health policy institute of ohio

Ohio **access** basics

October, 2012

What is access to health care?

Historically, access to care has been a broad concept that incorporates dimensions of health care such as health insurance coverage, health care workforce capacity, and barriers that individuals encounter in getting care.

For purposes of this paper, the Health Policy Institute of Ohio (HPIO) uses the definition of access to health care developed by the HPIO Access Collaborative:[1]

Access to health care means having timely use of comprehensive*, integrated and appropriate health services to achieve the best health outcomes.

*comprehensive includes physical, behavioral (mental health and drug and alcohol addiction services), oral and vision health care services.

Building upon this definition, the HPIO Access Collaborative identified three pillars that help ensure access to care: coverage & affordability, quality care, and diverse & sustainable workforce. Together, these pillars help ensure access to health care which leads to improved health outcomes and reduced disparities.

inside

Measuring access to care

The three pillars that ensure access to care can be translated into a framework for measuring access to care in order to provide a more complete picture. Major components of such a framework include:[2]

- The presence or absence of specific resources that facilitate health care, such as
  - Health insurance coverage
  - Usual source of care
  - Workforce capacity
- Assessments by patients of how easily they are able to gain access to health care, such as
  - Delay in, or inability to get, needed medical care, dental care, or prescription medicines
- Utilization measures as the ultimate outcome of good access to care
  - Screenings and prevention services
  - Ambulatory care for sensitive conditions
  - Hospitalizations for selected medical conditions
  - Visits for routine check-ups

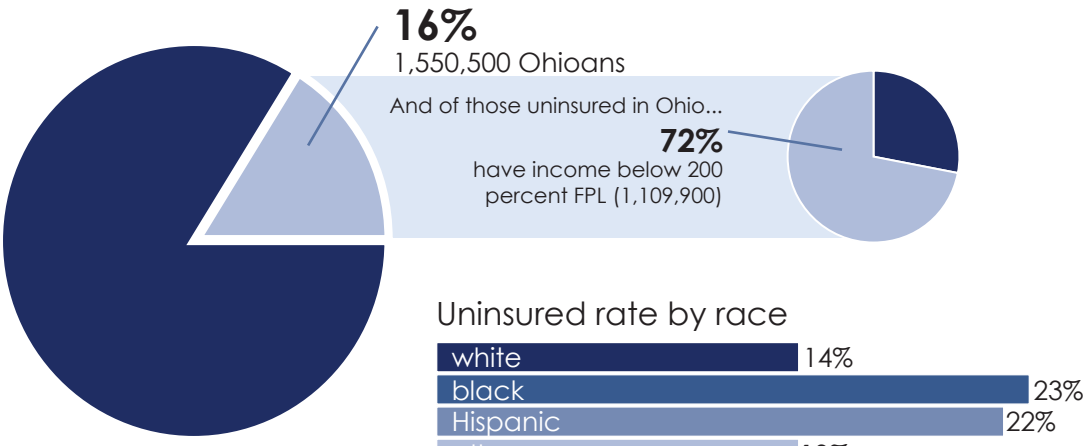
Other factors that can expand the definition of access include:[3]

- **Overall accessibility**: whether providers accept a particular form of insurance
- **Contact accessibility**: ease of contacting providers for appointments
- **Appointment accessibility**: length of time it takes to get an appointment
- **Geographic accessibility**: proximity of providers to patients

A snapshot of key access indicators in Ohio

Using this framework, here are some key indicators that provide a picture of Ohioans' access to health care.

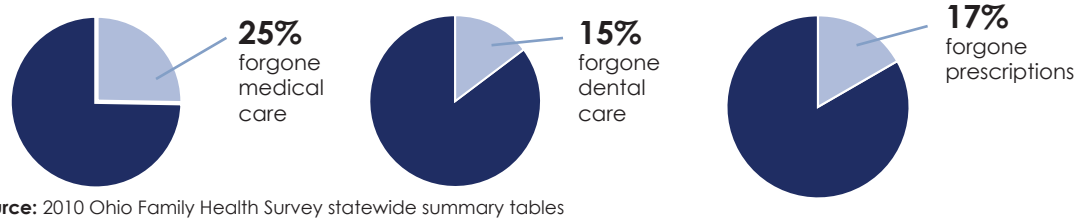
Uninsured rate (ages 0-64, 2010)



NOTE: Persons of Hispanic origin may be of any race; all other racial/ethnic groups are non-Hispanic."Other" includes Asian Americans, Pacific Islanders, American Indians, Aleutians, Eskimos and persons of "two or more races."

Source: The Kaiser Family Foundation State Health Facts

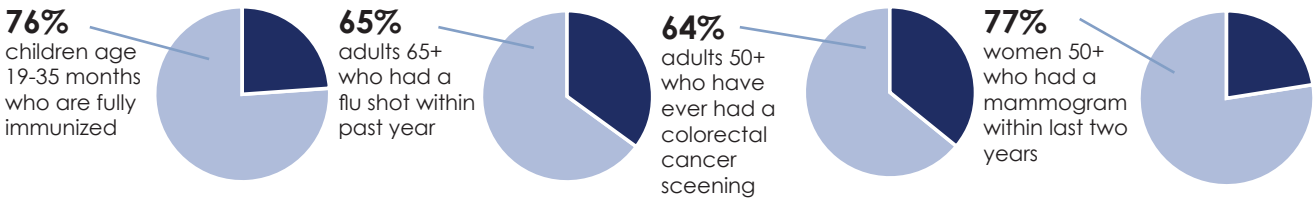
Ohio adults forgoing care in the past year (2010)



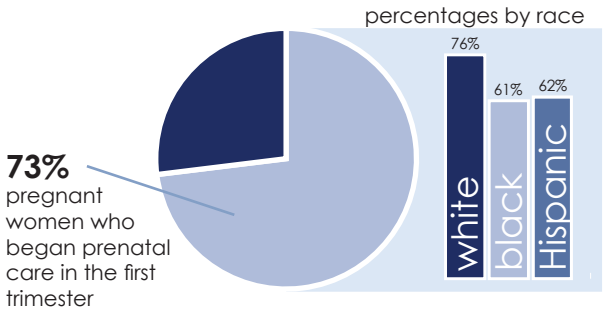
Source: 2010 Ohio Family Health Survey statewide summary tables

Ohio utilization measures and outcomes (2010)

Preventive

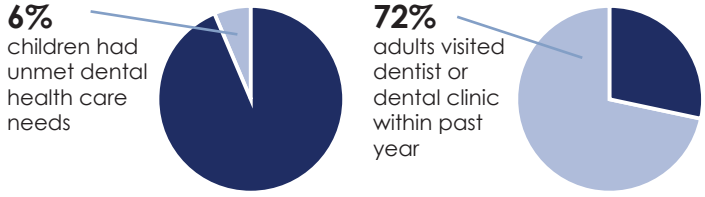


Source: The Kaiser Family Foundation State Health Facts



Source: Ohio Department of Health

Dental



Sources: 2010 Ohio Family Health Survey statewide summary tables; The Kaiser Family Foundation State Health Facts

Dental insurance

43% of Ohio adults lack coverage

15% of Ohio children lack coverage

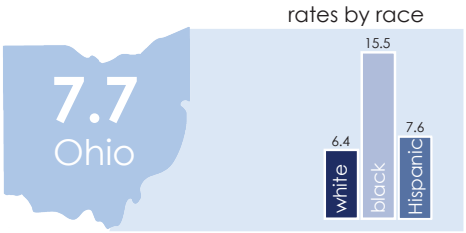
Source: 2010 Ohio Family Health Survey statewide summary tables

Mental health

Source: The Kaiser Family Foundation State Health Facts

Infant mortality rate (2006-2008)

(the number of deaths of children under 1 year of age, per 1,000 live births)



Source: The Kaiser Family Foundation State Health Facts

Where to find access data

Several national organizations produce online state scorecards or rankings that provide easy access to meaningful information about the status of population health and the health care system.

For more information, please visit the "HPIO guide to state health rankings and scorecards" at http://bit.ly/P8Juto. The following resources track access specifically:

- America's Health Rankings
- Commonwealth State Scorecard
- Commonwealth Local Scorecard
- County Health Rankings
- Kaiser State Health Facts
- Ohio Family Health Survey
- Robert Wood Johnson Foundation Data Hub

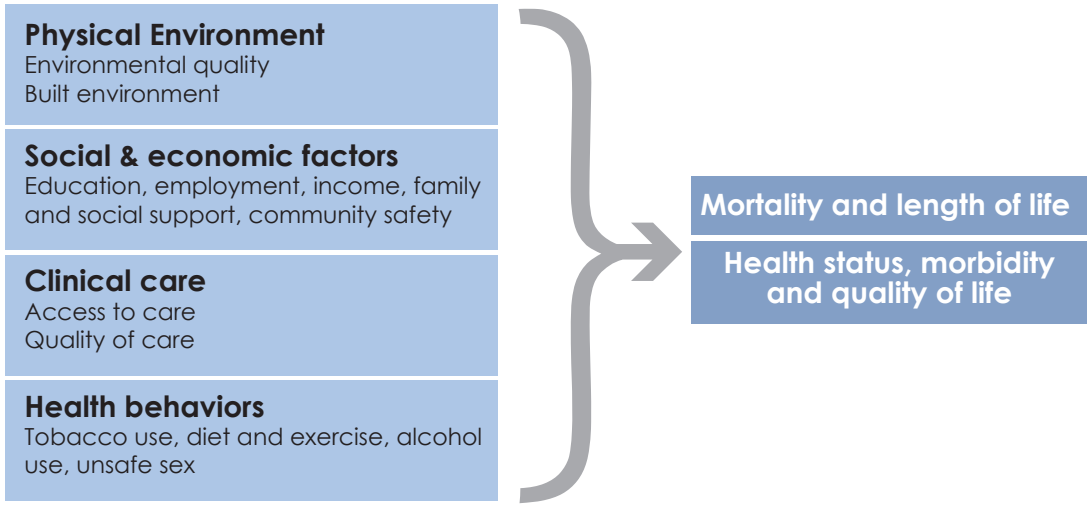
Access to care: One of many factors that affect health

Access to care is one of many interconnected factors that shape how healthy people feel and how long they live. Factors that affect health and wellbeing, often referred to as "determinants," include genetics and potentially modifiable conditions such as personal behavior, socioeconomic status, the physical environment, and characteristics of the health care system, including access to medical services.

While the importance of access to care relative to other determinants is difficult to estimate, it is clear that factors outside the doctor's office (such as personal behavior and access to healthy food and safe places to exercise and play) have a significant impact on health.[4,5]

The diagram below draws upon frameworks developed by University of Wisconsin Population Health Institute[6] and the Institute of Medicine[7] to illustrate modifiable determinants of health.

What influences health?



Why health insurance matters

How health insurance impacts health

In 2009 the Institute of Medicine issued a report that summarizes the extensive body of research regarding how health insurance improves access to health care, appropriateness and quality of care, and health outcomes.[8] This research finds that compared to insured individuals, uninsured adults and children are more likely to:

- Lack a usual source of care and routine check-ups
- Have medical debt
- Have unmet health needs

This lack of access and increased cost burden leads to several negative health outcomes for uninsured adults and children:

- Poorly managed chronic disease (such as inadequate blood pressure control)
- Cancer diagnosed at an advanced stage
- Poor self-reported mental and physical health status and functioning
- Premature mortality[9]

In addition to this national research, Ohio studies have found similar results. An August 2012 Ohio Health Issues Poll found that 84% of insured adult Ohioans had a usual source of care, compared to only 51% of uninsured Ohioans.[10] Analysis of the 2010 Ohio Family Health Survey concluded that compared to insured Ohioans, the uninsured were less likely to use medical and dental care and reported worse physical and mental health status.[11]

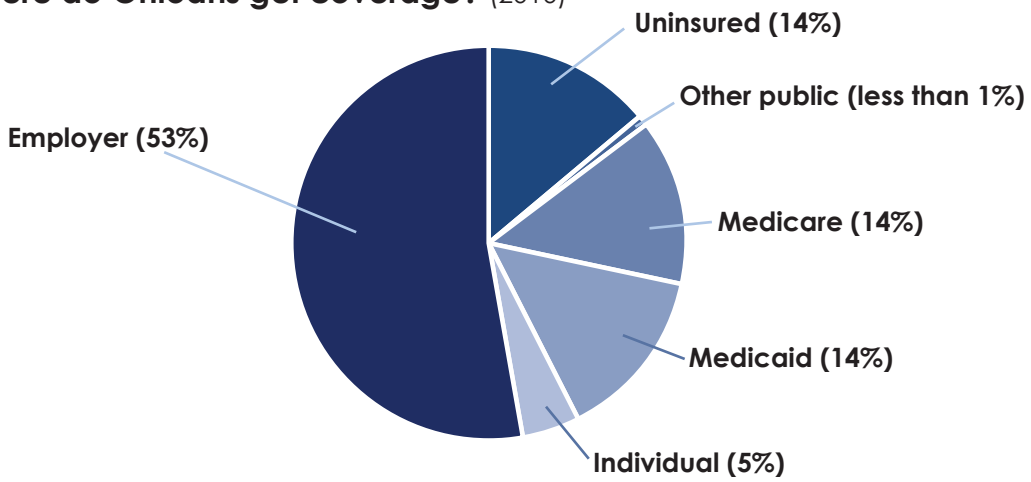
Who is insured and how?

When looking at the total population in Ohio, the predominant source of health insurance coverage is employer-sponsored coverage (53 percent). Fourteen percent of Ohioans are covered by Medicare, 14 percent by Medicaid and 14 percent are uninsured. A small percentage — 5 percent — purchase health coverage on the individual market.

How Medicaid impacts health

Medicaid is a public health insurance program that covers specific categories of low-income people. (For more information on Medicaid, see HPIO publication Ohio Medicaid Basics 2011, found at http://bit.ly/jYA32h). While Medicaid recipients typically have poorer health than those with private insurance, recent studies suggest that Medicaid is associated with improved health. A rigorous study in Oregon found that relative to uninsured low-income adults, new Medicaid recipients had less medical debt, used more health care, and reported better physical and mental health.[12] In a 2012 study that compared health outcomes for states that expanded Medicaid to those of neighboring states that did not, researchers found that the Medicaid expansions were associated with reductions in mortality and delayed care, and improved self-reported health status.[13]

Where do Ohioans get coverage? (2010)



Source: The Kaiser Family Foundation State Health Facts

NOTE: "Other public" includes individuals covered through the military or Veterans Administration in federally-funded programs such as TRICARE (formerly CHAMPUS) as well as some non-elderly Medicare enrollees

What about the underinsured?

Most people can define uninsured, but what does "underinsured" mean? People who are underinsured have health insurance that does not offer adequate financial protection. A more precise definition is people who are insured and have at least one of the following:

- Medical expenses that are 10% or more of income
- Annual income of less than 200% FPL and medical expenses that are 5% or more of income
- Health plan deductibles that are 5% or more of income[14]

Low-income families are most at risk of being underinsured, but the rates are rising for people at all income levels; nationally, 16% of adults with incomes between $40,000-$60,000 were underinsured in 2010, up from 5% of adults in 2003.[15]

Compared to those with insurance, the underinsured are more likely to forgo needed care. In addition the underinsured have financial stress similar to the uninsured.[16]

Who will remain uninsured after 2014?

One of the primary goals of the Affordable Care Act (ACA) is to expand health insurance coverage and reduce the size of the uninsured population. The main mechanisms for expanding coverage are health insurance reforms, subsidies for insurance purchased through a health insurance exchange, and a Medicaid expansion to 138% of the federal poverty level (FPL). As a result of the June 2012 Supreme Court decision on the ACA, the Medicaid expansion is optional for states. Ohio's plans for the Medicaid expansion are not yet known.

Estimates show that with a Medicaid expansion to 138% FPL, the number of uninsured Ohioans will fall by about half, from nearly 1.5 million in 2010 to 712,000 in 2017.[17]

A majority of the remaining uninsured will be nonelderly adults and will fall into these broad categories:[18]

	Uninsured Individuals (after ACA implementation)
Eligible for Medicaid but not enrolled	Individuals who are eligible for Medicaid and could be enrolled through better outreach and education. Mostly singles without dependents, or younger residents with lower incomes.
Undocumented immigrants	Undocumented immigrants are not subject to the individual mandate, and are not eligible for Medicaid or federal subsidies.
Those exempt from the individual mandate	Certain individuals are exempt from the requirement to carry a minimum level of health coverage (also known as the individual mandate). Exemptions include people with incomes so low that they do not have to file taxes ($9,500 for individuals;[19] $19,000 for married couples); people who do not have an affordable insurance option; members of certain religious groups and Native American tribes; incarcerated individuals; and undocumented immigrants.[20]
Eligible for subsidized coverage but not enrolled	Individuals who qualify for affordable subsidized coverage through insurance exchanges, but are not enrolled. Generally singles without dependents or younger residents with moderately low incomes.
Other uninsured adults	Individuals who have an affordable private insurance option, but do not qualify for a subsidy and voluntarily remain uninsured despite the mandate.[21] Some may have been previously insured, but chose to drop their coverage due to premium increases.[22]

Note: If Ohio does not expand Medicaid to 138% FPL, additional low income Ohioans, especially those under 100% FPL, will be uninsured because they may not be eligible for public insurance or federal subsidies for private coverage.

Barriers to access

Affordability

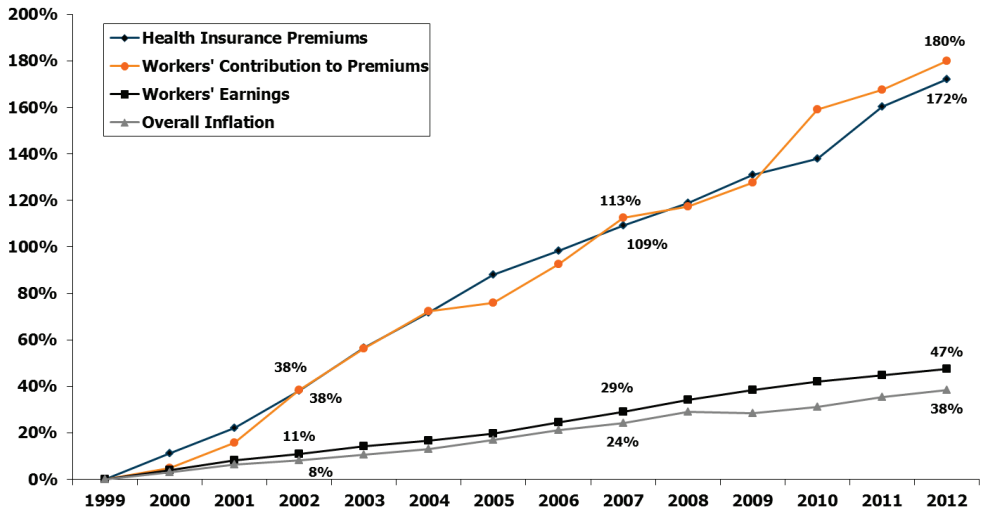
The cost of health care services and of health insurance coverage can be a significant barrier to accessing care. Consider the following:

- Among those Americans who report problems accessing health care, cost is the overriding obstacle to care, regardless of insurance status.[23]
- Fifty-one percent of uninsured Ohioans reported unmet health needs due to cost in 2010.[24]

Health insurance coverage can reduce financial barriers and facilitate access to care. Uninsured rates vary across income, with higher uninsured rates at lower incomes. Thirty percent of non-elderly Ohioans (ages 0-64) with incomes below 200% of the federal poverty level are uninsured, compared to 16% of all non-elderly Ohioans.[25]

For insured individuals, increases in the cost of health insurance premiums, as well as workers' contributions, continue to outpace inflation and earnings. The chart below illustrates this trend over time.

Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2012



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2012. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2012; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2012 (April to April).

Medical debt

Medical debt is money owed for medical services or products. It may be owed directly to a provider, a collection agent serving the provider, a credit card company, another lender, a family member or a friend.[26] Unlike other debt, medical debt is typically involuntary, meaning it arises from circumstances largely beyond a person's control. Even those who are insured are vulnerable to high health care costs. A 2012 Ohio poll showed that nearly 60% of Ohio uninsured adults reported having some medical debt, while nearly 40% of insured Ohio adults reported the same.[27]

In addition to the uninsured, people with low incomes, with self-reported fair or poor health, and African Americans have higher rates of medical debt.[28]

What do Ohioans owe money for?

According to the 2012 Ohio Health Issues Poll (OHIP), Ohioans reported their largest percentage of unpaid medical debt was for:

- Tests and diagnostic procedures (23%)
- In-hospital stays (20%)
- Emergency room visits (20%)

Ohio access profile

"I lost my job as an IT project manager in January 2008 and, as a result, our health coverage. I was 59 years old and there were very few jobs. I signed up for COBRA while I looked for work as my wife and I had preexisting conditions. Then the world fell apart with the housing/bank crisis and there were no jobs.

"The eighteen months of expensive COBRA coverage ran out faster than I ever imagined. In the fall of 2009, we applied for coverage with several major health insurance companies in Ohio and were turned down by all of them. We were able to apply for insurance with our preexisting conditions during a brief open enrollment period that provided us with coverage for $2200 a month. This coverage had a $5000 deductible so it covered virtually nothing until we exceeded the deductible. In January 2010, I dropped my coverage so we could afford my wife's coverage that year. They had raised the premium another $100 per month, bringing my wife's coverage to $1200 a month.

"After spending $14,000 that year and not exceeding the deductible again we dropped that high-risk coverage and decided to roll the dice. In June of 2011, we finally got some good news. A portion of the new health care act (Obamacare) went into effect that created temporary high-risk pools for those with preexisting conditions. We applied and were accepted. Our monthly premium was now $1050 for both of us and the deductible fell to $1500. Thank God, as in September I had a bad accident and fractured my pelvis in four places. It took several hospital visits, x-rays and finally an MRI to locate the fractures, resulting in bills for each of the services needed to diagnose and treat my injury. Luckily this coverage has protected us from going under."

— Eldon R. Motz of Summit County

Note: The high-risk pools will continue to provide coverage until January 1, 2014, when they are scheduled to be replaced by Affordable Insurance Exchanges, as described in the Affordable Care Act.

Medical debt and trouble paying medical bills can have far-reaching negative consequences, including:

- **Delayed medical care**, due to being embarrassed by outstanding bills, a desire not to take on additional debt, or being refused an appointment by a provider because of outstanding bills.[29]
- **Impaired credit**. Many medical bills ultimately end up in the hands of the collection industry. If unpaid, medical bills can linger for years, often long after medical providers have written them off the books as bad debt. Even small balances can have significant influence over one's credit, leading to problems ranging from being unable to qualify for a mortgage, being turned down from renting a home, and eviction or foreclosure.[30]
- **Tradeoffs in spending and saving priorities**. Among adults under age 65 reporting problems with medical bills or accumulated debt, one-quarter had been unable to pay for basic necessities like food, heat, or rent because of medical bills. Nearly 40% had used up all of their savings; one-quarter had taken on credit card debt; and 11% had taken out a mortgage against their home.[31]

Language barriers

Language barriers can impact access to care and can generally be categorized as low literacy or limited English proficiency.

Low literacy: Patients with low literacy lack the basic ability to read and understand the written English language. This can lead to low health literacy--the ability of patients to obtain, process, and understand basic health information.[32]

Nine percent of Ohio's adult population lacks basic literacy skills, compared to the national rate of 14.5%.[33] Franklin and Mahoning Counties' rates are above the state rate, at 13% and 10% respectively.[34]

Medical bankruptcy
Bankruptcies are generally classified as "medical" based on debtors' stated reasons for filing, income loss due to illness, and the magnitude of medical debts. While affecting a smaller number of people than medical debt, medical bankruptcies are an indicator of the toll that high health care costs can take on American families.

Illness and medical bills play an important role in a large proportion of bankruptcies, contributing to 62% of all U.S. bankruptcies in 2007, an increase of nearly 50% from 2001.[35] Most medical debtors were well educated and middle class. Less than one quarter were uninsured when they filed for bankruptcy.[36]

Limited English proficiency: Limited English proficiency (LEP) patients have a limited ability to speak, read, write or understand the English language because their primary language is not English and they have not developed fluency in the English language. This can cause difficulty communicating with health care providers. Limited access to trained interpreters at health care facilities exacerbates the problem.

Ohio's rate of limited English proficiency speakers is 2.3%, below the national rate of 8.7%, although Ohio's rate has been increasing slightly.[37]

Whether due to low literacy or limited English proficiency, language barriers impact access to care. Patients may have difficulty understanding medical information and basic instructions (such as medication treatments, medical appointment forms, and medical information pamphlets). Language barriers can result in misunderstandings between patient and provider, dissatisfaction with care, omission of vital information, misdiagnoses, inappropriate treatment, and lack of compliance.[38] In some cases, patients may avoid primary and preventive care facilities until emergency treatment becomes necessary.

Geographic barriers to health care

Geography can be a barrier to care, as general care providers and specialized care providers more often locate near suburban and metropolitan centers to practice. Further, public transportation usually does not extend out beyond urban and suburban areas.[39] This can lead to access challenges for rural areas.

In the United States, rural populations are typically disproportionately burdened by diseases such as cancer, heart disease and diabetes.[40]

This geographic disparity holds true in Ohio as well. According to the 2012 County Health Ranking Ohio Data, 14 of the 20 lowest ranked counties for "health outcomes" are located in Appalachia.[41] Fifteen of the 20 lowest ranked counties for "access to health care" are also in Appalachia.[42]

The table below summarizes several key access indicators across Ohio county types[43] in 2010 among adults age 18-64.[44]

Region	Uninsured	No dental coverage	Had difficulty paying medical bills, past 12 months	Health status, poor-to-fair	Mental health distress, 14 days or more in month
Appalachian	22%	45%	36%	24%	13%
Metropolitan	19%	39%	31%	21%	10%
Rural, non-Appalachian	15%	40%	30%	17%	6%
Suburban	17%	34%	27%	17%	7%
Ohio total	**19%**	**39%**	**31%**	**20%**	**10%**

Ohio access profile

Stephanie Wiersma
Chief Executive Officer, Lorain County Health & Dentistry

Perhaps the biggest sign of a growing need for safety net services in Lorain County can be found in the ongoing renovation of an old factory building in the city of Lorain.

Next March, the facility will become the new home to Lorain County Health & Dentistry, the only federally qualified health center, or FQHC, in the county.

"The new site will give us more room so we can hire more professional and support staff and see more patients," said Stephanie Wiersma, the center's CEO.

The center was founded in 2002 and became an FQHC through federal funding from the American Recovery and Reinvestment Act (the "stimulus bill") in 2009. The federal money accounts for about 18 percent of the center's annual budget, with most of the remaining money coming from payments by patients or their insurers.

"About 30 percent of our patients are uninsured and, even with a sliding fee up to 100 percent, we see quite a few patients who struggle with paying their required minimum fee," she said, noting that the number of uninsured patients has risen in recent years. "Of course, we work with them as much as we can, but it is still a struggle for many."

The center currently operates two sites in Lorain and is expanding to two sites in Elyria, about nine miles away, including one located within a public housing development. Wiersma said the center sees about 10,000 patients a year and provides a wide range of care from prenatal to adult and family medicine to general dentistry and podiatry.

Wiersma said she expects that the need for care offered at community health centers will continue to increase in the coming years. "There is a tremendous need for safety net services," she said. "Community health centers are very local; they really keep the pulse of their community and have the flexibility to adjust to meet changing needs. We're a critical part of the healthcare landscape in our community and I don't see that going away.

"As much as we do, I can't see how what we do could be absorbed by other providers," she added.

Access to quality health care not only helps individuals, Wiersma said, but also has an impact on the community as a whole.

"We see a lot of patients who have chronic conditions but come in for only sporadic care; if they don't come in for regular visits, we can assume that there is a negative impacy on the health and well-being of the community overall," Wiersma said. "Access to health care impacts whether a child gets to school regularly or whether an adult can work, or even look for work. And the challenges in the community we serve go far beyond what one might typically think of as 'health care.'"

While Wiersma said securing funding for capital construction projects has been difficult, she said an even greater challenge is keeping up with workforce demands. Wiersma said her center is "barely scratching the surface" to meet the need for quality care in her community, but in order to hire more doctors to meet that need, it must compete with other, larger health systems for a shrinking pool of primary care doctors.

"From my perspective, the greatest concern is recruiting quality professionals that want to work in a community health setting," she said. "We are about 30 miles from Cleveland, but the Cleveland health system has migrated into Lorain County, so we are competing for professional staff and we have to offer salaries that are competitive with what those providers offer."

One recruiting advantage that FQHCs have is access to federal and state loan repayment programs for its providers. "In terms of policy, that is very important because it sets us apart," Wiersma said. "I know policymakers always have to have an eye toward the budget, but in terms of keeping quality providers in the community, the opportunity for loan repayment is very important. You can only take care of people if you have the providers to do it."

Wiersma said another potential area for increasing access to primary care is for community health centers to partner more closely with colleges of medicine and dentistry. "There is a huge opportunity to partner with academic centers," she said.

Wiersma said similar partnerships with other local entities, such as early education programs and food shelters, could go a long way to stretching the funds that are available to increase access to care.

"In many communities, there are multiple organizations or agencies, both private and public, that operate to serve the same population," she said. "If we come together more and did some hard looking at what each has to offer, our community would be better off.

"I believe we have the raw materials to do so, and it wouldn't necessarily cost more money," she added. "We have to think about better, more efficient ways to use the money we collectively have."

Oral health access challenges

Oral health is essential to overall health and well-being. Research has established the connection between chronic oral infections, especially gum disease, and various diseases including diabetes, heart disease, stroke, and premature low-weight births.[45]

Healthy teeth and gums play a critical role in helping children achieve key developmental milestones and functions such as eating, speaking, and attaining normal social and emotional development.[46,47] Pain, infection and tooth loss impact the ability of people without access to dental care to maintain employment.

Many Ohioans cannot access the dental care they need. Consider the following:[48]

Adults

- Nearly 1.2 million adults (ages 18-64) report unmet dental needs.
- Almost 4 million adults (43%) over 18 years of age have no dental insurance – almost three times the number of Ohio adults without medical insurance.
- More than 900,000 (59%) seniors have no dental insurance. Most Medicare does not cover routine care.
- Lack of health insurance, lack of care providers within an area, and cost are commonly cited reasons for unmet dental needs for both Ohio children and adults.

Children

- Dental care remains the single most common unmet health care need for over 157,000 Ohio children across the income range.
- Almost 360,000 (15%) of Ohio's children have no dental insurance — roughly four times the number of Ohio children without medical insurance.
- Almost 340,000 Ohio children have never been to the dentist.
- Poor access to care is more common in children who live in Appalachian counties, who live in low-income families, and who are black.

Mental health care access challenges

In 2010, an estimated 20% of adults age eighteen or older in the United States experienced mental illness in the past year; an estimated 5% of adults experienced severe mental illness.[49]

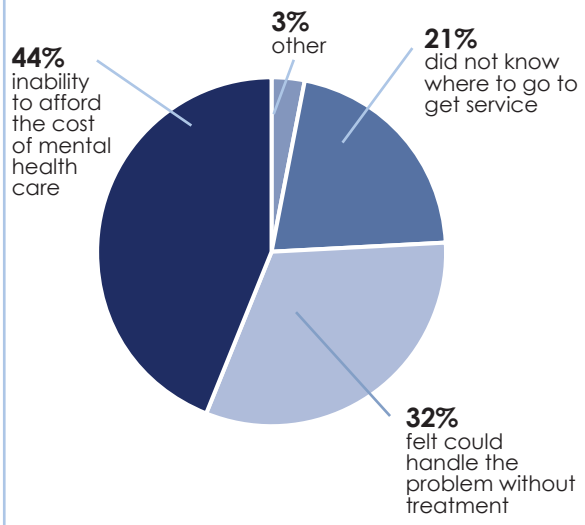
Based on these national rates, it is estimated that nearly two million Ohioans will need mental health services during their lives.[50]

Adults who were unemployed, who were receiving Medicaid, or whose family income was below the federal poverty level were more likely to have mental illness.[51]

National data show that access to mental health care falls short. Consider the following:[52]

- 60% of the 45.9 million adults with mental illness did not receive treatment in the past year
- 40% of the 11.5 million adults with severe mental illness did not receive treatment

Of those who reported an unmet need for mental health services, the most common barriers to receiving treatment were[53]:



A provider's perspective on access to mental health services

September, 2012

I am a Clinical Psychologist working at the Fairfield County Municipal Court. We have a specialized docket program that helps identify individuals with mental health and drug and alcohol issues that have also been convicted of a misdemeanor offense. Access to services is one of the biggest challenges that we face in this population and also in our community.

We have two community mental health agencies and a substance abuse agency within the county. Only one agency sees clients on a sliding scale basis because of monies provided to the local Alcohol Drug and Mental Health (ADAMH) board. However, the funding was depleted in the middle of the fiscal year and many people who were receiving services (counseling, case management, and medication services) no longer could continue to access services. Most in the criminal justice system do not have access to Medicaid because they do not qualify under current standards. In addition, they have difficulty finding employment because of their criminal records, not to mention the downturn in the economy. When there is an untreated mental illness or substance abuse problem, coping skills are poor and many end up homeless or commit more crimes, which is often referred to as "crimes of poverty." It is a vicious cycle that is very difficult to stop.

In addition to difficulty accessing services, rural communities (such as ours) also have difficulty accessing transportation. Fairfield County does not have a public transit or bus system. We do not have cabs or taxis (and who could afford them anyway). By accessing case management services, people are much more likely to attend appointments and obtain the services that are needed. Many individuals have health issues that make walking or biking difficult. When living in a rural community, the closest center might be several miles away that even healthy individuals would have difficulty navigating. Accessing health care that includes case management would be a very pragmatic but invaluable way to assist people in accessing services.

My position is paid for by the court after finding how difficult it was to access services. However, there is still a dearth of funding that severely limits people's ability to access services and there is still a huge need. I am only funded for three days a week and I cannot see everybody and the wait lists are out for months. We have had several people in our program that are in desperate need of inpatient treatment but have been turned away because of no funding. In many instances, the courts or jails bear the burden of responsibility and often resort to keeping people incarcerated for their own safety until a plan can be identified. We need lasting, significant changes in the mental health community.

Amynda Rhodes, Psy.D

Studies that examine life expectancy or premature mortality have shown that persons with mental illness die much sooner than those without mental illness.[54,55,56] Further, a high percentage of premature deaths are due to medical conditions other than the mental illness.[57]

There is promising evidence that integrating care (defined as when mental health specialty and general medical care providers work together to address both the physical and mental health needs of their patients) can increase access and improve health outcomes for people with mental illness and/or substance use disorders.[58]

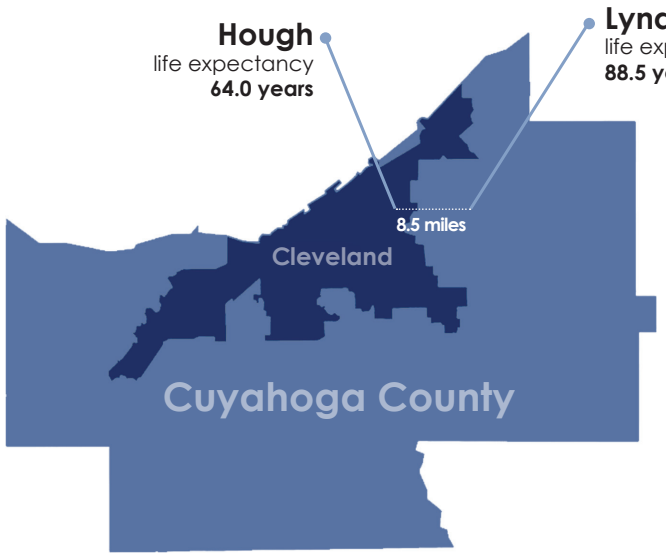
Medicaid health homes

In September 2012, Ohio received approval from the federal government to establish health homes for Medicaid clients with serious and persistent mental illness. This project will launch in October 2012 in Adams, Butler, Lawrence, Lucas and Scioto Counties. For more information, visit http://www.healthtransformation.ohio.gov/CurrentInitiatives/CreateHealthHomes.aspx

Health disparities

Many Ohioans live in healthy neighborhoods and have good access to health care that enables them to achieve good health. However, others live in neighborhoods with unfavorable characteristics (such as high crime rates, high poverty rates, and poor quality housing) and poor access to quality health care. As a result, these Ohioans face significant barriers to better health which can lead to poor health outcomes.

Life expectancy differences in Cuyahoga County

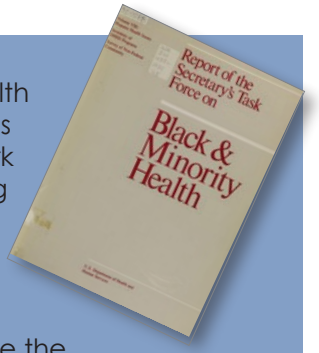


Source: 1999-2001 Vital Statistics data obtained from the Ohio Department of Health and 2000 census data. The life expectancy data was calculated in 2009 by: Cuyahoga County Board of Health and the Alameda County Public Health Department (Calif.)

Measurable differences in health outcomes that are closely linked with social, economic, and environmental disadvantage are known as health disparities.[61] They often are driven by the social conditions in which individuals live, learn, work and play. As a result, in order to improve health outcomes for everyone, it must be recognized that health starts long before illness, in homes, schools, and jobs.

Research has documented consistently that despite improvements in longevity for most Americans, disparities persist among racial groups and between the well-educated and those with less education. Compared to other populations, racial and ethnic minorities have poorer health outcomes, healthy lifestyle options, access to health care[62] and experience a lower quality of health services.[63] Educational attainment, a principal component of socioeconomic status, has direct beneficial effects on health through the adoption of healthier lifestyles, better ability to cope with stress, and more effective management of chronic diseases.[64] The indirect effects of education include access to better-paying jobs and higher incomes.[65]

Life expectancy is a commonly used indicator of the health of a population. Wide variations in life expectancy for different groups of Ohioans



In 1985, the US Department of Health and Human Services released a landmark report documenting the existence of health disparities for minorities in the United States. In the decades since the release of that report much has changed in our society — including significant improvements in health and health services throughout the nation. Nevertheless, health and healthcare disparities continue to exist and, in some cases, the gap continues to grow for racial and ethnic minorities, the poor, and other at-risk populations.[59]

Beyond the heavy burden that health disparities represent for the individuals affected, there are additional social and financial burdens borne by the country as a whole. These burdens constitute both ethical and practical mandates to reduce health disparities and achieve health equity.[60]

therefore illustrate the impact of health disparities. Variations in longevity by geography also point to disparities in neighborhood conditions, such as access to safe green space, healthy food, and health care. The geographic distribution of poverty closely aligns with the geography of life expectancy. For example, a recent analysis found that life expectancy in Cuyahoga County varies by over 24 years, ranging from a low of 64 years in the inner-city neighborhood of Hough to a high of 88.5 years in the suburb of Lyndhurst only eight and a half miles away.[66] Compared to Lyndhurst, Hough has much higher rates of poverty and unemployment, lower rates of educational attainment, and is home to a much higher proportion of non-white residents.

Promising policy strategies

As noted above, health disparities often are driven by the social conditions in which people live, work, learn and play and as a result, a comprehensive strategy to reduce disparities must address those conditions. Here are some examples of health policy strategies that can help reduce disparities:

Expand access to health insurance coverage: Research confirms that health insurance is critical to improve access to quality health care for minority and low-income populations.[67,68] Under the Affordable Care Act (ACA), coverage for low-income populations will expand with the establishment of health insurance exchanges. In addition, the ACA gives states the option to expand Medicaid eligibility to people under age 65 — who are not already Medicaid-eligible — with incomes up to 138 percent of the federal poverty level. Full implementation of these coverage options could greatly reduce racial and ethnic differentials in insurance coverage.[69]

Encourage delivery system reforms: The way in which health care is delivered has an impact on disparities. For example, the medical home model — broadly defined as a way to deliver health care that is organized around patients, team-based, coordinated and tracked over time — has been shown to reduce disparities. Patients with medical homes have better access to care, are more likely to receive recommended preventive services, and those with chronic conditions are better managed, compared to those without medical homes.[70] Not surprisingly, racial and ethnic disparities are significantly reduced when adults have medical homes.[71] Further, with health insurance and a medical home, income disparities lessen. With both, "low-income adults are nearly as likely as higher-income adults overall to receive recommended preventive services and rate the quality of their care as excellent or very good."[72]

The ACA contains several delivery system reform provisions with the potential to reduce health care disparities. The ACA encourages the development of health homes and accountable care organizations, and establishes The Center for Medicare & Medicaid Innovation (the CMS Innovation Center) to research and test new ways to pay for and deliver care. In addition, the ACA creates or bolsters a number of programs aimed at increasing workforce diversity.

Require better data: A recent report by the Institute of Medicine concluded that inadequate data on race, ethnicity, and language lowers the likelihood of effective actions to reduce health disparities.[73] Enhanced and

Federal disparities plan

In April 2011, the U.S. Department of Health and Human Services released the HHS Disparities Action Plan in conjunction with the release of the National Partnership for Action Stakeholder Strategy which can be used together to coordinate action to effectively address racial and ethnic health disparities. This plan builds upon Healthy People 2020 and leverages key provisions of the Affordable Care Act (ACA) and can be used as a common framework to address disparities. For more information, see http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=285

standardized data on the race, ethnicity, and language spoken by users of the healthcare system would allow better understanding of the barriers faced by various populations.

The ACA contains several provisions aimed at improving data collection and reporting procedures, explicitly to track and reduce health disparities. Perhaps most significantly, starting in 2012, all federally funded health programs and population surveys are required to collect and report data on race, ethnicity, language and other demographic characteristics using standards identified by the Department of Health and Human Services.

State of Ohio: a leader in reducing health disparities through policy change

Through the National Academy for State Health Policy (NASHP) State Health Equity Learning Collaborative,[74] Ohio has been a leader in exploring policy changes that impact health disparities:[75]

Health and Medical Homes: Ohio targeted its 2012 expansion of the Patient-Centered Medical Home Education Pilot Program to health providers who primarily serve racial and ethnic minorities and underserved communities. By targeting populations who bear a higher burden of disease and poor health outcomes, the state expects "a faster return on investment through improved health outcomes and health status and in cost savings.[76]

"The Patient-Centered Medical Home (PCMH) model of care is one that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient's family. Care is managed using modern tools such as registries, information technology, health information exchange and other means to assure that patients get the appropriate care when and where they need and want it in a culturally appropriate manner."[77]

For more information on Ohio's efforts to expand PCMHs, see http://www.odh.ohio.gov/pcmh.

Medicaid Managed Care Contracting and Education: The State of Ohio is considering including the following provisions in contracts with managed care plans (MCPs) who will be providing health care to the majority of Ohio Medicaid clients starting in 2013:

- Systematic collection of self-identified race, ethnicity and language patient data
- Better identification and management of groups known to experience health care disparities
- Use of culturally appropriate materials by the workforce
- Establishment of and participation in a Medicaid Health Equity Workgroup that will regularly review managed care contracts, create and implement baseline data measures, and link MCPs to organizations that can help them develop culturally appropriate materials and implement effective solutions to decrease health disparities.

Safety net

Health care providers who provide a substantial share of health care to uninsured, Medicaid, and other vulnerable patients often are referred to as "safety net providers."[78]

Two distinct characteristics qualify providers as safety net:

1. Under legal mandate or by explicitly adopted mission, care is provided to patients under any circumstances regardless of patients' ability to pay; and
2. A significant portion of patients served are classified as uninsured, Medicaid, or other vulnerable patients.[79]

The term "safety net," while commonly used to describe services for people who do not have other options, can be misleading in that it conveys a sense of comprehensiveness that does not exist. Safety net providers do not serve all areas of the state and, in some cases, are not able to provide all medically necessary services.

In addition to providing more affordable care, safety-net providers often are better able to meet the complex social, cultural, and linguistic needs that are more prevalent among vulnerable populations. Because safety net patients tend to be sicker, have more complex medical and behavioral problems, and often require other social supports, they may disproportionately benefit from greater clinical integration among providers, as well as a greater focus on team-based primary care and population-based strategies to improve health.[80]

Many safety-net providers are struggling to maintain their operations and meet the increased demand caused by the economic downturn.[81] Contrary to what some may believe, safety-net providers will continue to play a critical role after the Affordable Care Act is fully implemented because a significant portion of the population will remain uninsured and will depend on the safety net for care.[82]

The appendix of this document is an overview of safety net providers in Ohio.

Ohio access profile

Nancy Carter
Associate Dental Director, Cincinnati Health Department

For Nancy Carter, the challenge of access to dental care for the poor and uninsured can best be described in a simple scenario.

"Picture yourself with a toothache and no insurance," Carter says. "So you go to the ER to get treatment and you're told that you need to go to the dentist. You don't have a regular dentist and no money to pay for one. What would you do?"

It is a scenario witnessed on a regular basis by Carter, who is the Associate Dental Director for the Cincinnati Health Department. CHD operates five FQHC look-alikes that offer general dentistry to 12,000 lower income residents of the city each year. About 70 percent of the clinics' clients qualify to pay the minimum fee, meaning that their income is at or below the federal poverty level.

Carter said that tooth pain is one of the top reasons why uninsured people visit emergency departments. "ER doctors will tell you that dental issues are one of the top 10 issues that they see, they are extremely regular," she said. "So there is also the issue that dental issues are clogging up the ER."

She added that, "There are a lot of organizations that are coming together to direct ERs to primary care, so it's time for them to start including oral health."

"Our goal is to return function and aesthetics, which is really important, especially when a patient is looking for employment," Carter said.

For most of CHD's dental patients, the challenge of getting routine care is primarily financial, although it is often also hampered by a lack of transportation. "A lot of the people we treat rely on public transportation and sometimes they just can't afford that," Carter said. "We also see a lot of kids through [referrals from] school nurses, because many of them don't have adults who are willing or able to take them to the dentist."

In addition to treating patients with serious oral health issues, Carter said the clinics try to reach out to the population they serve to encourage routine, preventive care. "Sometimes in the population we work with, the standard of care is that you wait to go to the dentist when your teeth really start to hurt," she said. "Sometimes people just don't think about preventive care, so we try to work with our patients to try to get them to come in for routine visits before they are in pain."

The first step to address the issue, according to Carter, is for dental care to no longer be considered an optional service, as it is with Medicaid. "It is very frustrating to folks like us who realize that oral health is a part of general health," she said.

Carter said poor oral health can have significant consequences for both children and adults. "For kids, having access to dental care, they will do better in school because they will not be in pain... They can concentrate better and they miss less school," Carter said. "And for adults, employability is a major issue. Appearance affects your ability to get work and missing work because of tooth pain can make it hard to keep a job."

Is the healthcare workforce adequate?

Obtaining an accurate picture of Ohio's current healthcare workforce and projected future demand and supply is challenging. Like many states, Ohio does not have a single source for comprehensive data on health professionals in practice or in training. For example, the number of professionals licensed within the state is known; but it is not known how many of those licensed professionals provide health care, where, in what settings, and for how many hours. Without this information, knowledge of workforce capacity is limited.

Even with incomplete data, there is general consensus that parts of Ohio, and the nation, face primary care shortages. Several factors contribute to this trend, including:[84]

- Rising rates of chronic disease
- Aging population
- ACA coverage expansions

ODH workforce plan

The Ohio Department of Health's Draft Ohio Primary Care Workforce Plan[83] recommends that Ohio develop a Statewide Primary Health Care Workforce Data System that would include:

- Establishing a centralized health care workforce data repository
- Establishing a common core data set for health professional licensure
- Establishing a system to track health professions students into practice

What is a Health Professional Shortage Area (HPSA)?

A HPSA is a geographic area, population group, or health care facility that has been designated by the federal government as having a shortage of health professionals. In addition to these types of HPSAs, there are three categories of HPSAs: primary care (shortage of primary care clinicians), dental (shortage of oral health professionals), and mental health (shortage of mental health professionals).[85]

With limitations, Health Professional Shortage Areas (HPSAs) provide information about how many Ohioans live in areas where there are shortages of healthcare professionals and where those shortage areas are located. Because communities apply for and must meet defined criteria for this designation, there are likely additional communities in Ohio that meet the critieria but have not applied. As a result, the number of Ohioans living in shortage areas is likely higher. Below is a summary of HPSAs in Ohio, as of September, 2012.

Ohio Health Professional Shortage Areas September 2012

HPSA Category	Number of HPSAs	Total Population Living in Areas	Estimated Unserved Population Living in Areas
Primary Care Professional Shortage Areas	119	1,045,957	575,256
Dental Professional Shortage Areas	115	1,379,511	952,285
Mental Health Professional Shortage Areas	89	2,695,412	2,068,785

Source: "Designated Health Professional Shortage Areas (HPSA) Statistics," Office of Shortage Designation, Bureau of Health Professions, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services. Accessed 9/17/2012, http://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry&rs:Format=HTML3.2

Ohio access profile

Becky Hartman
Community health worker, Allen County Health Department

For many of the mothers that community health worker Becky Hartman assists, doctor visits can be intimidating.

Hartman has worked on an infant mortality prevention program at the Allen County Health Department since 2003. The program, which is funded through a grant from the Ohio Infant Mortality Reduction Initiative, serves pregnant African American women in the two zip codes in the county with the highest infant mortality rates. The program has three community health workers who serve these mothers until their baby turns 2 and it also has a male Community Health Worker who oversees the Male Involvement piece of the program to encourage fathers to become more involved in the life of their baby.

"We find that our moms feel alone at first, but when other resources are involved, we find that our joint efforts help produce a healthy baby," Hartman said.

One of the primary roles of the community health worker, Hartman said, is to ensure that patients feel comfortable in a medical setting. "When we get involved, there is a sense of trust with us," she said. "We strive to build a relationship and that in turn helps to build trust. If a patient doesn't understand the doctor, they'll come to me and my job is to bridge communication with the doctor to the client and explain it in lay terms."

Hartman said when she first started working with the program, she found that the way some doctors treated lower income, less-educated patients was eye-opening. "I am really surprised at how insensitive some -- but not all-- health care professionals can be," Hartman said. "For example, I had a client who had three children and was on her fourth pregnancy. She wanted to have a tubal ligation and the doctor would not listen to her wishes and was trying to talk her into a new form of birth control after she had stated several times her wishes."

"I've always been able to talk to doctors and ask questions and I have a good relationship with my doctors," she added, "so I was surprised to see how some doctors talk to some of my clients ... There's a stigma in our society that we've got to get past; every one of us is valuable no matter how they are able to access health care."

Hartman said that the trust built between a community health worker and a client is invaluable and is jeopardized by the way workers are often funded.

"We talk about a continuum of care and the whole health care team, but we need to understand that the majority of community health workers work on grants and when the grant's gone, we're gone," she said. "Community health workers need to be part of hospitals and other providers because if you're going to make health care better, community health workers need to be part of that."

Hartman said that community health workers play an integral role in connecting their clients who are often reluctant to get health care with other health care professionals.

"I think empowering the client to educate themselves about their health concerns will give them the ability to build their esteem so that they can be assertive," she said. "Once people learn to be assertive, they'll have the ability to ask questions and make decisions about their own care. And once that happens, we'll have a healthier community because people are taking control of their own health."

What are community health workers?

Community health workers (CHWs) are trained advocates and/or lay members of communities who work either for pay or as volunteers in association with the local health care system. CHWs usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve.[86]

CHWs work in a variety of settings and with a variety of patient populations. CHWs do not replace other health care workers nor do they provide clinical care. Instead, CHWs help patients navigate the health care system and provide information about staying healthy and managing diseases, emphasizing prevention and primary care. Research has shown that this can result in more appropriate use of the health care system, leading to lower overall costs of care.[87]

CHWs have been identified by numerous titles such as community health advisors, health advocates, promotoras, outreach educators, peer health promoters, and peer health educators. The CHW concept is not new but there is growing interest on the part of states and health care providers to partner with CHWs to help vulnerable individuals.[88]

CHWs in Ohio: In 2005, the Ohio legislature passed legislation to regulate the profession of CHWs in Ohio through the Ohio Board of Nursing. That same year, a certification program was established. Currently, three training programs operate in Ohio; they consist of at least 110 hours of classroom instruction and 132 hours of clinical instruction. After applicants complete an approved training program, they are awarded a "certificate to practice" credential.[89]

The **Ohio Community Health Workers Association** is working to establish and support Community Health Workers as professionals who are an integral part of the health and human services system. For more information, visit http://www.med.wright.edu/chc/programs/ochwa.

Glossary

Access to health care — Access to health care means having timely use of comprehensive, integrated, and appropriate health services to achieve the best health outcomes. Comprehensive care includes physical, mental/behavioral, oral, and vision health care services.

Affordable Care Act (ACA) — The federal health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Community health worker (CHW) — Trained advocate and/or lay member of communities who work for pay or as a volunteer in association with the local health care system. CHWs typically share ethnicity, language, socioeconomic status, and/or life experiences with the community they serve.

Federal Poverty Level (FPL) — Annually updated guidelines established by the U.S. Department of Health and Human Services to determine eligibility for various federal and state programs. In 2012, the FPL for a family of four is $23,050. More information can be found at http://aspe.hhs.gov/poverty/12poverty.shtml.

General Revenue Fund (GRF) — Resources are allocated by the state for programs from this fund. GRF is composed of all revenues from state taxes, as well as reimbursements from the federal government for some GRF expenditures.

Health disparities — Differences in health outcomes that are closely linked with social, economic and/or environmental disadvantage.

Health equity — Achieving the highest level of health for all people.

Health Professional Shortage Area (HPSA) — A geographic area, population group, or health care facility that has been designated by the federal government as having a shortage of health professionals. These are classified into three categories: primary care, dental, and mental health.

Health literacy — The ability to obtain, process, and understand basic health information.

Limited English proficiency (LEP) — Individuals with a limited ability to speak, read, write or understand the English language because their primary language is not English and they have not developed fluency in the English language.

Medical debt — Money owed for medical services and/or products. Medical debt is typically involuntary and arises from circumstances beyond an individual's control and which could not be planned for.

Medical bankruptcy — Bankruptcies are considered medical based on debtors' stated reasons for filing, income loss due to illness, and the magnitude of medical debt.

Medical home — An approach to providing comprehensive primary care that facilitates partnerships between individual patients, and their personal providers, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need it in a culturally and linguistically appropriate manner.

Safety net providers — Health care providers that provide a significant portion of health care to uninsured, Medicaid, and vulnerable populations.

Underinsured — Individuals with health insurance who meet one of the following criteria: have medical expenses that are more than 10% of their income, their annual income is lass than 200% FPL and medical expenses are 5% or more of income, or health plan deductibles are 5% or more of income.

Appendix: Ohio safety net providers

Child and family health services program

Description: The Child and Family Health Services (CFHS) Program is designed as an organized community effort of public health programs and services to improve the health status of women, infants, children, adolescents and families in Ohio. CFHS projects may provide program services in up to four of the following components: community health assessment and planning (required), child and adolescent health, perinatal health and the Ohio Infant Mortality Reduction Initiative (OIMRI). CFHS provides child, adolescent and perinatal health care services (community health assessment, outreach and case management, health education and referral, transportation, translation, home visiting, and obesity prevention programs) for uninsured and underinsured patients.

Funding: CFHS is funded through grant awards to local agencies, the Federal and Maternal and Child Health Block Grant (MCHBG) and the State General Revenue Fund (GRF).

Eligibility: CFHS programs target low income families, women, and children in racial and ethnic groups disproportionately affected by poor health problems.

Number served: For state fiscal year 2012, 59 agencies were funded for CFHS infrastructure, population-based, enabling and direct care services. Twenty agencies provided child and adolescent direct care services and 14 agencies provided perinatal direct care services to approximately 30,000 clients.[90]

For more information: http://www.odh.ohio.gov/odhprograms

Community Action Agencies

Description: Community Action Agencies (CAAs) are nonprofit organizations established under the Economic Opportunity Act of 1964 with the goal of increasing self-sufficiency and reducing poverty. Ohio has 50 CAAs, serving all 88 counties. CAAs provide a wide variety of services, including child care and early childhood programs, job training, programs for the elderly, and housing and emergency needs assistance. Some CAAs also provide health services, including family planning, particularly in rural areas.

Funding: Federal grants such as Title X of the federal Public Health Service Act are a major source of funding for safety-net family planning services.

Eligibility: Federal family planning funds are intended for low-income and uninsured residents and clinics typically have a sliding-fee scale based on income.

For more information: http://www.oacaa.org/index.html

Community mental health and alcohol and drug addiction systems

Description: Ohio's community mental health and alcohol and drug addictions systems are made up of partnerships and contracts among the Ohio Department of Mental Health (ODMH), Ohio Department of Alcohol and Drug Addiction Services (ODADAS), 53 local boards, and more than 400 local provider agencies.

The community mental health system provides treatment and recovery support services for people with mental illness. Services are provided in two ways:[91] at the community level, through which the local boards contract with provider agencies to serve individuals in their communities; and through six public regional psychiatric hospitals operated by ODMH.

The alcohol and drug addiction system provides prevention, treatment and recovery services for individuals with substance abuse disorders. In 2012, Ohio officials announced that the Ohio Department of Mental Health and Ohio Department of Alcohol and Drug Addiction Services will consolidate into one department, effective July 1, 2013. Visit http://www.adamh.ohio.gov/ for more details on consolidation.

Funding: The primary sources of funding for the community mental health and alcohol and drug addiction systems include Medicaid

reimbursement, local levies, State General Revenue Fund (GRF) subsidies and federal block grant funds (for substance abuse prevention and treatment).

Eligibility: Medicaid enrollees are entitled to certain mental health and addiction services. Uninsured and underinsured patients' eligibility varies across service areas depending on the availability of local funds and the demand for services. Not all services are provided at each facility.

Number served: In 2010, the community mental health system provided care to approximately 360,000 individuals, including 120,000 children.[92] Over 6,500 adults received treatment in the regional psychiatric hospital system.[93]

In SFY 2011, the alcohol and drug addiction system provided prevention services to 2.2 million Ohioans, and treatment services to 99,000 Ohioans.[94]

For more information: http://www.mh.state.oh.us/ and http://www.odadas.state.oh.us/public

Dental safety net clinics

Description: Ohio has approximately 100 dental safety net clinics that provide basic oral health care, including routine cleanings, x-rays, examinations, root canals, and fillings. In addition to these clinics, 12 dental safety net clinics provide preventive care only (such as sealants) and 6 provide oral surgery services only.[95]

Dental safety net clinics are operated by a variety of agencies, including public hospitals and health systems (dental schools and residency programs), health care districts, and private, non-profit agencies (faith-based agencies, local community action agencies and other non-profit agencies). Federally Qualified Health Centers operate 40% of Ohio's safety net dental clinics.[96]

Funding: Patient fees and Medicaid reimbursement represent the largest funding stream for dental safety net clinics. Funding also is available from the Ohio Department of Health (ODH); some clinics receive grants and private funding. Federal funding for FQHCs helps support the clinics they operate.

Eligibility: Dental safety net clinics serve patients who are uninsured, are underinsured, or have Medicaid. Payment options include sliding fee schedules based on family size and income, reduced fees, or free care to qualifying patients.[97]

Number served: The 20 clinics funded by ODH provided care for 81,000 patients in 2011. Over half were covered by Medicaid, and 44% were self-pay and/or uninsured.[98] Because ODH funding for these programs will be reduced by 55% in 2013, it is anticipated that significantly fewer Ohioans will be able to receive dental care through these clinics in the future. Data are not available for other clinics.

For more information: http://www.odh.ohio.gov/odhprograms/ohs/oral/oralhowdoi/clinics.aspx and http://ohiodentalclinics.com

Federally Qualified Health Centers and FQHC look-alikes

Description: Federally Qualified Health Centers (FQHCs) and FQHC look-alikes, more commonly referred to as Community Health Centers, provide care to underserved populations. Forty-one Ohio Community Health Centers serve over 165 locations in 46 counties, providing care to over a half million Ohioans. Community Health Centers provide comprehensive primary and preventive care including (but not limited to) medical, dental, mental health, substance abuse and vision care services.

Funding: FQHCs receive federal grant dollars through the Bureau of Primary Health Care to provide care to the uninsured; FQHC Look-Alikes do not. All Health Centers receive enhanced Medicaid and Medicare reimbursements based on cost reports, and accept private insurance as well. Patients below 200% of the Federal Poverty Level are charged according to a sliding fee schedule based upon ability to pay.

Eligibility: Community Health Centers provide care to all patients in need, regardless of ability to pay or insurance status.[99]

Number served: In 2010, Ohio FQHCs provided care for over 481,000 patients in over 1,570,000 visits. A majority of patients served were either uninsured (35%) or covered by Medicaid (42%).[100]

For more information: http://www.ohiochc.org/index.cfm

Free clinics

Description: Ohio free clinics provide free medical care to the uninsured. Services provided vary depending on location, however most provide primary care, prescription assistance, dental, vision and behavioral health services.[101]

Funding: Free clinics are funded primarily through private donations and grant funds; some funding is also available through the Ohio Department of Health.

Eligibility: Typically, uninsured and underinsured patients living within a free clinic community at or below 200% of the federal poverty line are eligible for services. Some clinics request a minimal fee.[102]

Number served: 41 free clinics are located within Ohio. In 2008, Ohio free clinics provided care to 55,000 uninsured and underinsured patients.[103]

For more information: http://www.ohiofreeclinics.org

Hospitals

Description: Patients with incomes under the federal poverty level who receive medically necessary care at a hospital, but cannot afford to pay for it, may be eligible for free care through the Hospital Care Assurance Program (HCAP).[104] In addition, many hospitals provide free or reduced price care to patients beyond the HCAP income eligibility levels. Both HCAP and hospital financial assistance programs cover only hospital charges, not bills from non-hospital providers.

Patients must apply for both programs and provide proof of income. Only those services that meet the definition of medically necessary, hospital-level services qualify for free or reduced care.

Funding: HCAP is funded through assessment levies on all acute care and freestanding hospitals, which are pooled with federal Medicaid Disproportionate Share Hospital (DSH) funds and then allocated back to hospitals.

Free or reduced care for patients beyond the poverty level is funded through a variety of means, including private donations, hospital foundations, and local levies.

Funding does not cover all care provided through these programs. As a result, hospitals provide a significant amount of uncompensated care, which is considered part of the larger community benefit that hospitals provide. In 2009, Ohio hospitals' net community benefit was $2.9 billion.[105]

Safety net hospitals will face new funding challenges in 2014. Under the ACA, hospitals are to receive new revenues from newly insured populations, especially through a Medicaid expansion to 138% of the Federal Poverty Level. This is countered by an anticipated significant decrease in other revenue streams, such as disproportionate share hospital (DSH) payments from Medicare and Medicaid. Now that the Medicaid expansion is optional for states, this loss of DSH funds coupled with the potential of reduced new revenues from newly insured populations, may endanger the financial viability of safety net hospitals.

Eligibility: To qualify for HCAP, patients must be Ohio residents with incomes at or below the federal poverty line, and not enrolled in Medicaid.

Many hospitals provide assistance to patients who do not qualify for HCAP. Eligibility and application processes vary from hospital to hospital.

For more information: www.ohanet.org or http://www.ohanet.org/hcap-frequently/

Local health departments

Description: Many of Ohio's 125 local health departments provide clinical preventive health services, including immunizations, health screenings, and testing for sexually transmitted infections and other communicable diseases.

Some also provide more extensive primary care services, including pre-natal care, well-child visits, reproductive and sexual health services, case management and care coordination, home health, and other medical services. Local health departments implement several maternal and child health programs, including the Women Infants and Children (WIC) nutrition program, Help Me Grow home visiting, and the Bureau for Children with Medical Handicaps program. Some local health departments also operate dental safety-net clinics and partner with FQHCs and the other community-based clinics described in this appendix.

Funding: Three-quarters of all local health department revenue is generated at the local level, including local general revenue, levy funds, and earned healthcare reimbursement (Medicaid, Medicare, sliding-fee scale patient fees). In 2010, 20% of local health department revenue was from federal sources (direct grants and "pass-through" funds allocated through the state) and 5% was directly from the state budget.

Eligibility: Eligibility varies based on grant requirements, community need, and available funding. Local health departments serve the uninsured, underinsured, and Medicare and Medicaid recipients.

Number served: According to the Association of Ohio Health Commissioners, local health departments provide direct clinical services to an estimated minimum of 750,000 Ohioans each year.[106]

For more information: http://www.aohc.net/index.cfm and http://www.odh.ohio.gov/localhealthdistricts/lhdmain.aspx

Planned Parenthood Health Centers

Description: Planned Parenthood health centers provide sexual and reproductive health care, education, and services. Preventive and primary care provided includes contraceptive care, testing and treatment of sexually transmitted disease, and screening for cervical and other cancers.

Funding: Planned Parenthood health centers are funded through patient fees, government funding, and private contributions from individuals, corporations and institutions.

Eligibility: While access varies by location, many Planned Parenthood health centers charge according to income; all accept health insurance.

Number served: Twenty eight Planned Parenthood health centers provide primary and preventive care in Ohio. An additional three Planned Parenthood centers provide abortion services in Ohio. In 2011, 90,900 patients were served, accounting for 142,800 visits. The most common preventive and primary care services included tests for sexually transmitted infections (108,000), cancer screenings (38,400), and pregnancy tests (34,100).[107]

For more information: http://www.plannedparenthood.org

School-based health centers

Description: School-based health centers (SBHCs) provide physical and mental health services to students in grades K-12. SBHCs are partnerships between local schools and community health organizations, where a health agency sponsors a school to provide care. Care is provided at the school and typically includes primary care for acute and chronic health conditions, mental health and substance abuse services, case management, dental health services, vision services, reproductive health care, nutrition education, health education and health promotion.

Funding: SBHCs are funded through local, state, and federal public health and primary care grants, community foundations, students and families, and reimbursement from health insurance.[108]

Number of SBHCs: In 2008, 17 Ohio SBHC partnerships were recorded. Although data is not yet available, it is estimated there are over 30 Ohio SBHCs in 2012.

For more information: http://www.osbhca.org

Sources

1. The HPIO Access Collaborative is a diverse group of stakeholders that started meeting on a quarterly basis in Fall 2011. Visit www.hpio.net/ access for more information.
2. "2010 National Health Care Disparities Report. AHRQ Publication No. 11-0005." U.S. Department of Health and Human Services. no. March (2011): 1-286. http://www.ahrq.gov/qual/nhdr10/nhdr10.pdf.
3. Allyson G. Hall, Ph.D., Christy Harris Lemak, Ph.D., Heather Steingraber, Stephen Shaffer, "Expanding the Definition of Access: It Isn't Just About Health Insurance," Journal of Health Care for the Poor and Underserved 19 (2008):625-637.
4. Actual Causes of Death in the United States, 2000. Mokdad, AH, Marks, JS, Stroup, DF, and Gerberding, JL. Journal of the American Medical Association. 2004. Volume 191(10).
5. The Case for More Active Policy Attention to Health Promotion. McGinnis, JM, Williams-Russo, P, and Knickman, JR. Health Affairs, 21, no 2 (2002): 78-93.
6. County Health Rankings Working Paper: Different Perspectives for Assigning Weights to Determinants of Health. Boolske, BC, et. al, February 2010. http://www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf
7. State of the USA Health Indicators: Letter Report, Committee on the State of the USA Health Indicators, Institute of Medicine, 2008.
8. Institute of Medicine, 2009. "America's Uninsured Crisis: Consequences for Health and Health Care."
9. Wilper, Andrew P., Steffie Woolhandler, Karen E. Lasser, Danny McCormick, David H. Bor, and David U. Himmelstein. "Health Insurance and Mortality in US Adults." American Journal of Public Health 2009: 99:2289-2295.
10. "Usual Source of Care and Wait Times in Ohio" Ohio Health Issues Poll report. The Health Foundation of Greater Cincinnati. August 2012.
11. Hull, Sharon K., Kristin R. Baughman, Joseph J. Sudano, Mike Hewit, and Ryan C. Burke. "Effective access to health care providers and services in Ohio: Analysis of intermediate and proximate outcomes."
12. Finkelstein, Amy, Sarah Taubman, Bill Wright, Mira Bernstein, Jonathan Gruber, Joseph P. Newhouse, Heidi Allen, and Katherine Baicker. "The Oregon Health Insurance Experiment: Evidence from the First Year." National Bureau of Economic Research Working Paper 17190. 2011.
13. Sommers, Benjamin D., Katherine Baicker, and Arnold Epstein. "Mortality and access to care among adults after state Medicaid expansions." The New England Journal of Medicine. 2012.
14. Schoen, Cathy, Michelle Doty, Ruth H. Robertson, and Sara R. Collins. "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent." Health Affairs. 30. no. 9 (2011): 1762-71.
15. Ibid.
16. Schoen, Cathy, Michelle Doty, Sara R. Collins, and Alyssa L. Holmgren. "Insured But Not Protected: How Many Adults Are Underinsured?." Health Affairs. 24. Web Exclusive (2005): 289-302.
17. Milliman Client Report. "Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange." August 31, 2011. Prepared for Ohio Department of Insurance, by Milliman, Inc. Accessed at http://www.ohioexchange.ohio.gov/Documents/MillimanReport.pdf.
18. Buettgens, Matthew, and Mark A. Hall. "Who Will Be Uninsured After Health Insurance Reform?" Robert Wood Johnson Foundation. No. March (2011).
19. Unaffordable is defined as insurance premiums which after employer contributions and federal subsidies exceed 9.8% of family income. H.R. 3590 Section 36B.(2)(C)(II). http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf. Pages 98-99.
20. H.R. 3590--111th Congress: Patient Protection and Affordable Care Act. (2010). http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf. Pages 128-130.
21. Milliman Client Report. "Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange." August 31, 2011. Prepared for Ohio Department of Insurance, by Milliman, Inc. Accessed at http://www.ohioexchange.ohio.gov/Documents/MillimanReport.pdf.
22. Ibid.
23. Tracking Report, Access to Care, Results from the Health Tracking Household Survey, No. 25, August 2011, Center for Studying Health System Change.
24. Kenney, Genevieve M., Stephen Zuckerman, Dana Goin, and Stacy McMorrow. "ACA Implementation- Monitoring and Tracking. Virtually Every State Experienced Deteriorating Access to Care for Adults over the Past Decade." Robert Wood Johnson Foundation. May. (2012).
25. The Kaiser Family Foundation, State Health Facts. Accessed September 18, 2012. http://www.statehealthfacts.org/.
26. Definition of medical debt provided by The Access Project.
27. "Going into debt to pay for healthcare in Ohio." OHIP—Ohio Health Issues Poll. July 2012.
28. These trends are consistent for Ohio and national data. See "Going into debt to pay for healthcare in Ohio." OHIP—Ohio Health Issues Poll. July 2012, and Sommers, Anna, and Cunningham, Peter J. December 2011. "Medical Bill Problems Steady for U.S. Families, 2007-2010, Results from the Health Tracking Household Survey, Tracking Report No. 28." Center for Studying Health Systems Change.
29. C. Pryor et al, Getting Care but Paying the Price: How Medical Debt Leaves Many in Massachusetts Facing Tough Choices, 2004, and C. Pryor et al, Playing by the Rules but Losing: How Medical Debt Threatens Kansans' Healthcare Access and Financial Security, 2006, cited in July 17, 2007 Testimony by Mark Rukavina, The Access Project, to the House Committee on the Judiciary Subcommittee on Commercial and Administrative Law.
30. Ibid.
31. "Gaps in Health Insurance: An All-American Problem, Findings from the Commonwealth Fund Biennial Health Insurance Survey", April 2006.
32. John A. Vernon, Antonio Trujillo, Sara Rosenbaum, and Barbara DeBuono, "Low Health Literacy: Implications for National Health Policy," George Washington University School of Public Health and Heath Services: 1-18, http://sphhs.gwu.edu/departments/healthpolicy/CHPR/downloads/LowHealthLiteracyReport10_4_07.pdf (accessed September 3, 2012).
33. Institute of Education Sciences: National Center for Education Statistics, "National Assessment of Adult Literacy (NAAL)." Accessed September 6, 2012. http://nces.ed.gov/naal/.
34. Ibid.
35. Himmelstein, David U., Thorne, Deborah, Warren, Elizabeth, and Woolhandler, Steffie, "Medical Bankruptcy in the United States, 2007: Results of a National Study." The American Journal of Medicine 122, no. 8 (June 2009): 741-746.
36. Ibid.
37. U.S. Census Bureau, "American FactFinder." Accessed September 6, 2012. http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml. Increase from 2.2%-2.3%.
38. Chandrika Divi, Richard G. Koss, Stephen P. Schmaltz, and Jerod M. Loeb, "Language proficiency and adverse events in US hospitals: a pilot study," International Journal for Quality in Health Care, 19, no. 2 (2007): 60-67.
39. Babitz, Marc. The University of Utah, "Healthcare: Facing Barriers: Geographic Barriers." Accessed September 27, 2012.
40. "NLM Health Disparities Strategic Plan and Budget, Fiscal Years 2009 -2013." National Library of Medicine. .http://www.nlm.nih.gov/pubs/plan/NLM_FY2009_2013_Health_Disparities_Strategic_Plan.pdf (accessed September 21, 2012).
41. County Health Rankings and Roadmap. Robert Wood Johnson Foundation, "Ohio: Download." Last modified 2012. Accessed September 21, 2012. http://www.countyhealthrankings.org/.
42. Ibid.
43. In 2008, 29 Ohio counties were considered a part of Appalachia, and 30 Ohio counties were considered rural-non Appalachia. A breakdown of the types of Ohio counties can be found at https://ckm.osu.edu/sitetool/sites/ofhspublic/documents/OFHS_Forum_Presentation.pdf.
44. Ohio Family Health Survey, "2010 Statewide Summary Tables." Accessed September 21, 2012. http://grc.osu.edu/ofhs/datadownloads/index.cfm. Percents are based on total population within the specified region.
45. National Center for Chronic Disease Prevention and Health Promotion, "Preventing Cavities, Gum Disease, Tooth Loss, and Oral Cancers At A Glance 2011." Last modified July 29, 2011. Accessed September 21, 2012. http://www.cdc.gov/chronicdisease/resources/publications/aag/doh.htm.
46. Y. Li and W. Wang, "Predicting caries in permanent teeth from caries in primary teeth: an eight-year cohort study," Journal of Dental Research 81:12 (December 2002).
47. K. Heller et. al., "Associations between the primary and permanent dentitions using insurance claims data," Pediatric Dentistry 22:6 (November-December 2000)
48. Data in this table is from Ohio Department of Health, "Oral Health Isn't Optional! A Report on the Oral Health of Ohioans and Their Access to Care, 2011 and 2010 Ohio Family Health Survey Statewide Summary Tables
49. Substance Abuse and Mental Health Services Administration, Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-42, HHS Publication NO. (SMA) 11-4667. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.
50. Ohio Department of Mental Health, Annual Report 2012. Accessed September 9, 2012 at http://www.mh.state.oh.us/assets/annual-reports/2012-annual-report.pdf
51. Substance Abuse and Mental Health Services Administration, Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-42, HHS Publication NO. (SMA) 11-4667. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.
52. Ibid.
53. Ibid. See also Jitender Sareen, M.D., Amit Jagdeo, M.D., Brian J. Cox, Ph. D., Ian Clara, M.A., Margreet ten Have, Ph.D., Shay-lee Belik, B.sc., Ron de Graaf, PH.D., and Murray B. Stein, M.D., M.P.H. "Perceived Barriers to Mental Health Service Utilization in the United States, Ontario, and the Netherlands." Psychiatric Services Vol. 58 No. 3 March 2007.
54. Felker B, Yazel J, Short D: Mortality and Medical Comorbidity Among Psychiatric Patients: A Review. Psychiatric Services 47:1356-1363, 1996
55. Miller BJ, Paschall CB, Svendsen DP: Mortality and Medical Comorbidity Among Patients with Serious Mental Illness. Psychiatric Services 57:1482-1487, 2006
56. Roshaneae-Moghaddam B., Katon W: Premature Mortality from

General Medical Illness Among Persons with Bipolar Disorder: A Review. Psychiatric Services 60: 147-156, 2009
57. Elizabeth E. Piatt, Ph..D., Mark R. Munetz, M.D., Christian Ritter, PH.D., "An Examination of Premature Mortality Among Decedents With Serious Mental Illness and Those in the General Population." Psychiatric Services, Vol. 61 No. 7 July 2010.
58. Agency for Healthcare Research and Quality, Integration of Mental Health/Substance Abuse and Primary Care, AHRQ Publication No. 09-E003, October 2008.
59. U.S. Department of Health and Human Services, "Healthy People 2020." Last modified 2012. Accessed September 27, 2012. http://www.healthypeople.gov/2020/default.aspx.
60. Smedley, Brian D., Adrienne Y. Stith, and Alan R. Nelson. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." Board on Health Sciences Policy. Institute of Medicine. March 20 (2002). http://www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx (accessed September 27, 2012).
61. U.S. Department of Health and Human Services, "HHS Action Plan to Reduce Racial and Ethnic Health Disparities." Last modified 2011. Accessed September 27, 2012. http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=285.
62. Centers for Disease Control and Prevention CDC Health Disparities and Inequalities Report, MMWR 2011;60 (Suppl):82. Available at http://www.cdc.gov/mmwr/pdf/other/su6001.pdf.
63. Smedley, Brian D., Adrienne Y. Stith, and Alan R. Nelson. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." Board on Health Sciences Policy. Institute of Medicine. March 20 (2002). http://www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx (accessed September 27, 2012).
64. Goldman DP, Smith JP. Can patient self-management help explain the SES health gradient? Proceedings of the National Academy of Sciences of the United States of America. 2002;99(16):10929-34.
65. Cameron McIntosh, Philippe Finès, Russell Wilkins and Michael C. Wolfson "Income disparities in health-adjusted life expectancy for Canadian adults, 1991 to 2001. Health Reports, 2009 Volume 20, Number 4:55-64.
66. Cuyahoga County Board of Health
67. Berenson, Julia, Michelle M. Doty, Melinda K. Abrams, and Anthony Shih. Issue Brief, "Achieving Better Quality of Care for Low-Income Populations: The Roles of Health Insurance and the Medical Home in Reducing Health Inequities." The Commonwealth Fund. May 2012.
68. Lillie-Blanton Marsha, and Hoffman, Catherine. "The Role of Health Insurance Coverage in Reducing Racial/Ethnic Disparities in Health Care." Health Affairs. 2005 Volume 24 no. 2: 398-408.
69. Clemans-Cope, Lisa, Genevieve M. Kenney, Matthew Buettgens, Caitlin Carroll, and Fredric Blavin. "The Affordable Care Act's Coverage Expansions Will Reduce Differences in Uninsurance Rates By Race and Ethnicity." Health Affairs. 2012 Volume 31, no. 5: 920-930.
70. Berenson, Julia, Michelle M. Doty, Melinda K. Abrams, and Anthony Shih. Issue Brief, "Achieving Better Quality of Care for Low-Income Populations: The Roles of Health Insurance and the Medical Home in Reducing Health Inequities." The Commonwealth Fund. May 2012.
71. A.C. Beal, M.M. Doty, S.E. Hernandez, K. K. Shea, and K. Davis, Closing the Divide: How Medical Homes Promote Equity in Health Care—Results from the Commonwealth Fund 2006 Health Care Quality Survey (New York: The Commonwealth Fund, June 2007).
72. ulia Berenson, Michelle M. Doty, Melinda K. Abrams, and Anthony Shih, Issue Brief, "Achieving Better Quality of Care for Low-Income Populations: The Roles of Health Insurance and the Medical Home in Reducing Health Inequities," The Commonwealth Fund, May 2012.
73. Institute of Medicine Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality. Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement. Washington, DC: The National Academies Press; 2009.
74. The NASHP State Health Equity Learning Collaborative was formed in August 2011. Seven states were selected to participate: Arkansas, Connecticut, Hawaii, Minnesota, New Mexico, Ohio, and Virginia. The Ohio team is made up of leaders from the Ohio Department of Health, The Ohio Commission on Minority Health, and the Ohio Department of Job and Family Services (Medicaid).
75. Hanlon, Carrie and Brittany Giles. "State Policymakers' Guide for Advancing Health Equity Through Health Reform Implementation." National Academy for State Health Policy, August 2012. See pages 17 and 20 for a more complete summary of these initiatives.
76. Ibid.
77. Ohio Department of Health, "Patient-Centered Medical Homes." Accessed September 27, 2012. http://www.odh.ohio.gov/landing/medicalhomes/pcmh.aspx.
78. E.L. Schor, J. Berenson, A. Shih, S.R. Collins, C. Schoen, P. Riley, and C. Dermody, Ensuring Equity: A Post-Reform Framework to Achieve High Performance Health Care for Vulnerable Populations, The Commonwealth Fund, October 2011.
79. Lewin, Marion and Stuart Altman. "America's Health Care Safety Net: Intact but Endangered". Institute of Medicine. March 2000.
80. E.L. Schor, J. Berenson, A. Shih, S.R. Collins, C. Schoen, P. Riley, and C. Dermody, Ensuring Equity: A Post-Reform Framework to Achieve High Performance Health Care for Vulnerable Populations, The Commonwealth Fund, October 2011.
81. Health Policy Institute of Ohio. "A Snapshot of Ohio's Health Safety net." April 2010.
82. "Shining a Light on the Reinvention of the Safety Net". Health Affairs. August 2012 vol. 31 no. 8 1728.
83. "Draft Ohio Primary Care Workforce Plan," The Ohio Department of Health. Accessed 9/18/2012 at http://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/chss/state%20office%20of%20rural%20health/draftworkforceplanupdated2_22.ashx
84. Ted Wymyslo, M.D., Director, Ohio Department of Health. "Working Together to Strengthen Ohio's Safety Net", April 28, 2011. Accessed at http://www.slideshare.net/healthpathohio/dr-wymyslo-final-health-path-mtg28-april-2011
85. Health Resources Services Administration, U.S. Department of Health and Human Services. http://bhpr.hrsa.gov/shortage/hpsas/faq.html
86. U.S. Department of Health and Human Services, "Community Health Worker National Workforce Study." Last modified March 2007. Accessed September 13, 2012. http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf. Excerpted from HRSA definition.
87. Goodwin, Christine, and Lauren Tobler. "Community Health Workers Expanding the Scope of the Health Care Delivery System." Council of State Legislatures April 2008. Accessed September 12, 2012.
88. Ibid.
89. Information provided by the Ohio Community Health Workers Association, 9/12/2012.
90. Data provided by Ohio Department of Health. E-mail correspondence September 18, 2012.
91. Ohio Department of Mental Health Annual Report 2012.
92. http://www.mh.state.oh.us/assets/who-we-are/odmh-description.pdf
93. Ibid.
94. Ohio Department of Alcohol & Drug Addiction Services SFY2012 Annual Report
95. Note: The number of dental safety net clinics can fluctuate. These numbers are current as of September 2012. Source: Ohio Department of Health, Oral Health Section.
96. "Dental Care," Ohio Department of Health. Downloaded August 7, 2012. http://odh.ohio.gov/odhPrograms/ohs/oral/oral1.aspx
97. Ibid.
98. Ohio Department of Health, Oral Health Section. E-mail correspondence 9/20/2012.
99. Ohio Association of Community Health Centers, last modified 2011, accessed August 23, 2012, http://www.ohiochc.org/index.cfm
100. Data provided by the Ohio Association of Free Clinics.
101. "Ohio's Free Clinics," Ohio Association of Free Clinics." Accessed August 28, 2012, http://www.ohiofreeclinics.org
102. Ibid.
103. Ibid.
104. State law and rule requires that hospitals provide "without charge to the individual, basic, medically necessary hospital-level services to the individual who is a resident of this state, is not a recipient of the Medicaid program and whose income is at or below the federal poverty line." (Ohio Administrative Code 5101:3-2-07.17)
105. Ohio Hospital Association 2009 Community Benefit Report, found at http://www.ohanet.org/community-benefits/. Note: A hospital's community benefit includes Medicaid losses, charity care expenses, community activity expenses, HCAP reimbursement, and Medicare DSH reimbursement.
106. Association of Ohio Health Commissioners. (2007). The Role of Local Health Departments in the Provision of Clinical Services in Ohio.
107. Data provided by Planned Parenthood Advocates of Ohio. E-mail correspondence September 26, 2012.
108. Information provided by Ohio School Based Health Care Association. E-mail correspondence September 20, 2012.

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