

V. PEOPLE ACCESSING QUALITY HEALTH CARE (STRATEGIC IMPERATIVE TWO)

Developing a high functioning community-based health care system requires a multi-pronged strategy that assures access to preventive, primary, and specialty care for all area residents, and concurrently assures that residents consistently receive the right care at the right time in the right place.⁹²

“A synthesis of findings from the literature on the quality of health care provides abundant evidence of poor quality. There are examples of exemplary care, but the quality of care is not consistent. Thus, the average American cannot assume that he or she will receive the best care modern medicine has to offer.”⁹³ – Institute of Medicine

MANCHESTER HSA HEALTH CARE CAPACITY

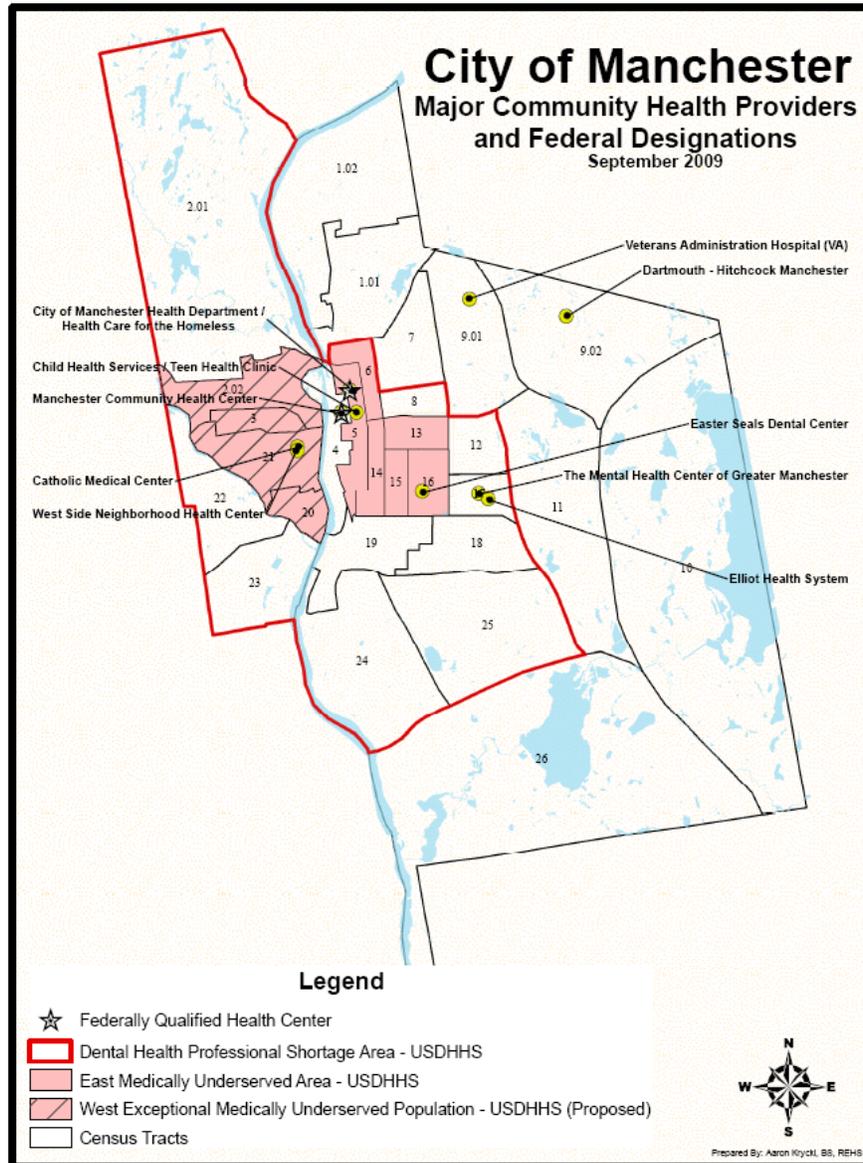
The Manchester Health Service Area (HSA) is fortunate to have a diverse primary health care system. A combination of public and private health care provides a loosely knit system of population-based public health services, social services, and primary, secondary, and tertiary care. Major provider institutions include: Catholic Medical Center (CMC), Dartmouth-Hitchcock Manchester (D-H), Elliot Health System (EHS), Child Health Services (CHS), Teen Health Clinic (THC), the Manchester Community Health Center (MCHC) and the Mental Health Center of Greater Manchester (MHCGM). Many other organizations, for example, the Manchester Health Department and the Health Care for the Homeless Project also provide some complimentary health care services to the local population.

The HSA capacity to provide oral health care is also growing. During 2009 alone the CMC Poisson Dental Facility expanded its fixed chair capacity from two chairs to three, D-H has made oral health services available through a portable dental unit, Easter Seals has opened a Dental Clinic with two fixed chairs, and the Manchester Health Department has partnered with community organizations to expand oral health services to children through the schools.

EHS continues to be the only provider of oral maxillofacial surgery in the area, and the private providers, Small Smiles, has provided access to dental care for many youth who use Medicaid.

While there is seemingly adequate health care capacity in the HSA, the health care delivery system is limited by the number and type of facilities able to serve its growing population and by the numbers of providers available and/or willing to serve low-income residents. In fact, the federal government has recognized priority neighborhoods in Manchester as medically underserved. By definition, Medically Underserved Areas (MUA) may be a whole county or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services. Medically Underserved Populations (MUPs) may include groups of persons who face economic, cultural or linguistic barriers to health care.

As of September 2009, six census tracts on the east side of Manchester make up its MUA. An additional four census tracts on the west side of the City have been proposed for designation as an MUP. In addition, with a ratio of one dentist for every 4,601 residents, 21 census tracts were designated as a Dental Health Professional Shortage Areas (DPSA) due to the low dentist to resident population ratio. The map below illustrates these designation areas (pending approval of HRSA as of September 2009).



MANCHESTER HSA GETS GOOD MARKS FOR QUALITY

The health care community of the Manchester area is not only committed to improving access to health care, but is also continually working to improve the quality of the care that is provided. As illustrated in the table below, the quality composite scores for hospitals serving the Manchester HSA are often higher compared to the state average.

MANCHESTER HSA HOSPITAL QUALITY REPORT SCORES (2008)*							
Acute Myocardial Infarction (Heart Attack)							
	Aspirin at Arrival	Aspirin at Discharge	Beta Blocker at Discharge	ACEI or ARBs for LVSD	Smoking Cessation Counseling	Composite Score	
Catholic Medical Center	99%	100%	100%	99%	100%	99%	
Dartmouth-Hitchcock Medical Center	98%	99%	99%	94%	99%	97%	
Elliot Health Center	100%	100%	99%	100%	100%	99%	
State Average	99%	99%	100%	96%	100%	98%	
Congestive Heart Failure							
	LVF Assessment	ACEI or ARBs for LVSD	Smoking Cessation Counseling	Discharge Instructions	Composite Score		
Catholic Medical Center	99%	100%	100%	90%	91%		
Dartmouth-Hitchcock Medical Center	100%	96%	95%	82%	84%		
Elliot Health Center	99%	94%	100%	73%	81%		
State Average	98%	96%	98%	89%	89%		
Community Acquired Pneumonia							
	Antibiotics Within 6 Hours	Blood Cultures Prior to Antibiotics	Appropriate Antibiotics	Pneumococcal Vaccination	Influenza Vaccination	Smoking Cessation Counseling	Composite Score
Catholic Medical Center	99%	98%	97%	94%	100%	100%	93%
Dartmouth-Hitchcock Medical Center	85%	90%	92%	88%	87%	80%	73%
Elliot Health Center	94%	89%	93%	98%	100%	100%	88%
State Average	96%	95%	94%	94%	93%	96%	86%
Surgical Care Improvement Project (SCIP)							
	Prophylactic Antibiotic Received Within One Hour Prior to Surgery	Prophylactic Antibiotic Discontinued within 24 Hours After Surgery	Recommended VTE Prophylaxis Ordered	Recommended VTE Prophylaxis Received	Controlled 6am Postop Serum Glucose	Appropriate Hair Removal	Composite Score
Catholic Medical Center	98%	98%	94%	98%	98%	100%	92%
Dartmouth-Hitchcock Medical Center	96%	99%	92%	99%	98%	97%	89%
Elliot Health Center	90%	98%	93%	94%	94%	0/0*	84%
State Average	96%	98%	94%	94%	92%	91%	87%
* no patients were medically eligible to receive this treatment							
* This table was developed from the NH Quality Care Reports published by the Foundation for Healthy Communities and Northeast Health Care Quality Foundation which summarize hospital data from January 2008 through December 2008. These indicators are benchmark indicators for quality of care for hospitals from around the state for the specific common diagnoses of heart attacks, heart failure, pneumonia, and surgical infections. ²⁴ (Dartmouth-Hitchcock Medical Center numbers include data from the Mary Hitchcock Memorial Hospital in Lebanon).							

Many quality improvement initiatives are being initiated by the area health providers. A few examples of such projects include the monitoring of physician practice-based immunization rates, timely intervention and screening of diabetics, implementation of electronic medical record (EMR) technologies, and community reporting of benchmark data.

MANCHESTER DOES WELL ON ACCESS TO PREVENTIVE SCREENING MEASURES

Manchester area providers do well compared to the rest of the state in providing screening services to the Manchester City and HSA population. Improvements are needed in providing influenza vaccination.

ACCESS				
	MANCHESTER	MANCHESTER HSA	NH WITHOUT MANCHESTER	HP2010
Had routine check up in past year, NHDHHS BRFSS 2005-2007	76.9%	76.3	71.5%	
Percent of the population age 18-64 who received an influenza vaccination within the last 12 months, 2008, NHDHHS BRFSS	31.4%	32.7%	36.0%	
Percent of women age 18-64 who have gotten a pap smear within the last three years, 2008, NHDHHS BRFSS	87.1%	87%	86.1%	90%
Percent of female population over 50 years old who have gotten a mammogram in the past two years, 2008, NHDHHS BRFSS	92.6%*	89.8%	84.7%	70% for 40 and older
Had Cholesterol checked in past five years, NHDHHS BRFSS 2005-2007	95.4	96.5	95.9	
* Significantly different from the rest of NH Source: NH DHHS, Behavioral Risk Factor Surveillance System				

UNDERUSE OF PRIMARY CARE

Underuse of primary care is a quality concern for the Manchester area. The Institute Of Medicine (IOM) national roundtable summarized three major themes of health care quality for which our society pays a substantial price: overuse, underuse, and misuse of health care services.⁹³ We use the themes of underuse and misuse to talk about the quality of the primary care system in Manchester HSA.

“Lack of health insurance is a major contributing factor to underuse.”⁹³

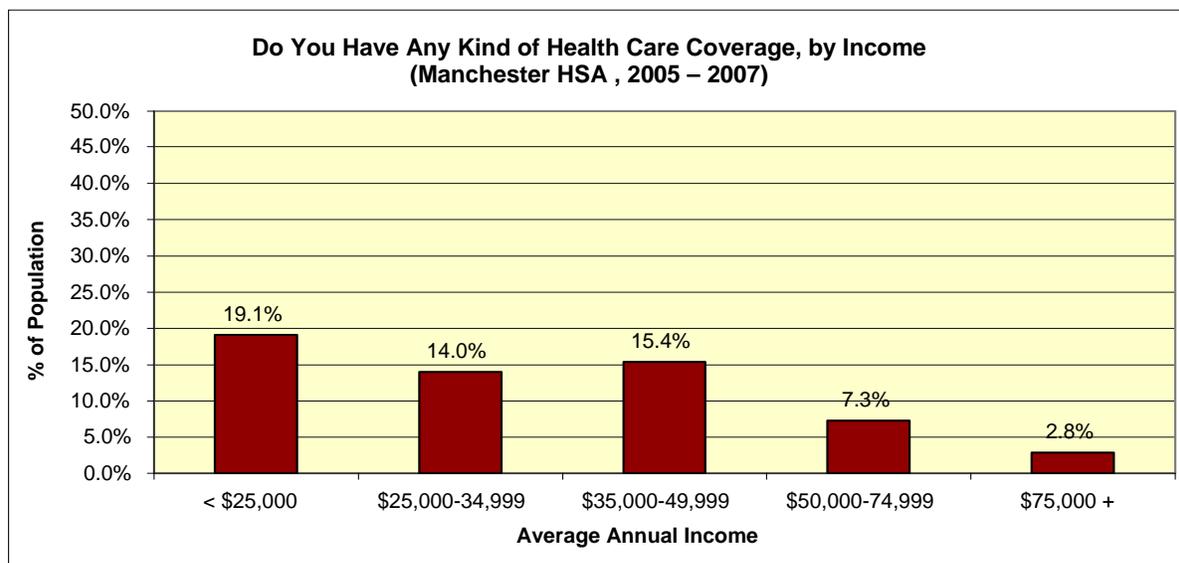
Not having health insurance or a medical home is associated with underuse of primary care. Persons with no health insurance are less likely to receive medical care, to receive medical care in a timely fashion, or high-technology interventions. They are also more likely to die from treatable conditions compared to their insured counterparts.⁹⁵ Persons without health insurance also receive fewer preventive services and less regular care for chronic conditions.⁹⁶

In addition to the challenge of obtaining health insurance, Manchester’s residents have other barriers to accessing quality care. Having a relationship with a regular medical provider, (i.e., having a medical home) has been shown to be a valuable contributor to access to quality health care services. A “medical home” is a community-based primary care setting that integrates quality and evidence-based standards in providing and coordinating family-centered health care, including promotion and wellness services as well as acute and chronic care management. Once a medical home has been established for an uninsured or underinsured individual, that individual is more likely to gain access to services, including preventive care and regular physician visits.⁹⁷ Having a consistent source of care has also been associated with lower use of the emergency department and shorter hospital stays. In the Manchester HSA, having health insurance, being able to pay for care, and having a regular source of care are associated with income, age, and in some cases, gender.

LACK OF ACCESS

LOWER INCOME

Not having health insurance and not being able to access care because of cost is associated with lower income.



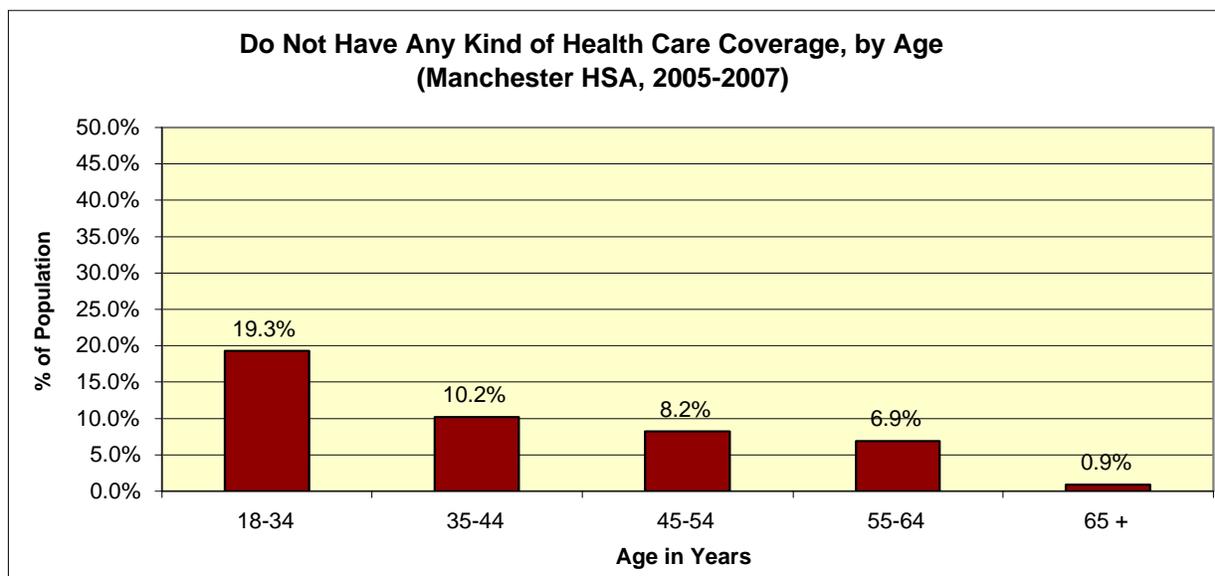
Source: NH Behavioral Risk Factor Surveillance System

Nearly twenty percent of the poorest HSA residents - those with incomes below \$25,000 per year - reported that they had no health care coverage compared to 7% of HSA residents with incomes of \$50-74,999 and 3% of residents with incomes of \$75,000 or above (2005-2007).⁶³

- Additionally, approximately 23% of HSA residents with incomes below \$25,000 reported that they could not get health care services because of the cost of care compared to 14% for those with incomes between \$35,000-49,000; and 3% of those with incomes of \$75,000 or greater (2005-2007).⁶³
- As might be expected, those in the lower income groups were more likely to report that they did not have a personal care physician compared to those in the higher income groups (for example, 21% of those with incomes below \$25,000 reported no personal health provider compared to 15% (\$25,000-34,999), 10% (\$35,000-49,999), 7% (\$50,000-74,999) and about 5% (\$75,000+).⁶³
- Finally, 32% of the HSA population with incomes below \$25,000 reported having only fair/poor health compared to 26% of those with incomes of \$25,000-34,999, 7% of those with incomes between \$35,000-\$49,999, 8% of those with incomes between \$50,000-\$74,999 and only 3% of those with incomes of \$75,000 or greater (2005-2007).⁶³

AGE

Not having health insurance and not being able to access care because of cost is also associated with age (being younger).



Source: NH Behavioral Risk Factor Surveillance System

Being younger is also associated with having no health care coverage. About 19% of Manchester HSA adults, ages 18 to 34 years reported having no coverage compared to 10% of those ages 35 to 44, 8% of those 45 to 54, 7% of those 55 to 64 and about 1% of those 65 and older (these residents are assumed to be covered by Medicare).⁶³

Additionally, 15% of HSA adults ages 18 to 34 report not being able to get care because of cost compared to about 11% for those 35 to 44, 9% of those 45 to 54, 4% of those 55 to 64 and 1% of those 65 and older.⁶³

And about 15% of HSA adults ages 18 to 34 report having no personal health provider compared to about 14% for those 35 to 44, 7% of those 45 to 54, 5% of those 55 to 64 and 5% of those 65 and older.⁶³

However, those who are younger report having better health. Only about 7% of HSA residents ages 18 to 35 reported that their health was fair/poor compared to about 9% of those ages 35 to 44, 14% of those 45 to 54, 13% of those 55 to 64 and about 22% of those 65 and older.⁶³

GENDER

Not having health insurance and not being able to access care because of cost is associated with gender. In the Manchester HSA, a significantly higher proportion of males reported that they did not have health insurance compared to females (12.8%, CI 11.6-14.0 compared to 10.4%, CI 9.5-11.2).

However, a significantly higher proportion of females (11.3%, CI 10.5%-12.2%) reported that they were not able to access care because of cost compared to males (8.1%, CI 7.2-9.0). In addition, a significantly higher proportion of males (12.7%, CI 9.6%-15.7%) compared to females (7.1%, CI 5.2%-9.0%) reported that they did not have a personal care provider.

RACE AND ETHNICITY

Not having health insurance and not being able to access care because of cost is associated with Race and Ethnicity.

In 2004, the New Hampshire Minority Health Coalition published “The Health of African Descendents and Latinos in Hillsborough County”.⁹⁸ It reports that:

- 38% of African descendents had no medical coverage;
- 62% of Latinos had no medical coverage;
- 6% of African descendents and 29% of Latinos with no coverage received reduced fee/discounted care;
- of those with health insurance, 22% of African descendents and 14% of Latinos were covered by Medicare or Medicaid;
- 30% of African descendents and 42% of Latinos had no regular health provider; and
- barriers to access included cost, language and clinic hours.

In 2006, Ryan et al. further analyzed this information to explore whether self-reported racial discrimination was associated with mental health status and if variation across race/ethnicity (African descendents and Latinos) or immigration status existed. Using three separate study methods, the authors concluded that perceived discrimination may be an important predictor of poor mental health status among African descendent and Latino immigrants.⁹⁹ Furthermore, it was concluded that the association between self-reported discrimination and lower mental health status was stronger for immigrants who had resided in the United States for longer periods of time.

BURDEN ON COMMUNITY

Lack of insurance is a burden that affects more than just the individual – it also affects the entire community.

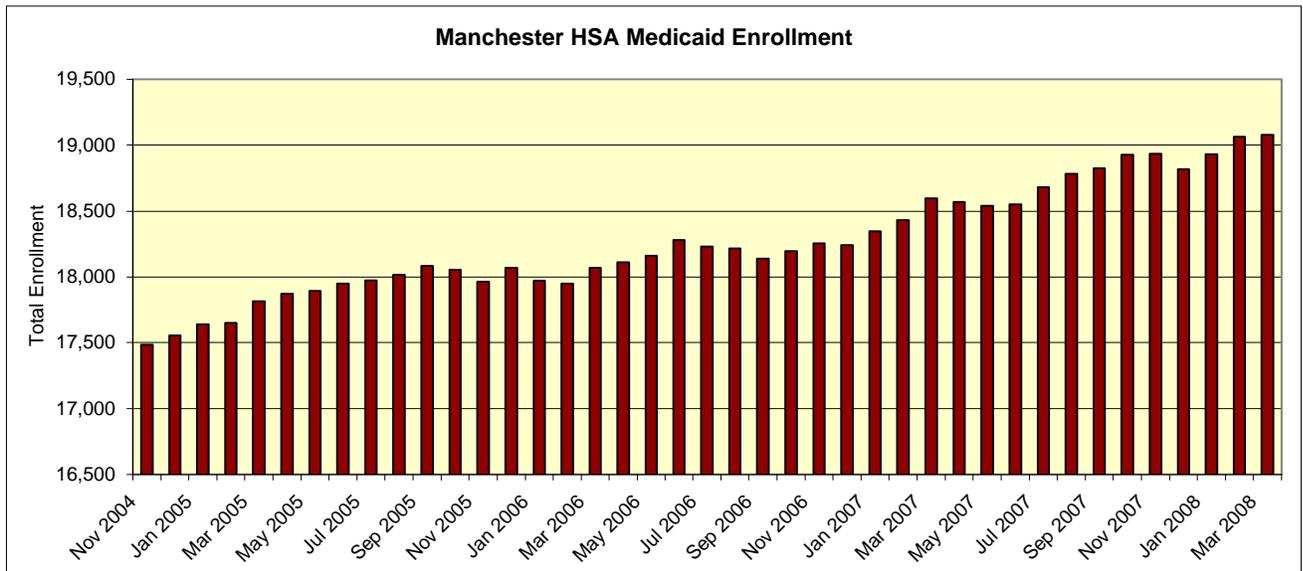
“The presence of a sizable or growing population of uninsured persons may impose destabilizing financial stresses on the health care providers that serve all community members and on the public and private sources that finance local health care.”¹⁰⁰

The Institute of Medicine (IOM) reports that having one or more uninsured members in a family can have adverse consequences for everyone in the household.¹⁰¹ Manchester primary care providers (including mental health providers) reported caring for 17,119 unique patients who were uninsured in 2008. This number represents about 8% of all patients seen during this time (please note this number is an estimate as we can not determine if patients have been double counted across community organizations).

PATIENTS BY PAYER MIX						
	PRIMARY CARE					
	MCHC	D-H	CHS*	ELLIOT PCPS	CMC PCPS	MHCGM
Number of Unique Patients (unduplicated 2006-2008)	7,587	64,312	1,856	79,396	32,811	22,342
Payer Distribution						
Percent Medicaid	30%	15%	52%	8%	3%	28%
Number of Medicaid Patients	2,304	9,399	966	6,428	984	6,340
Percent Medicare	7%	8%	0%	16%	23%	14%
Number of Medicare Patients	543	5,124	9	12,782	7,547	3,213
Percent Commercial	14%	72%	7%	72%	69%	38%
Number of Commercial Patients	1,078	46,146	124	57,158	22,640	8,400
Percent Self-Pay and No Insurance	48%	6%	41%	4%	5%	20%
Number of Self-Pay and No Insurance	3,662	3,643	756	3,028	1,641	4,389
<i>* CHS numbers include main program and Teen Health Clinic</i>						
<i>Source Manchester local health care organizations</i>						

MEDICAID

Medicaid is a program that funds defined health care services for low-income families and individuals who meet certain eligibility criteria. Medicaid is jointly funded by the state and federal government; however, the rates of reimbursement do not cover the full cost of care by most providers. Between November 2004 and April 2008, the number of HSA persons enrolled in the Medicaid program has increased by about 9% (from 17,482 persons in 2004 to 19,082 in 2008). The increased growth of this under-funded program is creating a financial burden for the entire region that needs to be shared between all health care provider organizations that serve the community. Between 2005 and 2008 the City of Manchester experienced a 15% increase in the number of children enrolled in the Medicaid program with over 10,000 children reported to be enrolled in 2008.



Source: NH DHHS

UNCOMPENSATED CARE COSTS

Community providers incur financial losses every time they take care of a Medicaid patient (due to poor provider reimbursement) or a patient who is uninsured (due to costs of care not being paid for by any insurer). These losses are defined as “uncompensated care”. The amount of uncompensated care provided by the HSA health care organizations is another indicator that reflects the growing rate of growth of the uninsured and underinsured populations in the HSA.

UNCOMPENSATED CARE COSTS					
	FREE CARE (UNCOMPENSATED)	MEDICAID (ABOVE REIMBURSEMENT)*	MEDICARE (ABOVE REIMBURSEMENT)	INTERPRETATION (UNCOMPENSATED)	TOTALS
Manchester Community Health Center					
FY04	\$784,037	\$44,197	\$25,923	\$68,395	\$922,552
FY05	\$724,354	\$0*	\$12,435	\$76,513	\$813,302
FY06	\$895,417	\$0*	\$19,312	\$110,365	\$1,025,094
FY07	\$872,725	\$0*	\$14,308	\$140,877	\$1,027,910
FY08	\$907,752	\$333,627	\$76,903	\$118,217	\$1,436,499
Dartmouth-Hitchcock					
FY04	\$960,983	\$2,651,959	\$2,138,378	\$61,715	\$5,813,035
FY05	\$1,234,914	\$2,923,624	\$2,467,544	\$64,916	\$6,690,998
FY06	\$2,195,330	\$3,674,913	\$3,550,244	\$129,921	\$9,550,408
FY07	\$2,460,469	\$4,206,485	\$4,320,846	\$116,637	\$11,104,437
FY08	\$2,273,400	\$4,706,871	\$4,967,233	\$213,533	\$12,161,037
Child Health Services					
FY04	\$166,430	\$1,006,570	not applicable	\$24,774	\$1,197,774
FY05	\$170,762	\$932,240	not applicable	\$30,865	\$1,133,867
FY06	\$151,802	\$922,198	not applicable	\$31,815	\$1,105,815
FY07	\$176,270	\$1,037,599	not applicable	\$28,907	\$1,242,776
FY08	\$246,004	\$975,016	not applicable	\$29,657	\$1,250,677
Mental Health Center of Greater Manchester					
FY04	\$423,162	not tracked	not tracked	\$33,925	\$457,087
FY05	\$434,734	not tracked	not tracked	\$18,520	\$453,254
FY06	\$461,934	not tracked	not tracked	\$42,577	\$504,511
FY07	\$1,306,478	not tracked	not tracked	\$55,091	\$1,361,569
FY08	\$1,317,306	not tracked	not tracked	\$62,327	\$1,379,633
Catholic Medical Center					
FY04	\$5,211,298	\$3,170,650	\$6,680,639	\$22,622	\$15,085,209
FY05	\$2,978,197	\$4,140,131	\$8,860,785	\$27,795	\$16,006,908
FY06	\$4,603,877	\$5,058,360	\$10,624,876	\$54,716	\$20,341,829
FY07	\$4,891,039	\$6,556,228	\$11,500,427	\$54,111	\$23,001,805
FY08	\$5,666,411	\$5,708,464	\$16,687,495	\$58,588	\$28,120,958
Elliot Health System					
FY04	\$5,057,339	\$3,755,889	\$5,861,532	\$42,953	\$14,717,713
FY05	\$6,184,954	\$4,421,925	\$5,154,347	\$40,905	\$15,802,131
FY06	\$6,627,200	\$5,357,769	\$7,165,160	\$77,970	\$19,228,099
FY07	\$7,272,925	\$7,934,263	\$14,304,696	\$86,828	\$29,598,712
FY08	\$7,695,558	\$11,011,448	\$13,393,257	\$133,703	\$32,233,966
TOTAL	\$74,353,061	\$80,530,426	\$117,826,340	\$2,059,738	\$274,769,565
<i>*Medicaid settlement for costs above what has already been paid is still under review</i>					
<i>Source: Community Provider Organizations Uncompensated Care Provided by Manchester Health Care Organizations: FY 2004 – FY 2008</i>					

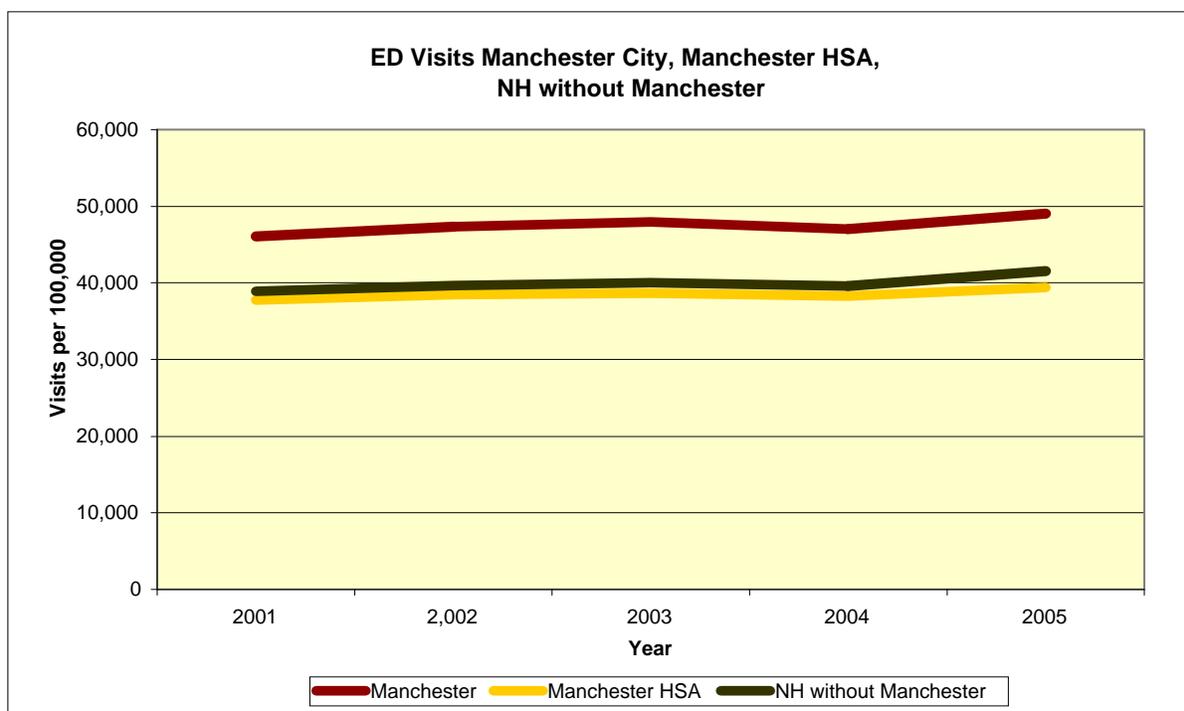
From 2004 to 2008, the costs to the HSA health care organizations for providing uncompensated care increased by about 50%. During this time, the HSA health care organizations (MCHC, D-H, CHS, MHCGM, CMC, EHS) contributed a total of \$274,769,565 in uncompensated care to the community. This represents \$74,353,061 in free care, \$80,530,426 for costs of care provided for

Medicaid patients above and beyond what is reimbursed by the Medicaid program, \$117,826,340 for the cost of care provided to Medicare patients above reimbursement by the Medicare program, and \$2,059,738 for interpretation services.*

MISUSE—ACCESSING CARE IN THE WRONG PLACE, AT THE WRONG TIME, AT HIGHER COST

Misuse in the form of medical errors and accessing care in the wrong place has adverse affects not only on the patient but also the health care system. Medical errors have been associated with preventable death and adverse drug events. Delaying a medical visit until late at night when the only available provider is the emergency department (ED) not only puts the health of the patient at risk, but also increases the cost of care exponentially as the average cost of an ED visit is about five times more than a primary care visit.

The combination of inadequate insurance and lack of a medical home often results in inappropriate utilization of health care services. In fact, “lack of accessible primary care is the factor most commonly named in determining why patients, regardless of their insurance status or acuity, seek care in the ED.”⁹⁵ As illustrated in the figure below, overall ED visits (for all causes) for Manchester residents have consistently occurred at significantly higher rates compared to the rest of the state for the years 2001 through 2005. However, visits for all HSA residents compared to the state (HSA includes Manchester) did not differ significantly during this time. These data suggest that Manchester residents may have more trouble accessing primary care than do those who reside in the towns surrounding Manchester.



Source: NH DHHS

* Free care is defined by the community health care organization as the total unreimbursed cost of the free or reduced fee care provided due to a patient's financial situation.

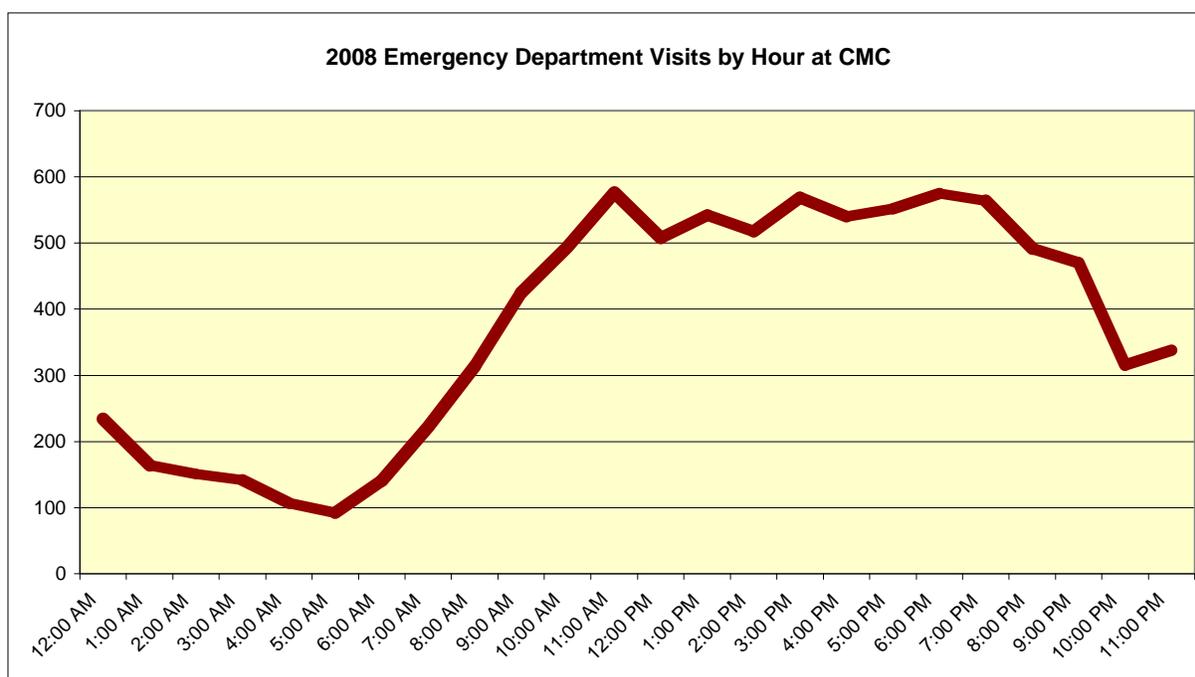
LOCAL EMERGENCY DEPARTMENT (ED) VISITS

Recent data from the two HSA community hospital EDs illustrate that many residents are using the EDs to obtain services or care that often could be provided in a primary care setting which is more cost effective for the entire community.

In 2008, CMC and EHS EDs provided 88,100 ED visits to 56,109 unique individuals (an average of 1.6 ED visits per person per year). Of these 88,100 ED visits 10,856 resulted in patient admission to the hospital.

Also, 26% (n=19,793) of these ED visits are classified as level one (LI) or level two (LII) visits (visits for care that could have been obtained in a primary care physician's office)

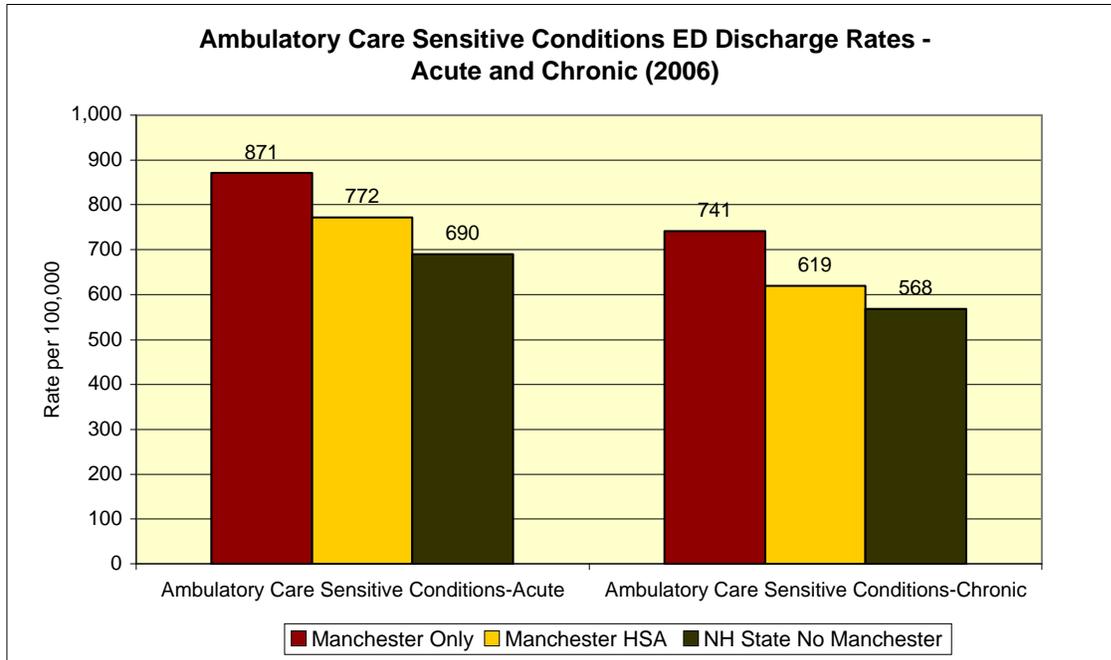
- 89% (n=17,220) of these LI & LII visits were for persons who lived in the HSA.
- 70% (n= 13,515) were for persons residing in Manchester.
- 19% (n=3,705) were for persons living in the towns surrounding Manchester included in the HSA as defined by this report.
- 36% of the 19,793 LI & LII visits (n=7,222) were for self-pay patients (those who are uninsured or underinsured).
- ED usage at Catholic Medical Center peaks between 11:00am and 7:00pm which may speak to the need for expansion of primary care hours during the day, open scheduling across community providers, and or education of patients on how to appropriately use primary care and area EDs.



Source: Catholic Medical Center

Like the Level I and II ED visits, Ambulatory Care Sensitive Conditions (ACSC) are defined as medical conditions that are less likely to require inpatient hospitalization if timely and appropriate primary care is received.

These local data depicting high use rates of the area EDs for non-urgent care is supported by 2006 data provided by NHDHHS. An indication that the health care organizations in the area may not be functioning as a coordinated system for the population for which they are responsible is the significantly higher rates of ACSC discharges (for Manchester area residents) compared to the ACSC discharge rates for the rest of the state's residents as illustrated in the figure below.



Source: NH DHHS



AREA RESIDENTS WEIGH IN: ACCESS TO QUALITY HEALTH CARE SERVICES

HEALTH CARE AVAILABILITY OVERVIEW

In general, focus group participants and key leaders from the HSA towns outside of Manchester recognized that several options exist for accessing health care services in the Manchester area. Participants mentioned by name The Greater Manchester Mental Health Center, Easter Seals, The Senior Center, West Side Neighborhood Clinic, Manchester Community Health Center, Child Health Services, Elliot Health System, Catholic Medical Center, Dartmouth Hitchcock-Manchester, Urgent Care, Poisson Dental Center, 211 information line, and several physicians in private practices as being available to provide them services.

However, despite having access to these many providers, participants stated that the cost of care (particularly for medications and dental care) and getting access to oral health, substance abuse, mental health and vision care was very difficult, especially for those lacking insurance, or those insured by Medicaid or Medicare. In addition, access to specialty care services was an issue for those living outside of Manchester. Making and keeping appointments and coordinating administrative processes for billing were mentioned as often being difficult.

ISSUES OF ACCESS

Forty-five percent of focus group participants reported having problems accessing care in the past twelve months. The table below displays the problems described by participants in order of prevalence.

ACCESS	%
Difficulties getting transportation	11%
Long waiting times in office	11%
Lack of convenient hours	8%
Could not find a doctor accepting new patients	7%
Difficulties in making appointments	6%
Don't know where to get health care	5%
Can't get off from work	3%
Difficulties getting child care	2%
Do not understand medical directions	2%

Transportation

The access issue mentioned by most participants was transportation. Focus group participants are aware of the medical transportation systems in the area (public transportation, ServiceLink, Caregivers, Easter Seals, etc.), but stated that these services do not adequately address their needs. The participants said the bus routes are too far apart, not handicapped accessible, and schedules are too difficult to match to medical appointments in a timely fashion.

Towns Surrounding Manchester: Several town leaders mentioned transportation for the elderly as an issue. Elderly have a difficult time traveling within their towns, as well as out of town to medical appointments in Manchester or Concord, especially specialty care appointments which are most often out of town.

People Don't Know Where to Get Health Care Services

Several focus group participants stated that they were not aware of the services available in their community and did not know where to turn for advice.

Towns Surrounding Manchester: Leaders interviewed from the towns surrounding Manchester brought this issue of awareness up several times especially in regard to mental health services, specialty care services, and in general, knowing what services were available in the area.

Securing Interpretation Services is a Challenge

Securing medical interpretation services remains a challenge for participants who represented minority and immigrant populations. One woman stated that immigrants do not go to the doctor because they are not understood by the person on the phone who says, "I cannot understand you." She also reported that the immigrant community needs to rely on friends or family members to help with medical interpretation and that this affects care.

Participants from Somalia stated that they are able to get their needs met with help from the staff at the Somalia Development Center (SDC). Several respondents in this group stated that "all their needs are taken care of by the SDC". SDC schedules appointments, handles transportation, provides translation at the appointments, and picks up prescriptions. Additionally, the SDC will call the ED if needed in the middle of the night.

Mental Health Care

Mental health care access was most important to participants dealing with mental health issues and disabilities and for those needing treatment for mood disorders, suicide and substance abuse. Participants dealing with mental health issues talked about the challenge of finding appropriate services for their adult dependent children, the lack of training for those in law enforcement and criminal justice systems, and the shortage of mental health professionals available to respond to individuals experiencing a mental health crisis in the ED.

Several respondents talked about how difficult it is to support someone through a mental health crisis. They stated that after an acute episode involving ED or hospital care, they had experienced incidents of being referred back to the community to seek follow-up care which had not been readily available to them in the first place. Additionally, it was noted that there is no detoxification center in the area and that there is lack of access to adequate mental health care and medication in the area prison system.

Towns Surrounding Manchester: Several leaders from the HSA towns surrounding Manchester noted that gaining access to mental health providers is often difficult as there may still be a stigma attached to obtaining this type of care. Leaders thought it would be helpful to have mental health services provided through primary care in the local area. Additionally, leaders mentioned a general lack of awareness about where to get mental health care services.

Oral Health Care

The high cost of oral health care for either preventive or restorative work was a concern addressed in every focus group. Community members are aware of the importance of good oral health and how it impacts their general health status, but many go without routine care. Many focus group participants did not have dental insurance, or if they had Medicaid, could not find dental practices in the area who

would accept this payment. Participants stated that they could make appointments when they needed them, but simply could not afford the cost. Therefore, they put off care unless they had a crisis or if they did go for an appointment, have only the necessary services and forego more expensive care, such as x-rays. One Manchester resident stated that she travels more than 60 miles north of the HSA for oral health care because the cost of cleanings is cheaper.

Towns Surrounding Manchester: Leaders from the HSA towns surrounding Manchester stated that access to oral health care services because of cost was an issue both for children and for adults.

Several of the participants had diabetes and were acutely aware of the impact of poor oral health on their insulin levels. They too had experienced barriers to obtaining oral health care. Most participants were aware that oral health services are provided by the Poisson Oral Health Clinic, although, they reported that they had had difficulties getting appointments there. Almost all participants were aware of the oral maxillofacial surgical unit at the Elliot Health System.

Specialty Care – Towns Surrounding Manchester

It was noted by leadership from the HSA towns outside of Manchester that there were long waits for specialty care services, including access to dermatologists and neurologists.

Use of the Emergency Department

The median number of visits that the focus group participants (or someone in their family) made to the emergency department during the past year was one, and the maximum number of visits was ten. Of those participants who utilized an emergency department, 54% reported that they had considered seeing a doctor in his or her office before going to the emergency department.

The participants were asked to describe their decision-making process leading to the ED visit. In the case of non-critical visits, all but one of the participants stated that he or she went to the ED only after first calling their doctor's office. This person went to the ED because he or she had tried calling his doctor, but did not get a response.

Services for Those with a Disability or Mental Health Issue

In the focus groups with individuals dealing with a disability and/or a mental health issue, there was concern about the availability of services and getting assistance for individuals with disability when they become 21 years old. Up to that point, the local school districts assume much of the cost for helping individuals function somewhat independently. However, when they turn 21 years old, their benefits shift to the NHDHHS. Caregivers and individuals alike are deeply concerned with the state's inability to meet their needs. One caregiver said "it will result in more emergency room visits".

ISSUES OF COST

According to data from the 2007 National Health Interview Survey, 8% of Americans (23.1 million) delayed medical care at least once in the previous year due to the cost of care. Additionally, 6% (17.3 million) did not receive care at all because of the cost of care. Thirty-four percent of the focus group participants reported having trouble seeing a doctor in the past 12 months due to cost. Among participants, the biggest cost barriers were related to no insurance (18%), cost of insurance (11%) or they could not afford a doctors visit (11%).

COST BARRIERS	%
Trouble Seeing a Doctor Because of Cost	34%
Specific Cost Barriers	
No insurance	18%
Can't afford medications	11%
Can't afford to visit the doctor	11%

Cost of Insurance

Many participants had experienced a recent job loss or they were concerned of an imminent separation from work for a family member. Several participants said they couldn't afford to purchase their health insurance through COBRA because their unemployment benefits were too little. The lack of health insurance coverage was recently documented in a publication from Families USA.¹⁰² This report gives a state-by-state profile on the status of insurance coverage and documents that as the income levels of individuals go down, uninsured rates go up. Specifically, of the 279,000 uninsured New Hampshire residents nearly three-quarters (72.4%) went without health coverage for six months or longer (2007-2008). According to this report, the majority of the uninsured are full-time workers (69.7%) or part-time workers (9.5%).¹⁰²

Cost of Prescriptions

Several participants had a hard time paying for medications and made difficult choices to address their medical priorities. One participant stated that he lied for several months to his doctor about the quantity and frequency of use of his insulin. His wife was recently laid off from work and he could no longer afford the co-pay for the office visit and his medication. He was desperately afraid of running out. In an attempt to stretch out his supply, he was taking less and less. Finally, he told his doctor about his fear of being dropped from the practice because he could not pay the co-pay and his struggle to buy the medication. Another participant faced a similar situation. As a recent cancer survivor and pulmonary patient, she could not afford the mounting expenses to treat both conditions. Caught in the "donut hole" with Medicaid and the need to spend down, she decided to stop taking the medication for her cancer. Acting completely rationally she said, "I need to breathe more". She continues to explore alternative ways to purchase cheaper drugs either on-line or in Canada.

In terms of getting prescriptions filled, several respondents mentioned they missed the pharmacy at DH-M. It was very convenient as they could fill their prescription when at the facility for their appointment.

Growing Gap between Those with and Those without Insurance Coverage

Several participants stated that they felt a strong resentment toward the government, toward populations perceived to be getting care and services more easily (e.g., new immigrants) and the health care system in general. Given the downturn in the economy, several participants stated that

they felt that they had no options or a place to turn to help them pay for the cost of their medical care, prescriptions, or dental work. For those who had applied for assistance, many were denied benefits because their income was too high based on their most current earnings.

ISSUES OF QUALITY

Most focus group participants were very satisfied with the quality of care they receive from their medical providers. A handful of participants said they had experiences with uncaring staff at the emergency department (ED), but attributed this to the staff being overworked.

Several participants talked about feeling alone dealing with either their medical problems or with that of a family member. In one focus group, a participant stated that a family member was sent home after major surgery with a feeding tube and no visiting nurse or help in place to provide care. Participants thought that this sense of isolation occurs, in part, because the provider office visits are often too short, and leave the patients little time to explore their concerns. Several participants stated that they did not have the knowledge to ask the right questions to prepare themselves for discharge from a medical stay. Also, several participants stated that they needed help with coordinating services, making decisions about care for more complicated conditions, exploring options for themselves or a loved one, and helping with information and referral.



DATA SNAPSHOT: PEOPLE ACCESSING QUALITY HEALTH CARE

The table below summarizes the main themes talked about by Key Leaders and Focus Group Participants in regard to what the community is doing well and where it could do better in regard to issues of *Health Care Availability* and *Access to Transportation and Interpretation Services*.

INDICATOR	MAIN THEMES
Health Care Availability	<p>WHAT WE ARE DOING WELL</p> <ul style="list-style-type: none"> • Immunizations • Health providers do a good job providing access to the uninsured • Kudos to providers • Mobile Community Health Team is a success • Healthy families are ok • Poisson Dental Clinic <p>WHERE WE COULD DO BETTER</p> <ul style="list-style-type: none"> • Increase the number of oral, mental, and vision care providers who accept Medicaid and Medicare, and offer sliding fee scales • More primary care providers in towns surrounding Manchester • Expand school-based dental services in towns surrounding Manchester • Increase services for aging population • How to pay for services for the uninsured? • Emergency Department volume is a big concern especially in relationship to inappropriate use of these services • More public education about the appropriate use of health care services, including Emergency Department services • Develop disincentives for Emergency Department use • Develop a day center for the homeless • Improve economic access • Cost is an issue for chronically ill, terminally ill, and vulnerable populations • Wrap around for those who need it for a finite period • Medicaid creates a disincentive to work • We need day care, job training, and health insurance for everyone and then wean them off during 2-3 year period • Better access to specialty care especially in the towns surrounding Manchester • Increase capacity of the Manchester Community Health Center
Health Care Access (Transportation and Interpretation)	<p>WHAT WE ARE DOING WELL</p> <ul style="list-style-type: none"> • Connections to International Center are helpful • Language line • Health Department welcome center • We are trying to meet community needs for interpretation and translation services • Attorney in district court translated forms into several languages • Easter Seals transportation • Health systems shuttle buses

	<p>WHERE WE COULD DO BETTER</p> <ul style="list-style-type: none"> • We need more funding for interpretation and translation services • Interpretation is an unfunded mandate • Interpretation is expensive • Translation for disabled is expensive • Interpretation for Deaf • Transportation issues are unique for different populations • It is hard for people to get to work and to appointments when they have to rely on the public transportation system • The elderly in and outside the City struggle with the issue of transportation • Transportation is a big issue for towns outside the public transportation system of Manchester • City transportation services as designed are not meeting the needs of the public • The City needs more funding for refugee resettlement • NH refugee resettlement office should be located at NHDHHS. Child care is impossible to afford for those on TANF who need to work 30 hrs/week to maintain this benefit • Emergency planning and responders for towns outside of Manchester should be enhanced
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CONCLUSION

Historically, public health has focused on the prevention and control of infectious diseases. Advances in medical technology, combined with effective population-based public health interventions have influenced a transition from a focus on communicable disease to a focus on managing chronic conditions. Patients requiring ongoing care for chronic conditions need to be supported with an integrated, coordinated system ranging from primary care to specialist consults and community-based interventions are needed to compliment these services. Thus, it is essential that the community and all of its providers collaborate to prevent chronic disease and produce more desirable health outcomes.

Key leaders in Manchester recognize that our medical system is focused on treatment rather than prevention, and that assuring positive health outcomes for area residents will necessitate a commitment to system redesign framed by quality measured and health outcomes data.

As for enhancing the ancillary services that must be developed if Manchester hopes to create a comprehensive quality primary care system “Manchester struggles with being small and big” simultaneously. It was noted by key informants and local residents that the City seemed too big to rely on the transportation and translation and social services it currently has, but on the other hand is too small to raise enough money to build the infrastructure needed to support the population in these areas.