Priority Goal: Access to Health Care

Goal 1: Improve access to comprehensive, quality health care services by addressing identified gaps in services and barriers to accessing care.

Process Snapshot:

Assuring access to quality health care is an essential public health service. Through the 2018 community health assessment, South Heartland made a deliberate effort to evaluate gaps in services and barriers to accessing care. To address access to care concerns, the CHIP strategies, objectives and key performance indicators will address the barriers and gaps identified by health system users, community leaders and providers. Top identified barriers included cost, affordability, insurance/reimbursement, transportation and education/awareness. Top identified gaps included mental health practitioners, substance abuse prevention and treatment services, school-based health services, specialty services, emergency services and chronic disease management. These barriers and gaps are addressed through strategies that expand services, address transportation needs and insurance coverage, provide system navigation and support, promote evidence-based practices, address disparities, and connect people and organizations to resources and information.

Line of Sight Performance Measures and Targets

Local targets were set to achieve a 6% improvement over the next 6 years, consistent with the target of 10% change over 10 years set by Healthy People 2020.
Source- *BRFSS, 2016* (adults, >18 years)

- Increase the proportion of persons with a personal doctor or health care provider.
  Baseline: 83.5% (State 80.9%)
  Target: 84.0%
- Increase the proportion of persons who report visiting the doctor for a routine exam in the past year.
  Baseline: 67.0% (State 64.1%)
  Target: 71.0%
- Decrease the proportion of persons aged 18 – 64 years without healthcare coverage.
  Baseline: 13.9% (State 14.7%)
  Target: 13.0%
- Decrease the proportion of persons reporting cost as a barrier to visiting a doctor in the past year.
  Baseline: 11.4% (State 12.1%)
  Target: 10.7%
- Increase the proportion of persons who report visiting a dentist for any reason in the past year.
  Baseline: 64.7% (State 68.7%)
  Target: 68.5%

Priority Area 1: Access to Health Care			
Strategy 1a: Access to health care through expanded services			
6 Year objective: Expand access to primary care, oral health and behavioral health services by securing a satellite Federally Qualified Health Center (FQHC) in Hastings			
What will be measured: • Services are available through a satellite FQHC in Hastings.	**Baseline/Target:** • 0 / 1 Satellite clinic	**Data Source:** N/A	**Timeframe:** by 2024
Continuum of Care: • Access	**Population:** • Uninsured, Underinsured, and Vulnerable Populations	**Setting:** • FQHC	**Lead Organizations:** • Heartland Health Center • SHDHD • Mary Lanning Healthcare
Evidence Based: CHRR – FQHC, access regardless of ability to pay; Medical Homes		**Lead workgroup:** Access to Care Steering Committee	
Short Term Key Performance Indicators (KPIs): • Community partners provide data and resources to support the application process. • Initiate education to stakeholders for history and current progress toward a satellite FQHC in Hastings.	**Intermediate Term KPIs:** • Application submitted to HRSA for satellite access point. • Complete education to stakeholders for history and current progress toward a satellite FQHC in Hastings.	**Long Term KPIs:** • If funding secured, assure FQHC is operational within 120 days.	
Partners: Heartland Health Center (Grand Island), SHDHD, Mary Lanning Healthcare, Primary Care Providers, Lanning Center for Behavioral Services and other Behavioral Health Providers, South Central Behavioral Services (SCBS), Dental providers			

Priority Area 1: Access to Health Care			
Strategy 1b: Access to health care through expanded services			
6 Year objective: Improve access to substance misuse/behavioral health acute care services by assessing medically-assisted detox and related services			
What will be measured: • Completed assessment report with recommendations	**Baseline/Target:** N/A	**Data Source:** N/A	**Timeframe:** by 2024
Continuum of Care: • Access	**Population:** N/A	**Setting:** • Healthcare System • Community	**Lead Organizations:** N/A
Evidence Based: CHRR – mobile applications for MH		**Lead workgroup:** Access to Care Steering Committee	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs:**	**Long Term KPIs:**
• Establish a task force to assess availability of resources and services for acute substance use/behavioral health needs in Adams, Clay, Nuckolls and Webster counties.	• Report with recommendations based upon the assessment.	• Initiate action on task force recommendations.

Considerations: Patient population (adult, pediatric), regulations, costs, resources, staffing/workforce, location, training needs. Utilize/expand current MLH-based Mental Health/Substance Use Task Force
Partners: Hospital ERs, law enforcement/EMS, justice system, mental health providers/Lanning Center (outpatient behavioral health services), MLH (inpatient behavioral health services), South Central Behavioral Services, Mid-Plains Center (Grand Island, serving 23 counties), SHDHD, Region 3 Behavioral Services, DHHS Division of Behavioral Health

Priority Area 1: Access to Health Care			
Strategy 1c: Access to health care through transportation			
6 Year objective: Improve access to care by expanding transportation options			
What will be measured: • Availability of and gaps in reliable transportation (public and private)	**Baseline/Target:** TBD	**Data Source:** • CTSA • Local map/listing	**Timeframe:** by 2024
Continuum of Care: • Access	**Population:** • Residents requiring transportation assistance (physical, financial)	**Setting:** • Community	**Lead Organizations:** • United Way
Evidence Based: CHRR Rural Transportation Services		**Lead workgroup:** Access to Care Steering Committee	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs:**	**Long Term KPIs:**
• Completed environmental scan of available transportation services in all four counties (hours of operation, schedule requirements, costs).	• Proposal for increasing transportation services with recommendations.	• Number of recommendations implemented to reduce gaps and increase availability.

Considerations: volunteer liability/safety of volunteer and patient, hours of operation, schedule requirements, number of vehicles/drivers, cost, voucher options, reimbursement (insurance, Medicaid, ACEs, other benefactors)

Priority Area 1: Access to Health Care			
Strategy 1d: Access to health care through insurance coverage			
6 Year objective: Improve access through empowering people with knowledge to obtain and utilize insurance options			
What will be measured: • The percentage of insured adults, ages 18-64	**Baseline/Target:** 84.9% / 90%	**Data Source:** • BRFSS (2017) **Target Setting Method:** 1% per year improvement	**Timeframe:** by 2024
Continuum of Care: • Access	**Population:** • Adults, ages 18-64+ • Uninsured, self-employed, fixed income	**Setting:** • Community/Service CBO • Provider office/hospital • Worksites	**Lead Organizations:** • MAAA • United Way • BMH • MLH
Evidence Based: HP2020/SDOH AHS-1.1; CHRR Health insurance enrollment outreach & support; MH benefits legislation; Ten Attributes of a Health Literate Organization #10		**Lead workgroup:** Access to Care Steering Committee	
Short Term Key Performance Indicators (KPIs): • Identify lead agency or workgroup to implement strategy. • Inventory of insurance education resources.	**Intermediate Term KPIs:** • Proposal for increasing insurance education resources or promoting current resources. • Develop tool for measuring effectiveness of interventions.	**Long Term KPIs:** • The number of recommendations implemented to assist people in obtaining and utilizing insurance. • Report on effectiveness of interventions.	
Considerations: focus on understanding and utilizing insurance (private/commercial, Medicare/Medicaid, expanded Medicaid, Medi-share/Healthshare, Tricare/Veterans, clinic memberships, fee for service, sliding-scale), worksite HR **Partners:** AARP, Medicaid Managed Care, MAAA, local insurance agents, insurance navigators (community/clinic/hospital)			

Priority Area 1: Access to Health Care			
Strategy 1e: Access to health care through system of navigation and support			
6 Year objective: Improve access through professional or lay workers trained in patient navigation, coaching and advocacy			
What will be measured: • Professional or lay workers trained in patient navigation, coaching and advocacy	**Baseline/Target:** TBD	**Data Source:** • SHDHD survey/inventory from CHW project	**Timeframe:** by 2024
Continuum of Care: • Access	**Population:** • Individuals at risk for poor health outcomes; vulnerable; those experiencing barriers	**Setting:** • Community • Healthcare	**Lead Organizations:** • SHDHD
Evidence Based: USPSTF, Community Guide – Chronic disease, behavioral health; CHRR – CHW engagement to expand access, Patient Navigators		**Lead workgroup:** Access to Care Steering Committee	
Short Term Key Performance Indicators (KPIs): • Create taskforce to lead an environmental scan of assistive workforce current status and emerging needs. • Inventory of community / organizational needs for trained professional and lay workers who navigate, coach, and/or advocate (assistive workforce). • Summary of current workforce serving in these roles.	**Intermediate Term KPIs**: • Gap analysis of training programs, curriculums, career pathways, competencies, and certifications for professional and lay workers who navigate, coach, and/or advocate (assistive workforce). • Recommendations for system/policy changes needed to identify, train, support and utilize this assistive workforce. • Develop ROI promotion for development of community-based and health system-based assistive workforce (see considerations, below).	**Long Term KPIs:**: • The number of recommendations implemented to identify, train, support and utilize this assistive workforce. • Implement ROI Promotion for development of community-based and health system-based assistive workforce.	
Examples: Community Health Workers - CHW (Promotora, Lay health ambassadors, Lay health workers), navigators, social workers, health coaches, chronic care managers, case managers, home visitation, and EMS expanded roles **Partners:** AHEC, CCC, Pathways Program, Hastings College, Providers, Employers, Community Based Organizations, PHAN Community Health Worker Section **Considerations:** Scopes of practice, core competencies, certifications, liability, curriculums, cost/return on investment, internships, community needs/system drivers, career development/career pathways, workforce development; ROI promotion (organizational productivity, efficiency, revenue; jobs/economic development; quality of care/access to care, and patient outcomes), CCC Project HELP (support education completion/guidance to healthcare jobs)			

Priority Area 1: Access to Health Care			
Strategy 1f: Access to health care through evidence-based practices			
6 Year objective: Improve access to care through adoption of evidence-based practices that strengthen communication and understanding of health information			
What will be measured: • Adoption of evidence based practices	**Baseline/Target:** TBD	**Data Source:** TBD • Options: Local survey, Self-report	**Timeframe:** by 2024
Continuum of Care: • Access	**Population:** • Patient population	**Setting:** • Healthcare (target audience: clinic staff and providers)	**Lead Organizations:** • BMH • MLH • SHDHD
Evidence Based: CHRR (Health Literacy, Telehealth, telehealth services, text message interventions, medical homes); USPSTF - HIT; HP2020 AHS-3		**Lead workgroup:** Access to Care Steering Committee	
Short Term Key Performance Indicators (KPIs): • Identify lead agency or workgroup to prepare a list with supporting rationale of evidence-based practices and protocols that strengthen communication, sharing and understanding of health information.	**Intermediate Term KPIs:** • Determine champions or expertise to educate and assist implementation of evidence based healthcare practices. • Create a toolkit of evidence based practices and protocols to include associated experts and champions (local/regional/state), and/or tools and training for implementation.	**Long Term KPIs:** • Marketing and promoting use of evidence based practices and protocols that strengthen communication, sharing and understanding of health information in healthcare settings. • Number of practices that adopt new policies as a result of the toolkit information.	
Examples: EHR use (dashboards and reports), portals, patient reminders, community based referrals, text message based health interventions, health literate practices, mobile phone apps, digital monitoring, telehealth, preventative care provided at each visit, patient follow up, bi-directional communication, patient understanding and uptake of technology, behavioral counseling/one-on-one education, medical homes **Considerations:** communications and information-sharing: within clinics and between providers (including beyond PCP), between CBOs and providers, between providers/clinic and patients; goal: strengthen compliance, empower patient for healthy choices/decision-making, improve health outcomes, patient and provider education on use and benefits, relationship of low health literacy to portal barriers and use			

Priority Area 1: Access to Health Care			
Strategy 1g: Access to health care through addressing disparities.			
6 Year objective: Improve access by increasing awareness and understanding of factors that contribute to disparities			
What will be measured: • Organizations / individuals implementing a policy change to address disparities	**Baseline/Target:** TBD	**Data Source:** • Local training database	**Timeframe:** by 2024
Continuum of Care: • Access	**Population:** • Vulnerable populations	**Setting:** • Community	**Lead Organizations:** • United Way
Evidence Based: CHRR - Cultural competence training and culturally adapted healthcare		**Lead workgroup:** Access to Care Steering Committee	
Short Term Key Performance Indicators (KPIs): • Training Plan: training/education and target audiences identified. • Disparities Toolkit – examples of training, action planning and evidence-based policies and protocols that reduce disparities for identified populations.	**Intermediate Term KPIs:** • Training Plan initiated • Policy Toolkit/Resources launched and marketed.	**Long Term KPIs:** • Number of organizations implementing a policy change to reduce disparities in an identified population.	
Considerations: Vulnerable populations/those experiencing disparities to include: those living in poverty; military service men/women, veterans, and their families; rural/Ag geographically isolated / self-insured; race/ethnicity/language; school settings, older adults **Awareness Trainings:** Bridges Out of Poverty; Military Cultural Competency; Culturally and Linguistically Appropriate Services (CLAS); Trauma-Informed Care; ACEs and 40 Developmental Assets; AgriMedicine; Ask the Question Campaign (for Veterans, military service men/women, & their families), Older adult needs/services, Social Determinants of Health (e.g., food insecurity, housing insecurity and resulting family stressors)			

Priority Area 1: Access to Health Care			
Strategy 1h: Connecting people/organizations through access to resources.			
6 Year objective: Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services			
What will be measured: • Percent of users satisfied with the Resource Guide	**Baseline/Target:** N/A	**Data Source:** • Survey	**Timeframe:** by 2024
Continuum of Care: N/A **Level of Action:** Systems	**Population:** • General population; referral organizations	**Setting:** N/A	**Lead Organizations:** • Hastings Public Library
Evidence Based: CHRR – promotion of shared decision making in patient centered care & medical homes		**Lead workgroup:** Access to Care Steering Committees	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs**:	**Long Term KPIs:**
• Identify work group to implement strategy (to include at least one member from each Steering Committee). • Resource gaps are identified and filled. • A platform is determined to support interactive/accessible resource and referral guide.	• Promotion/education on the improved Resource Guide.	• Resource Guide that is more interactive and accessible (i.e., websites, Apps) to people and partners. • Resource Guide Evaluation/Satisfaction Survey Report.

Potential considerations: 211 system, Network of Care, Library system, SHDHD and Partner websites, App, Task Force (MCC, Social Workers, Catholic Social Services, Salvation Army, WIC, Churches, cities/counties, etc.), include application of Culturally and Linguistically Appropriate Services (CLAS) and health literacy practices, no wrong door! MyLNK app – use as example resource

Potential resources to include in the Guide: providers (Medicaid, holistic and alternative medicine), insurance education (expanded Medicaid, Medicaid/Medicare, Commercial Insurance), services in rural areas, provider – led resources, CHW/Navigators, Chambers of Commerce

"Bike Rack" Strategies

Access to Health Care "Bike Rack" Strategies are strategies identified through the CHA/CHIP process that have merit and may be included in future as additions or revisions of the Community Health Improvement Plan. These strategies also could be included in the strategic plans of individual organizations, as they are aligned with the CHIP Access to Health Care priority.

Access to Health Care through:

1. Schools
   - School-based Health Centers (EB: CHRR) [note – could be outreach of a federally-qualified health center]
   - Telemedicine [as an alternative/augmentation to school-based health centers for schools, school nurses and families]
2. Telemedicine/telehealth (EB: CHRR, deliver services remotely for patients with limited access to care)
3. Uptake and understanding of technology, e.g. intergenerational partnering, mentorship (EB: unknown)
4. System/Process that promotes consistent and collaborative health communications (SHDHD Strategic Plan) (EB: HP2020 HC/HIT-2)
5. Partnerships between CBOs, ACOs, etc. to improve patient outcomes (include in toolkit?)
6. Filling Gaps in Service: volunteer EMS (rural setting) – recruiting, retention, training

Abbreviations:
ACOs = Accountable Care Organizations
CBOs = Community-based Organizations
CHA = Community Health Assessment
CHIP = Community Health Improvement Plan
CHRR = County Health Rankings and Road Maps
EB = Evidence-based
EMS = Emergency Medical Services
HP2020 = Healthy People 2020