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Evaluation of Access to Care: Minority and Low-income Populations and Non-profit Health Organizations

Erika Hooper

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EVALUATION OF ACCESS TO CARE:
MINORITY AND LOW-INCOME POPULATIONS AND NON-PROFIT HEALTH
ORGANIZATIONS
BY
ERIKA M. HOOPER

April 14, 2016

INTRODUCTION: Impeded access to care has been an issue long awaiting resolution. Many Americans, whether insured or uninsured, go without regular care because access is limited. Those with the most difficulty obtaining adequate access to care are those of low-income status, minority populations and the disabled. In addition, to free clinics, many non-profit organizations ease the burden of limited access to care by providing services to those in a set population. Some of these services include transportation, providing counseling and advocacy, as well as finding low cost care options.

AIM: The intended goal is to evaluate access to care and how non-profit organizations help alleviate the issue as it pertains to low income, minority and disabled populations.

METHODS: Using insights and analysis aided through research and practicum experience, to describe what access-enhancing programs are available, the services they provide, to what extent they are provided and used, and what factors influence their utilization.

RESULTS: Many non-profit organizations offer aid to help people access care in the form of counseling and advising. Few offer transportation and funding to aid in receiving quality access to care. This is primarily due to funding issues and the number of individuals and families who need services.

DISCUSSION: Many health-centered non-profit organizations aid populations in obtaining access to care through transportation, resource sharing and at times, cost of care. Since many non-profit organizations are public and receive funding for the services they provide, the services they provide can and usually are limited. Receiving continuous aid from the public can and has proven to be difficult if the organization is targeted toward specific populations or disabilities. Partnerships with local businesses, car dealerships, or car services and receipt of support from national sponsors are just suggestions to aid in assisting the necessary populations. Deeper investigation into what else can help improve non-profit organizations' ability to help people access care, especially for special vulnerable or disadvantaged populations is not only vital but necessary.

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ORGANIZATIONS
BY
ERIKA M. HOOPER
B.S., GEORGIA STATE UNIVERSITY

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of the
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30303

APPROVAL PAGE

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ERIKA M. HOOPER

Approved:

___Lee Mobley, PhD_____

Committee Chair

___Anisa Palmer, MPA, CNP, CPC_____

Committee Member

___April 22, 2016_____

Date

Acknowledgments

Author's Statement Page

In presenting this capstone as a partial fulfillment of the requirements for an advanced degree from Georgia State University, I agree that the Library of the University shall make it available for inspection and circulation in accordance with its regulations governing materials of this type. I agree that permission to quote from, to copy from, or to publish this capstone may be granted by the author or, in his/her absence, by the professor under whose direction it was written, or in his/her absence, by the Associate Dean, School of Public Health. Such quoting, copying, or publishing must be solely for scholarly purposes and will not involve potential financial gain. It is understood that any copying from or publication of this capstone which involves potential financial gain will not be allowed without written permission of the author.

In conjunction to the above statement, I would also like to acknowledge that with the practicum experience and the guidance of my preceptor, Anisa Palmer, I was drawn to focus on the issue of access to care. I appreciate the knowledge and experience shared during my practicum experience. Upon volunteering with I Will Survive, Inc., I was drawn more into focusing on access to care as it effects minority and low income populations, both being populations I identify closely with. Choosing to focus on The American Cancer Society and C-Change allowed to me learn how the issues of access can be changed depending on who and how manages an organization. On my path to one day own and or operate a specialized clinic, I hope to be able to incorporate the solutions offered by all three organizations and apply them on a grander scale.

____Erika M. Hooper_____
Signature of Author

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Introduction

During recent years, affordable health care has been an increasingly prominent subject across the United States of America. Health insurance and access to care are two of the most important aspects to those seeking care. Those who cannot afford or are ineligible for health insurance have very few options when it comes to seeking and receiving adequate healthcare. Those without proper access also have the same issue. Low-income families and those of African American and Hispanic populations have more instances of failed access to care than other population subgroups. Furthermore, individuals with certain illnesses have increased difficulty in obtaining health insurance and difficulties arise when seeking disability insurance from employers or the government. For these people, help from outside organizations exists.

Health Insurance

Throughout the years, health insurance in the US has evolved. There are different types of insurance as well as different types of coverage. Some elect to use private insurance, while others choose to use public. Health insurance is “supposed” to be the primary way for the public to gain access to healthcare. Private health insurance plans are insurance plans that are employer-based, own-employment based or direct-purchase based (US Census Bureau, 2015). Employer-based insurance plans are health insurance plans provided by the employer or union and can be used for dependents and legal partners. Own-employment based insurance plans are plans offered through an individual’s own employment and are the only policyholders of the plan. Direct-purchase insurance plans are plans obtained directly from a private company (US Census Bureau, 2015).

Public health insurance plans are insurance plans provided by the government. The most commonly known of these plans are Medicaid, Medicare, and Children’s Health Insurance

Program (CHIP) (U.S. Census Bureau, 2015). Medicare is a federal program and usually pays for services provided to individuals over the age of 65 and to those with long-term disabilities who are under the age of 65. Medicaid is provided at the state level and offers care to those with low-incomes, dependent children or disabilities (U.S. Census Bureau, 2015a, 2015b). Although the program is available for those considered “needy”, becoming eligible for Medicaid and receiving services has proven to be difficult. Those who are serving or have served in the military also use government programs. For those injured, Veterans Affairs insurance is also available (Democratic Policy Committee, 2009). While many populations seem to be able to receive coverage through both private and public health insurance programs, many others still lack insurance due to ineligibility for these programs.

More recently, the Patient Protection and Affordable Care Act, or ACA, sought to ease the burden of acquiring health insurance. In doing this, the government put in place a marketplace for individuals and their families to purchase health insurance without worry of discriminatory practices commonly used by health insurance companies (Democratic Policy Committee, 2009). Of these discriminatory practices, refusal of coverage to those with pre-existing conditions was one of the most limiting issues, along with unaffordable prices. With issues like these keeping individuals from obtaining needed healthcare, providing quality access to care should be something of primary focus.

Access to Care

Access to care has long been an issue awaiting resolution for many all over the United States. Over the years, access to care has continued to be an issue for those of minority, low-income and disabled populations. Many strides have been made to battle the issue of quality in access to care but much is left to be done and desired. Access to care refers to "an individual's

ability to obtain medical services on a timely and financially acceptable basis. Factors determining ease of access also include availability of health care facilities and transportation to them and reasonable hours of operation (Kovner, Knickman, & Jonas, 2011). Access to care is also influenced by other factors, or barriers, such as price of services, income, race, attained education levels and health-seeking behaviors and customs. In order to properly address barriers to care, Americans need to understand them and their influence.

Barriers to Access

Many things influence access to care, many of them negatively. These barriers to access are what cause minority, low-income, and disabled populations to suffer more than other population subgroups. Barriers to access include both economic and non-economic factors, each proving to have its own significant influence. Economic barriers revolve around monetary and financial inequalities while non-economic barriers encompass all other barriers.

Economic barriers primarily affect those individuals who work part-time, are young and are not offered health insurance by their employers because of part-time status or simply not enrolling when benefits are offered (Kovner, Knickman, & Jonas, 2011). Most individuals who are uninsured are between the ages of 18 and 34, with the younger adults having higher rates of unemployment compared to their older counterparts. Without adequate income, not only is it hard to make other ends meet, but suddenly health care is not a priority. Inflation of health care prices does not ease the issue, mainly because individual incomes are not matching the rise of cost associated with care (Kovner, Knickman, & Jonas, 2011).

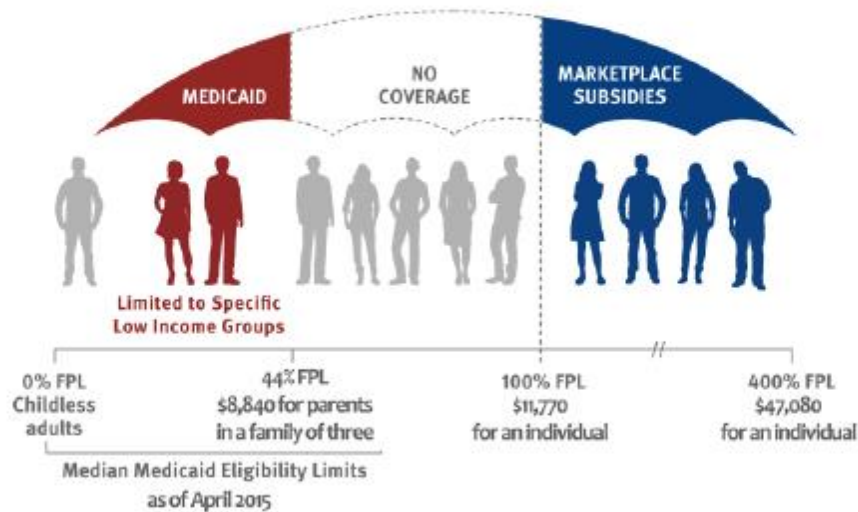
As stated previously, Medicaid is available on the state level and eligibility requirements are set based on income, age, disability and pregnancy. In Georgia, the income limit is set at different levels depending on family size and age of children. Without pregnancy included, the

income limit ranges from 133% to 205% of the federal poverty level which is lower than most states and lower than the level set by the ACA (Centers for Medicare & Medicaid Services, N.D.). Because Georgia did not expand Medicaid with the implementation of the ACA, approximately 282,000 individuals in Georgia do not meet the eligibility requirements (HealthInsurance.gov, 2015).

The Patient Protection and Affordable Care Act sought to alleviate health insurance issues. It helped many but without backing from states for expansion of Medicaid, many were left still in need (Figure 1, Community Catalyst, 2015). Issues with the health insurance marketplace came in the form of site issues and unexpectedly high prices. Had expansion taken place about three times as many would have had more reasonable access to insurance and care.

Figure 1

In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.



Source: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels, updated to reflect state Medicaid expansion decisions as of March 2015, and 2014 Current Population Survey data.



Source: Community Catalyst, 2015

Having health coverage is only the first step in obtaining adequate access to care. Non-economic barriers also limit access. Having health care facilities in an area, qualified trained professionals in that facility, and transportation to and from that facility all go hand in hand in providing enhanced accessing care (Kovner, Knickman, & Jonas, 2011). If there are little to no health care facilities a population can suffer. Also if there are no qualified health care professionals providing quality care, disparities will persist. Making sure quality professional have obtained the necessary education is only one end of the spectrum. Consumers with adequate education and informed opinions are at an advantage when seeking care and in obtaining a full-time job with benefits, and the sufficient discretionary skills to choose an appropriate health insurance plan. Education also aids in increased health literacy. “Health literacy is more than the ability to read. It refers to the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions”(Riegelman, & Kirkwood, 2015).

In turn education has an effect on health outcomes. Individuals who have obtained more education typically have better health than those who haven't (Riegelman, & Kirkwood, 2015). Education can also be a byproduct of environment, which also has an effect on access to health and health outcomes. The environment encompasses many things and everything in it affects the population within it. Whether there is public transportation or greens spaces enhanced the ability for residents to get around and provides a healthier environment (Riegelman, & Kirkwood, 2015). But other parts of the environment are more physical. Urban and rural areas have different influences. Urban areas tend to have more people per provider, and providing services for those people can, at times, prove to be difficult.

Minority Populations

Every population is affected by its environment and culture; some more than others. Minority populations like African Americans and Hispanics, along with the low-income populations and the disabled, suffer from health disparities like inadequate access to care. Due to their history of receiving unequal education or living in less than favorable areas, African American and Hispanic populations continue that cycle but carry it into their healthcare outcomes. When assessing quality of care African Americans received worse care than their Caucasian counterparts for 41% of quality of care measures. African Americans also received worse access to care for 32% of access to care measures (Agency for Healthcare Research and Quality, 2011). Hispanics had worse access to care for 63% of access to care measures and received worse care than their Caucasian counterparts for 39% of quality of care measures (Agency for Healthcare Research and Quality, 2011).

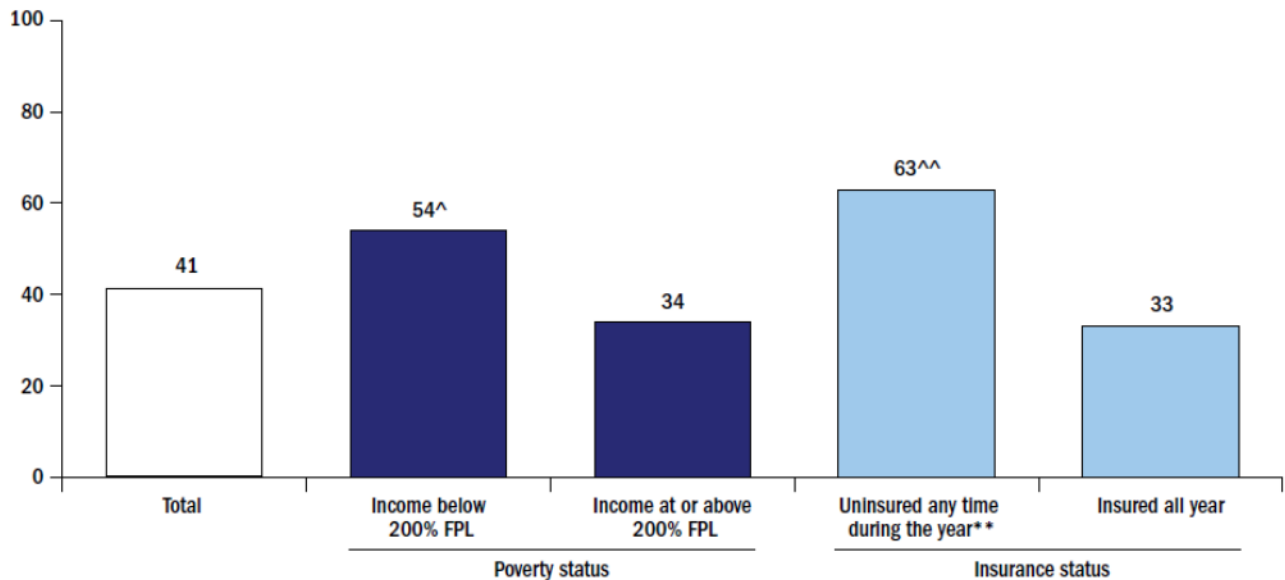
Both African Americans and Hispanics also tend to live in areas that compound their disadvantage. Poor school systems, unsafe neighborhoods and poor built environments keep income from reaching adequate levels. Not surprisingly, these subpopulations are often members of the low-income population. With low-income comes less access and poorer quality of care. Those in low-income families received worse care and worse access to care than their higher income counterparts at 47% and 89% of measures, respectively (Agency for Healthcare Research and Quality, 2011). It all seems to be a cycle.

“Evidence suggests that lack of health insurance results in worse health outcomes because the uninsured tend to receive less preventive care, to be diagnosed at more advanced disease stages, to receive less comprehensive care, and to have higher mortality rates (Coleman et al. 2002)” (Guy, Adams, Atherly, 2002, pg.52).

As represented by Berenson, Doty, Abrams, & Shih (2012), those with low income as well as those who are uninsured have higher rates of cost related barriers to access to care (Figure 2).

Figure 2 Low-Income and Uninsured Adults Report High Rates of Cost-Related Access Problems

Percent of adults ages 19–64 who reported any of four cost-related access problems*:



Notes: FPL refers to federal poverty level. Percentages are adjusted for age, sex, race, and health status.

* Respondent had at least one of four access problems because of cost: did not fill prescription; skipped recommended test, treatment, or follow-up; had a medical problem, did not visit doctor/clinic; and did not get needed specialist care.

** Because of small sample size, "Insured now, time uninsured in past year" and "Uninsured now" are combined.

[^] Significant difference compared with income at or above 200% FPL (p <0.05 or better).

^{^^} Significant difference compared with insured all year (p <0.05 or better).

Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

Source: Berenson, Doty, Abrams, & Shih (2012)

Disabled Populations also have their share of disparities when it comes to access to quality care.

For some, limited mobility creates a disadvantage. Even with aid, many suffer from less than favorable access. Those with disabilities have higher rates of risk factors that worsen overall health outcomes and contribute to the development of chronic conditions such as heart disease and cancer (Community Catalyst, 2015).

Non-Profit Organizations

In order to ease some of the difficulties of acquiring care or just wanting to help, "A non-profit organization is a group organized for purposes other than generating profit and in which no

part of the organization's income is distributed to its members, directors, or officers”(Law Information Institute, N.D.). A non-profit organization can be private or public. Private non-profits receive most, if not all of their funding from private donors or turnover from investments, whereas public non-profit organizations receive their funding from the public or through fundraising or receipt of goods (McMullen, 2016).

A focus on how public organizations help bridge the gap of access is essential to meet the needs of the population served by the organization. For example, national organizations like The American Cancer Society and C-Change, and local Georgia organizations like I Will Survive, Inc. strive to make a difference in the lives of those suffering from cancer and ease the limitations it places on access to quality care. When it comes to access to care, The American Cancer Society has a program called Road to Recovery which is designed to help cancer patients get to and from cancer treatments. There are, however stipulations regarding this transportation. Transportation is limited to treatment appointments and does not include any follow-up appointments after treatment. Patients must also be able to move around without assistance or have a third party assisting them, presumably for liability issues (American Cancer Society, 2016).

C-Change, another organization focused on cancer patients, focuses on advocacy for patients. The organization is aware of deficits in access for those with cancer and are proactive in finding solutions. They push for the government, on all levels, to assist. One of the most important points that C-Change focuses on is increasing support for primary care programs for the underinsured (people with insufficient health insurance to meet their needs) and uninsured (C-Change, 2010).

I Will Survive, Inc. depends on volunteers and local car services, such as Uber and Lyft, to provide transportation to and from treatments and other various appointments. It relies on donations, both monetary and physical goods, to maintain funding for the survivors they assist. It also holds education workshops to aid in advocacy to encourage involvement in obtaining quality access to care. Each organization expand their assistance efforts further, but funds are always a factor when being non-profit. The American Cancer Society and C-Change focus on care on a national level and different types of cancer. They make information readily available and provide resources to keep those served informed. I Will Survive, Inc. is more community based and provides a family-like experience. Experience with this organization has shown that smaller organizations can form tighter bonds and foster longer lasting relationships while aid is being administered. All of these organizations take a stand and promote advocacy and call for those affected by cancer to be leaders and take charge when it comes to their health. Teaching others to be leaders while being a leader is something important to be a part of especially when it come to health and longevity.

Trends

Disparities seem to be present throughout healthcare. The same racial and environmental issues that affect the populations with low income also affect them in terms of healthcare. Those with less typically receive less or have fewer options. Non-profit organizations try to help alleviate that disadvantage by catering to special populations. Some disabled individuals cannot receive the same treatment as another and being able to receive any aid from an outside source is not only refreshing but honorable. It seems those who do not know about care, are not confident in receiving care, or already have physical and monetary restrictions, receive less than adequate care and access to that care.

Call for Action

Much is left to be done to alleviate the burdens place on those who suffer from the barriers of access to care. More funding for non-profit organizations by community sponsors and private donors would help, but only to a certain degree. Although there is incentive to donate to non-profit organizations, many don't feel the need to donate until personally affected in some way to the organization they choose to donate to. Some organizations receive donated automobiles, while others take on volunteers. More non-profits should work in conjunction with local community centers, clinics and hospitals to help those they serve.

Providing education workshops for health and lifestyle could also help these special populations. Advocacy is almost always a normalizing force, but possibly providing that lesson of advocacy outside the facility and in the community would help bolster unity and a call to action. C-Change took a step further and organized a list of peer-reviewed articles that focused on access to care and how and what organizations and the government can do to help. It also documented ways to build coalitions to battle the issue of access to care, among many others.

Conclusion

Combining a bit of advocacy, fundraising, community involvement, and business outreach could prove to be beneficial in aided those with limited access to care. Many smaller non-profits, like I Will Survive, Inc. would benefit from engaging the communities and local businesses more. Being able to branch out and serve more, would prove beneficial. Finding sponsors can prove to be difficult but helping people is the goal and to achieve it would be more than rewarding.

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