Mercer County, Ohio Access to Health Care Report

2022

COLT HEALTH COMMITTEE

March 18, 2022

Community Organizations Linking Together (COLT) Health Committee

The COLT Health Committee is a collaborative group of local agency partners and stakeholders working together to improve the overall health of the population of Mercer County. The group works to accomplish this goal by determining the health needs of Mercer County residents and working to ensure those needs can be met.

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- The following COLT Health Committee members gave time and feedback to ensure success of the study.

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Executive Summary

The Mercer County Health District and the COLT Health Committee are committed to improving health equity and overall access to health care for the residents of Mercer County. To that end, the committee undertook this assessment to establish the baseline for access to care in Mercer County and identify areas for future improvement.

Data for this assessment were gathered using multiple methods. Secondary data was collected from various state and federal sources and used to contribute to the county profile and local health system capacity sections of this report. Primary data was gathered from Mercer County residents through the online Mercer County Access to Health Care Survey. Additional primary data was gathered from various parties who work with vulnerable populations in Mercer County through focus groups and key informant interviews.

By examining the data collected using the various tools above, the committee was able to identify several vulnerable segments of the Mercer County population, including people who have Medicaid health care coverage, people who have high-deductible insurance plans, and natives of the Marshall Islands. Barriers to access include lack of local providers who accept Medicaid, underutilization of Medicaid by those who have the coverage, difficulty in keeping Marshallese individuals engaged in their care over the long term, mental health problems, and lack of adequate transportation.

This report serves to illuminate current issues with access to health care in Mercer County and provide a basis for the local public health system to begin taking steps to close gaps in access. The conclusion of this report discusses strategies to begin doing just that in order to reach a state of more equitable access to care for all who call Mercer County home.

Purpose of This Assessment

An important role of public health, in collaboration with the health care system, is the assessment of the population's access to health care services and the capacity of the health care system to meet the health care needs of the population (i.e., Essential Service #7 of the Ten Essential Public Health Services[1]). Therefore, the Mercer County Health District has undertaken this appraisal of access to health care in Mercer county, in collaboration with other members of the local public health system who make up the COLT Health Committee. This assessment involves:

- Assessing the capacity of the local health care system;
- Identifying populations who experience barriers to personal health services; and
- Pinpointing gaps in access to health care and barriers to the receipt of care.

Public health also plays a role in efforts to increase access to needed health care services, particularly primary care. As noted by *Healthy People 2030*[2], individuals who cannot obtain the care they need may experience more preventable complications, hospitalizations, emotional stress, and higher health care costs. Identifying access problems and working to correct them can remedy these problems.

What Does "Access to Health Care" Mean?

The National Academy of Medicine (NAM- formerly the Institute of Medicine) defines access to health services as "the timely use of personal health services to achieve the best health outcomes".[3] According to the NAM, access to health services requires 3 distinct steps[i]:

- Gaining entry into the health care system (usually through insurance coverage);
- Accessing a location where needed health care services are provided (geographic availability); and
- Finding a health care provider whom the patient trusts and can communicate with (personal relationship).

Health care access and quality is one of 61 topic areas in *Healthy People 2030*, a comprehensive set of 10-year national goals and objectives for improving the health of all Americans. Several access to care objectives (denoted below with an asterisk) are included among the nation's Leading Health Indicators, which communicate high-priority health issues. Access to care objectives[4] focus primarily on:

1. Increasing the proportion of persons with health insurance. *
2. Increasing the proportion of persons with a usual primary care provider. *
3. Increasing the proportion of persons who have a specific source of ongoing care.
4. Reducing the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines.
5. Reducing the proportion of hospital emergency department visits in which the wait time to see an emergency department clinician exceeds the recommended timeframe.

Methodology

A county-wide access to health care assessment was conducted in Mercer County, Ohio between December 9, 2021 and January 21, 2022. The focus of this broad appraisal was:

1. Assessing the capacity of the local health care system;
2. Identifying populations in Mercer County that experience perceived or real barriers to health care services; and
3. Understanding the reasons these population groups are not receiving needed care or are experiencing barriers to care.

The assessment process involved the following steps:

Step 1: Creating a County Profile, using secondary data collected from a variety of sources by health department staff.

The profile on pages 9-18 describes community demographics commonly linked in some way to health disparities (e.g., race, ethnicity, socioeconomic status, age, sex, disability status, and residential location). Basic demographic information was collected through the U.S. Census Bureau American Fact Finder and American Community Survey[6] and other sources.

Step 2: Describing the Capacity of the Local Health Care System, using publicly available secondary data. When this assessment is repeated in the future, consideration will be given to collecting capacity data from local health care providers.

The profile on pages 19-23 describes the local health care system, including primary and specialty care, acute care, emergency care, long-term care, hospice services, behavioral health, and oral health. Capacity is expressed as the ratio of health care providers to residents. In this way, local capacity can be compared to state and national data from the U.S. Department of Health & Human Services, Health Resources and Services Administration. Visual representations of this data were created using Community Commons.

Step 3: Identifying Vulnerable Populations, using primary data collected during the 2021 Mercer County Community Health Needs Assessment.

Community health assessment data including social determinants, provider to resident ratios and perceived needs for improved community health were reviewed in an effort to identify local populations that may experience perceived or real barriers to health care. COLT Health Committee members also brainstormed to determine specific members of the local population who could provide valuable information on access to care, either because of their own vulnerability or because of their knowledge of access barriers through their involvement in the community.

Step 4: Interviewing Vulnerable Populations and Community Agencies and Providers Serving Them, through focus group interviews and written and electronic surveys.

Primary data was collected through a survey, multiple focus group sessions and multiple key informant interviews to further explore the barriers experienced and possible gaps in care availability.

A publicly-available online survey was distributed countywide by agencies who participate in the COLT Health Committee. The survey was also made available in paper form if requested. The survey was conducted electronically using SurveyMonkey, and written responses were manually entered into the electronic survey to facilitate data analysis available through SurveyMonkey. The purpose of the survey was to gather information on access to health care challenges in our community from those who have direct knowledge of those challenges.

Focus group and key informant interview participants were recruited by COLT Health Committee members who agreed to conduct sessions with several of the informants on the list resulting from the brainstorming session. In the case of focus groups, contact may be made with a local agency or organization of interest and the person contacted would recruit the focus group participants internally. Sessions were held at the host's facility or the participants' facility according to the preference of the participants. No incentives were offered for participation. Participants were informed that all information collected would be used for research purposes only and would remain confidential and anonymous. All participants gave permission to record the sessions for detailed notetaking after each session concluded. All participants gave permission to include their names in this report, although this report will not link any specific comments or statements with any specific individuals or agencies. All participation was voluntary.

Primary data was also collected via survey (in electronic and written formats) from community agencies and health care providers serving these vulnerable populations. Institutional Review Board (IRB) approval was granted through the Ohio Department of Health. The purpose of the survey was to gather information from agencies and providers with greater awareness of the barriers faced by the vulnerable populations they serve.

The access to care survey and a guide including questions for key informant interviews and focus groups can be found in Appendix A along with the full report of results.

Mercer County Profile

With one quarter of its population of approximately 40,000 people concentrated in the county seat of Celina, Mercer County is a mostly rural county. Mercer County is located on the Ohio-Indiana border, roughly halfway between the cities of Toledo and Cincinnati.

Well known for agriculture, Mercer County is perennially one of the top agricultural producers in Ohio. Agriculture contributes greatly to the local economy, and has also been found to contribute to water quality problems in Grand Lake St. Marys, the source of drinking water for the City of Celina. Many conservation practices and other efforts have been undertaken over the past couple of decades to minimize the unnecessary discharge of excess nutrients into the lake, and it appears that these efforts are beginning to pay off in improved water quality.

Mercer County's transportation infrastructure consists of well-maintained roadways and streets and a small commercial airport. Like other rural counties, Mercer County does not have a public transportation system. This lack of public transportation can present a barrier to some people needing to access health care services who lack a reliable vehicle and may not live within reasonable walking distance of their medical provider.

In addition to the City of Celina, there are seven incorporated villages in Mercer County. Four of these villages have one grocery store each, and multiple grocery stores are located in Celina. Five of the villages have at least one gas station and convenience store. There is a Dollar General store located in or around four of the villages in the county. These stores offer a reasonable selection of prepackaged grocery items, but no fresh foods. The only large department store in the county is located in Celina.

The major employers in the county are found mostly within the manufacturing, education and health care sectors. As mentioned previously, agriculture is also a large part of the economy. Most farmers are self-employed or are contracted to raise livestock or poultry on their own property for a larger company. Mercer County perennially boasts one of the lowest unemployment rates in Ohio.

A community group called COLT (Community Organizations Linking Together) is made up of leaders of various local government agencies and community organizations and meets monthly to share information and discuss ways to meet the various needs of the community. The COLT Health Committee is an offshoot of the COLT group that works specifically to address health equity and unmet health needs in Mercer County. Local schools, public libraries, and the Wright State University Lake Campus are trusted institutions within the county.

Mercer County is a politically conservative community that values hard work and self-sufficiency. The community generally displays unity in the face of adversity, coming together to help those who suffer losses due to natural disasters or other tragedies, and helping individuals who are generally disadvantaged.

The county government is led by the Mercer County Commissioners, who oversee several county agencies. The townships, villages, and the City of Celina all have their own governing structures. A representative of each of these political subdivisions sits on the Health District Advisory Council, which provides high-level oversight to the Mercer County Board of Health and the health department, which operate in conjunction with but outside the authority of the Mercer County Commissioners. The health department is the local government agency primarily responsible to lead community efforts to address health equity and access to health care.

Demographics

Access to health care often varies based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location.[11] Therefore, this section describes these characteristics of Mercer County's residents.

Residents[7]

		Mercer County	Ohio	United States
Total Population	Total Population	40,884	11,689,100	324,697,795
Gender	Male	50.6%	49.0%	49.2%
	Female	49.4%	50.1%	50.8%
Age	Under 5 years	6.0%	5.9%	6.18%
	5-17 years	16.4%	16.1%	16.6%
Age	18-64 years	61.0%	60.2%	61.8%
	65 years and over	16.7%	17.5%	15.6%
Race	White	97.7%	83.9%	75.3%
	Black or African American	1.2%	14.2%	14.0%
	American Indian/Alaska Native	0.2%	0.9%	1.7%
	Asian	0.7%	2.8%	6.6%
	Native Hawaiian/Pacific Islander	0.6%	0.1%	0.4%
	Other	0.4%	12.0%	5.5%
	Two or more races	0.7%	2.9%	3.3%
Ethnicity	Hispanic or Latino	1.9%	3.8%	18.0%
	Not Hispanic or Latino	98.1%	96.2%	82.0%
Language Spoken at Home	English only	98.2%	98.2%	78.4%
	Language other than English	1.8%	7.2%	21.6%
	Spanish	0.5%	2.3%	13.4%
	Other Indo-European languages	0.4%	2.6%	3.7%
	Asian and Pacific Islander languages	0.8%	1.2%	3.5%
	Other languages	0.1%	1.0%	1.1%

		Mercer County	Ohio	United States
Marital Status	Never married	23.5%	32.7%	33.9%
	Now married (except separated)	59.0%	47.0%	47.6%
	Divorced or separated	11.4%	13.9%	12.7%
	Widowed	6.1%	6.3%	34.5%
Veterans	Civilian veterans	7.3%	7.8%	7.3%

Note: above percentages may not sum to 100% due to rounding.

Households[7, 8]

		Mercer County	Ohio	United States
Total Households	Number of households	16,234	4,676,358	120,756,048
Household Type	**Family households**	70.6 %	62.2%	64.8%
	Married couple (family)	57.4%	45.8%	48.2%
	Male householder, no wife present (family)	6.0%	4.8%	4.9%
	Female householder, no husband present (family)	7.1%	12.5%	12.4%
	Nonfamily households	29.4%	37.8%	35.2%
Other Household Types	Household with own children under 18	28.7%	26.2%	27.6%
	Householder living alone	25.3%	30.5%	27.9%
	65 years of age and older	11.3%	12.0%	11.0%
Household Size	Average household size	2.49	2.43	2.62
	Average family size	2.98	3.03	3.23
Grandparents as Caregivers	Children under 18 years living with a grandparent householder	5.2%	7.2%	8.0%
Computers and Internet Use[2]	Total Households	16,234	4,676,358	120,756,048
	With a computer	89.5%	89.1%	90.3%
	With a broadband Internet subscription	83.8%	82.0%	82.7%

Note: above percentages may not sum to 100% due to rounding.

Disability Status[7]

		Mercer County	Ohio	United States
Disability Status	Total with a disability	10.3%	14.0%	12.6%
	Under 18 years	3.8%	5.0%	4.2%
	18-64 years	7.7%	11.9%	10.3%
	65 years and over	29.6%	34.2%	34.5%

Note: above percentages may not sum to 100% due to rounding.

Social Determinants of Health

Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes.[12] This section described these conditions. More commonly known as social determinants of health, these conditions include, but are not limited to, access to social and economic opportunities; the resources and supports available in homes, neighborhoods, and communities; the quality of education; the safety of workplaces; the cleanliness of water, food, and air; and the nature of social interactions and relationships.

Employment Status[9]

		Mercer County	Ohio	United States
Employment Rate of Civilian Labor Force	Employed	97.4%	95.3%	94.2%
	Unemployed	2.6%	4.7%	5.8%

Income and Poverty[8]

		Mercer County	Ohio	United States
Household Income	Per capita income	$29,756	$31,552	$34,103
	Median household income	$62,952	$56,602	$62,843
	Mean household income	$76,115	$76,958	$88,607
Poverty Status of Families	<100% Federal Poverty Level (FPL)	4.2%	9.9%	9.5%
	100-199% FPL	14.0%	23.7%	14.9%
	At or above 200% FPL	86%	76.3%	85.1%
Poverty Status of Those Under 18 Years Old	<100% Federal Poverty Level (FPL)	9.0%	19.9%	18.5%

Food Insecurity[10]

		Mercer County	Ohio	United States
Food Insecurity Rate (estimated)	Overall Population	9.3%	13.2%	10.9%
	Children	10.6%	17.4%	14.6%
Eligibility for Federal Nutrition Programs (estimated)	**Overall Population**			
	Above Other Nutrition Program threshold of 185% FPL	41%	37%	31%
	Between 130-185% FPL	23%	14%	19%
	Below SNAP threshold 130% FPL	36%	49%	50%
	Children			
	Likely Ineligible for Federal Nutrition Programs (above threshold of 185% FPL)	22%	32%	23%
	Income-eligible for Federal Nutrition Programs (below threshold of 185% FPL)	78%	68%	77%

Education Indicators[10]

		Mercer County	Ohio	United States
Graduation rate	High school graduation rate			
Educational Attainment	No high school	1.3%	2.8%	5.1%
	Some high school/no diploma	6.6%	6.8%	6.9%
	High school graduate	45.3%	33.0%	27.0%
	Some college/no degree	17.2%	20.4%	20.4%
	Associate's degree	11.3%	8.7%	8.5%
	Bachelor's degree	11.4%	17.6%	19.8%
	Graduate/professional degree	6.9%	10.7%	12.4%

Limited English Proficiency[9]

	Mercer County	Ohio	United States
Population age 5+	37,979	10,960,686	304,930,125
Population age 5+ with limited English Proficiency	208	277,197	25,615,365
Population age 5+ with limited English proficiency, percent	0.55%	2.53%	8.40%

Health Insurance Status

Insurance coverage is the primary means for gaining entry into the health care system. Lack of adequate coverage makes it difficult for people to get the health care they need and, when they do get care, burdens them with large medical bills. Uninsured people are:

- More likely to have poor health status
- Less likely to receive medical care
- More likely to be diagnosed later
- More likely to die prematurely.[13,14,15]

For these reasons, a primary goals of the Affordable Care Act (ACA) was to make affordable health insurance available to more people. This was accomplished by 1) providing subsidies that lowered costs for households with incomes between 100% and 400% of the federal poverty level (FPL), 2) expanding Medicaid to individuals with incomes up to 138% FPL, 3) allowing adult children to be covered under a parent's health insurance plan up to age 26, and 4) requiring individuals to maintain minimum essential health insurance coverage starting in 2014 (or else pay a penalty)[16].

Health Insurance Coverage[7,8]

		Mercer County	Ohio	United States
Uninsured	**Total without health insurance**	3.5%	6.1%	8.8%
	Males	4.0%	7.1%	9.9%
	Females	3.0%	5.2%	7.8%
	Under 19 years	1.3%	4.4%	5.1%
	19-64 years	5.6%	8.4%	12.4%
	65 years and older	0.0%	0.5%	0.8%
	Income < $25,000	7.1%	8.8%	13.7%
	Income $25,000 and greater	13.5%	24.0%	35.9%
With Health Insurance	**Total with health insurance**	96.5%	93.9%	91.2%
	Private health insurance	80.7%	69.4%	67.9%
	Public health coverage	29.7%	37.2%	35.1%
	Under 19 years old	95.4%	95.5%	95.0%
	19-64 years	93.2%	92.0%	87.7%
	65 years and older[2]	93.9%	93.0%	89.8%

Sources: [7] U.S. Census Bureau, American Community Survey 1-Year Supplemental Estimates (2017)
[8] U.S. Census Bureau, American Community Survey 5-Year Estimates (2019)

Types of Health Insurance in Mercer County[2]

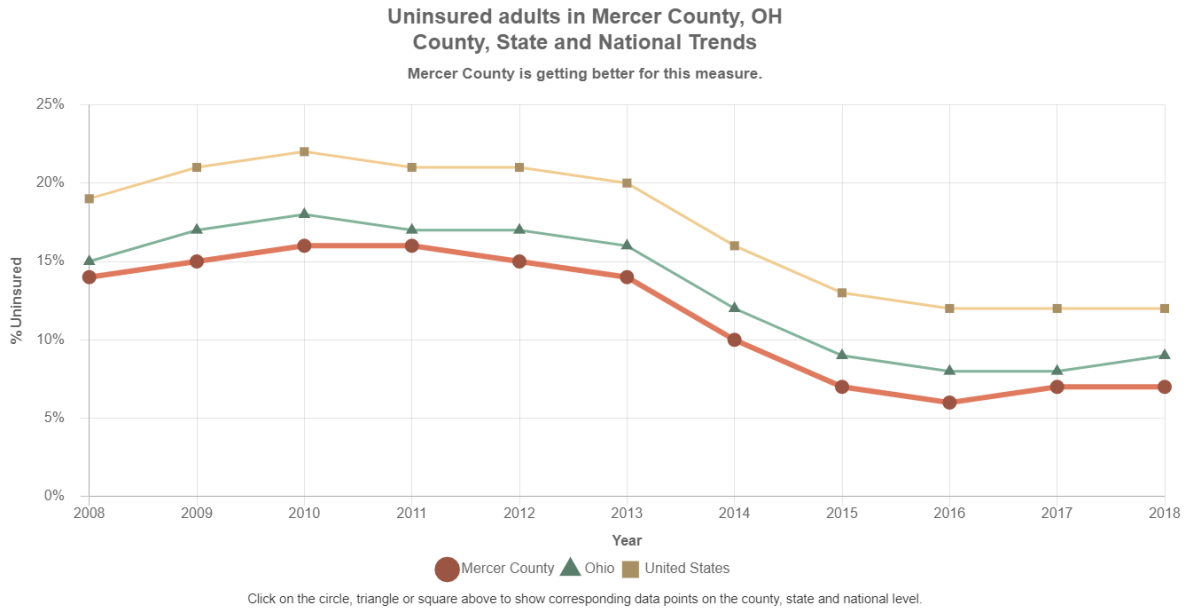
		Mercer County	Ohio	United States
Private Health Insurance Coverage	**Total with private health insurance**	80.7%	69.4%	67.9%
	Employment-based health insurance	68.4%	59.4%	55.2%
	Direct purchase health insurance	15.4%	11.9%	13.6%
	Tricare/military health insurance	1.3%	1.6%	2.7%
Public Health Insurance Coverage	**Total with public health insurance**	29.7%	37.2%	35.1%
	Medicare coverage	18.6%	18.5%	17.3%

Medicaid/means-tested coverage	12.6%	20.6%	20.2%
VA health care coverage	1.9%	2.3%	2.3%

Sources: 8 U.S. Census Bureau, American Community Survey 5-Year Estimates (2019)

Trends in Uninsured Adults

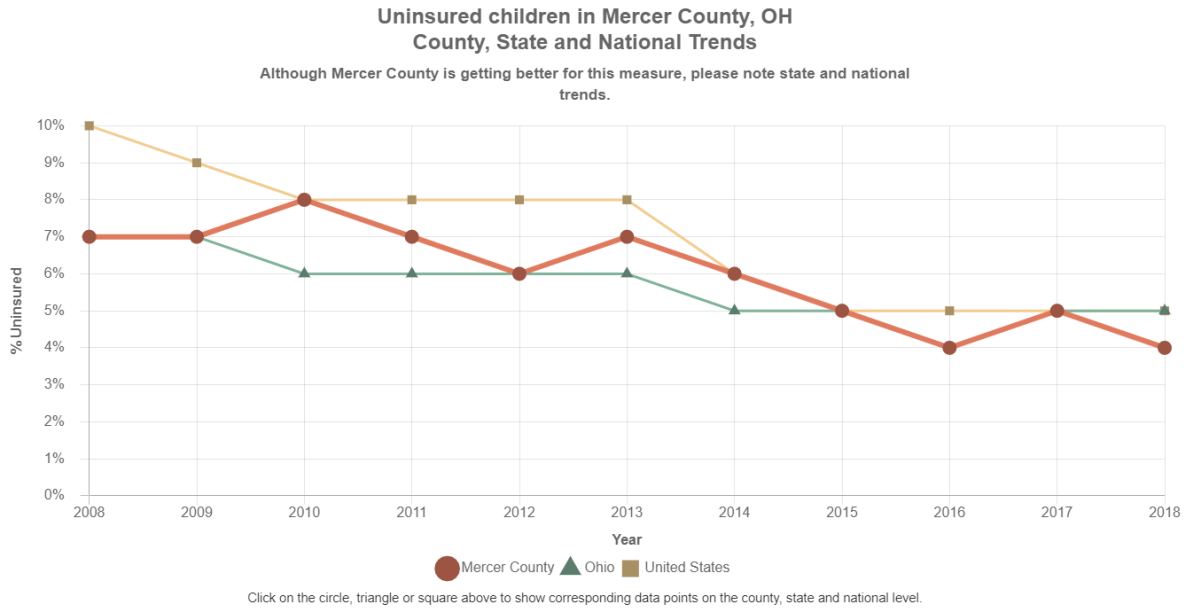
The various provisions of the Affordable Care Act, enacted in 2010 and gradually implemented over a four-year period, resulted in the percentage of uninsured adults ages 18 to 64 in Mercer County dropping significantly between 2013 and 2016. The chart below shows a decrease in percentage of uninsured adults from 14% to 6% during that time period.



Source: 2021 County Health Rankings[17]

Trends in Uninsured Children

Ohio Healthy Start (federally known as Children's Health Insurance Program or CHIP) provides free or low-cost health insurance for families with children.[18] It is designed to provide increased access to health coverage for children in families with income too high to qualify for Medicaid but too low to afford private coverage. The federal Children's Health Insurance Program was signed into law in 1997.[19] As a result, the percentage of uninsured children (i.e., under age 19) has been lower than the percentage of uninsured adults for several decades. In 2018, the percentages of uninsured adults and uninsured children were 7% and 4% respectively.



Source: 2021 County Health Rankings[20]

The Capacity of Mercer County's Health Care System

While health insurance coverage helps individuals gain entry into the health care system, it does not guarantee access to care. There must also be a sufficient number of health care providers and facilities available to meet local needs. Using the health care delivery model illustrated below, this section describes the current capacity of the health care system in Mercer County. This section focuses primarily on the types of care most important for population health - primary care, behavioral health (i.e., mental health and substance abuse treatment), and oral health care.

Providers

Primary Care Providers

Healthy People 2020 notes improving access to health care services depends, in part, on ensuring that people have a usual and ongoing source of care (i.e., a provider or facility where one regularly receives care).[21] Having a primary care provider (PCP) who serves as the usual source of care is especially important.

The National Academies of Sciences, Engineering, and Medicine (formerly known as the Institute of Medicine) define primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[22]

According to Healthcare.gov, a primary care provider is a physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.[23] More specifically, doctors classified as "primary care physicians" by the American Medical Association include General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs.

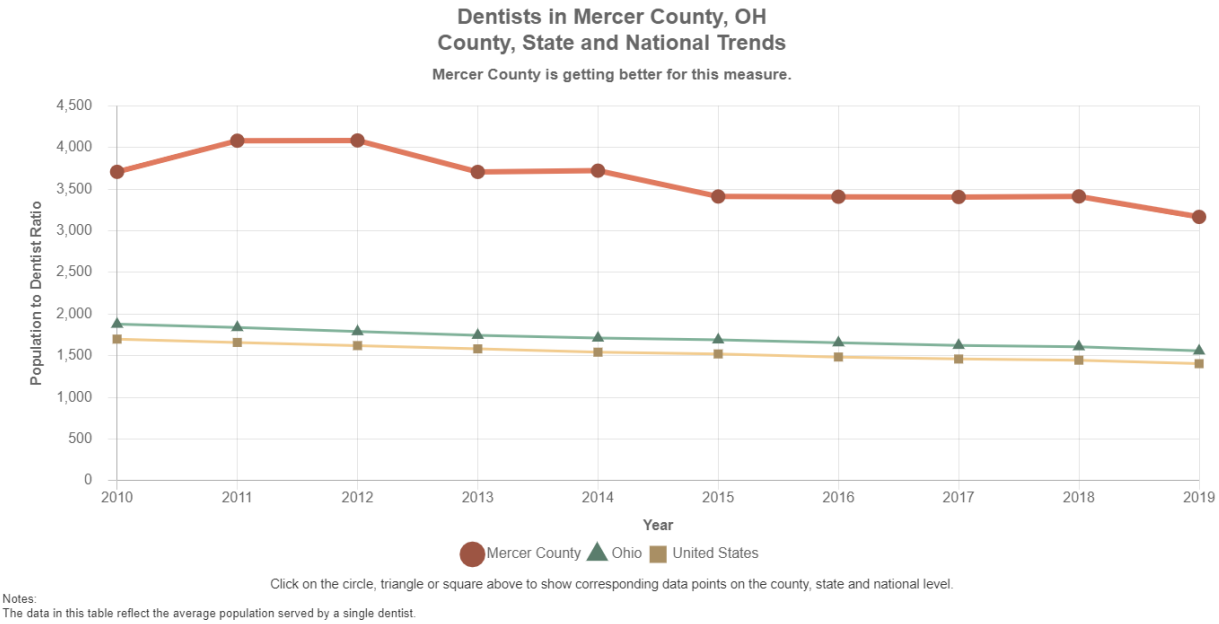
An increasing need for primary care providers is being driven primarily by population growth and aging, with health insurance expansion playing a more modest role. It is estimated that nearly 52,000 additional primary care physicians will be needed in the United States by 2025.[24] Mercer County has significantly fewer providers of all categories than the Ohio and National averages.

Health Care Providers and Provider Ratios

		Mercer County	Ohio (Avg)	United States
	Total Population			
Access to Primary Care Providers	Primary Care Physicians	2,156:1	1,303:1	1,319:1
	Dentists	3,170:1	1,210:1	1,560:1
	Mental Health Providers	1,110:1	270:1	380:1
	Specialty Providers	5,050:1	644:1	654:1

Source: 2021 County Health Rankings https://www.countyhealthrankings.org/app/ohio/2021/rankings/mercer/county/outcomes/overall/snapshot. Last accessed 01/21/2022

Sparkmap, Appalachian Health Disparities Report https://healthinappalachia.org/disparities-report/interactive-report/. Last accessed 01/21/2022.



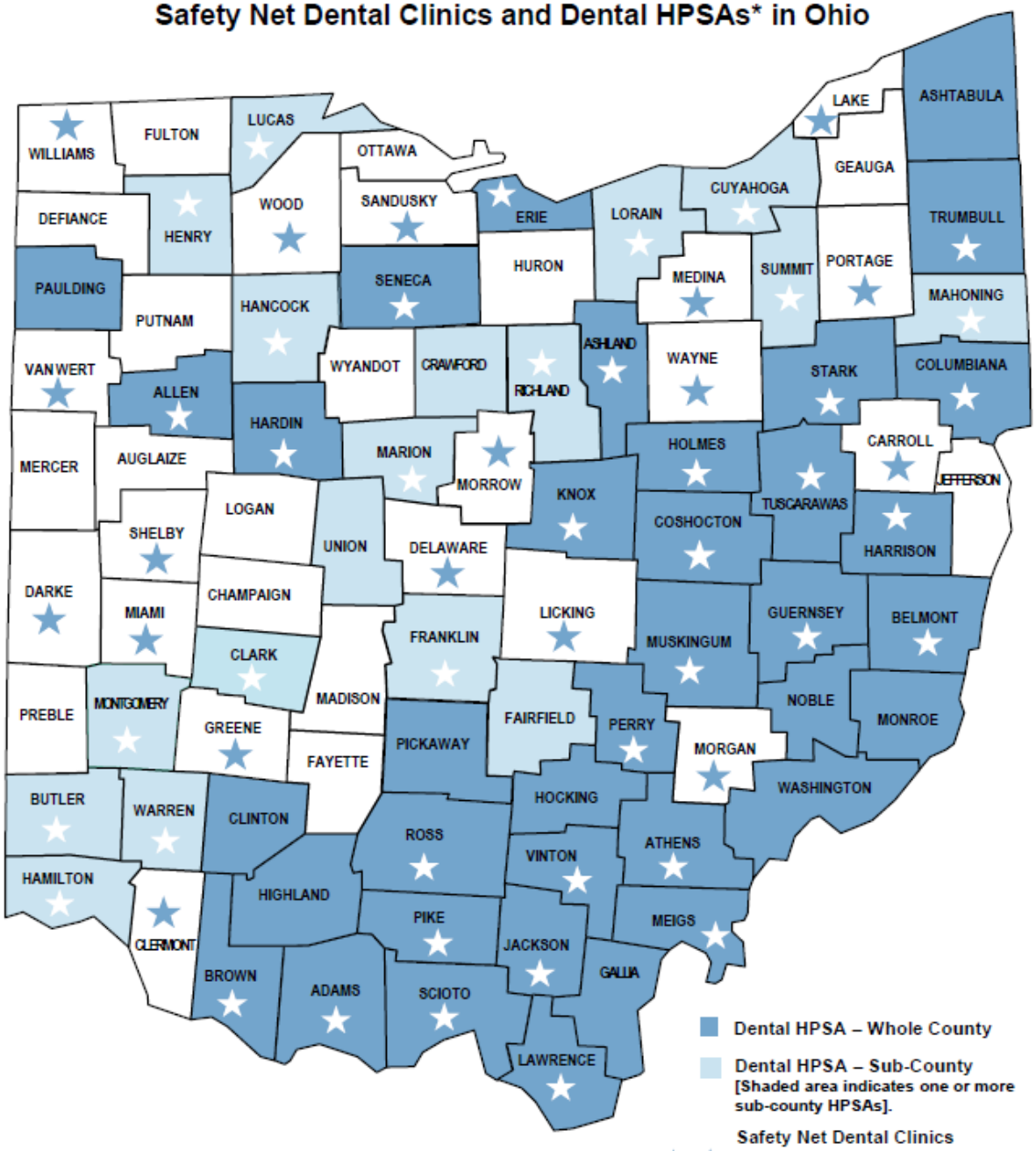
Source: *Community Commons…..*

Oral Health Care Providers

According to *Access to Dental Care in Ohio, 2000* (the state's most comprehensive dental access assessment),[25] dental care was the #1 unmet health care need identified for both Ohio children and adults in 1998. The largest disparities in oral health and access to dental care were related to low family income, followed by residence in an Appalachian county, and finally by race. This report also noted the potential for increasing private dentist participation in Medicaid was limited because reimbursement was lower than their usual customary fees and there was little incentive to become a Medicaid provider.

As noted in the table above, the patient to dentist ratio in Mercer County is 3,170 to 1. This is more than double the patient to dentist ratios for Ohio and the United States. Mercer County also lacks a safety net dental provider, meaning people who are covered by Medicaid or uninsured must travel to an adjacent county our beyond to receive dental care.

Safety Net Dental Clinics and Dental HPSAs* in Ohio



Map current as of January 2022

*A HPSA (dental health professional shortage area) is a federally designated geographic area without enough dentists to serve the people living there.

Behavioral Health Care Providers

The importance of behavioral health care for individuals suffering from mental health and substance abuse problems has been increasingly recognized in Mercer County over time. Although Mercer County has a variety of mental health care providers, the ratio of providers to population is much higher than that of the state of Ohio or the United States, as noted in the provider ratio table above.

Safety Net Providers

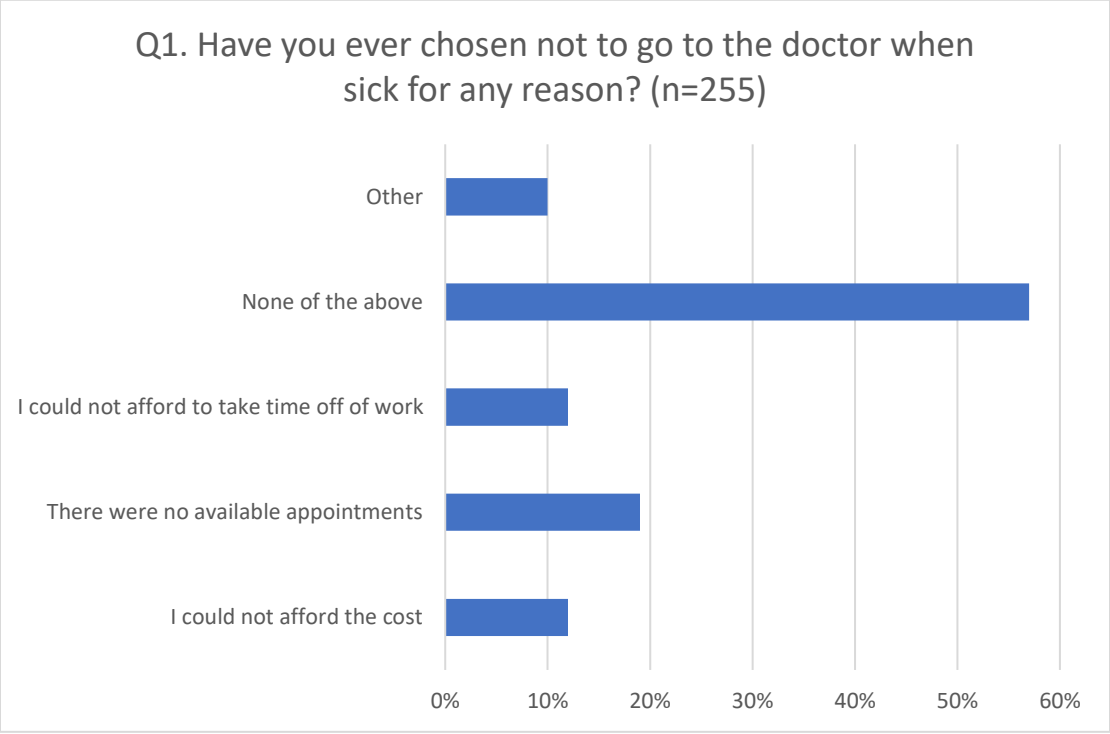
Even with expanded health insurance coverage (and more so in its absence), safety-net providers are critically important. The IOM Committee on the Changing Market, Managed Care and the Future Viability of Safety Net Providers defined safety-net providers as "[t]hose providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients".[26] That committee further identified core safety-net providers as having two distinguishing characteristics: "(1) by legal mandate or explicitly adopted mission they maintain an 'open door,' offering access to services to patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients".[27]

As noted by the IOM Committee on Assuring the Health of the Public in the 21st Century, when the delivery of health care through the private sector falters, the responsibility for providing some level of basic health care services to the poor and other special populations often falls to governmental public health agencies (i.e., local health departments) as one of their essential public health services. The Mercer County Health District makes immunizations available to all county residents, including those who are covered by Medicaid or who are uninsured. The main safety net provider for other primary care services is the Mercer Health medical system.

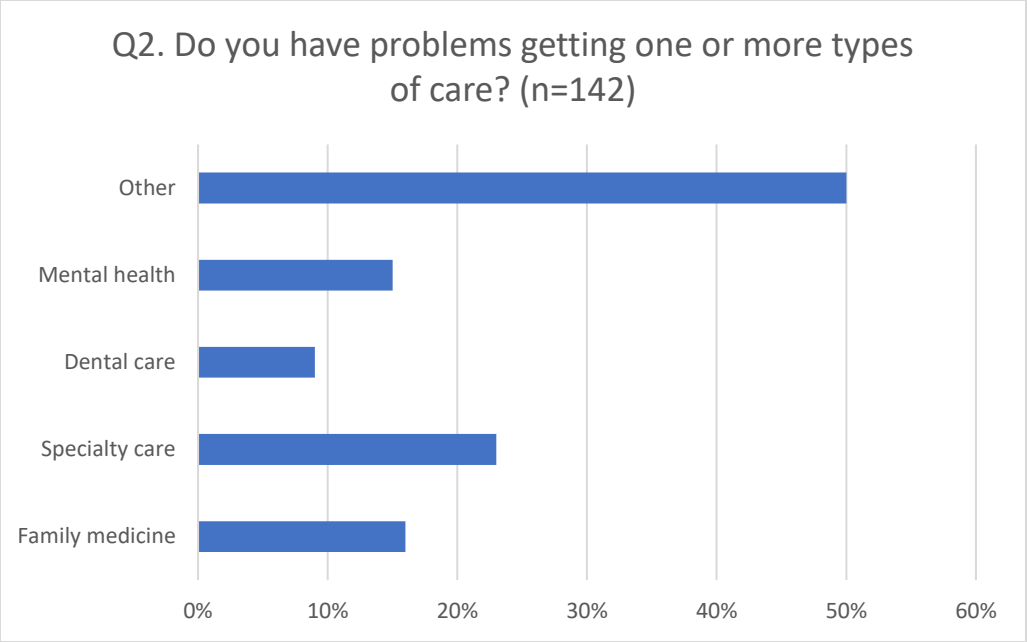
Assessment Results- Access to Care Survey

A total of 246 Mercer County residents responded to the Mercer County Access to Health Care Survey, offered digitally via SurveyMonkey and also made available as a paper survey as necessary. The following charts show quantitative results from multiple choice survey questions. In some cases, percentages do not add up to 100% because only the top five responses were included in the graph. As this was the first comprehensive access to care assessment performed by the COLT Health Committee, several opportunities for improvement have been identified in the process of analyzing data and developing this report. For one, future surveys will collect demographic details to help better identify specific segments of the population who may experience access disparities.

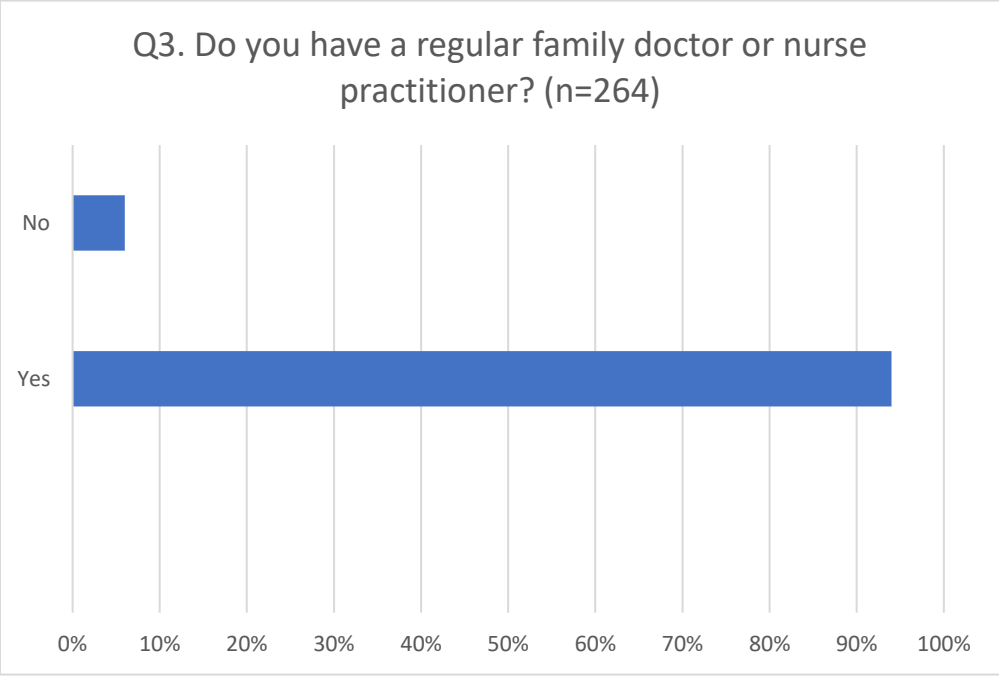
Quantitative Data

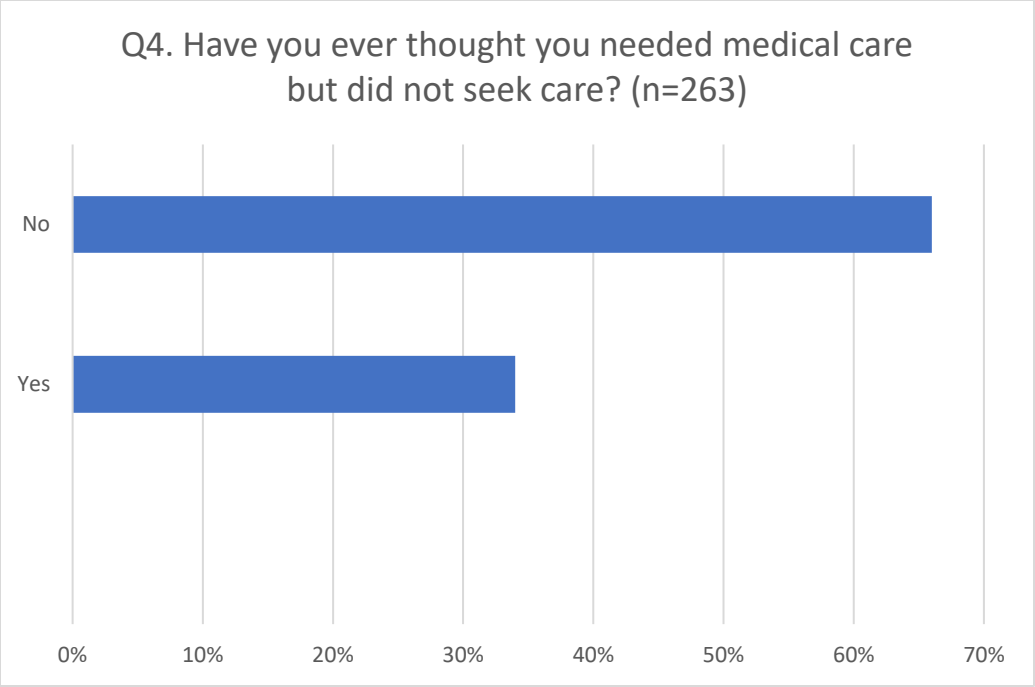


More than half of the respondents to this question indicated that they had not chosen not to go to the doctor when sick for any of the reasons presented, including “other”. If this question is used in the future, the “none of the above” response option would simply be changed to “no”. Significant barriers cited by respondents were lack of availability of appointments and inability to afford to take time off of work or pay the cost of care.

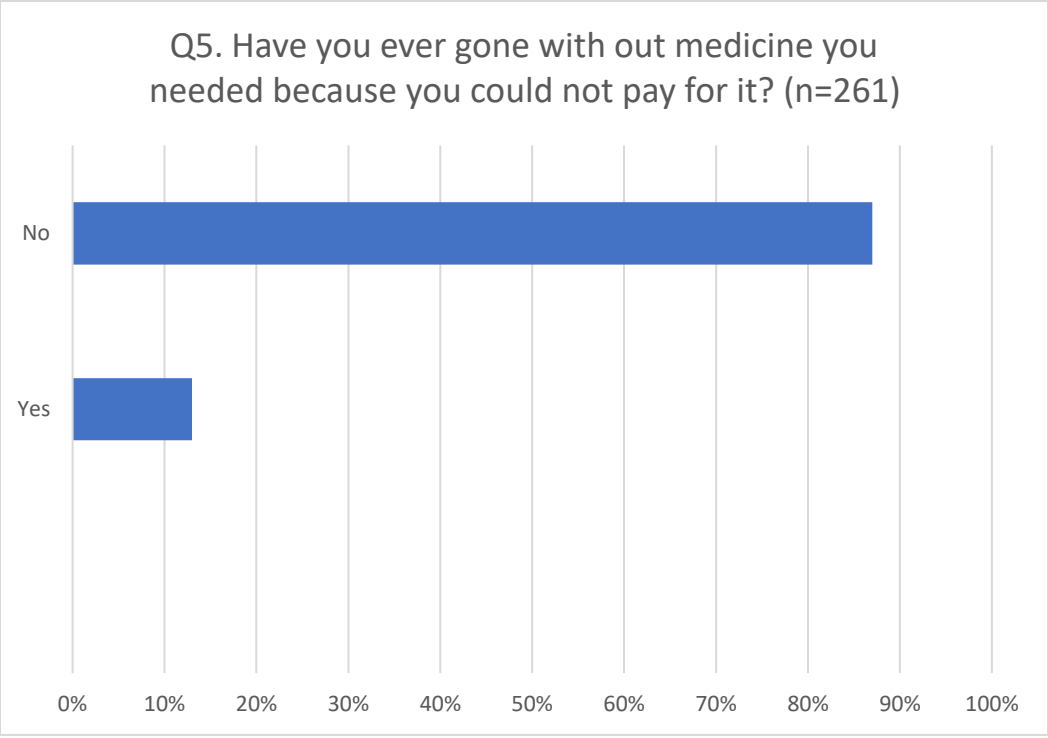


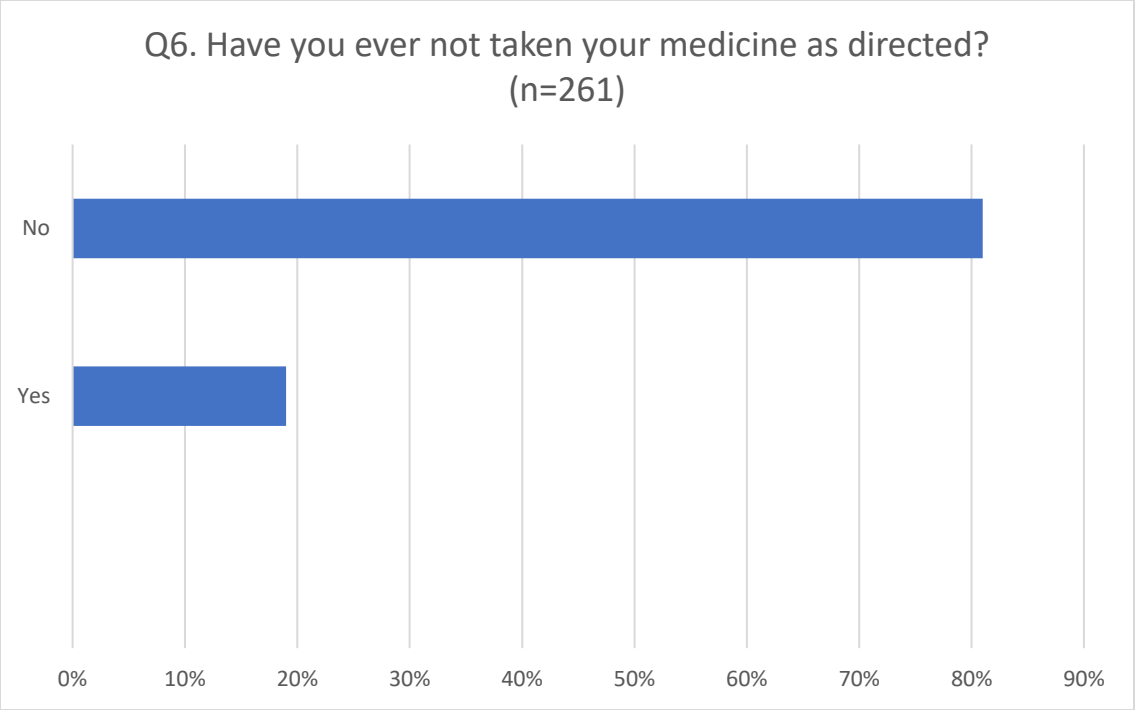
Relatively small proportions of respondents reported having problems obtaining the care they need in specific care categories, but added together, those who reported experiencing some type of problem getting the care they need made up more than half of all respondents. Like the previous question, this survey question should have included a “no” option. Of the respondents who answered “other”, 84% (or approximately 40% of all respondents) indicated that they do not have problems getting the care they need. Additionally, nearly half of the survey respondents skipped this question entirely.

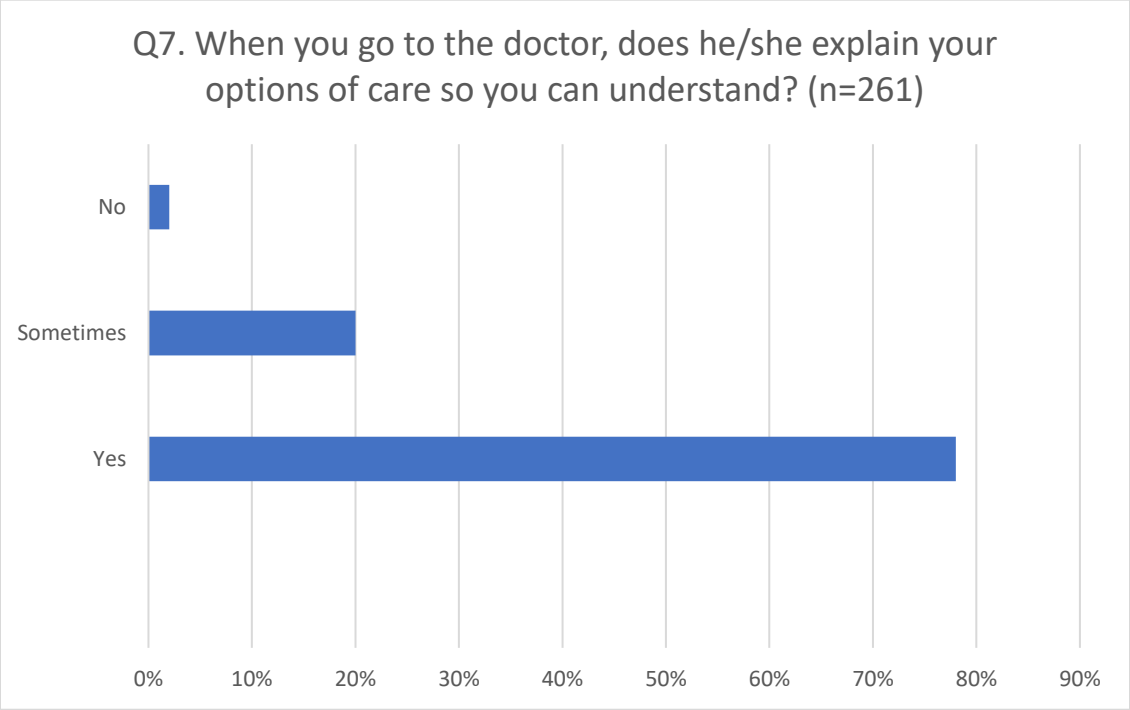


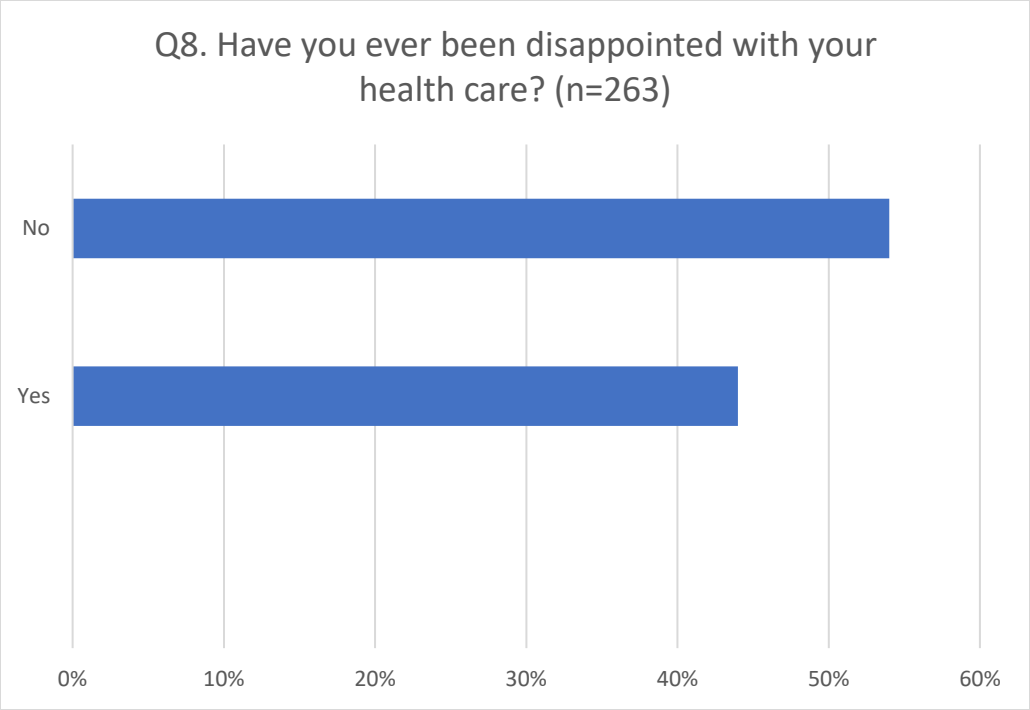


Respondents who answered “yes” to this question were asked to provide additional information in a comment box. The reasons why people did not seek needed medical care are examined in the Qualitative Data section of this report.

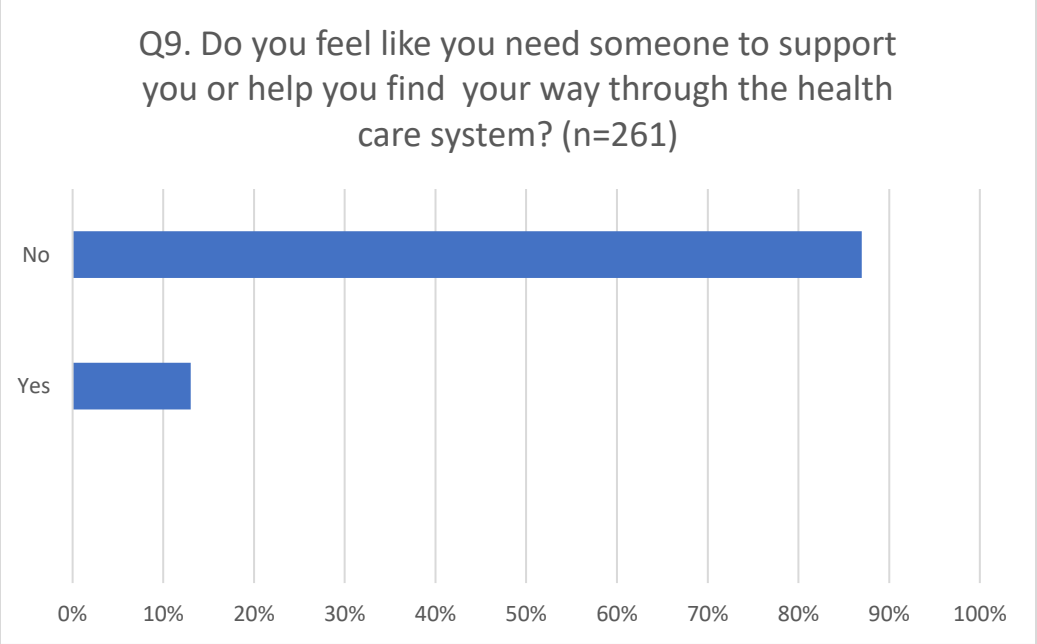



Q6. Have you ever not taken your medicine as directed? (n=261)
No
Yes
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%

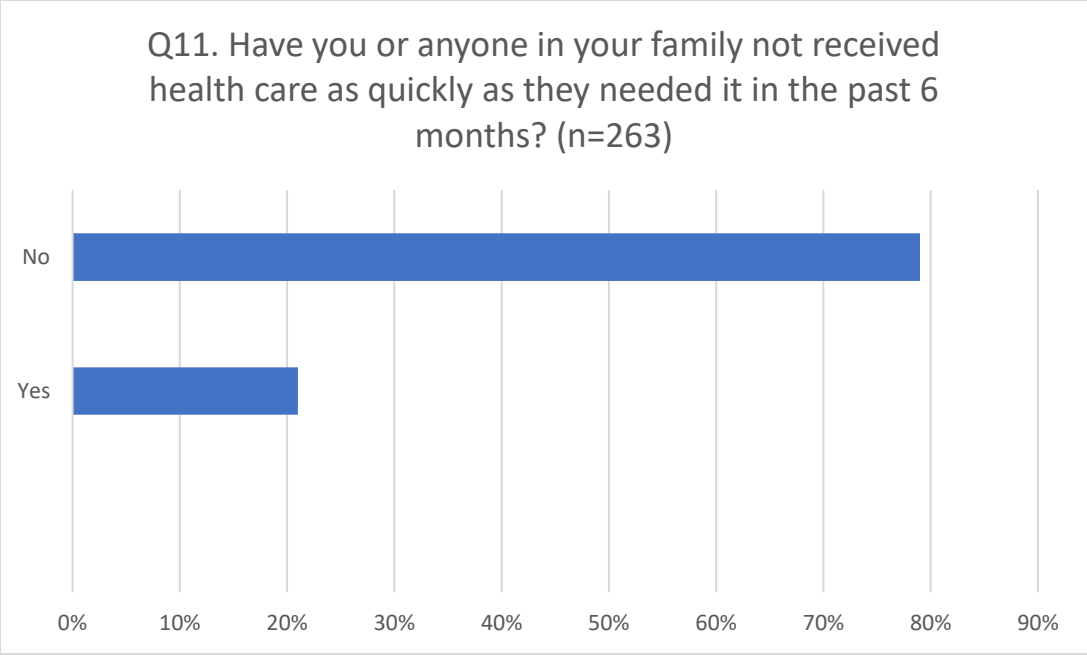

Q7. When you go to the doctor, does he/she explain your options of care so you can understand? (n=261)
No
Sometimes
Yes
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%



Respondents who answered “yes” to this question were asked to provide additional information in a comment box. The reasons why people said they have been disappointed in their health care are examined in the Qualitative Data section of this report.



This question did not include an open-ended follow-up. In a future assessment, it may be useful to ask respondents to share what type(s) of support they believe they need.



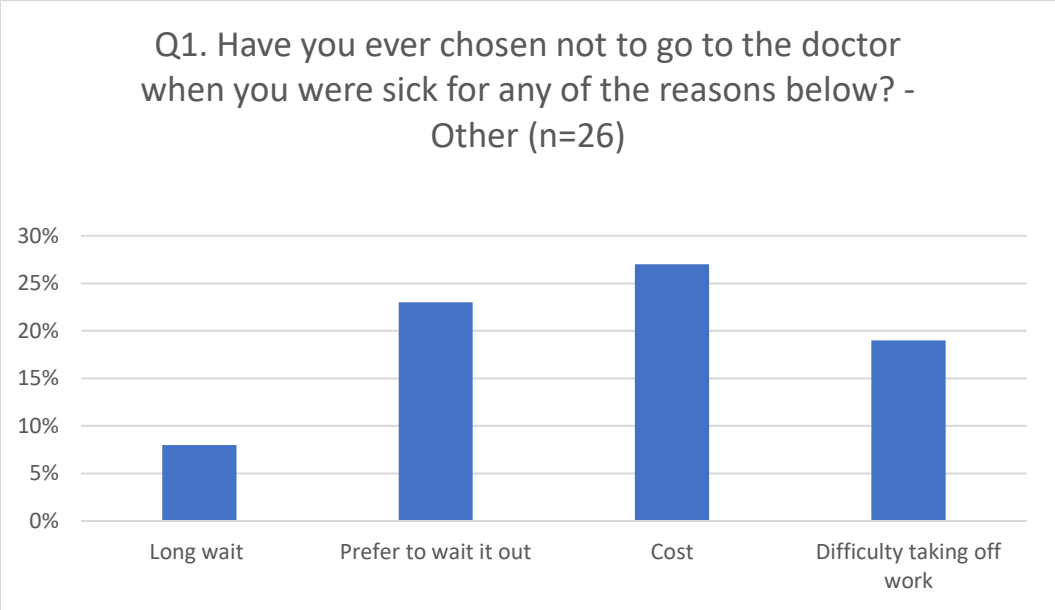
Respondents who answered "yes" to this question were asked to provide additional information in a comment box. The reasons why people did not receive care as quickly as they needed it are examined in the Qualitative Data section of this report.

Qualitative Data

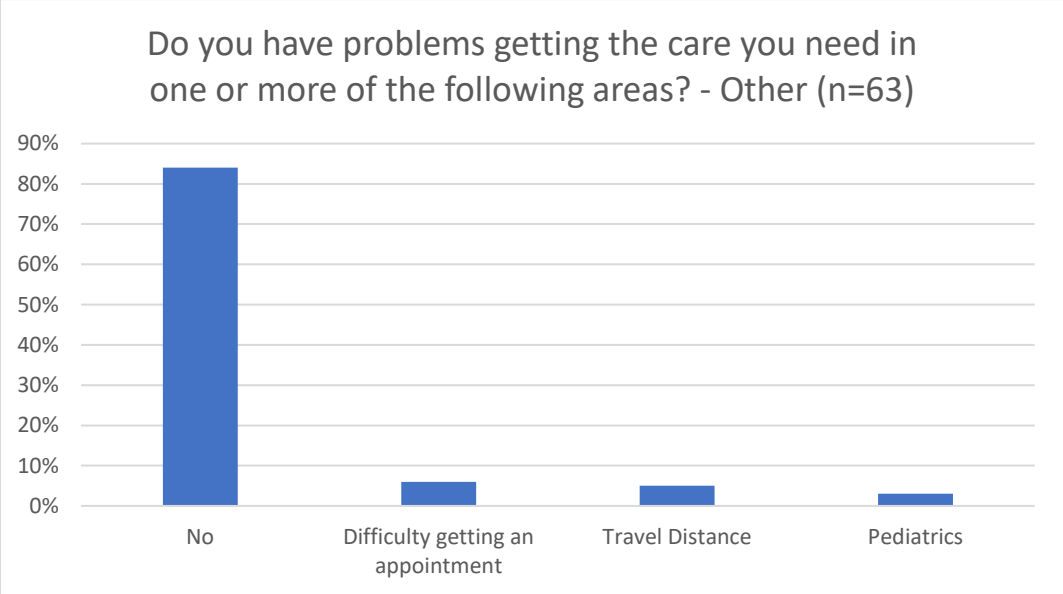
Qualitative data for this assessment were gathered from two sources. The responses to open-ended questions in the Mercer County Access to Care Survey add clarity to the answers to many of the questions discussed above. Additional qualitative data were gathered by conducting focus groups and key informant interviews with various community partners who work closely with people who may have difficulty obtaining the health care they need. This was the COLT Health Committee's first attempt at using key informant interviews and focus groups to gather data for a large-scale assessment. In a future assessment, more pertinent data will be collected by going beyond service providers to talk directly with members of vulnerable populations to determine their wants, needs, challenges, and successes.

The data from the survey questions were compiled and examined to find themes or recurring answers to the questions. The answers were manually coded according to the category of each repeated answer to identify trends involving barriers to care. All notes from the key informant interviews and focus groups were compiled, reviewed, and coded in a similar manner. The results of the analysis are shared here.

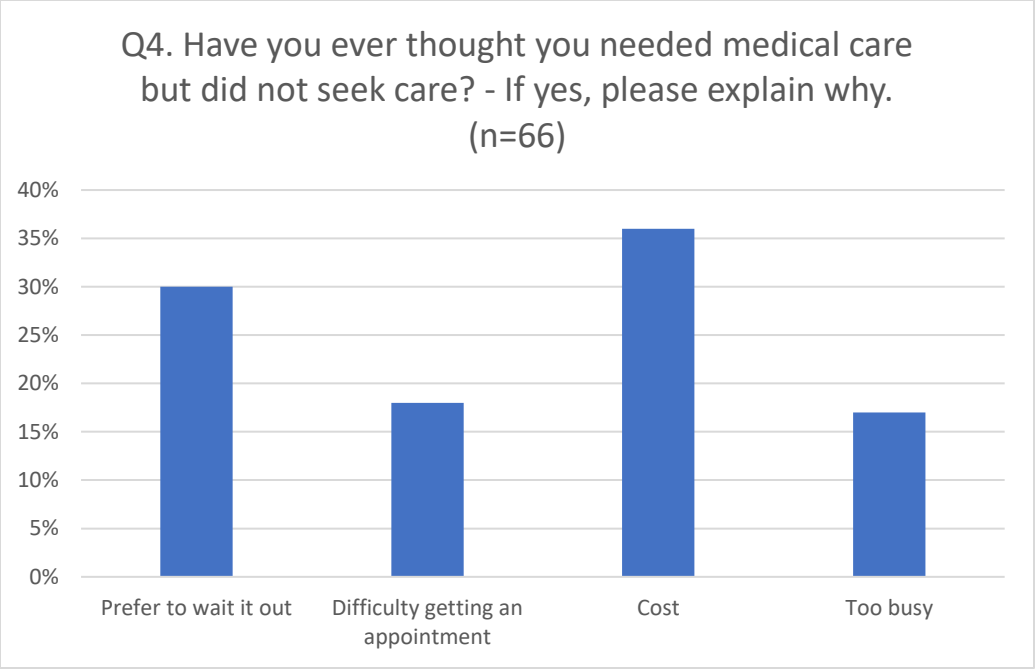
Open-Ended Survey Questions



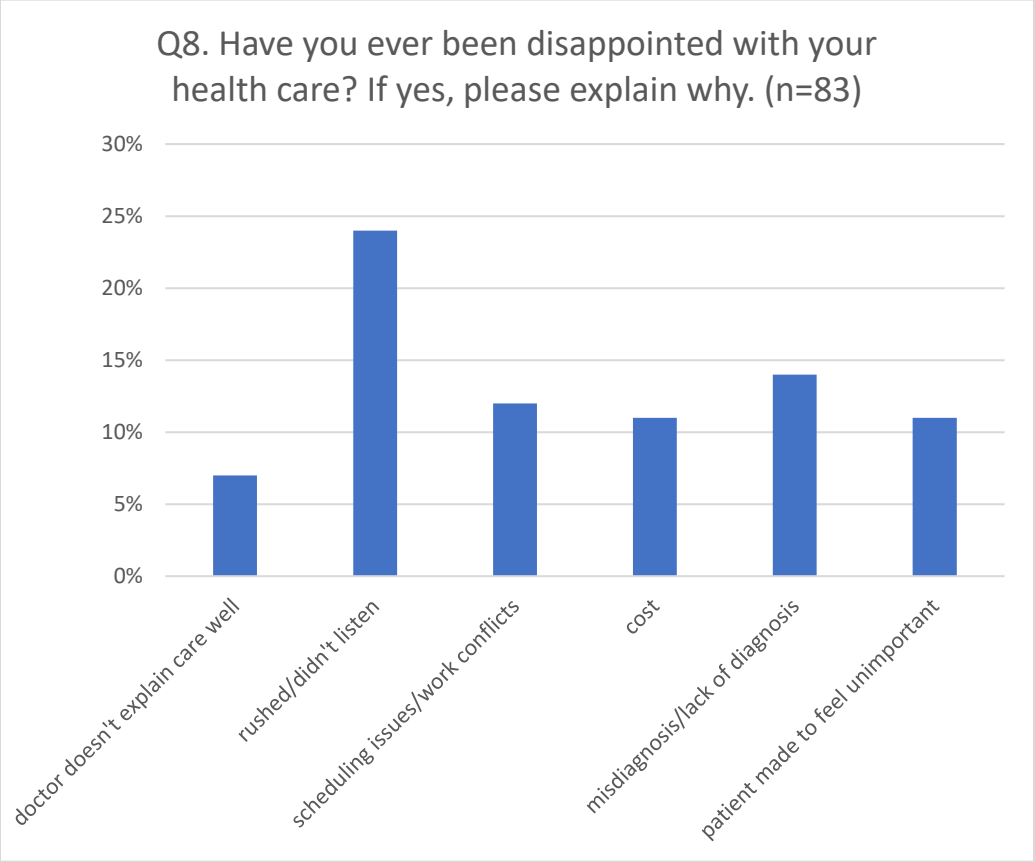
These are the top four "other" reasons for choosing not to seek medical care even when sick, according to the survey respondents who answered this question. Note that the scale only goes to 30%.

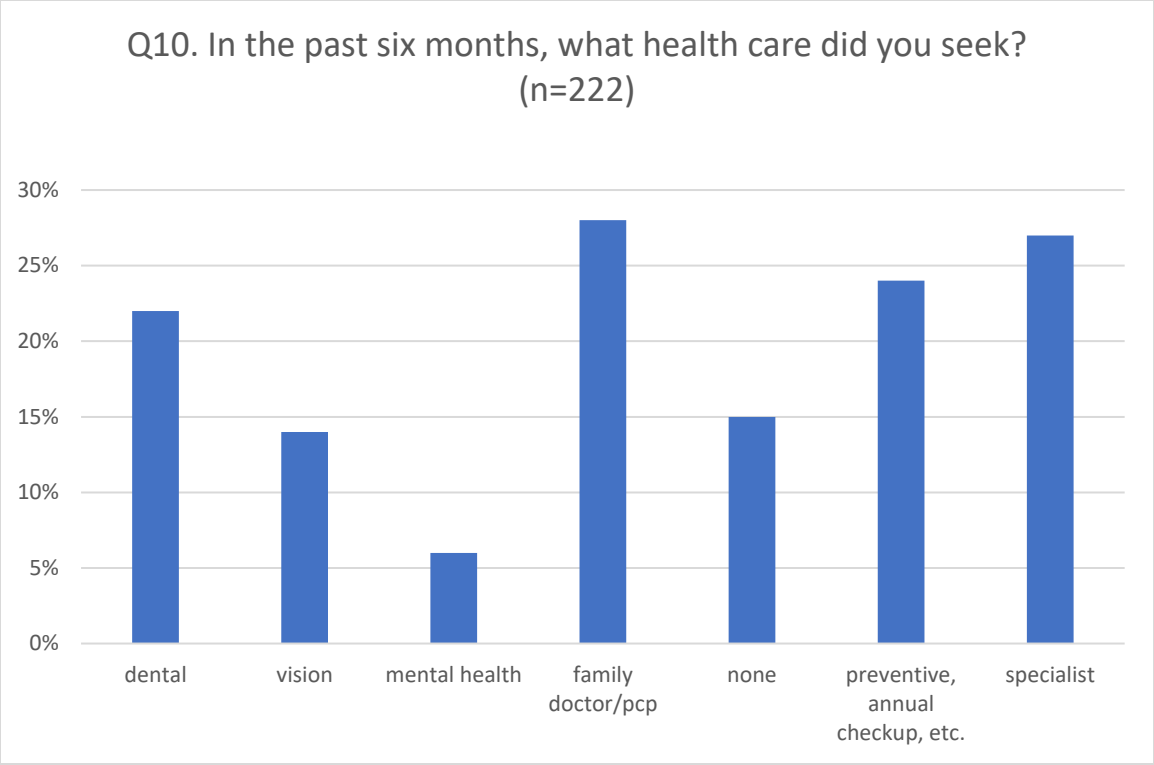


Although this question was about different areas of care such as medical, dental, or vision, some respondents chose to share the reasons they have difficulty getting care. Also, the vast majority of "other" respondents indicated they do not have problems obtaining care. This illustrates an opportunity for improved question wording in future surveys.

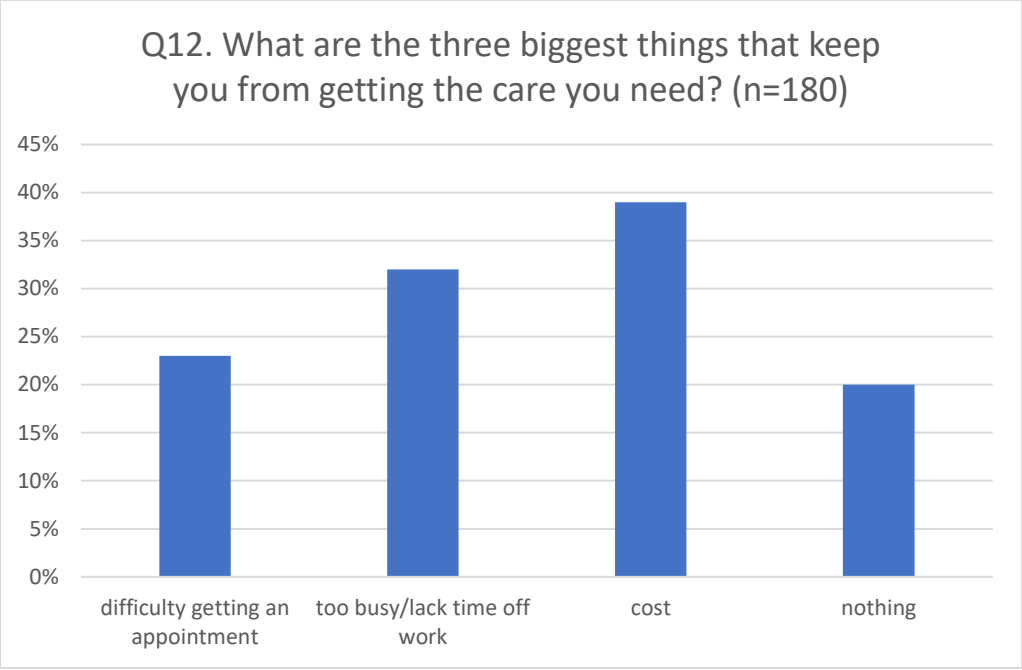


In retrospect, this question is very similar to Q1, and it produced similar responses.

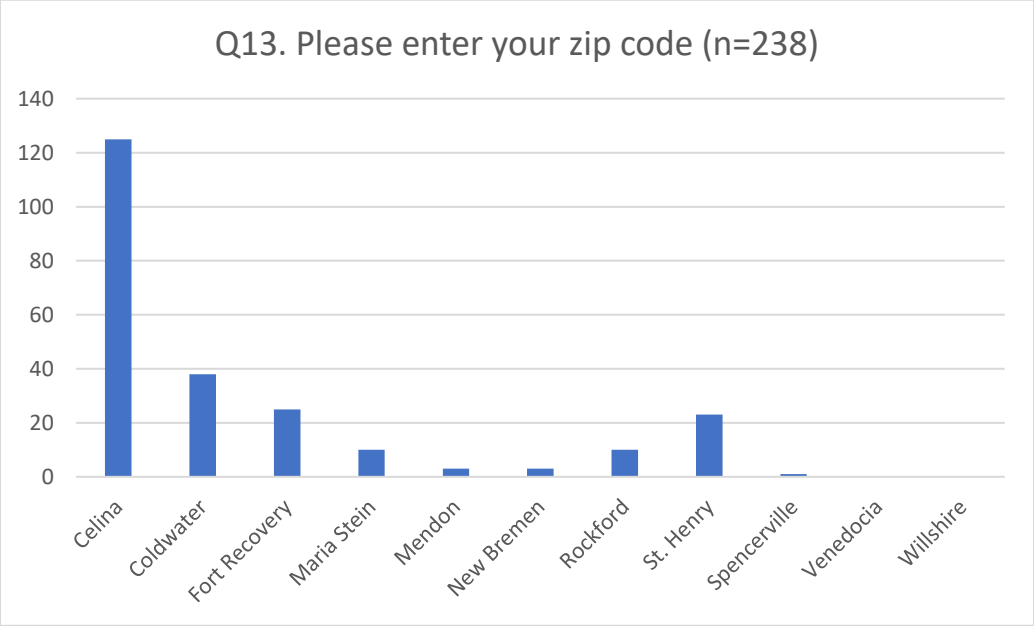




The most common answer to this question underscores one of the most common responses to Q1 and Q4.

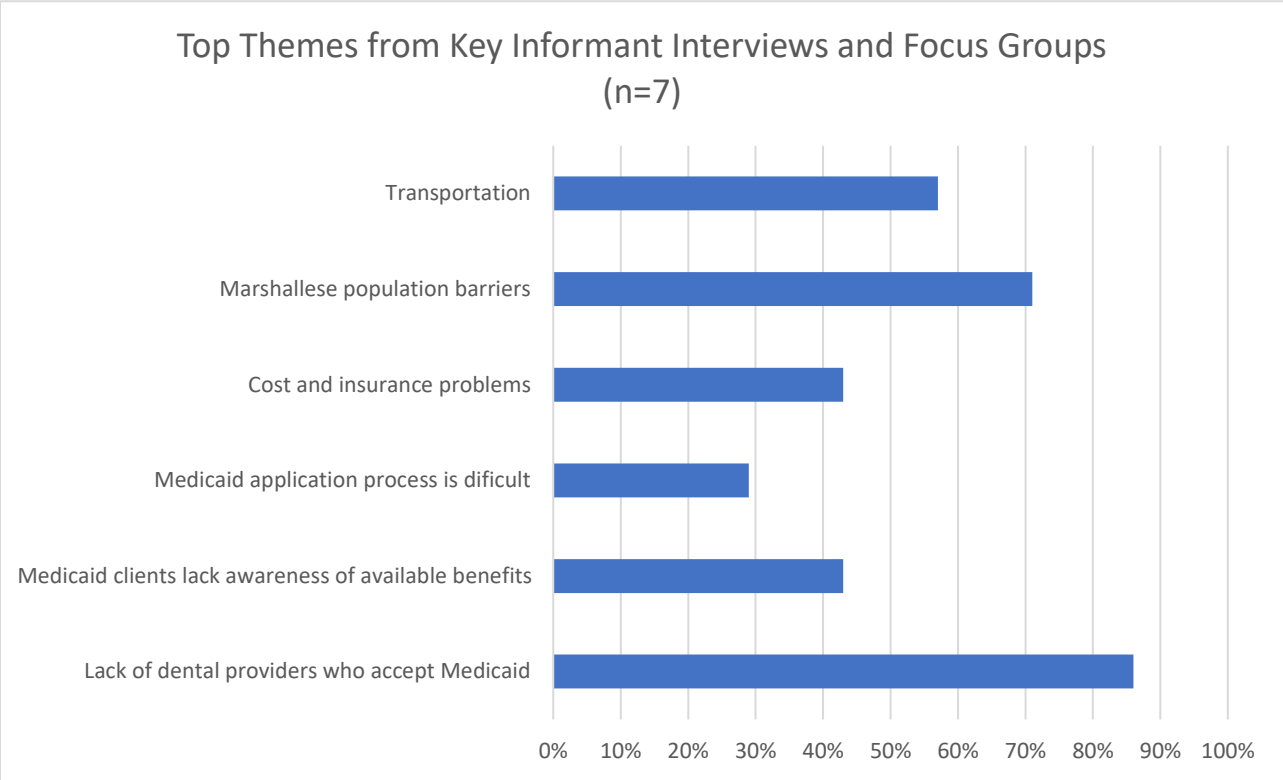


Cost, difficulty finding time and difficulty getting an appointment have emerged as major themes among survey respondents.



Several respondents indicated by their zip codes that they were not Mercer County residents. The data provided by these respondents were removed from the qualitative analysis. In the future, this and other demographic questions will have multiple choice answers. Furthermore, only Mercer County zip codes will be allowed so that respondents who are outside the scope of the survey do not complete the survey.

Key Informant Interviews and Focus Groups



The most common themes that emerged during key informant interviews and focus group discussions are shown here. Some of these themes were mentioned multiple times during a discussion, but for the purposes of this visual each theme was counted once for each group that mentioned it, regardless of how many times it came up in discussion.

Vulnerable Populations

Information gathered during the Mercer County Access to Health Care Assessment has led to the identification of multiple population groups who experience barriers to health care services. Explanations are provided below.

- **People who have Medicaid health care coverage**- there is a lack of local dental providers who provide care for Medicaid clients, meaning Medicaid clients must go outside the county to meet even their most basic dental needs. There is a wide gap between the cost incurred by a dental provider and the reimbursement received from Medicaid, such that it is not feasible for many providers to accept Medicaid insurance. Additionally, many Medicaid clients may not be fully aware of the benefits available to

them. For example, Medicaid provides transportation to some out-of-county appointments, but this benefit is not always well-utilized.

- **Natives of the Marshall Islands and their descendants (Marshallese)**- there is now a significant Marshallese population in Mercer County. Providers and others who provide assistance report difficulty keeping Marshallese individuals engaged in their own health care. Although the language barrier sometimes presents a challenge, cultural differences appear to be the most formidable obstacle to better engagement. In the Marshall Islands, one might have to travel a long distance for routine medical care, making such care unfeasible for many islanders. As a result, going to a provider routinely for preventive care may not be part of the general mindset of many Marshallese people in Mercer County. Providers report some difficulty in conveying the importance of follow-up care to members of the Marshallese population. The availability of Medicaid has helped narrow the access gap for the Marshallese residents of Mercer County.
- **Residents with high-deductible health insurance plans**- Many Mercer County Access to Healthcare Survey respondents cited cost of health care as a deterrent to pursuing care when they thought they needed it. This was often a factor even for those who had insurance, as high deductibles still presented a substantial cost burden.

Understanding Vulnerable Populations' Barriers to Care

Outside of the Mercer County Access to Healthcare Survey which was made available to the entire Mercer County population, information on vulnerable populations' barriers to care was gathered indirectly by conducting key informant interviews and focus groups with healthcare providers and those who provide various forms of public assistance to help vulnerable individuals obtain the care they need. Some of the main takeaways from these information gathering activities are listed here:

- Medicaid patients experience difficulty obtaining routine and advanced dental care in Mercer County due to lack of in-county providers who accept new patients. These patients are referred to Medicaid dental providers in other counties, sometimes as far away as Dayton. Because of the overall lack of providers, these people must often endure substantial wait times to get the care they need. Additionally, the added distance presents a transportation challenge for people who are already financially disadvantaged. Some may not have a reliable vehicle, others may lack sufficient money to afford the cost of gas and other travel expenses.
- Medicaid benefits appear to be underutilized. Many Medicaid clients are not fully aware of the benefits available to them. Many eligible school-aged children are not covered. The Medicaid enrollment process is complicated for those who work with clients, and is probably even more so for the clients themselves. Throughout the declared public health emergency due to the COVID-19 pandemic, no one has been removed from

Medicaid coverage. When the public health emergency ends, all Medicaid clients will be required to reapply to determine their eligibility. This is normally done annually. This will be an enormous undertaking for those who administer Medicaid. More importantly, this process may come as a surprise to clients who have obtained initial Medicaid coverage during the pandemic and are not accustomed to the annual cycle. Failure to recognize or respond to mailed correspondence in a timely manner could result in many people suddenly finding themselves without healthcare coverage.

- Local providers experience difficulty in keeping Marshallese patients engaged over time to ensure proper follow-up care to promote long-term health. Marshallese cultural norms appear to play a more prominent role than the language barrier, as the younger members of many Marshallese families are usually able to translate. Even so, it is sometimes difficult for providers to gauge whether they have adequately communicated the details and importance of the actions needed to maintain good health.
- Mental health problems exacerbate many barriers to healthcare. Someone who is experiencing anxiety or depression may not be able to navigate the system to find the care they need. Even seemingly simple things like making phone calls to line up appointments may be very difficult. Driving to unfamiliar locations outside the county can be an enormous challenge for someone who is struggling with anxiety. Anxiety or depression can prevent a person from making it to a scheduled appointment. In some healthcare systems, two missed appointments can get a patient "blacklisted", rendering them unable to obtain the services they need.
- Transportation causes problems beyond being able to go to a doctor's appointment. For someone who lacks reliable transportation it can be difficult to maintain a job. Without a job, it is difficult to afford healthcare or even provide healthy meals and a healthy housing environment needed to promote good health.

Emerging Access Issues in Mercer County

The Mercer County Access to Healthcare Survey and other data collection conducted as part of the access to care assessment revealed several emerging issues with access to health care, listed here:

- Lack of sufficient providers to care for those who are covered by Medicaid- this is an especially severe problem with regard to dental providers. Responses from multiple key informant interviews and focus groups supported the idea that the lack of providers is primarily due to low reimbursement rates. One respondent estimated that it would take 3-4 Medicaid patients to bring in the amount of revenue generated by one privately insured patient receiving the same treatment.

- Medicaid disenrollment- The number of people in Ohio covered by Medicaid has increased substantially during the COVID-19 pandemic, in part because people lost employer-provided insurance. This Medicaid expansion population now constitutes almost 24% of Medicaid enrollees (Protecting Ohio, 2020). These individuals are guaranteed continuous coverage throughout the federally-declared COVID-19 public health emergency, but that guarantee will expire at the end of the quarter during which the public health emergency ends (Millions of Children, 2022). At that time, all Mercer Countians who are covered by Medicaid will need to submit information for a determination of eligibility. Those who do not provide the information will lose their coverage.
- Healthcare workforce concerns- the COVID-19 pandemic has led to concerns that healthcare workers will leave the workforce and prospective healthcare workers will choose to follow different career paths to avoid experiences similar to those of the past two years.

Opportunities for Community Action

The Health Care Access Barriers (HCAB) Model developed by Carrillo et al. is a helpful framework to use when exploring opportunities for community action, since it focuses on modifiable health care access barriers in order to serve as a practical tool for root-cause analysis and community-based interventions.[ii]

Access to health care often varies based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location. The HCAB Model describes three categories of modifiable health care access barriers:

- Financial barriers relate to the cost of care and health insurance status. Common examples are being underinsured or lacking health insurance altogether.
- Structural barriers limit the health care system's availability. Barriers occurring outside of health care facilities include, but are not limited to, availability and proximity of facilities, transportation, child care, and telephone or Internet access to providers. Structural barriers within a facility include its hours of operation, excessive waiting times, multi-step care processes, and multiple locations for tests and specialists. While challenging for many, these barriers most adversely affect lower-income persons living in neighborhoods of social and economic distress.
- Cognitive barriers relate to knowledge and communication. They are rooted in a person's beliefs about and knowledge of disease, prevention, and treatment, as well as in the communication that occurs in the patient-provider encounter. A person's lack of awareness of accessible health services may also compound health barriers. Limited

health literacy, as well as linguistic and cultural barriers (e.g., the lack of translator services, translated educational materials, or providers of various racial and ethnic backgrounds), may further prevent an individual from understanding and acquiring the necessary knowledge to carry out prevention or treatment directions.

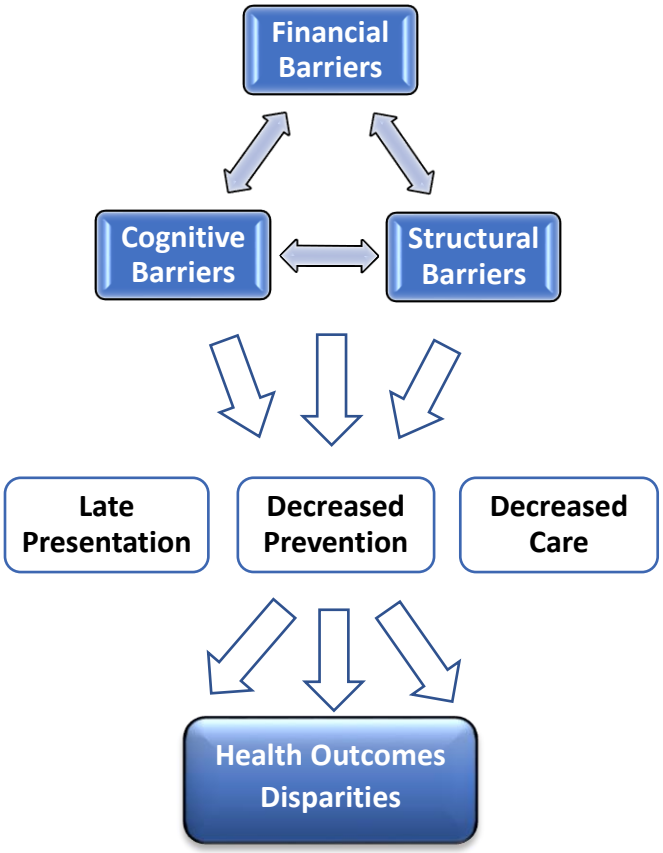


Figure 1. HCAB Model (JE Carrillo et al. "Defining and Targeting Health Care Access Barriers." *Journal of Health Care for the Poor and Underserved* 22 (2011): 562–575.)

These three categories of barriers are mutually reinforcing and affect health care access individually and collectively. For example, cognitive barriers can aggravate or compound financial and structural barriers. Similarly, financial barriers may lead to structural or cognitive barriers.

The HCAB Model also defines three variables - prevention, timely care, and treatment- that can serve as intermediate measures reflecting the impact of access barriers. The three types of

health care access barriers are associated with decreased screening, late presentation to care, and lack of treatment, which in turn result in poor health outcomes and health disparities. By targeting those barriers that are measurable and modifiable, the model facilitates root-cause analysis and intervention design.

This model enables discussions about health care access barriers; provides a systematic approach for conducting the root-cause analyses of demonstrated disparities; and facilitates the design of interventions addressing racial and ethnic disparities. Once identified, strategies may be developed and implemented to address these measurable and modifiable barriers to care (e.g., culturally and linguistically appropriate staff and materials, transportation services) and link people to appropriate personal health services through the coordination of provider services. Carrillo et al provide further guidance regarding how to use the HCAB Model in this way. [28]

The following sections provide evidence-based (when possible) strategies that may be useful in addressing access to health care barriers identified during this assessment.

Strategies to Increase Number of Dental Providers Accepting Medicaid

Respondents in several key informant interviews and focus groups conducted during the access to care assessment suggested that shortage of dental providers accepting Medicaid is largely due to insufficient reimbursement rates for the services they provide. None of the people who suggested this were dental providers, so a logical first step would be to reach out to local dental providers to ensure the root cause of the problem is understood.

Because there is good reason to believe the additional information gathering described in the previous paragraph will corroborate the suggested reason for the Medicaid dental provider shortage, this report offers a couple possible solutions. First, an increase in reimbursement rates for dental services may help to entice more providers into accepting Medicaid[29]. This is a state level decision, so local public health system partners could organize to advocate for our state legislators to make a change. This advocacy may take place alongside the efforts of Ohioans for Dental Equity. An increase in Medicaid reimbursement rates may be a long-term objective, as the COVID-19 pandemic has simultaneously decreased state budget revenue while increasing costs in part due to increased Medicaid enrollment.

Another potential avenue to expand availability of dental services for the underserved population is to advocate for expansion of the scope of duties what are known as allied dental professionals. Allied dental professionals include dental assistants, dental hygienists, and dental therapists. State regulations specify the scope of practice of each type of professional, particularly to what extent they can work independently of the supervision of a dentist. Many states have revised or are considering revising dental scope of practice laws to allow allied dental professionals to provide a wider range of services independently[30]. More information is needed on how these services would be reimbursed by Medicaid. If the same reimbursement is provided for a service regardless of what level of provider is used, employing dental hygienists and/or dental therapists to provide basic services may result in a more favorable cost to reimbursement ratio for a dental practice.

Strategies to Maintain Medicaid Coverage

Mercer County Department of Job and Family Services will be heavily engaged in the process of Medicaid eligibility redetermination. It will be important to inform current Medicaid clients that redetermination is coming and they should be on alert for any correspondence from the Medicaid program. Because the continuous coverage assurance has been in place for well over a year, some Medicaid clients may have moved and will be more difficult to reach.

To help ensure opportunities for continued coverage for the highest number of Mercer County Medicaid clients possible, the Mercer County Department of Job and Family Services should coordinate with community partners across the public health system, leveraging their networks to promote awareness of this emerging access to health care issue across the widest possible audience.

Strategies to Promote Optimal Utilization of Medicaid Benefits

According to input received during key informant interviews and focus group discussions, navigating Medicaid can be an overwhelming experience due to the sheer volume of information available and the complexity of the application process. Mercer County's local public health system should explore a Medicaid client "navigator" model that would make the application process easier and help clients coordinate their care in a way that takes maximum advantage of the benefits available to them.

Strategies to Ensure Adequate Health Care for People with Mental Illness

Increased communication and awareness between mental health and medical providers could alleviate multiple problems in this area. Local public health system partners should work to strengthen the network between mental health and medical providers to avoid duplication of efforts when patients present to medical providers with mental health problems. Increased collaboration between these two health sectors may also promote awareness and increase flexibility for patients who may experience difficulty participating in their own medical care *because* of their mental illness.

Strategies to Remove the Transportation Barrier to Care

Feedback obtained during key informant interviews and focus groups suggested that many people who have health care coverage under Medicaid may not be aware that Medicaid provides access to some transportation services to enable them to get the care they need. Mercer County public health system partners should collaborate to promote increased awareness of the services that Medicaid offers.

Rural transportation services are suggested to increase mobility in areas of low population density. Because of this lower population density, rural transportation systems often have higher per capita costs. This potential obstacle can be countered by cooperation between multiple entities whose clients would benefit from the service. Capital and operating assistance can be obtained from the US Department of Transportation through Section 5311 grants.

Population income is a determining factor when pursuing a 5311 grant[31]. Partners across the Mercer County public health system should continue to seek a feasible option for transportation assistance in the county.

Resources

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