alternative sources of medical care were accessible at that time (due to time of day/week or lack of transportation).[13]

[13] Physician interviews discussed later in the paper provide additional considerations in this matter.



On a positive note, the percentage of accidents was very low (7.7%) of physically disabled participants, indicating both a cautious lifestyle and safe environment.



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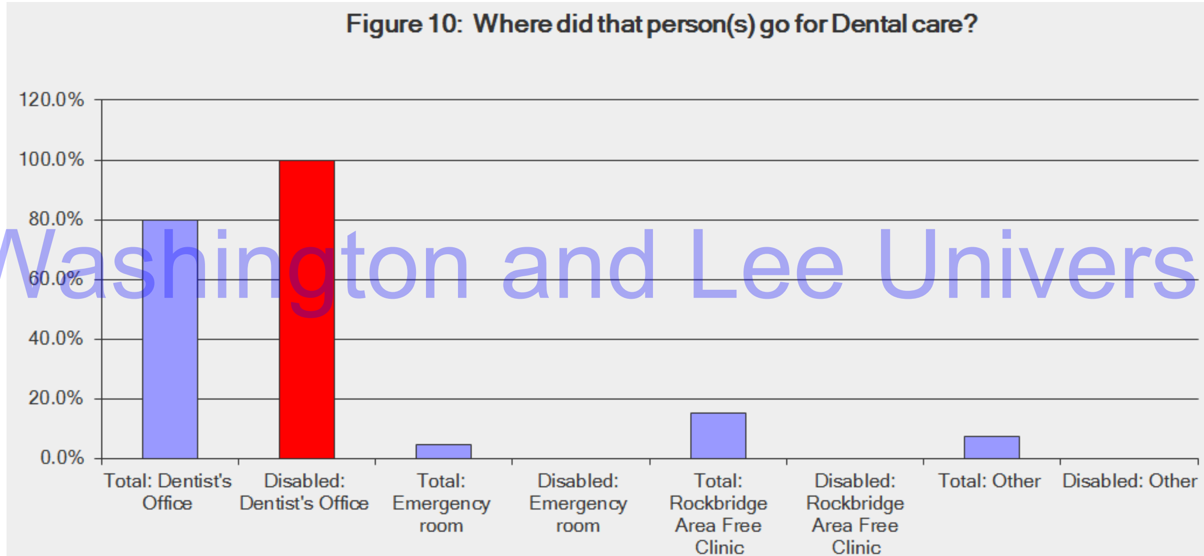
Survey results regarding **dental care** utilization revealed a significantly different trend from that observed with medical care (Figure 9). The local physically disabled population (31.3%) was significantly less likely to receive dental care within the last two years as compared with the general population

(75.2%). Lack on dental insurance or coverage among the disabled populations is likely responsible for this statistic as Medicare[14] and Medicaid[15] for adults (age 21 or older) covers care in a very limited number of circumstances such as medically necessitated oral surgery or extractions. In fact, following transportation, lack of dental coverage was the most frequent response regarding unmet needs written in at the end of the survey. The type of providers from which the physically disabled sought dental care, displayed in Figure 10, further supports this profile.



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[14] "Medicare Dental Care." Centers for Medicare and Medicaid Services. 2012, Accessed April 18, 2012 http://www.cms.hhs.gov/Medicare/Coverage/MedicareDentalCoverage/index.html
"Currently, Medicare will pay for dental services that are an integral part either of a covered procedure (e.g., reconstruction of the jaw following accidental injury), or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Medicare will also make payment for oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances. Such examination would be covered under Part A if performed by a dentist on the hospital's staff or under Part B if performed by a physician."

[15] "Dental Benefits for Medicaid Adults". 2010. Department of Medical Assistance Services, Accessed April 18, 2012 http://www.dmas.virginia.gov/downloads/pdfs/dnt-adlt_bstm.pdf
"Dental treatment for adults is covered under certain circumstances through Virginia's dental program, *Smiles For Children*. Adult dental services are limited to medically necessary oral surgery and associated diagnostic services, such as X-rays and surgical extractions. Preventive, restorative, endodontics, and prosthetic services e.g. cleanings, fillings, root canals and dentures are not covered for adults. Dental conditions that may qualify for reimbursement are ones compromising a patient's general health and such conditions must be documented by the dentist or medical provider. Symptoms would include pain and/or infection."

Of the 31.3% who received dental care, all sought care at a Doctor's office. Although Medicare and Medicaid provide minimal dental coverage, possessing these public health insurance policies disqualifies most disabled persons from receiving care at the Rockbridge Area Free Clinic. This is evidenced in the fact that no disabled persons utilized the local free clinic. Additionally the observation that none of the physically disabled persons used the ER for dental care could reflect that emergency dental procedures are more likely to be covered by Medicare or Medicaid.

Given the lack of coverage for routine dental care and that only one of the physically disabled persons surveyed had private insurance, it is likely that many of the visits to a dentist's office in Figure 10 were funded out of pocket.

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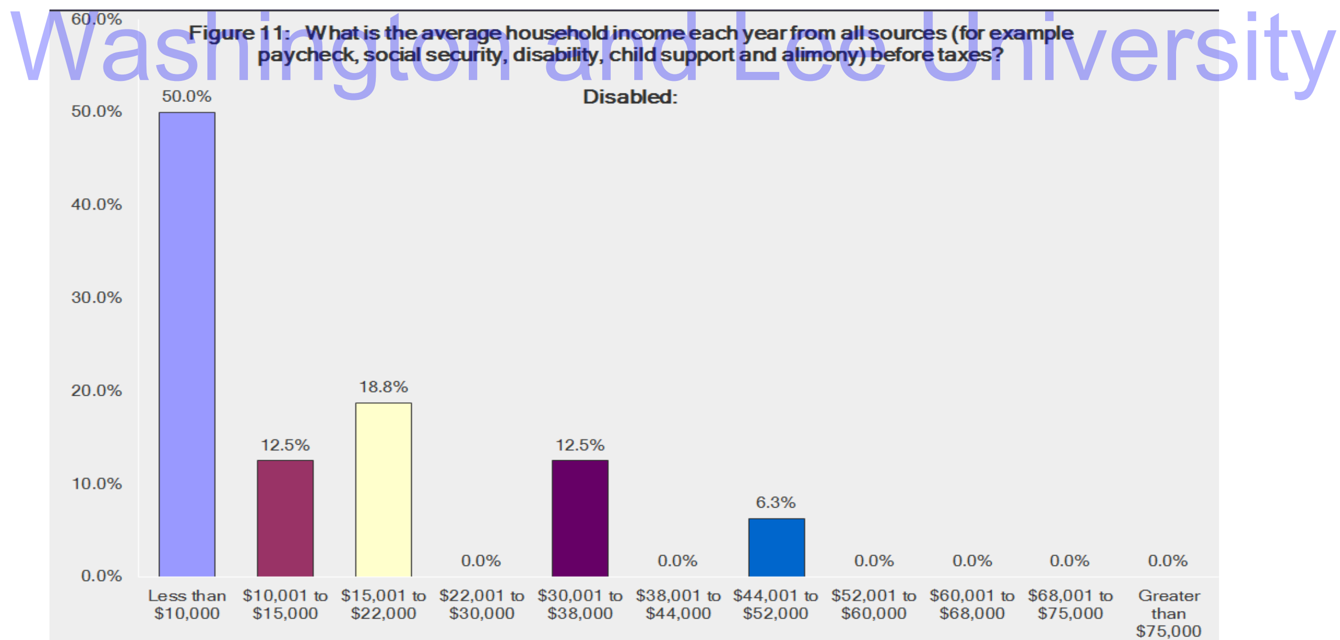
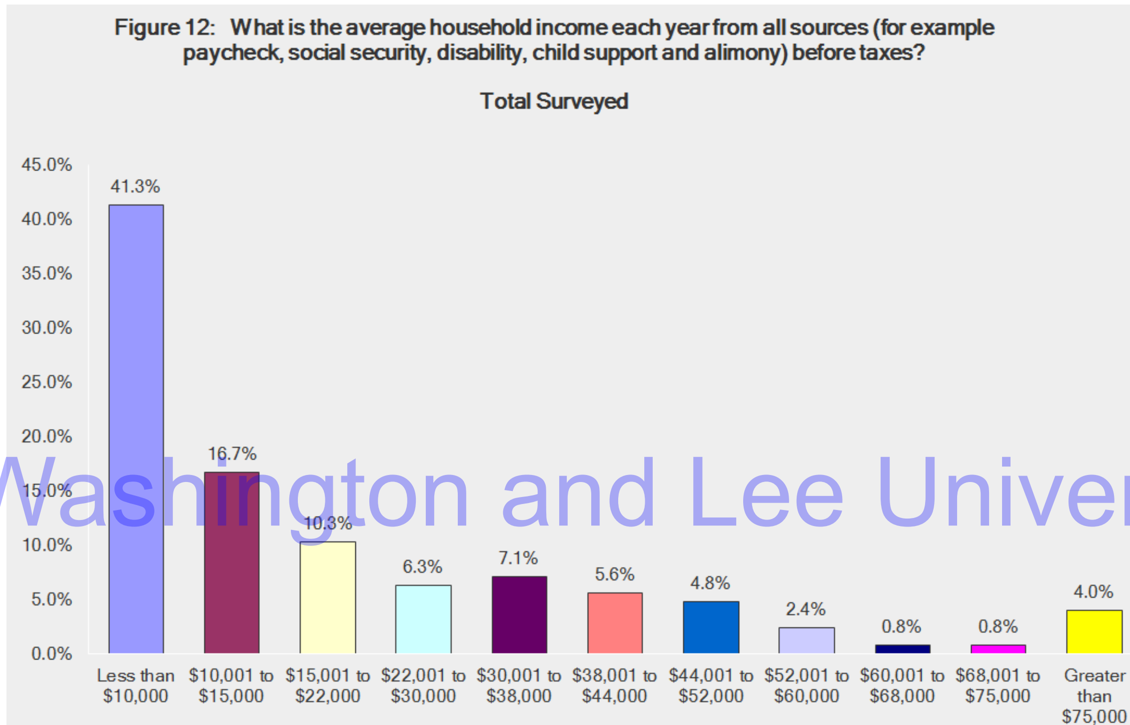


Therefore, it is important to note the extremely low income level of the physically disabled survey participants (Figure 11). Of those with a physical disability, 50% have an income of less $10,000 per year. The maximum annual

income recorded for a physically disabled participant was of $44,001 to $52,000; this participant was also the sole participant who had private insurance. Although the income distribution for the total population survey also fell heavily within the lowest levels, the distribution was spread more over a higher range of income levels as displayed in Figure 12.



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Such findings reflect the profile of the Rockbridge County workforce estimated in by the US Census Bureau's 2008-2010 American Community Survey (Table 3) in which disabled persons represent greater portions of the unemployed labor force and non-labor force as compared to Rockbridge residents who do not have a disability. All persons encompassed under the Census Bureau's measure of disability compose 7.14% of Rockbridge County's employed work

force and 8.79% of unemployed persons in the labor force.[16] However disabled persons represent 36.6% of the unemployed work force. Therefore the disabled in general constitute a disproportionately large number of persons in the labor force, as the disabled compose only 16.3% of the population (Table 1). While these findings are not unexpected given the definition of disability as a medical impairment which limits activities and participation, they provide evidence that the survey population appropriately represents this population within the county at large. Additionally these findings emphasize the disabled status as disadvantaged.

Table 3: Data from US Census Bureau, 2008-2010 American Community Survey 3-year Estimate	Rockbridge County	
	Estimate	Margin of Error
Total:	13,509	+/-153
In the labor force:	10,638	+/-541
Unemployed:	591	+/-272
With a disability:	52	+/-59
With a hearing difficulty	0	+/-165
With a vision difficulty	22	+/-35
With a cognitive difficulty	30	+/-49
With an ambulatory difficulty	22	+/-35
With a self-care difficulty	0	+/-165
With an independent living difficulty	0	+/-165
No disability	539	+/-272
Employed:	10,047	+/-591
With a disability:	718	+/-219
With a hearing difficulty	204	+/-115
With a vision difficulty	179	+/-103
With a cognitive difficulty	312	+/-135
With an ambulatory difficulty	247	+/-124
With a self-care difficulty	47	+/-44
With an independent living difficulty	149	+/-98
No disability	9,329	+/-574
Not in labor force:	2,871	+/-550
With a disability:	1,052	+/-325
With a hearing difficulty	195	+/-153
With a vision difficulty	105	+/-127
With a cognitive difficulty	726	+/-284
With an ambulatory difficulty	688	+/-280
With a self-care difficulty	248	+/-180
With an independent living difficulty	671	+/-290
No disability	1,819	+/-499

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The same trend was observed in the census data was used to estimate the composition of the Rockbridge County labor force for the physically

[16] American FactFinder. 2012. US Census Bureau. accessed April 2, 2012 http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?ref=geo&refresh=t#none

disabled.[17] Physical disabled persons compose about 2.45% of employed person in the labor force and a larger 3.72% of unemployed persons in the labor force. Should a physical disabled person be capable of participating in the work force, their chance of finding employment is lower than their non-disabled counterparts. Finally, in Rockbridge County, persons with physical disabilities compose 23.9% of the persons not in the labor force.[18] Again the number of physically disabled persons unemployed or not in the labor force indicates a disproportionately large number of physical disabled persons when compared against the 7.10% of the overall population 18-64 years of age and 19.9% of 65 years and older. As discussed for the broad category of disability, the census data provides an explanation for the extremely low income distribution observed for disabled persons (Figure 11).

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An additional consideration in the income level or financial profile of survey participants is household structure (Figure 13). Physically disabled persons' households contained substantially fewer members, as all age group as contained less than 1 average person. The majority of households did not contain children. Living alone lowers the resources available to physically disabled individuals as co-habiting family members can act as caregivers and

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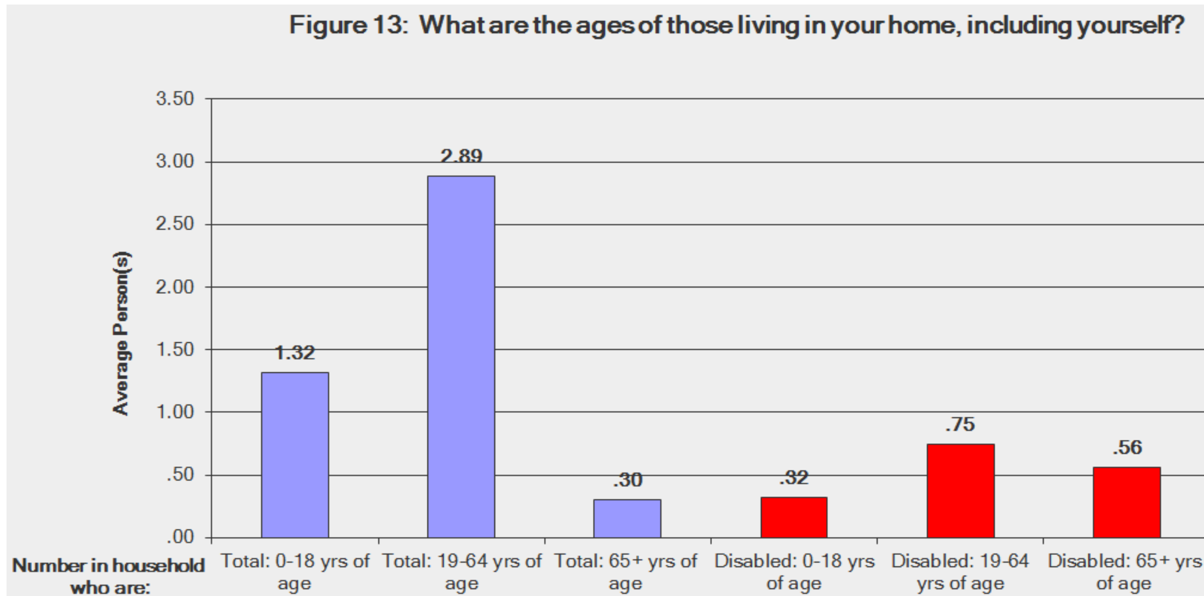
[17] As mentioned previously, an individual can be counted multiple times, or for each difficulty listed. Therefore the percentages for the physically disabled were estimated using the highest scoring category composed to the physically disabled (ambulatory, safe-care and independent living difficulties). See Table 3 for numbers used in the calculation.

[18] "How the Government Measures Unemployment." 2009 US Department of Labor. Accessed April 19, 2012, http://www.bls.gov/cps/cps_htgm.htm#nilf
"Labor force measures are based on the civilian non-institutional population 16 years old and over. Excluded are persons under 16 years of age, all persons confined to institutions such as nursing homes and prisons, and persons on active duty in the Armed Forces. The remainder—those who have no job and are not looking for one—are counted as "not in the labor force." Many who are not in the labor force are going to school or are retired."

provide transportation. Therefore household composition builds upon the financially vulnerable established in survey results an



d census data.

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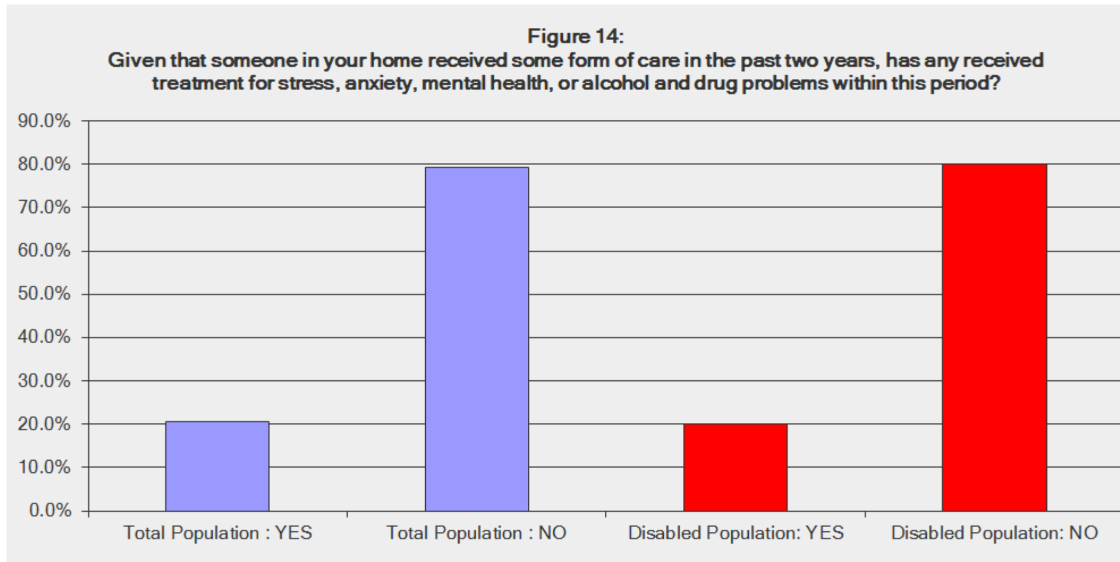
In returning to the discussion of health services utilized, the results of **mental health care**, such as treatment for stress, anxiety, mental health or alcohol and drug problems are displayed in Figure 14. Overall, the utilization of mental healthcare services was low for both the physically disabled population (20.0%) and the total community (20.7%).



However difference in the source of mental health care was observed between the physically disabled and the total population (Figure 15), as 50% of the physically disabled sought care at Rockbridge Area Community Services Board and 25% received care at the ER. Again the majority of disabled participants had Medicare and/or Medicaid and therefore do not qualify for mental health services provided by the Rockbridge Area Free Clinic.

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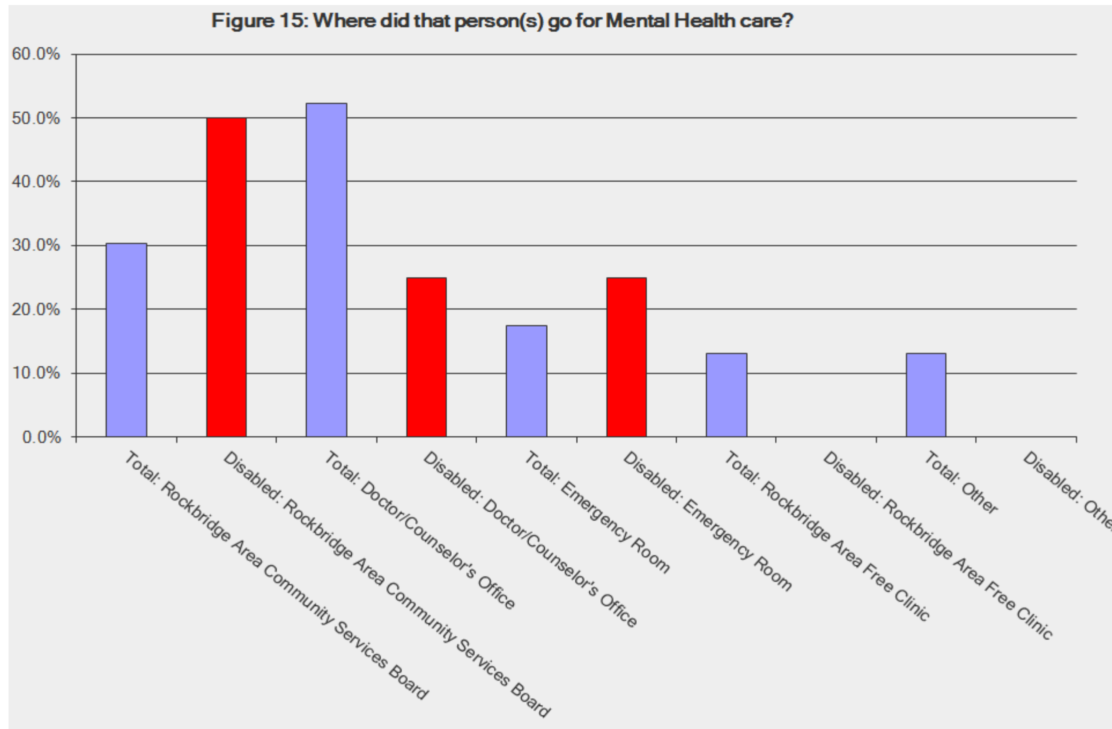

The explanations for the difference in type of provider used likely stems from the same sources discussed in regard to the trends in dental care - lack of insurance coverage and the strain of out-of-pocket costs on limited financial resources. Additionally these findings reemphasize the possibility of ER overutilization. The local ER care is not the most effective method of treating mental health disorders and does not provide a sustainable model for treating ongoing mental illness or stress related disorders.

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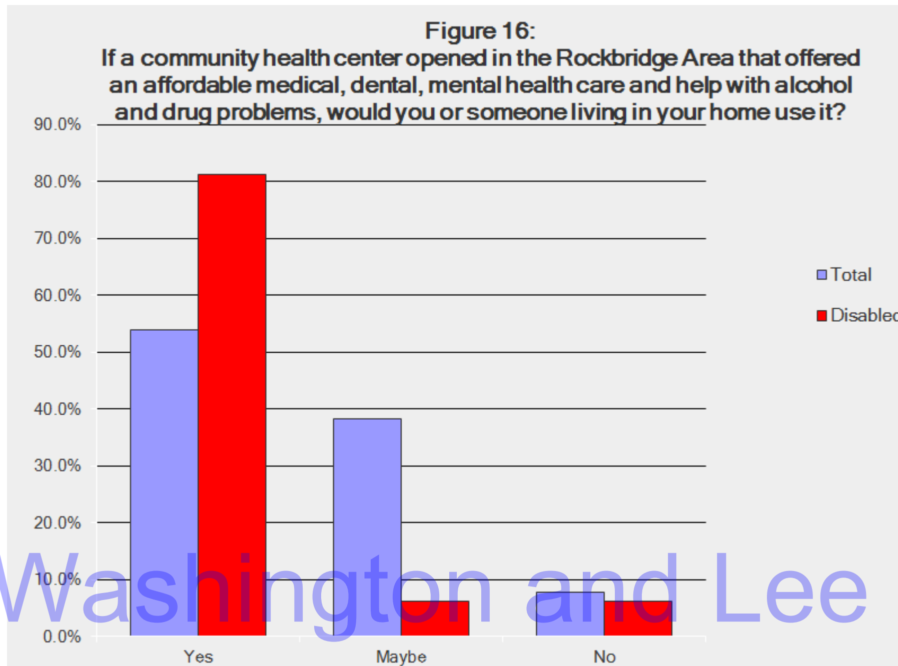
Community Health Survey – Predicted Usage:

In addition to the goal of assessing the healthcare services available to disadvantaged Rockbridge County residents, the MAPP assessment sought to gage interest in the potential development of a Federally Qualified Community Health Center (FQHC) founded upon the current resources of the Rockbridge Area Free Clinic. As an FQHC the facility would be able to offer services to those with Medicare and/or Medicaid and the underinsured, in addition to the uninsured area residents. As presented in Figure 16, the physically disabled population expressed a substantially higher level of interest (81.3%) than the total surveyed population (53.9%). One of the participants, who responded "maybe," stated her interest was contingent on not being mistreated; she had sighted mistreatment by the local ER as a primary source of concern elsewhere in the survey. The participant who responded "no" was also the participant with private insurance who stated that he/she preferred to stay with current doctors with whose treatment he/she was very satisfied.



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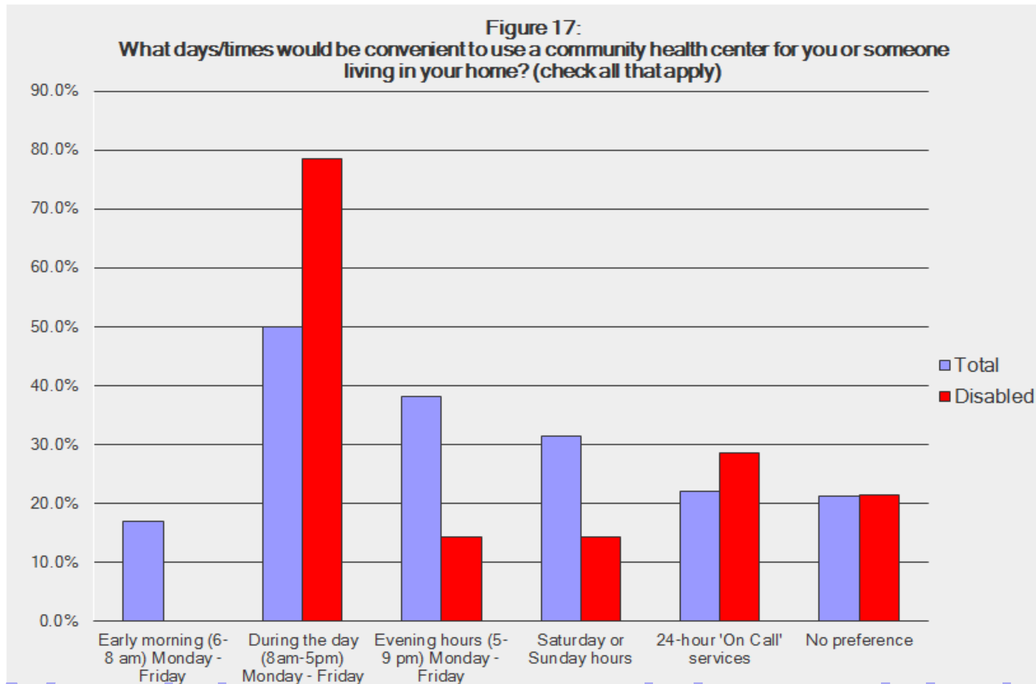
Additional questions were asked to determine the potential role of the

community health center. Figure 17 presents the days and times which survey participants listed as being convenient



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preferences of the physically disabled participants differed from those of the total participants. Those with disabilities displayed the highest interest for daytime week day hours. This likely reflects the physically disabled's dependent on transportation services which run Monday through Friday between 8 am-6pm (Maury River Express/ RADAR) or 8am-5pm (RATS). Furthermore as the majority of physically disabled persons surveyed were the sole members of their household (Figure 13), they are less likely to prefer the times outside traditional weekday business hours when family members could assist in their transportation. This suggests the possibility that responses would have differed if the question would have implied that transportation services would also be made available at any time. Finally the response with

the second highest preference was the 24 “On Call” services, which if introduced have the possibility to addressing concerns raised earlier in the study regarding ER overutilization.

The survey also asked which of the potential services that could be offered by the community health center appealed to the participants. Not surprisingly interest in dental care ranked the highest (85.7%) and greater among the physically disabled participants (total interest equaled 73.70%).

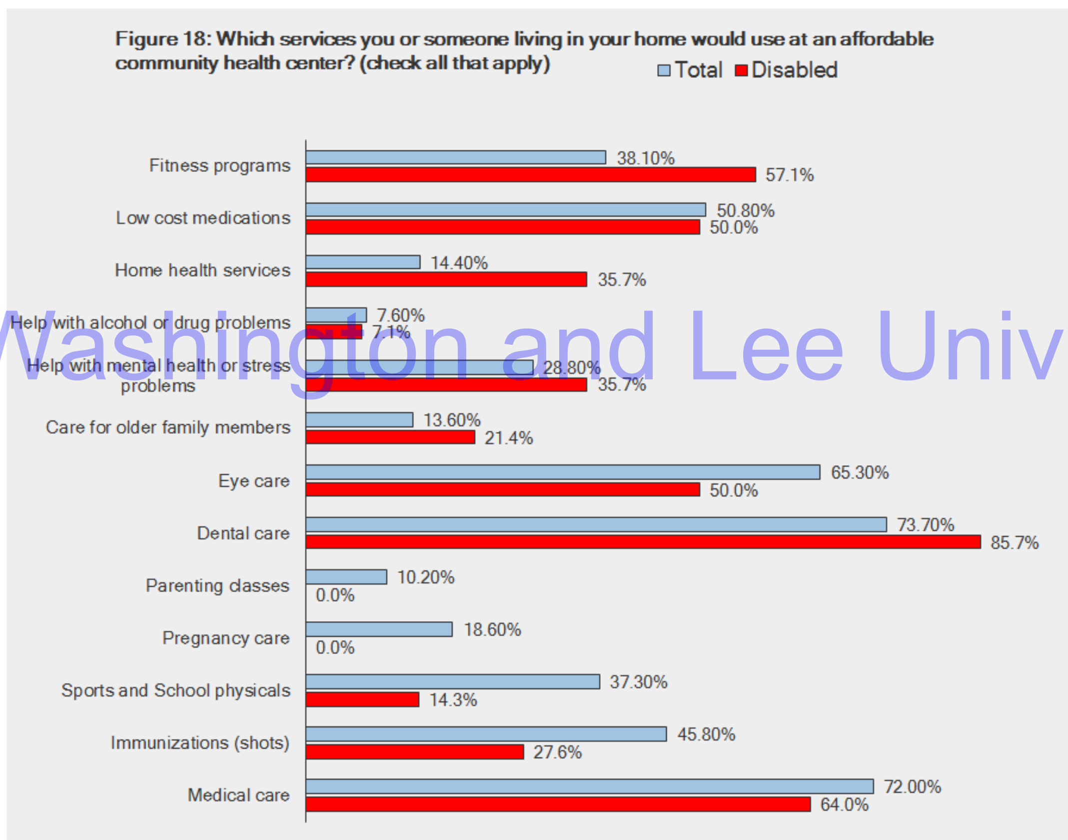

Figure 18: Which services you or someone living in your home would use at an affordable community health center? (check all that apply)

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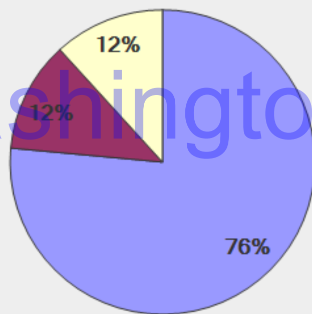
Physically disabled persons also expressed a strong interest in medical care (64.0%). This percentage was lower than the general population (72.0%) which correlates with the previous discussion that the physically disabled persons had higher utilization of medical services within the past two years. High levels of interest

were also expressed of fitness programs (57.1%), low cost medication (50.0%) and eye care (50.0%). The physically disabled participants expressed a far greater interest (35.7%) than the total pool surveyed (14.4%) for home health services. The household structure discussed earlier was also reflected in the substantially lower interest in parenting class (0%) and pregnancy care (0%) compared with the total population's responses of 10.2% and 18.6% respectively.

When considering the services which interested the physically disabled participants it is interesting to note a question asked earlier in the survey: "Does your insurance provide for the majority of your household's health needs? Yes? No? Does not apply?" (Appendix: Community Heath Survey). Although 76% responded "Yes," 44% responded to the following "If 'NO' what things do you or others in your home have trouble paying for? Medications? Tests? Co pays? Other (please list)?" The results of this question are provided in Figure 20. The discussion of a similar question during one of the Focus Groups sparked a debate between the participants which indicated that the responses discussed above reflects the patients' mindsets rather than "incorrect" completion of the surveys. Many interpreted this question as asking 'is your health insurance *the means* by which your household meets its health care needs?' to which the most probable

Figure 19: Does your insurance provide for the majority of your household's health care needs?



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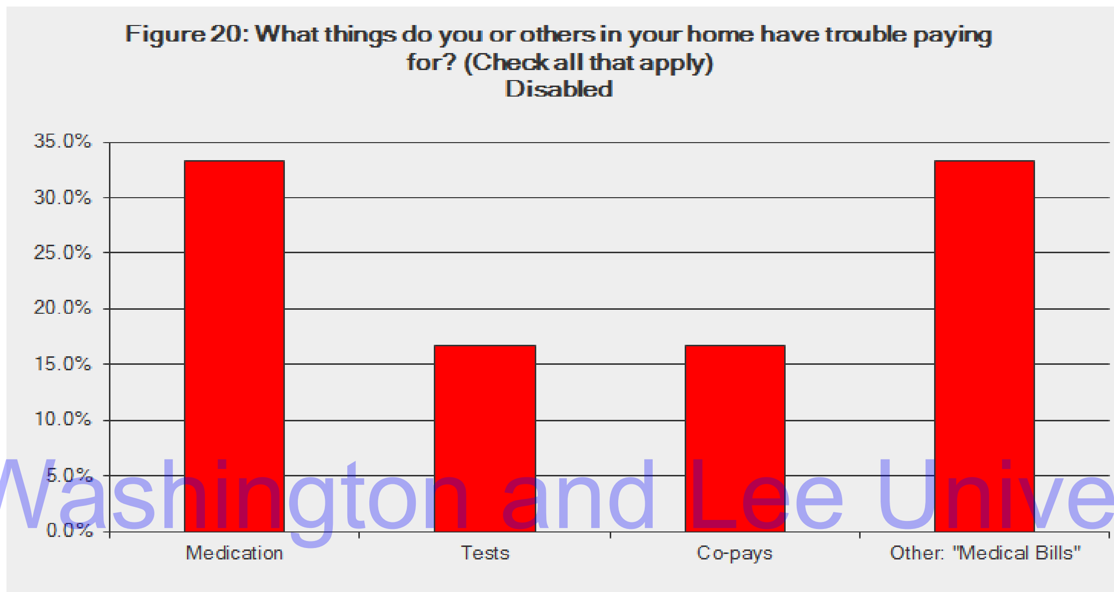
answer is "yes." While others interpreted the question as "do the services covered by your health insurance *adequately meet* your households existing health needs?' In filling out the "if NO…" portion of the question, the participants were responding to the latter interpretation, even if their answer to the first part was completed using the former conceptualization of the question.



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Furthermore the final question of the survey asked "Is there anything else we should know about your (or someone living in your home) health care needs in the Rockbridge area?" and provided the participants with the ability to write in additional comments. The responses reflected the need for more extensive, affordable transportation, dental care, and assistance paying for medical services (Appendix). These comments on the needs described in Figure 20 and the measure of interests in services potentially offered by a community health center are detailed in Figure 18.

Focus Groups- Patient and Provider Perspective:

A second component of the MAPP health assessment of Rockbridge County consisted of Focus Group interviews with target populations. Provider interviews were also performed as a corollary. While both patient focus groups and provider interviews had significant overlap with the results of the Community Health Survey discussed above, there was a divide between the patient and provider perspectives. While the focus groups of physically disabled persons tended to err on the side of dissatisfaction with health services (especially the local hospital), the providers were more optimistic and laudatory towards the existing health services within the county.

The most extreme commentary from the patients stated "Stonewall Jackson only knows how to put on band-aids" or related an instance when a hospital doctor allegedly told a patient "You ain't got nothing." However there were also positive reports of applauding their primary care physicians opening a meeting with the phrase "What can I do for you today?" Among the physically disabled patients there appears to be some misgivings about the local hospital's ability to treat physical disabled persons. This sentiment is apparent in the following account: "We had emergencies, but we had to drive her to Roanoke. Because this hospital over here cannot see her, they don't know how to handle a child on a ventilator. So they won't touch her…" This is especially interesting when considering the heavy utilization of the local ER revealed in the survey.

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When discussing this topic in a provider interview, the physician responded that "ER will take anyone" as well as discussed of the 'local culture' surround patients opinions and usage of the hospital. The physician stated the "ER will take anyone… Rockbridge Co. is very lucky to have Stonewall Jackson Hospital. Although some do not understand that it is a critical access hospital. People expect it to be like a TV show [or misinterpret standard medical practice as the hospital's mistake]." The interviewee also mention "frequent flyers" who seek care when medical care is not actually needed because of psychological effects of receiving care. This interview also identified a shortcoming in the current health care delivery system as lack of same day or next day transportation, stating "it breaks my heart when a patient needs to get lab-work done next day and does not have a way to get there, or is driven by a neighbor who charges the patient heavily of their assistance." Focus groups of disabled persons echoed the struggle with transportation, especially when traveling to specialist outside of the Rockbridge Area.

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Focus groups also heavily emphasized some elements only briefly touched upon in the survey, such as home health care services or aides. One patient's story painted a dramatic picture of the home health care aid shortage, which has resulted in the family receiving this service for far fewer hours than they qualify. The parent of the disabled child stated: "I have recently called every home health agency in the phone book, and there is only one in the entire phone book that will take the Rockbridge County area. But they have no nurses available." Beyond just impacting the child's quality of living, the parent

also notes the impact on his/her life since having to shoulder a greater burden as a caregiver: “I don’t really get to go anywhere, ya’ know. We don’t really get to do any family time because my daughter has got to be my main concern because she doesn’t get the nursing coverage that she is supposed to.” (The provider perspective has yet to be attained regarding the homecare aide shortage.)

Physician interviews also provided an account of future services in Lexington. As of recent years, there has been an increase in the number of specialist from outside the Rockbridge area to travel to the city of Lexington and operate on office there one or two days a week. A doctor commented that “patient base was always here,” although providers are just recently recognizing the fact. Thus it can be predicted that the number of specialists in Lexington will continue to increase in the future. However these interviews also highlighted a concerning trend as “rumors of cuts to Medicare reimbursement… and holding payment have made it hard to run practice” prompting many practices to stop taking on new Medicare patients.

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Recommendations:

Given the findings of this study, the Rockbridge Area ought to become a Federally Qualified Community Health Center. A community health center would have to ability to provide dental care, reduce ER utilization, and help offset the shortage of physicians accepting patients with public health insurance. Secondly improvements are need to the transportation system. A mobile unit, run out of the community health center, which periodically services remote areas of the county,, could help overcome a substantial barrier to accessing care for the physically disabled populations. Furthermore RATS and/or RADAR should increase the increase availability of same day/next day for medically necessities. Currently both services suggest potential clients request transportation at least 5 days in advance, although limited "Urgent" transport is available in limited quantities. Additionally efforts need to be made to increase the number of specialist services available within the area. Finally steps ought to be taken to improve the local hospitals relations with physically disabled persons. This may take the form of improved communication and a better understanding within the community of the limitations and role of critical access facilities.

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Continuation of Study:

Over the following weeks additional information regarding the provider perspective, specifically Carilion Stonewall Jackson Hospital and a social service worker will be added to this report. Information regarding the increase in specialists will also be sought. Additionally the profile of local services provided in the Appendix will be completed and reformatted.

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Appendix:

Survey page 1 of 2

The Rockbridge Area Free Clinic, in partnership with CSJH and the Health Department, is working to learn more about your health care needs. Please answer the following questions with the best answer(s). All surveys will be kept confidential. PLEASE, ONLY ONE PERSON FROM EACH HOUSEHOLD SHOULD COMPLETE THE SURVEY. THANK YOU!

1. Where do you live?
□ Lexington City □ Buena Vista City □ Glasgow □ Goshen □ Rockbridge Baths
□ Raphine □ Fairfield □ Vesuvius □ Natural Bridge □ Natural Bridge Station □ Other________________

2. Has anyone in your home gone somewhere for medical care in the past two years?
□ Yes □ No
If so, where did that person(s) go for care? (*Check all that apply)*
□ Doctor's Office (Please list which doctor) ____________________________
□ Emergency room (Please list which one) _________________ __________
□ Lexington or Buena Vista Health Department (which one) _________________
□ Rockbridge Area Free Clinic
□ Other: ____

3. Has anyone in your home gone somewhere for dental care in the past two years?
□ Yes □ No
If so, where did that person(s) go for care? (*Check all that apply)*
□ Dentist's Office (Please list which office) ________________________
□ Emergency room (Please list which one) ________________________
□ Rockbridge Area Free Clinic
□ Other: ____

4. Has anyone in your home gone somewhere for help with stress, anxiety, mental health, or alcohol and drug problems in the past two years?
□ Yes □ No
If so, where did that person(s) go for care? (*Check all that apply)*
□ Rockbridge Area Community Services Board
□ Doctor/Counselor's Office (Please list which doctor/counselor) ________________________
□ Emergency room (Please list which one) ____________________________
□ Rockbridge Area Free Clinic
□ Other: ____

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5. Have you or someone living in your home been to the emergency room in the last two years?
□ Never □ Once □ 2 or 3 times □ More than 3 times
If yes, please tell us why you or someone living in your home used the emergency room on the last visit:
□ Accident
□ Illness
□ Dental problems
□ Mental health or stress problems
□ Alcohol or drug problems
□ Having a baby
□ Other: ____
Please list which emergency room ____________________________________

6. <u>If you responded "YES" to Questions 2, 3 and/or 4, skip to Question 7.</u>
If you responded "NO" to Question 2, Question 3 and/or Question 4, please tell us why you or someone living in your home does not get medical, dental, mental health care or help with alcohol or drug problems? (*Check all that apply)*
□ Too expensive
□ The location of the office/clinic is too far away.
□ The office/clinic hours are not convenient.
□ We don't have transportation.
□ We don't have a babysitter
□ We can't get an appointment when we need it.
□ When we do get an appointment, we have to sit in the waiting room too long.
□ We don't trust doctors/clinics.
□ We use alternative natural and herbal remedies.
□ Someone in our family takes care of us.
□ Prayer and God takes care of us.
□ Other: ____

7. If you or someone living in your home has insurance, what type is it? (*Check all that apply)*
□ FAMIS □ Medicaid □ Medicare □ Veterans □ Other: ________________
□ Private (Examples: Aetna, Anthem, Blue Cross/Blue Shield, Cigna, Farm Bureau, etc.)

8. Does your insurance provide for the majority of your household's health care needs? □ Yes □ No
If "NO," what things do you or others in your home have trouble paying for
□ Medications □ Tests □ Co pays

Survey page 2 of 2

□Other (please list)____

9. **How many children (less than 18 years) living in your home DO NOT have insurance for:**
   Medical services ________ Mental health services ________
   Dental services ________

10. **How many adults (18 years and older) living in your home DO NOT have insurance for:**
    Medical services _______Mental health services _______
    Dental services _______

11. **Please select the person in your home who has been without insurance for the longest time. How long has that person been without insurance?**
    □ less than 1 year
    □ 1-2 years
    □ 3-4 years
    □ 5 years or more

12. **Why don't you or someone living in your home have insurance? (*Check all that apply)***
    □ Lost job that provided insurance
    □ There is no work right now
    □ Too expensive
    □ Insurance is not available at my job
    □ Do not qualify for Medicaid, FAMIS, or Medicare
    □ Other: ____________________________

13. **If a community health center opened in Rockbridge County Area that offered an affordable medical, dental, mental health care and help with alcohol and drug problems, would you or someone living in your home use it?**
    □ Yes
    □ Maybe
    □ No **If "no," please tell us why**____

14. **If you responded "YES" or "MAYBE" to Question 13, please tell us which services you or someone living in your home would use at an affordable community health center? (*Check all that apply)***
    □ Medical care
    □ Immunizations (shots)
    □ Sports and school physicals
    □ Pregnancy care
    □ Parenting classes
    □ Dental care
    □ Eye care
    □ Care for older family members
    □ Help with mental health or stress problems
    □ Help with alcohol or drug problems
    □ Home health services
    □ Low cost medications
    □ Fitness programs
    □ Other ____

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15. **What days/times would be convenient to use a community health center for you or someone living in your home? *(Check all that apply)***
    □ Early morning (6 a.m. to 8 a.m.) Monday through Friday
    □ During the day (8 a.m. to 5 p.m.) Monday through Friday
    □ Evening hours (5 p.m. to 9 p.m.) Monday through Friday
    □ Saturday or Sunday hours
    □ 24-hour "On Call" services
    □ No preference

16. **How many people are living in your home including yourself?** ____________ **uses scooter**
    What are the ages of those living in your home, including yourself?
    ○ Number who are 0 to 18 years of age ____________
    ○ Number who are 19 to 64 years of age ____________
    ○ Number who are 65 years of age or older ____________

17. **What is your average household income each year from all sources (for example paycheck, social security, disability, child support and alimony) before taxes?**
    □ Less than $10,000 □ $22,001 to $30,000 □ $44,001 to $52,000 □ $68,000 to $75,000
    □ $10,001 to $15,000 □ $30,001 to $38,000 □ $52,000 to $60,000 □ greater than $75,000
    □ $15,001 to $22,000 □ $38,001 to $44,000 □ $60,001 to $68,000

18. Is there anything else we should know about your (or someone living in your home) health care needs in the Rockbridge County area? (Please write your answer here)

Focus Group Agenda page 1 of 2

The Focus Group Agenda

1) Facilitator introduces him/herself
2) Brief explanation of why the focus group has been gathered and how the focus group will be run. The explanation should read as follows:

We are meeting to discuss your experiences when seeking health care. We are part of a team looking to improve health care services in the Rockbridge area. We want to hear from you about what works, what doesn't work , and how we can all work together as a community to make things better.

I will start by asking you to briefly describe an experience you have had seeking health care in our county. Then we will go on to discuss some of your experiences in more detail. The entire session will probably take about 1 and a half hours. During this time we will provide you with something to eat and drink.

What we discuss here will remain confidential. We will tape this session, but all the information will remain anonymous and names will not be used in any reports. ***(If participants are clients of an agency, reiterate (as stated in consent) that no staff members will see the original transcripts or hear the tapes.)***
We are taping the sessions because we need to have an accurate record of the discussions. The work we are doing is part of a county-wide assessment project.

3) The facilitator introduces the team and encourages everyone to make themselves comfortable

4) The facilitator invites members of the focus group to introduce themselves and say a short word on.
- who they are
- the area of the county/ city they are from

5) The facilitator then starts the discussion with the following opening sentence:

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Before we get started, we would like to do a quick brainstorming session about what health means to you? Let's just throw out some words that you would use to define health. (The scribe will need to write the words on a flip chart so that everyone can see.)

Now, very briefly, would each of you please describe a situation when you went to seek health care in Rockbridge County. Think about a time you were sick, needed help with stress, or needed a dentist. Who would like to start? (expected time: about 20 minutes)

The facilitator and/or scribe will need to make short notes on each story as they go through, to help him/her decide who will be selected for more detailed story-telling.

6) After everyone has completed their stories, indicate that you would like to focus on a few stories in more detail. The facilitator will need to select about 5 stories to focus on. The stories should be diverse and representative of experiences with primary care, mental health, dental and wellness/prevention, as well as positive and negative experiences. (expected time: about 1 hour)

The stories that you have told are very interesting. I would now like us to focus on the details of a few of these stories. I would like to start with X's story. X, could you please describe your experience again in a little more detail. While X is describing the experience, I would like everyone else in the group to think about what happened to X and how they would have felt in X's situation. After X has retold the story, I will ask some questions for clarification. I would then like to open up the discussion for the whole group to ask questions and make any comments on their reaction to X's story. Once we have finished discussing X's experience, we will go on to discuss another story. I would like us to cover four or five stories told here today in a similar way, so I will keep an eye on the time so that we have a chance to hear a variety of stories. Now, X, would you please start.

Focus Group Agenda page 2 of 2

7) After completion of the first story, the facilitator should prompt the respondent for more information using the following questions, if necessary and not covered by the respondent:

- **Please tell me more about the place where you saw the health care provider? For example was it the ER, the Free Clinic, a local doctor, dentist or counselor, the Community Services Board?**
- **Was this your usual place of care?**
- **How long ago was the incident you are describing?**
- **How were you treated by the doctors/nurses/staff?**
- **What did you think of the place where you received care"**
- **Was it easy to go there and get the help you needed?**
- **If you could change anything about the experience, apart from whether or not you got better, what would you change?**

Now, please would the rest of the group like to discuss their reaction to X's story?

The facilitator should move on to the next story, once no more comments are forthcoming from the group, or as time allows.

8) This is the final section of the focus group.

This is the final part of our focus group. Many of you have told stories about health care experiences, but we were wondering whether any of you here have been sick but then chose not to seek any health care. If any of you have had that experience, would you please spend a little time telling us about it? If you have not had that experience, then think about things that you do or people who help you stay healthy so that you don't need to seek health care.

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- Make sure their description answers the questions: why did you not seek health care? or what do you do to stay healthy? or where do you go for information about how to stay healthy or take care of yourself?

9) The facilitator should close the session by thanking everyone for their participation:

Your stories have been very insightful and interesting. I would like to thank you all for your participation.

Written response to unmet needs:

Rockbridge Health Survey: Question 18 **Is there anything else we should know about your (or someone living in your home) health care needs in the Rockbridge County area? (Please write your answer here)**

Comment B
"(I am wheelchair dependent)
need medical care on weekends and evenings - for non-emergency medical care;
need wheelchair transportation evenings and weekends in addition to weekdays;
need to support RATS to provide lower priced rides for all, including those with disabilities"

Comment C
"(I use a wheelchair)
wheelchair transportation is available but a bit costly; Medicare should pay RATS for my transport OR RATS needs more subsidizing;
AFFORDABLE Dental care is NEEDED"

Comment D
"(use scooter) Needs affordable dental care"

Comment G
"NEED someone to help cooks meals and cleaning house (light)"

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Comment H:
"I was mistreated several times at Carilion Stonewall Jackson Hospital. They would never help me."
"It has been very difficult for me to find quality health care in Rockbridge County. Now, I have to go to Roanoke, Fishersville, and Charlottesville. My insurance does not pay for dental care. The Rockbridge Area Free Clinic won't help me."

Comment J:
18. "We have trouble paying medical bills and medicine"

Comment K:
18 "need help paying medical bills"

National and State Policies:
ADA
Insurance
    Medicare
    Medicaid
    Social Security
SCHIP or FAMIS
Patient Protection and Affordable Care Act

Local Services and Providers:
HEALTH SECTOR:
Hospital
Primary care
Specialists
Dental
Mental Health
Health Department
Rockbridge Area Free Clinic
Resources outside community

NON-HEALTH SECTOR:
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Social Services
Transportation
    RADAR/Maury River Express
Career opportunities
    Supported Employment?
    RAOC
Housing
Home care aids
Nutrition
Exercise
Financial

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	B	C	D	E	F	G	H	I
2								
3	**Type of Service**	**Name of Service**	**Provider Type**	**Service Area**	**Service Hours**	**Cost**	**Special Accomadations:**	**Contact Info:**
4	Transportation	RADAR: Maury River Express	Public transportation; Non-emergency, paratransit	Lexington, Buena Vista, "Rockbridge County" (see route)	M-F: 8am -6pm Sat: 10am - 4pm (see schedule)	$0.50 per trip, exact change must be paid on boarding	ADA certified individuals: request deviated route for pick-ups & drop-offs (no more than 3/4 mile) (see application)	(800) 964-5707 ex or 4
5	Transportation	RATS (Rockbridge Area Transport System)	Public transportation, paratransit; Non-emergency	Lexington, Buena Vista, Rockbridge County: demand response. Destinations may include regional medical centers (C'ville, Roanoke, Lo Moor, Fishersville)	M-F: 8am- 5pm	sliding fare schedule based on income (see table)	Medicare	540-463-3346 Me riders 866-386-83
6	Transportation	Central Shennandoah Planning District Commission	Rideshare Agency	Augusta County; Bath County; Highland County; Rockbridge County; Broadway (Rockingham Co.); Craigsville (Augusta Co.); Elkton (Rockingham Co.); Glasgow (Rockbridge Co.); Goshen (Rockbridge Co.); Grottoes (Augusta, Rockingham Co.); Monterey (Highland Co.); Timberville (Rockingham Co.); Buena Vista; Harrisonburg; Lexington; Staunton; Waynesboro; Broadway		Offer free carpool and SchoolPool matching, vanpool coordination. Operate a Guaranteed Ride Home program to provide free rides home in an emergency. works with employers to develop and implement traffic reduction programs. market the region's Park and Ride lots.	n/a	(434) 295-6165 - t free (888) 974-550
7	Emergency Transportation	Fire Department	Emergency	Separate locations: Buena Vista, Glasgow, Clifton Forge	24/7 emergency			call 9-1-1
8	Transportation	Logisticare	all Medicaid funded rides	nation-wide call center	24/7, call at least 5 days in advance	free if qualify	Medicaid-covered, Urgent care if less that five days	1-866-386-8331
9	Transportation	The Susan Brown Transportation Program	ALS Association	DC, MD, VA (no other transportation available)	M-F 9am-5pm	reimburse transportation costs up to $2,500 per year for medical appointments, an annual monetary cap of $250 for non-medical transportation expenses.	for people with ALS (PALS), wheelchair v	Director of Patien Family Services, (3 978-9855, toll-free (866) 348-3257
10	Transportation	Road to Recovery	program of American Cancer Society	statewide: VA (give zipcode to check in area)	M-F 8am - 5pm, call at least 4 days in advance	free, volunteer drivers	Transportation to treatment, surgery, etc. only. Must be ambulatory.	1.800.227.2345
	Financial							(804) 662-9000 T