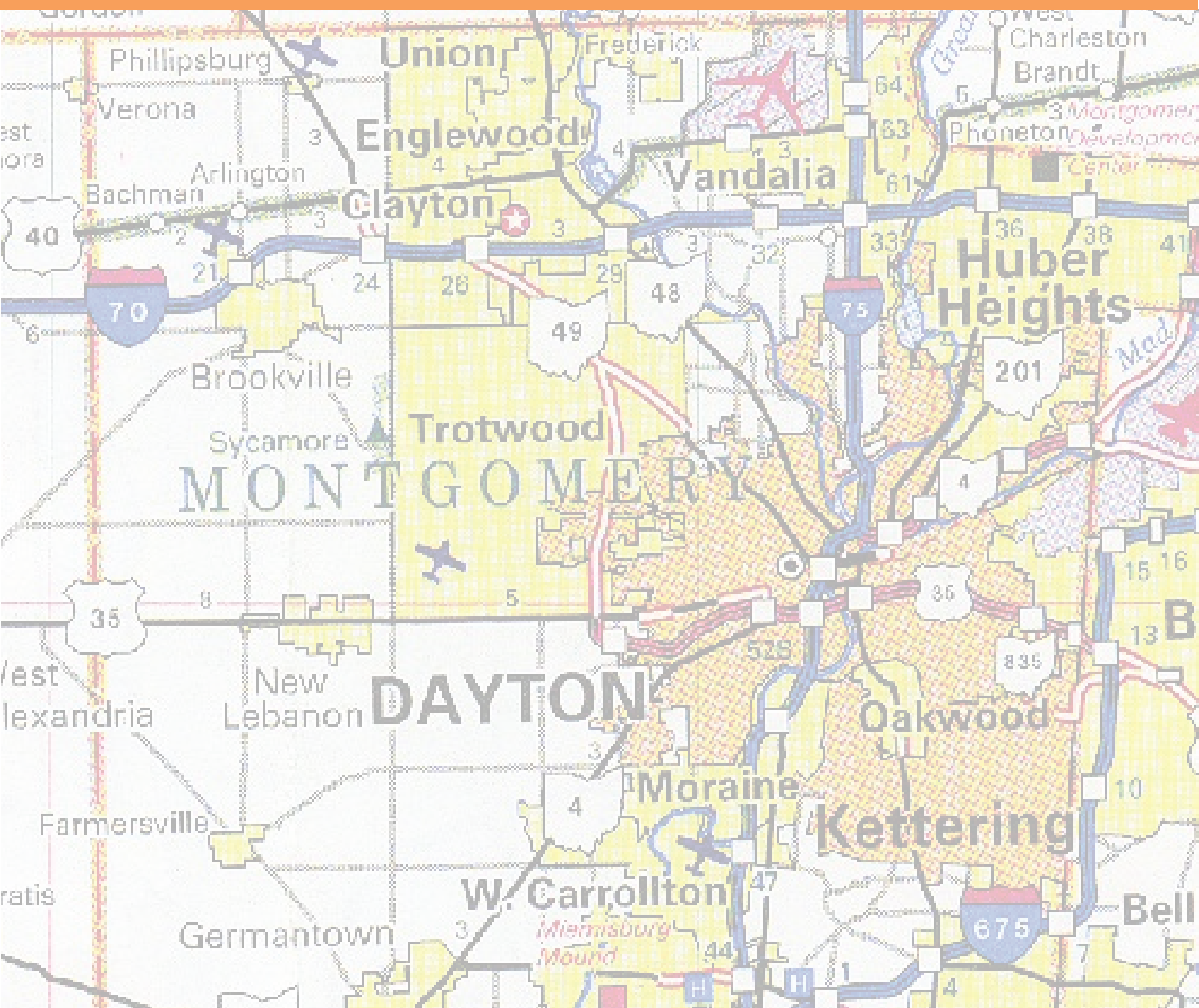


An environmental scan of the **MONTGOMERY COUNTY SAFETY NET**



Prepared for the **Montgomery County Affordable Care Act Task Force** by



October 2013

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An Environmental Scan of the Montgomery County Safety Net for the Montgomery County Affordable Care Act Task Force

Executive Summary

October 2013

Background

The Montgomery County Affordable Care Act Task Force (MCACATF) was created in April 2013 to prepare the community for the implementation of the Affordable Care Act and its impact on the human service safety net in Montgomery County. The MCACATF contracted with the Health Policy Institute of Ohio (HPIO) to conduct an environmental scan and assessment of the current access, capacity, and delivery system of the physical, behavioral, and dental healthcare safety net for vulnerable populations in Montgomery County. Conducted between May and September 2013, the scan included qualitative research to assess how the safety net is currently working for vulnerable populations, and quantitative research to review data, analyze trends and conduct a workforce capacity analysis.

HPIO is a nonprofit organization that serves as Ohio's nonpartisan, independent source for forecasting health trends, analyzing key health issues, and communicating current research to policymakers, state agencies and other decision-makers. HPIO's research partners for this project included:

- National Center for the Analysis of Healthcare Data: mapping services and workforce analysis
- Transformative Consulting: data collection, analysis and synthesis
- Usable Research: qualitative research, including focus groups, wait-time survey, and key informant interviews.

Staff from the Alcohol, Drug Addiction and Mental Health Services Board of Montgomery County (ADAMHS), the Greater Dayton Area Hospital Association, and Public Health-Dayton & Montgomery County provided data, analysis and insights.

The Montgomery County Safety Net

Safety net providers are defined as health care providers who serve a significant portion of patients who are classified as uninsured, enrolled in Medicaid, or other vulnerable populations, and those living in underserved rural or inner city areas. Montgomery County's safety net includes three community health center organizations, two free clinics, hospital emergency departments, a few dental clinics, and the Alcohol, Drug Addiction and Mental Health Services Board mental health agencies. In addition to delivering 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.

Montgomery County's safety net providers will remain an important part of the health care delivery system going forward as the Affordable Care Act is implemented, serving much of the newly insured population and continuing to serve as the safety net for the remaining uninsured and vulnerable populations. Because the safety net provides care for patients with some of the most complex needs and the fewest resources, the anticipated stresses of health reform on the overall health care delivery system—increased demand, maldistributed workforce, shifts in financing streams – may be felt more acutely in the safety net.

Demand for the Montgomery County safety net is driven by factors such as the economy, uninsured rate and health status, with data revealing health disparities within the county along income and racial/ethnic lines. Health status, income, race/ethnicity, poverty by family and by community, and access to health care are all linked, with geographic analysis showing alignment between the biggest gap in primary care, the most prevalent health disparities, and high rates of emergency department utilization.

Key themes

The environmental scan yielded the following key themes:

The safety net is critical for Montgomery County's low-income and vulnerable populations, as well as for a significant portion of out-of-county residents.

Thirty-four percent of county residents live in families with incomes under 200% of the federal poverty level (\$39,060 annually for a family of three); 15% of county residents under the age of 65 are uninsured; and 123,000 county residents are covered by Medicaid. Many of these rely upon safety net providers for care. In addition, the resources within the county take on a greater burden as a result of demand from other counties: Twenty-one percent of all patient visits in Montgomery County emergency departments and 31% of visits to Montgomery County Medicaid dental providers were from out-of-county residents.

Evidence of current unmet need and future demand point to the need to continue the growth and coordination of the safety net.

While safety net capacity has been increasing modestly, as evidenced by the fact that the number of patient visits to safety net providers continues to grow, many residents go without access to the care they need. Community health centers currently serve about 27,400 of the county's 183,000 low-income residents, with free clinics and private providers/hospital outpatient clinics that accept Medicaid serving some, but not all, of the rest.

Nearly 20% of adults in the county report they have no personal doctor or health care provider; 15% report they have delayed a visit to the physician due to cost; and 35% of adults have not visited a dentist or dental clinic in the past year. New patients (those who do not have an established relationship with a health care provider) face challenges in securing health care appointments. This unmet need contributes to the trends of rising hospital uncompensated care, and rising numbers of emergency department visits, where seven of the top ten reasons for visits are preventable in

many cases. Better primary care access, care coordination and patient education can help ensure patients receive the appropriate care in the appropriate setting.

Montgomery County faces health care workforce shortages, most notably a shortage of primary care physicians. However, maldistribution of providers may be a more significant problem than overall shortages. The distribution of the health care workforce in Montgomery County follows the same general pattern across physical, dental, and behavioral health sectors, leaving shortage areas in the northeast portion of the county as well as in much of Dayton and neighborhoods to the west of the city.

An estimated 42,000 currently uninsured county adults are eligible for subsidized coverage through Ohio's new Health Insurance Marketplace. If Ohio expands Medicaid, the county could see 29,000 newly-eligible adults enroll; the county has already experienced 15% growth in Medicaid caseloads between January 2012 and June 2013. These newly insured residents will create additional demand for services from a safety net that is already stretched.

As one young dad shared, "It's harder to get health care now – if you don't have insurance, forget it. I can't get hurt, I can't get sick. If I go to the ER they scoff at me."

The Montgomery County community has a strong history and strengths on which to continue to build, such as actions taken to study the safety net and health system over the past decade. Given the track record of creating new programs including Montgomery County Care and two new community health center systems (Community Health Centers of Greater Dayton and Five Rivers Health Centers), the community is well positioned to act collectively to coordinate and strengthen the safety net. Strong leadership, engaged stakeholders, and dedicated resources will be key to continuing progress.



RECOMMENDATIONS

Recommendation A

Build broader stakeholder understanding of and support for the Montgomery County safety net

While members of the Task Force and key stakeholders are knowledgeable about the safety net, its role, and its value, other stakeholders and many in the general public are not. In addition, some question whether or not the safety net will be necessary after implementation of the Affordable Care Act.

As a result, the Task Force should consider a coordinated strategy to educate and inform key stakeholders and policy makers about the role of the Montgomery County safety net (across physical, oral, and behavioral health), its strategic value to the county, and its current and future needs. This effort can help ensure that local, state and federal policymakers, as well as the general public, are informed and equipped as relevant policies are debated and decided.

Recommendation B

Convene and sustain a strategic table for key stakeholders from all levels of the safety net and other health care entities

Montgomery County is to be commended for its track record of improving and expanding the safety net, especially over the past several years. While unmet need remains, the community has much upon which to build.

Yet feedback from key informants within various parts of the county's health care infrastructure signals that communication and collaboration still remain inconsistent within various parts of the delivery system. This prevents maximum coordination and collective impact.

The Task Force should consider convening and sustaining a strategic table for key stakeholders from all levels of the safety net and other health care entities. The

convener needs to be a strong leader who is well-respected across the stakeholders and is perceived to be neutral.

Models include Access HealthColumbus, Better Health Cleveland and the Cincinnati Health Collaborative, all public/private partnership organizations that help direct initiatives to improve access and coordination of care across the spectrum of organizations and government agencies. The organization could provide a neutral approach to collective priority setting, identification of resources, and strategic implementation.

Recommendation C

Monitor and report regularly on Montgomery County access to care

This project included the development of the Montgomery Care Access to Care Dashboard, designed to provide an overview of key indicators related to access to health care in Montgomery County; provide a tool to track progress over time; and guide investment and strategy. The Dashboard can be found <http://bit.ly/1g4zWfa>.

The Task Force should ensure strategic and widespread dissemination of the Dashboard and commit to engaging community stakeholders in a process to use the dashboard to inform priorities and strategies. The Dashboard should be updated and released annually.

In addition, the Task Force should consider developing a system to track and report on the trends related to demand, utilization, and access specific to safety net providers. This would require agreement among providers on a common set of indicators that provide a point-in-time view of how coverage changes and other ACA policies are impacting safety net providers and that can be updated regularly.



RECOMMENDATIONS (CONT.)

Recommendation D

Increase capacity across primary care, dental, and behavioral health for vulnerable populations

The environmental assessment confirms current unmet health care needs of Montgomery County's vulnerable populations as well as projected future need. The Task Force should make increasing capacity a top priority for the near- and middle future, focusing on shortage areas. Suggested strategies include:

- Support current safety net providers' plans to increase capacity in the short-term.
- Focus on managing chronic conditions for vulnerable populations and further integration of care. Managing chronic conditions effectively assures patients receive the appropriate care in the appropriate setting, contributing to better health outcomes and maximizing limited health care resources.
- Support expansion of team-based models of care, including the patient-centered medical home (PCMH) and the use of mid-level providers. This requires infrastructure capacity, resources, and workforce acceptance to transition effectively to the PCMH model. Racial and ethnic health disparities are reduced when adults have medical homes.

Recommendation E

Strengthen primary care, oral and behavioral healthcare workforce capacity

Maldistribution and insufficient numbers of providers contribute to healthcare workforce shortages within Montgomery County and within the region. Not only does this create access barriers for vulnerable populations, it also carries a loss of economic benefits to the wider community. The Task Force should make strengthening health care workforce capacity a top priority, focusing on shortage areas.

Suggested strategies include:

- Engage health and civic leaders from surrounding counties to address workforce and access issues on a regional basis
- Strengthen incentives for serving in shortage areas, including seeking all available HPSA designations
- Partner with medical, dental and allied health training programs to develop strategies to meet short and long-term needs, including strengthening and supporting community-based training

Recommendation F

Ensure eligible Montgomery County residents access new coverage options by developing and supporting a coordinated strategy for outreach, education and consumer assistance

Local, state and national research confirms that many consumers do not know how the Affordable Care Act may impact them or their families, nor if they may be eligible for new coverage options beginning in 2014.

Montgomery County leaders should ensure that the community develops and supports a coordinated strategy for outreach, education and consumer assistance. A neutral entity may be best to coordinate this effort and should include those entities that have a formal role (Navigators, Certified Application Counselors, community health center outreach and enrollment grantees, Job and Family Services, among others) as well as the wider group of interested stakeholders who want to ensure that their constituents have accurate, timely information.

In addition, the strategy could include consumer education and assistance in how to access and utilize health care effectively to stay healthy and prevent/manage illness.

An Environmental Scan of the Montgomery County Safety Net for the Montgomery County Affordable Care Act Task Force

Introduction

Background and Purpose

The Montgomery County Affordable Care Act Task Force (MCACATF) was created in April 2013 to prepare the community for the implementation of the Affordable Care Act and its impact on the human service safety net in Montgomery County.

To begin the process, the MCACATF commissioned an environmental scan and assessment of the current access, capacity, and delivery system of the physical, behavioral, and dental healthcare safety net for vulnerable populations in Montgomery County. The purpose of the environmental scan is to:

- Provide a current status of how well the current health care safety net operates and supports the real daily needs for vulnerable populations,
- Identify major deficiencies,
- Offer recommendations/suggestions of:
 - Priorities that need solutions
 - Options that may address the needed solutions
 - Key organizations or individuals that should be involved in the solutions

In May 2013, the MCACATF contracted with the Health Policy Institute of Ohio (HPIO) to conduct the environmental scan. HPIO is a nonprofit organization that serves as Ohio's nonpartisan, independent source for forecasting health trends, analyzing key health issues, and communicating current research to policymakers, state agencies and other decision-makers. HPIO's research partners for this project include:

- National Center for the Analysis of Healthcare Data: mapping services and workforce analysis
- Transformative Consulting: data collection, analysis and synthesis
- Usable Research: qualitative research, including focus groups, wait-time survey, and key informant interviews.

Staff from the Alcohol, Drug Addiction and Mental Health Services Board of Montgomery County (ADAMHS), the Greater Dayton Area Hospital Association, and Public Health- Dayton & Montgomery County provided data, analysis and insights.

Throughout this research, three key themes have emerged:

- **The safety net is critical for Montgomery County's low-income and vulnerable populations, as well as for a significant portion of out-of-county residents.**
- **Evidence of current unmet need and future demand point to the need to continue the growth and coordination of the safety net.**
- **The Montgomery County community has a strong history and strengths on which to continue to build, such as actions taken to study the safety net and health system over the past decade.** From these assessments the county has created new programs including Montgomery County Care and two new community health center systems. The continued development of the comprehensive community health assessment is a major asset as well.

This report outlines the findings of this research which support these key themes and includes recommendations to consider moving forward.

The Montgomery County Access to Care Dashboard was developed as a separate, stand-alone document, and is available at <http://bit.ly/1g4zWfa>.

Research Objectives and Methods

Below are the objectives for the environmental scan upon which HPIO and the core leadership team of the MCACATF agreed and the methods which HPIO used:

1. Review and synthesize existing data in order to establish a Montgomery County baseline.
 - Research and analyze Affordable Care Act (ACA) community implementation strategies and models
 - Identify and gather existing data sources
 - Conduct a series of in-person and telephone meetings with safety net leaders and stakeholders (For a complete list of meetings, see Appendix A.)
 - Identify key indicators of access and system capacity
 - Create a snapshot of Montgomery County health status
2. Develop a Montgomery County access dashboard that can be updated periodically and used to inform strategy and investments.
 - Review existing data and local/county dashboards
 - Recommend criteria for selection of indicators
 - Propose model
3. Conduct consumer and provider focus groups to assess how vulnerable populations currently access health care and the current understanding of possible new coverage options.
 - Conduct two consumer focus groups (one for uninsured, one for those with Medicaid coverage)
 - Conduct a series of individual meetings with providers who provide direct service to safety net clients
4. Test availability of and wait time for primary care appointments across physical, behavioral, and oral health providers.
 - Wait-time audit conducted via telephone with 44 providers identified as accepting new Medicaid patients (18 physical health primary care, 15 dental providers, and 11 behavioral health providers on contract with ADAMHS Board of Montgomery County)
5. Analyze current Montgomery County health care delivery system for vulnerable populations.
 - Conduct key informant interviews with Task Force members and other local stakeholders
6. Conduct Montgomery County health care workforce capacity analysis to identify potential access strengths and gaps.
 - Use data from licensure boards of targeted health professions to calculate the number of providers in Montgomery County and map their locations

The Montgomery County Safety Net

Safety net providers are defined as health care providers who serve a significant portion of patients who are classified as uninsured, enrolled in Medicaid, or other vulnerable populations,¹ and those living in underserved rural or inner city areas.

In addition to delivering 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.

Contrary to what some may believe, safety net providers will remain an important part of the health care delivery system going forward as the Affordable Care Act is implemented, serving much of the newly insured population and continuing to serve as the safety net for the remaining uninsured and vulnerable populations. Because the safety net provides care for patients with some of the most complex needs and the fewest resources, the anticipated stresses of health reform on the overall health care delivery system—increased demand, maldistributed workforce, shifts in financing streams – may be felt more acutely in the safety net.

Montgomery County Safety Net Providers

In most communities, the safety net consists of medical and dental primary care clinics as well as behavioral health care agencies (including mental health and alcohol and substance abuse). In Montgomery County the longevity and reach of the safety net varies. The nearly 50-year old federally-supported community health center system, which is a significant part of the safety net in many urban communities around the United States, is still somewhat in its infancy in the Dayton area with the exception of the Samaritan Healthcare for the Homeless clinic, which has existed since 1992.

In addition to the three community health center organizations, two free clinics, hospital emergency departments, a few dental clinics, and the Alcohol, Drug Addiction and Mental Health Services Board of Montgomery County (ADAMHS) behavioral health agencies comprise the main components of the Montgomery County safety net. The specific agencies and organizations are listed on the next page.



RECOMMENDATION A

Build broader stakeholder understanding of and support for the Montgomery County safety net

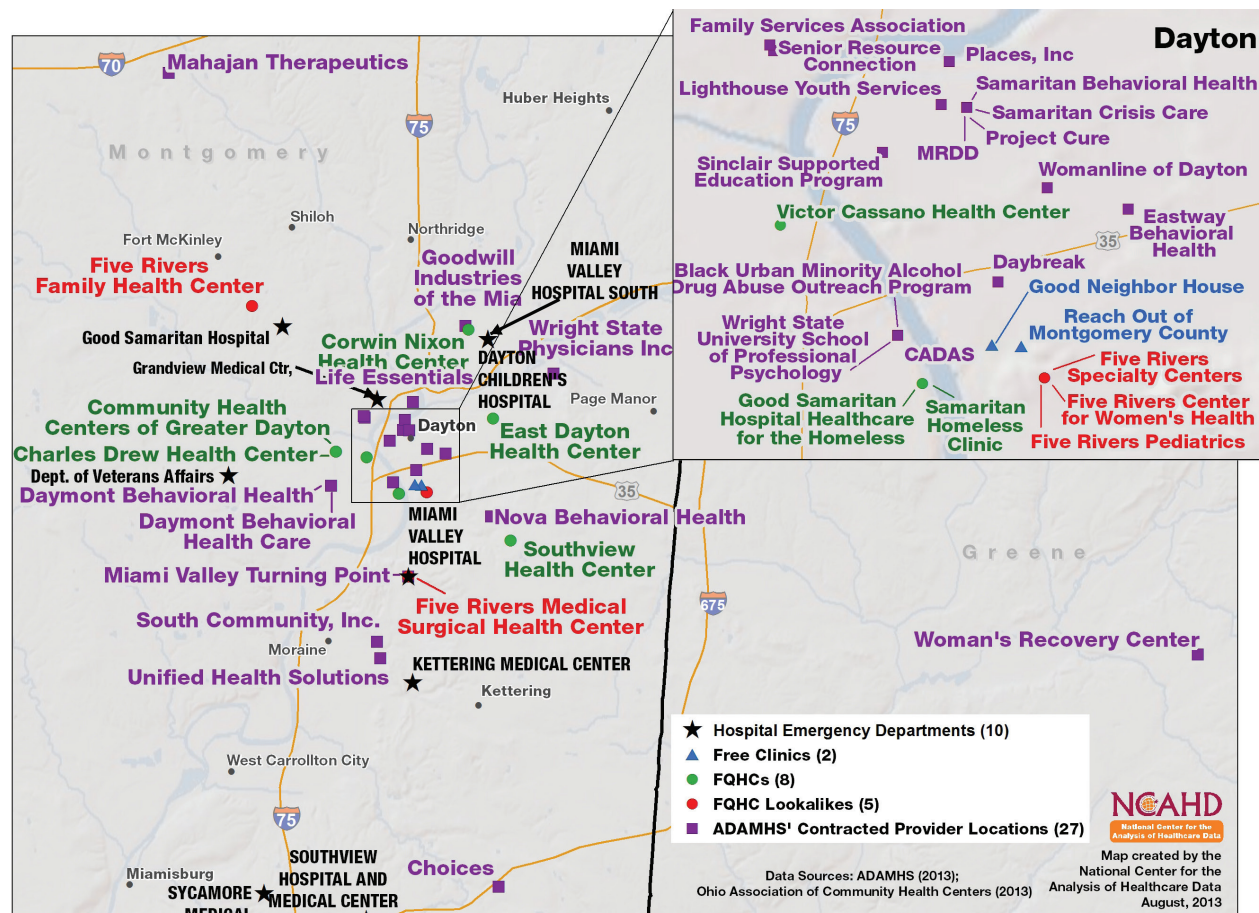
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As a result, the Task Force should consider a coordinated strategy to educate and inform key stakeholders and policy makers about the role of the Montgomery County safety net (across physical, oral, and behavioral health), its strategic value to the county, and its current and future needs. This effort can help ensure that local, state and federal policymakers, as well as the general public, are informed and equipped as relevant policies are debated and decided.

Physical Health	Dental	Behavioral Health
• Hospital Emergency Departments • Free Clinics ◦ Good Neighbor House ◦ Reach Out of Montgomery County • Community Health Centers ◦ Community Health Centers of Greater Dayton ◦ Five Rivers Health Centers* ◦ Samaritan Homeless Clinic *As of September 2013, Five Rivers is a federally-designated health center look-alike.	• Good Neighbor House • Miami Valley Hospital* • Samaritan Homeless Clinic • Sinclair Community College Dental Hygiene Clinic • Community Health Centers of Greater Dayton** *Scheduled to transition to Five Rivers Health Center in Fall 2013 **Plans to offer dental services by early 2014	(Those under contract with the ADAMHS Board for Montgomery County) • Black Urban Minority Alcohol Drug Abuse Outreach Program • Center for Alcoholism and Drug Addiction Services (CADAS) • Choices • Daybreak • Daymont Behavioral Health • Daymont Behavioral Health Care • Eastway Behavioral Health • Family Services Association • Goodwill Industries of the Miami Valley • Life Essentials • Lighthouse Youth Services • Mahajan Therapeutics • Miami Valley Turning Point • MRDD, now known as MCBDDS – Montgomery County Board of Development Disabilities Services • Nova Behavioral Health • Places, Inc. • Project Cure • Samaritan Behavioral Health • Samaritan Crisis Care • Senior Resource Connection • Sinclair Supported Education Program • South Community, Inc. • Unified Health Solutions • Womanline of Dayton • Woman's Recovery Center • Wright State Physicians, Inc. • Wright State University School of Professional Psychology

The map below shows the location of the safety net providers throughout the county.

Montgomery County safety net providers



In addition to these providers, several other entities are part of, or support, the Montgomery County safety net:

Montgomery County Care (MCC)

provides limited healthcare benefits for uninsured residents with incomes below 200% of the federal poverty level and who are not eligible for Medicaid. The program connects members to one of the community health centers or one of the participating private practice physicians in the county. As of September 2013 the program reported having 3400 members. MCC is funded by Montgomery County human service levy dollars; CareSource provides pro bono administrative services.

Originally scheduled to expire at the end of 2013, Montgomery County Care is approved for a six-month extension

through June 30, 2014 unless an Ohio Medicaid eligibility expansion occurs before that time – at which point the program would sunset. New enrollees will not be added, although program attrition may allow additional eligible residents to apply and enroll to backfill those slots. If Ohio's General Assembly decides not to expand Medicaid, the future of Montgomery County Care and the benefits its members receives is unknown beyond June 2014.

Montgomery County Indigent Care Consortium:

Currently led by the Center for Global Health housed at Wright State University's Boonshoft School of Medicine's Department of Community Health, the Indigent Care Consortium is an association of service providers and stakeholders with vested

interests in increasing health care and prevention access for underserved citizens of Montgomery County, Ohio. The Consortium serves primarily as an information-sharing forum.

Montgomery County Medicaid Outreach Consortium: Led by the Center for Healthy Communities at Wright State University's Boonshoft School of Medicine, the mission of the consortium is to empower community members through education to make informed healthcare decisions by bringing a local focus to federal and state Medicaid policy. The Consortium hosts periodic educational forums.

How is the safety net funded and how will that change?

Safety net providers rely upon a mix of funding sources, which vary according to type of provider entity as well as patient population and eligibility. These sources include:

- Insurance
 - Private insurance
 - Medicaid
 - Medicare
- Self-pay (sliding fee scale according to income level)
- Partnership arrangements with sponsors or other entities
 - In-kind
 - Financial
- State and federal grants and payments
- County levy funds
- Private/philanthropic support

Coverage changes as a result of ACA implementation are expected to shift the funding streams for the safety net. However, given the uncertainty of Ohio's proposed Medicaid expansion, the extent of the changes is unclear. Expected changes to the funding stream include:

Disproportionate Share Hospital payments (DSH):

Under the ACA, hospitals are to receive new revenues from newly insured populations, including through a Medicaid expansion to 138% of the federal poverty level. This is countered by a decrease in other revenue streams such as disproportionate share hospital payments from Medicare and Medicaid. In states that do not expand Medicaid, the loss of

Who is served by the safety net?

- **Low-income residents**
34% of Montgomery County residents live in families with incomes under 200% of the Federal Poverty Level (\$39,060 annually for a family of three)
- **Uninsured**
15% of Montgomery County residents under age 65 are uninsured²
- **Medicaid**
123,000 Montgomery County residents are covered by Medicaid³
- **Homeless and other vulnerable populations**

DSH funds without corresponding revenue increases from an expansion will impact the safety net to a greater degree.

Potential Medicaid expansion: If Ohio policymakers decide to expand Medicaid, nearly 29,000 newly eligible residents of Montgomery County are expected to enroll.⁴ For those who are currently uninsured and served by the safety net, gaining Medicaid coverage will benefit both the **patient**, by providing a comprehensive set of health benefits and eliminating financial barriers, and the **provider**, by bringing a more stable funding stream to the mix. This is especially true for community health centers because they receive enhanced Medicaid reimbursement for providing care to a vulnerable low-income population that has significantly higher rates of chronic disease and therefore requires more intensive services.

On the flip side, about 10,000 of those who would enroll as a result of a Medicaid expansion are currently enrolled in private insurance plans.⁵ For private providers, reimbursement associated with these clients may decrease, given Medicaid's low reimbursement rates compared to commercial insurance.

Regardless of whether expansion occurs, the county's Medicaid enrollment is growing and is expected to continue to grow.

As noted above, **Montgomery County Care** is currently operating on a funding extension through June 2014, beyond its original sunset of January 1, 2014. If Ohio passes a Medicaid expansion, most of those clients could transfer to Medicaid coverage; if it does not, the community will have to determine ongoing sustainability of the program.

Marketplace coverage: Qualified health plans that sell insurance through the Marketplace are required to include a certain portion of a region's essential community providers in their provider panels. Community health centers are

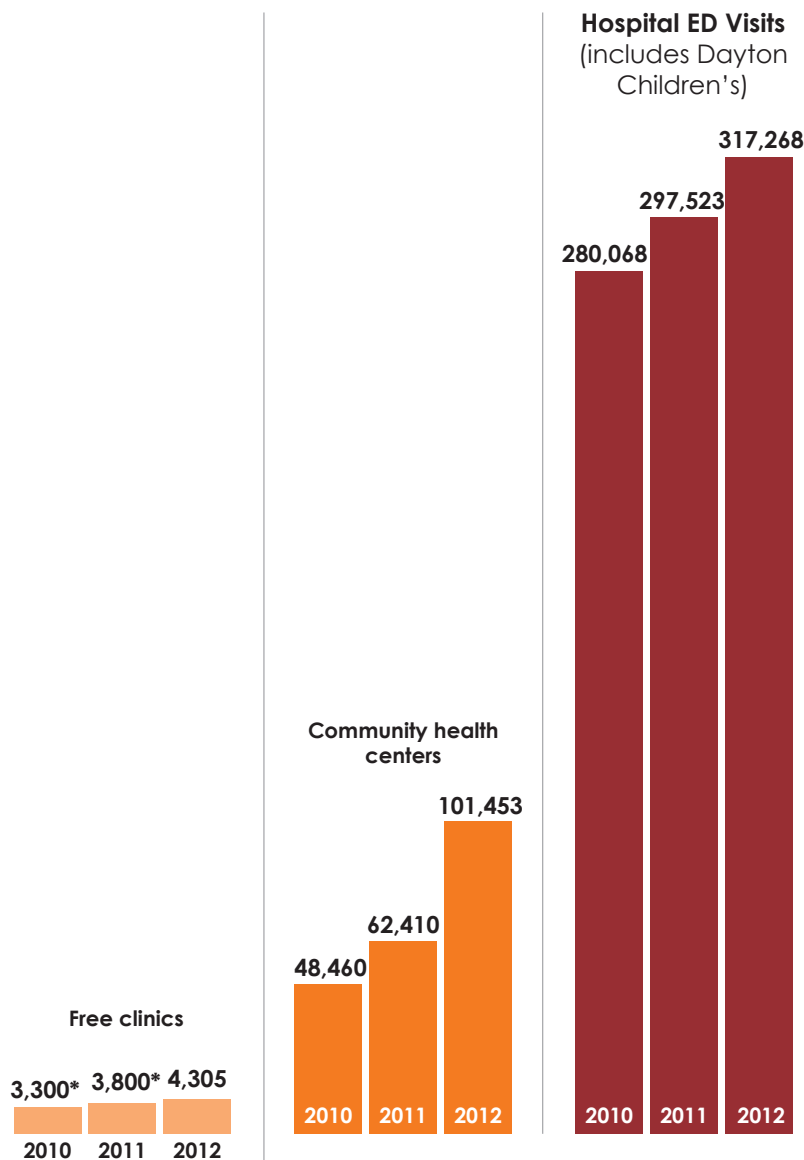
considered essential community providers under the ACA and can therefore help qualified health plans meet this requirement.

How many visits does the safety net provide?

The figure below shows the volume of patient visits across physical health safety net providers. This data shows a consistent trend of increasing patient visit volume. However, please note the following caveats:

- Because Five Rivers was formed in part by taking over three Premier residency clinics, the growth in visit capacity in community

Visits to Montgomery County physical health safety net providers



health centers between 2011 and 2012 is inflated.

- Emergency department data are for all visits, regardless of whether they can be categorized as safety net. While it is not possible to quantify what portion of visits are safety net, at least seven of the top ten reasons for visits to the emergency department were for causes that are preventable in many cases. See page 15 for a more complete discussion of emergency department visits and trends.

Key informant insights

There is general understanding that a Medicaid expansion would primarily benefit the working poor who are currently uninsured. However, some people have pointed out that because of Montgomery County Care and more news about Medicaid in general lately, the payer mix has already changed somewhat as people who did not realize they are currently eligible already are applying for Medicaid. This is known as the “welcome mat” or “woodwork” effect. Data from Montgomery County Department of Job and Family Services confirm this; Medicaid enrollment increased by 15% during the 18-month period of January 2012 through June 2013.

There is some expectation that after 2014, small employers that carry insurance now may drop it with the assumption that their employees will be able to pick up insurance in the Marketplace. Estimates regarding the extent of this trend vary.

“Integration of care”

We explored the question of the extent to which services are integrated through key informant and stakeholder interviews. That research provides the following insights:

The degree of integration within medical care depends on (a) whether the person has Medicaid and (b) which medical care systems one includes. People with Medicaid appear to experience a good degree of integration between primary and specialty care. Even uninsured people who used specialty care reported that the path was fairly seamless from the primary care provider’s office to the specialist’s.

Integration does not extend very far into dental and mental health care. If a patient is seen at a primary care clinic that is affiliated with a dental care clinic, the records will be integrated. Beyond that, it was noted that integration ends and the only coordination that might occur would be if a dental surgeon calls a patient’s primary care provider to obtain a medical history prior to surgery.

Several key informants agreed that primary care and mental health care integration is even worse than primary care and dental care integration, and is complicated further by privacy concerns among professionals for mental health records. One reported that mental health providers are reluctant to keep electronic health records because of concerns that they will not be able to meet the legal requirements attached to privacy. Currently only a small percentage of mental health professionals are integrated into the major electronic health records systems and a key informant noted that a few have withdrawn from those systems.

What drives demand for the Montgomery County safety net?

Two main factors drive demand for the Montgomery County safety net: demographics and population health status.

Demographics

As the adjacent table shows, Montgomery County (and when data is available, Dayton) has a higher poverty rate, higher unemployment rate, lower median income, and more uninsured residents compared to Ohio. These economic pressures, and a lack of insurance, create financial barriers to accessing health care through the mainstream system and help drive people to the safety net.

Population health status

The overall health of the population helps drive demand for health care as well as provides

	Dayton	Montgomery County	Ohio
Total population	141,359	534,325	11,544,225
Below poverty level (2007-2011 ACS average)	32.5%	16.0%	14.8%
Median household income (2007-2011 ACS)	\$28,843	\$44,885	\$48,071
Uninsured rate	NA	15.1%	14.3%
Unemployment	9.6%	8.1%	7.3%

Sources: Ohio Department of Job and Family Services, Office of Workforce Development, Bureau of Labor Market Information

insights into what type of care may be sought. The table on the next page compares rates between Montgomery County and Ohio for select indicators. For more information on health status, see Appendix F and also the Montgomery County Community Health Assessment 2010, <http://www.phdmc.org/resources/cha>

Economic pressure and health care: consumer perspectives

There was widespread agreement among the uninsured patient focus group we conducted that cost is the most significant barrier to regular healthcare. One gentleman said that he tried to use his Medicaid card at a doctor's office, but since it had been canceled he did not carry through with the appointment because he could not pay.

People without insurance also tend to lack someone they consider their personal healthcare provider. While four of the five patients with Medicaid have a personal doctor or nurse, only two of ten uninsured patients in the focus group reported the same. Lack of a personal healthcare provider and an inability to pay for regular healthcare can lead to greater emergency department use as preventable problems become acute. In fact, six of the fifteen total focus group participants had been to the emergency department instead of going to a doctor's office in the past year.

People without insurance also find it very difficult to pay for anything that is considered an "extra," such as dental care. "You have to pay something up front, and more if you need more," said one focus group participant, a point that is borne out by our audit study. While no callers posing as uninsured patients were turned away, dental offices required upfront payments ranging from \$29 to \$84 for a first exam only; treatment of any problems would require additional payment. These costs can present a barrier for families with limited incomes, making it difficult to pay for anything but acute care.

Health status, income, race/ethnicity, poverty by family and by community, and access to health care are all linked. An examination of county-level data reveals health disparities within Montgomery County along racial/ethnic and income lines, including:

	Montgomery County	Ohio
Adults reporting fair or poor health status	18.8%	18.0%
Adults reporting a depressive disorder	18.9%	18.9%
Adults reporting an anxiety disorder	12.1%	13.4%
Residents diagnosed with diabetes	11.6%	11.6%
Residents diagnosed with hypertension	35.4%	32.7%

- The **mortality rate** for the Black/African-American population is significantly higher than the overall county rate for:
 - All deaths⁶
 - Diabetes
 - Heart disease
 - Breast cancer⁷
- **Obesity** rates are higher among the Black/African-American population than the overall county or state rate⁸
- **Timely prenatal care and infant mortality rates** are worse for Black/African Americans compared with Whites⁹
- Low-income adults in the poorest areas of Dayton have prevalence of **high blood pressure** that is five percentage points higher than the figure for all Ohioans¹⁰
- The percent of low-income residents (annual income under \$15,000) who reported a **depressive episode or anxiety disorder** was nearly double that of the overall county population¹¹

Our analysis of communities within Montgomery County shows the following relationships among access to health care, poor health status and disparities:

Provider perspectives

These trends contribute to inappropriate use of health care resources. As one doctor said, "A lot of people end up using the emergency rooms as their doctor because they don't have access to anyone else. They really need primary care – diabetes care, prescription refills, follow-up visits for blood pressure, blood work."

- Significant overlap occurs in low-income populations, Black/African-American populations, and areas of healthcare workforce shortages.
 - Correlation exists between zip codes with the highest emergency department utilization and the highest percent of low-income residents
 - Alignment exists between the biggest gap in primary care (based on workforce shortages and the percent of low-income populations not served by a health center), the most prevalent health disparities and over-utilization of the hospital emergency departments
- Areas of high need (based on characteristics noted above) also tend to be the areas with the largest concentrations of adults who are uninsured and would be eligible for the proposed Medicaid expansion.

Targeting safety net expansion and services so that more vulnerable populations can access coordinated, comprehensive primary care can help address these health disparities. Research has demonstrated that racial and ethnic disparities are significantly reduced when adults have medical homes.¹² (The medical home model is broadly defined as a way to deliver health care that is organized around patients, team-based, coordinated, and tracked over time.) Further, with health insurance and a medical home, income disparities lessen.¹³



RECOMMENDATION B

Convene and sustain a strategic table for key stakeholders from all levels of the safety net and other health care entities

Montgomery County is to be commended for its track record of improving and expanding the safety net, especially over the past several years. While unmet need remains, the community has much upon which to build.

Yet feedback from key informants within various parts of the county's health care infrastructure signals that communication and collaboration still remain inconsistent within various parts of the delivery system. This prevents maximum coordination and collective impact.

The Task Force should consider convening and sustaining a strategic table for key stakeholders from all levels of the safety net and other health care entities. The convener needs to be a strong leader who is well-respected across the stakeholders and is perceived to be neutral.

Models include Access HealthColumbus, Better Health Cleveland and the Cincinnati Health Collaborative, all public/private partnership organizations that help direct initiatives to improve access and coordination of care across the spectrum of organizations and government agencies. The organization could provide a neutral approach to collective priority setting, identification of resources, and strategic implementation.

Is the Montgomery County safety net adequate?

Can people access care through the safety net?

The environmental scan includes several types of qualitative research designed to provide insights into how vulnerable populations access care through the safety net, including:

- Two consumer focus groups (one for clients covered by Medicaid and one for clients who are uninsured)
- Interviews with 5 providers
- Wait-time audit of a sample of 44 provider offices designed to test availability of and wait time for primary care appointments across physical, behavioral, and oral health providers.
- Key informant interviews with 18 community and healthcare leaders.

(See Appendices B, C, and D for a full description of methodology and results of each of these research efforts.)

Because of sample sizes, this research is not representative. However, it provides insights into consumer experiences and a degree of local context for the data provided elsewhere in the report.

Several key themes emerged from this research:

Based on a sample study, new patients may face challenges in securing health care appointments.

Despite targeting provider offices that are identified in some way as accepting new Medicaid or uninsured patients, our callers still found that one-third of the providers were unwilling to accept new Medicaid/uninsured patients, or any new patients at all. Further, callers were able to make appointments within two weeks with only 20 percent of the physical and behavioral care provider offices.

In a one-on-one interview, a family physician told a story relating to the frustration of those without private insurance. As a sole practitioner, his office turns away many people who have Medicaid or are uninsured each week, including a woman who said that she was working through a list she had been given and his office was 25th out of a total of 32. Another provider said, "It's

universal that people (in the safety net) cannot get appointments if they don't have an established relationship with a primary care provider."

Cost is the most significant barrier to primary healthcare for uninsured people.

All members of the uninsured consumer focus group reported that they had delayed going to the doctor because of cost at some point in the past. The provider offices we called that offer appointments to uninsured patients charge between \$35 and \$160 for an office visit. Although \$35 might not be unreasonable for someone who is working, the clinic is able to charge that amount because its physicians are volunteers. Private practices are more likely to charge closer to the higher amount. Moreover, only 20 percent of the uninsured consumers stated that they have a personal doctor, while 67 percent of those with Medicaid felt they had a personal doctor.

Dental care, while theoretically available, is functionally scarce.

Medicaid will pay for dental care, but few providers will take Medicaid. On the other side, dental providers are happy to accept payments up-front for care, but most are priced too high to be truly accessible. The charge for uninsured patients ranges between \$29 and \$84 just for an initial exam; callers are told that if any problems are found, an estimate of the costs to resolve them will be developed and work must be paid for ahead of time. An uninsured participant commented, "You have to pay something upfront, and more if you need more done."

Transportation is an important secondary barrier to healthcare access.

Of the 15 consumers in our focus groups, only two (a married couple) had a car. Relying on public transportation creates a smaller area of familiarity for those who depend on it. A Medicaid participant noted, "It's hard to find a good dentist because of our insurance. You have to call the back of the card to get help find who will take the insurance. Then you have to look up those people. They'll give you these random places and you're like, where is that?" "At least give me something on public

transportation," said another. Struggling with public transportation is frustrating for both the consumers and for the providers, who experience late arrivals and no-shows for appointment times.

CrisisCare continues to be the primary source of mental health assessments and referrals. While we were able to make two appointments directly with ADAMHS Board-funded behavioral health offices,

four offices sent the caller to CrisisCare for an initial assessment and referral. Sending callers to be assessed through CrisisCare can be the appropriate step to take for behavioral health providers, if the caller is uninsured or if the provider office does not employ a staff member who is licensed to conduct clinical assessments. The ADAMHS Board is moving toward a policy of "no wrong door" to behavioral health treatment, but CrisisCare continues to be the primary assessment organization for now.

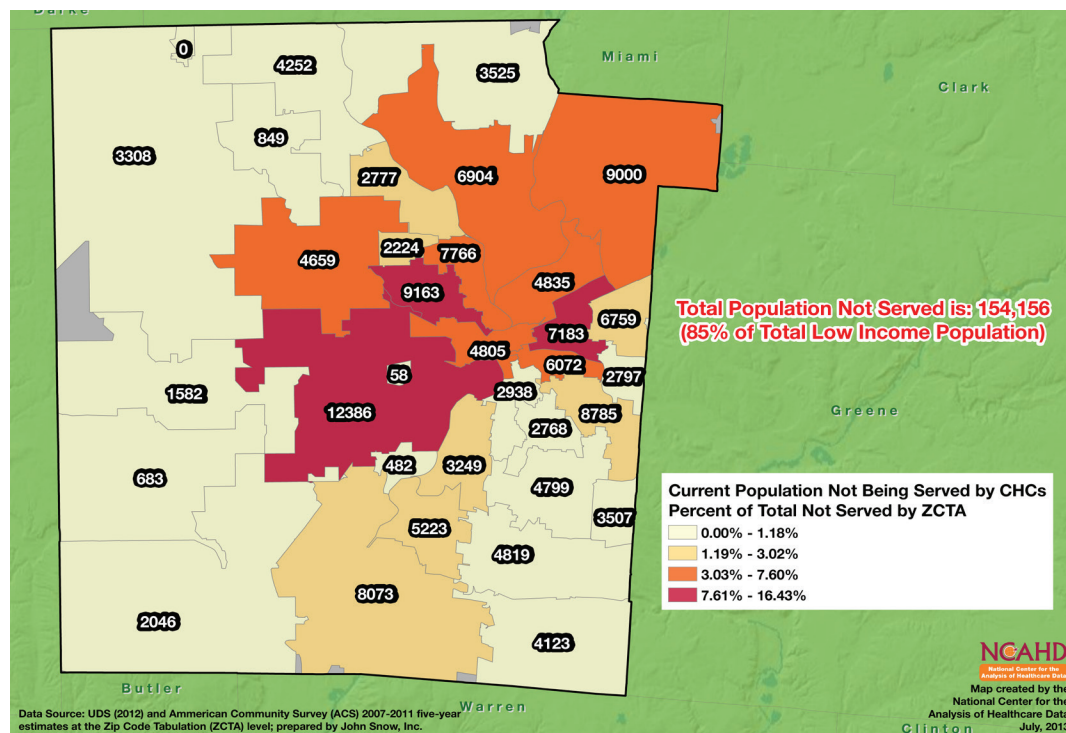
These findings are consistent with data that show the following barriers:

- Nearly 17% of Montgomery County adults report that they do not have a personal doctor (2011-2012)¹⁴
- 17.5% of Montgomery County adults report they could not see a doctor due to cost in the past 12 months (2011-2012)¹⁵
- 27,400 of Montgomery County's low-income population (under 200% FPL) were served by community health centers in 2011, leaving 154,000 low-income Montgomery County residents not served by a community health center. (See map above. Some of those low-income residents are served by other health care providers, but many are not.)

Hospitals

One entity that is a critical but overused component of the safety net is the hospital

Low-income population not served by community health centers



emergency department (ED). A look at the following three indicators provide context related to overall health care needs and access as well as insights into the primary care infrastructure:

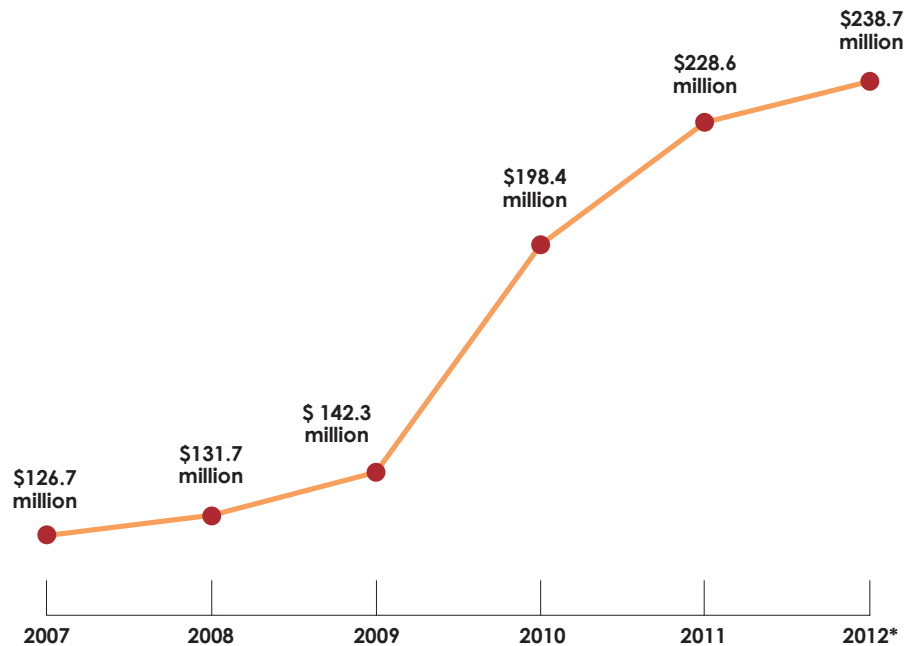
- Hospital Uncompensated Care Costs
- Emergency department utilization
- Admissions/discharges for conditions that were potentially avoidable; also known as Ambulatory Care Sensitive Conditions

This assessment did not analyze hospital admissions and discharge data. Unlike states that continue to have Certificate of Need (CON) in place, Ohio's Department of Health discontinued CON two decades ago and thus does not collect and analyze this data.

Hospital uncompensated care costs

The figure on the next page shows the trend for Montgomery County hospital uncompensated care for uninsured and underinsured populations.¹⁶ Between 2007 and 2011, hospital uncompensated care increased by 80%, and if the projection for 2012 holds, the rate will have increased by 88% between 2007 and 2012. As noted earlier, if Ohio does not expand Medicaid, scheduled cuts to the Disproportionate Share Hospital program (DSH) will hit hospitals especially hard, given that they will not gain new revenues from patients newly covered by the Medicaid expansion intended to offset those cuts.

Hospital uncompensated care in Montgomery County



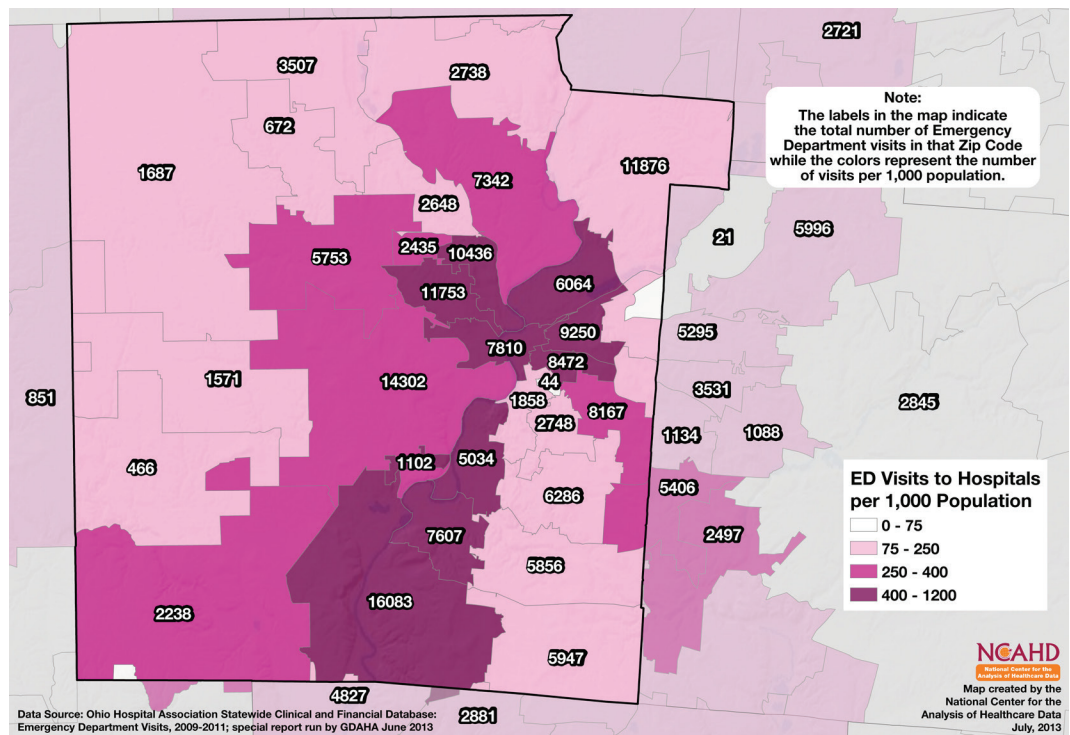
* based on first 6 months projection of 2012

Emergency department utilization

Analysis of Montgomery County hospital emergency department utilization revealed several trends:

- There has been a steady increase in visits over the four-year period from 2009 through 2012. Total ED visits increased nearly 14%, from 280,000 in 2009 to 317,000 in 2012.¹⁷
- The ED utilization rate of 593 per 1000 population for the county's hospitals is close to Ohio's rate, which is among the top five highest in the nation.¹⁸ A number of zip codes in central Dayton boost this rate as several exceed ED utilization rates of

Montgomery County hospital total number of emergency department visits and visit rate per 1,000 population by zip code



500 per 1000. These zip codes also coincide with those areas where a high number of low-income individuals not served by a community health center reside.

The map on the previous page shows the rate of emergency department visits by zip code. As noted earlier, several zip codes in central Dayton exceed the county and state rates. Further there is notable overlap in low-income populations not served by community health centers (see map on page 14) and highest levels of emergency department utilization.

As the adjacent figure shows, seven of the top 10 reasons for visits to the emergency department were preventable – at least in many cases. Although nearly any situation can be classified as an emergency, most concerning is that several of the conditions regularly showing up would not be classified as an emergency in most cases, and/or more severe onset could have been prevented through care provided in an outpatient primary care setting, and in some cases, outpatient specialty service practice: for example, headache, otitis media (earache), fever, sore throat, and urinary tract infection among others were among the top ten. The top ten reasons comprised nearly 20% of all emergency department visits at the county's hospitals. Better primary care access, care coordination, community education and outreach and ED diversion programs can help prevent some of these unnecessary ED visits and ensure patients receive the appropriate care in the appropriate setting.

In 2012 a total of 21% of all patient visits in Montgomery County hospital EDs originated from other counties.¹⁹ Thus the resources in the county take on a greater burden as a result of health care deficiencies in other counties, as well as the likelihood that a number of individuals feel more comfortable using larger urban hospitals where they perceive they will receive better care compared with facilities in smaller towns.

Physical health

Access to a regular source of primary health care is considered a standard need for all

Montgomery County emergency department visits: Top diagnoses

ICD9 Description	# cases	% of visits
1. Acute upper respiratory infection	8,995	3.0%
2. Abdominal pain	7,326	2.5%
3. Headache	6,176	2.1%
4. Otitis media	5,557	1.9%
5. Urinary tract infection	5,368	1.8%
6. Lumbago (lower back pain)	4,906	1.6%
7. Head Injury	4,708	1.6%
8. Chest Pain	4,587	1.5%
9. Fever	4,455	1.5%
10. Acute Pharyngitis (sore throat)	4,230	1.4%
Total	56,328	18.9%

individuals and families. However, analysis shows that access is limited for Montgomery County's 183,000 low-income residents. The community health center system currently serves about 27,400 of these residents;²⁰ a patchwork of providers who accept Medicaid provides care to an additional portion. Two free clinics absorb a share of the need by caring for nearly 4000 uninsured individuals with low incomes.

Consumer perspectives

Focus group findings are consistent with this data. Participants expressed that lack of access can prompt visits to the emergency department; **6 of 15 participants** reported that they had visited the emergency department rather than a doctor in the past year.

The critical role of Community Health Centers in the safety net and ACA

The steady growth of the community health centers is likely to continue to help meet the need among low-income populations. Montgomery County's two federally-funded community health centers (known as FQHCs), Community Health Centers of Greater Dayton and the

Samaritan Healthcare for the Homeless clinic, and the Health Center Look-alike-- Five Rivers Health Centers, are part of a federally-funded and supported system that provides care for more than 21 million Americans. The US Health Resources and Services Administration (HRSA) supports both the federally-funded FQHCs as well as the Look-alikes under the direction of its Bureau of Primary Health Care. HRSA also

administers the federal health care workforce incentive, placement and training programs, among others, through its Bureau of Clinician Recruitment and Service, and Bureau of Health Professions.

The HRSA-supported health centers provide the largest safety net for low-income and vulnerable populations in the nation. These federally-supported and locally-controlled and operated organizations serve federally designated Medically Underserved Areas and/or Medically Underserved Populations. In exchange, they receive enhanced Medicaid and Medicare reimbursement. Uninsured patients with incomes at or below 200% of the federal poverty level can access care on a sliding fee scale; the federal grant assists health centers in providing this care.

Health centers are viewed as a critical part of the national healthcare infrastructure, and it is expected they will provide a significant level of access to those newly covered by Medicaid in many communities where states expand coverage. Health centers are considered Essential Community Providers (ECPs) under the ACA. In the new Health Insurance Marketplaces a Qualified Health Plan (i.e., participating insurer) must include a certain portion of a region's ECPs on its panel. Health centers also will be critical providers for serving those individuals who remain among the ranks of the uninsured.

As a result, going into 2014, with or without a Medicaid expansion in Ohio, the health centers in Montgomery County can play a critical role in increasing access for currently uninsured residents and current Medicaid enrollees who lack access to health care as well as those newly insured through the ACA's Health Insurance Marketplace. Federal financial and technical support systems as well as local and statewide partnerships are keys to the successful advancement of this safety net

system.

As of Summer 2013, community health center plans include the following:

Five Rivers Health Center, is currently a federally-designated health center Look-Alike. The organization applied to become a fully-funded Federally Qualified Health Center (FQHC) but was not funded in a highly competitive national grants process, for which results were announced in September 2013. The organization likely will have other opportunities to pursue FQHC funding in the next year or two, contingent on federal funding. Five Rivers has an ample supply of medical residents to provide care, but lacks facility space as all of its locations have reached capacity. As a result, Five Rivers needs more than \$5 million to build a new facility on the northwest side of Dayton adjacent to the campus of Good Samaritan Hospital. This facility would replace a smaller primary care facility located about a block away, and would nearly double its primary care capacity.

Community Health Centers of Greater Dayton has opened two new sites, for a total of six clinics, partly to replace capacity lost when Public Health stopped offering primary care services. It continues to work to increase provider capacity to capitalize on expanded facilities and plans to add dental services in the near future.

Samaritan Healthcare for the Homeless expanded medical care last year through time-limited funding, but has not been able to leverage other sources of revenue to sustain the increase and will decrease some of its advanced practice nurse capacity as a result.

These trends are summarized below.

Provider	Projected/ potential (FTE)	Current patients/visits	Potential patients/visits
Community Health Centers of Greater Dayton	1.0 to 3.0 additional FTEs	12,000 (≈ 34,000 visits)	14,000-16,500 patients (46,000-55,000 visits)
Five Rivers Health Centers	Need additional facility capacity	15,000 patients/ (48,000 visits)	Needs additional facility capacity
Samaritan Healthcare for the Homeless	0.5 FTE NP decrease in APN capacity	2,700 patients (≈ 12,000 visits)	Decrease of 500+ visits

Free Clinics

Free clinics play a critical role in providing care for those who are uninsured and lack access to needed medical care through other providers. Most clients have low incomes and many live in poverty. Free clinics can serve as a stop-gap to keep individuals out of hospital emergency departments, and to link individuals to a more regular source of care. A number of long-term uninsured, low-income individuals may use a free clinic as a primary source of care. Free clinics rely primarily on volunteer clinicians/providers and other in-kind donations, and funding sources that help sustain care.

Montgomery County's free clinics, Good Neighbor House and Reach Out of Montgomery County, are an integral part of the safety net. A summary of their medical, pharmacy, and vision services is below:

Good Neighbor House serves uninsured working people with incomes under 250% of the federal poverty level (FPL), providing 400 medical visits and 45 vision visits annually. Its capacity varies depending on the level of volunteer service. (See page 19 for a description of Good Neighbor House's dental services.)

Reach Out of Montgomery County serves the uninsured with incomes under 250% FPL. In 2012, 2295 patients were served through 3860 visits. Reach Out also filled over 26,600 prescriptions for 4600 pharmacy patients in 2012.

Both free clinics would like to augment their volunteer capacity with some paid staffing to increase capacity and improve efficiency.

Oral health

Before embarking upon the environmental scan, Task Force members hypothesized that based on anecdotal evidence, dental care in Montgomery County may be especially challenging for vulnerable populations. The data confirm challenges in this area.

Dental provider shortages exist for low-income populations in Montgomery County, particularly for those living within lower income Dayton neighborhoods. The greatest



RECOMMENDATION C

Monitor and report regularly on Montgomery County access to care

This project included the development of the Montgomery Care Access to Care Dashboard, designed to provide an overview of key indicators related to access to health care in Montgomery County; provide a tool to track progress over time; and guide investment and strategy. The Dashboard can be found <http://bit.ly/1g4zWfa>.

The Task Force should ensure strategic and widespread dissemination of the Dashboard and commit to engaging community stakeholders in a process to use the dashboard to inform priorities and strategies. The Dashboard should be updated and released annually.

In addition, the Task Force should consider developing a system to track and report on the trends related to demand, utilization, and access specific to safety net providers. This would require agreement among providers on a common set of indicators that provide a point-in-time view of how coverage changes and other ACA policies are impacting safety net providers and that can be updated regularly.

shortages are found within two dental Health Professional Shortage Areas (HPSAs) that exist in two of the more impoverished areas of the city of Dayton: East Central Dayton and West Dayton. Within these two geographic areas alone, there is a dentist shortage of 10.5 FTEs, resulting in a population to dentist ratio of 11,741:1,²¹ well above the shortage threshold ratio of 5000:1.

Overall, 65% of Montgomery County adults report having visited a dentist or dental clinic in the past year; this is not surprising given Ohio's overall rate is 67% and that more Ohioans lack dental insurance than lack health insurance. Even more concerning, the percentage of Montgomery County Black/non-Hispanic

Qualitative research findings

Our qualitative research confirms dental access challenges in several ways:

- Compared to physical health and behavioral health providers, dental clinic providers were more willing to take uninsured patients, as long as they can pay the full charge up front. However, this payment requirement likely prevents many self-pay patients from accessing dental care.
- Even though HPIO chose its sample of dental care provider offices for the wait-time audit from a list of Medicaid providers, one-third stated they are not accepting Medicaid patients.
- Because Medicaid and uninsured consumers have a difficult time finding regular dental care, they tend to utilize hospital emergency departments for emergency dental care more often than would usually be needed.

adults who reported a dental visit was much lower at 45%.

Among Montgomery County residents of all ages enrolled in Medicaid, only 36% received dental care in 2011, suggesting that even with dental coverage, dental access is a challenge.

An analysis of Medicaid dental providers and visits in Montgomery County revealed the following:

- Similar to the county's hospitals, dental providers within Montgomery County are experiencing significant demand from other counties, as 31% of visits to Medicaid dental providers in Montgomery County were from out-of-county residents. This signals a regional shortage of dental care. ODH data also demonstrates regional dental capacity shortages, and thus the extent and impacts of this issue regionally warrants further exploration.
- 98% of Medicaid dental visits occurred in offices that accept more than 250 Medicaid patients. Most of these visits are attributed to large private dental practices

such as Aspen, ImmediaDent and Small Smiles, as well as a handful of other private dentists who accept large numbers of Medicaid. Thus, most Montgomery County dental practices are not providing access for this population.

In addition, because of the limited capacity of the dental safety net only two percent of Medicaid dental visits occurred in settings such as hospital or community health center dental clinics. However, these safety net providers account for the main, albeit limited in scope, dental safety net and include:

- **Miami Valley Hospital Dental Center**, operations of which are being transferred to Five Rivers Health Centers in Fall 2013. The dental clinic will continue to be located at Miami Valley Hospital, and dental residents will continue to be the main providers.
- **Good Neighbor House Dental Program**, provides dental care to individuals who do not have dental insurance. The program expanded its dental capacity when it moved to its new facility earlier in 2013 and could expand further with the addition of paid staff.
- **The Samaritan Health Care Clinic for the Homeless**, provides dentistry for homeless populations. The program anticipates its current dental capacity will be reduced by about 35% as a result of an expiration of a private grant.
- **Sinclair Community College Dental Hygiene Clinic**, provides dental hygiene services only, not comprehensive dentistry, through its dental hygiene training program.
- **Ohio's OPTIONS program**: In addition to the safety net clinics, 40 dentists in Montgomery County participate in Ohio's voluntary OPTIONS program (down from 50 participants in 2011). Within this program, private dentists volunteer to accept low-income patients who are uninsured, or who may have a disability. The care provided can be either free, or low-cost, and treatment plan and cost arrangements are made between the participating dentists and the patients. Out of the 40 registered dentists, 8 are specialists and 32 practice primary/comprehensive dentistry. As of

June 30, 2013, 72 county residents were on the waiting list which is slightly higher than other peer urban counties.

In addition, Community Health Centers of Greater Dayton plans to offer dental services by early 2014 and to grow that capacity over a period of several years. This requires that CHCGD secure scope of practice approval from the Health Resources Services Administration and renovate a facility.

Emergency departments and oral health

One effect of inadequate dental access is that hospital emergency departments have become the default safety net for oral health emergencies, even though they are not equipped or staffed appropriately to provide comprehensive dental care.

The Ohio Department of Health conducted a study of hospital ED utilization for dental concerns and found the following²²:

- 4,016 emergency departments visits by Montgomery County residents were for dental-related diagnoses.
- The top three reasons accounted for 85% of these dental-related visits and all three are preventable and treatable in a primary care dental setting
 - 'unspecified disorder of the teeth and supporting structure'
 - 'dental caries'
 - 'periapical abscess without sinus' (otherwise known as dental abscess)
- Montgomery County's Medicaid population's rate of utilization compared to other urban counties in Ohio was among the lowest. However, Montgomery County's uninsured population represents a higher portion of all dental visits compared to other counties in Ohio (in Montgomery County 53% of ED dental visits were by uninsured patients vs. 44% in Ohio overall).

Similar to physical health, these data suggest that increasing dental capacity for vulnerable populations may result in fewer inappropriate emergency department visits for dental-related reasons.

Behavioral health



RECOMMENDATION D

Increase capacity across primary care, dental, and behavioral health for vulnerable populations

The environmental assessment confirms current unmet health care needs of Montgomery County's vulnerable populations as well as projected future need. The Task Force should make increasing capacity a top priority for the near- and middle future, focusing on shortage areas. Suggested strategies include:

- Support current safety net providers' plans to increase capacity in the short-term.
- Focus on managing chronic conditions for vulnerable populations and further integration of care. Managing chronic conditions effectively assures patients receive the appropriate care in the appropriate setting, contributing to better health outcomes and maximizing limited health care resources.
- Support expansion of team-based models of care, including the patient-centered medical home (PCMH) and the use of mid-level providers. This requires infrastructure capacity, resources, and workforce acceptance to transition effectively to the PCMH model. Racial and ethnic health disparities are reduced when adults have medical homes.

One of the most comprehensive safety nets within Montgomery County is the system of behavioral health care under the direction of the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board for Montgomery County. The ADAMHS Board oversees a network of nearly 30 independent behavioral health agencies that provide services throughout Montgomery County, with the largest concentration in Dayton. The agencies serve outpatient and inpatient treatment to more than 22,000 low-income residents of the county and provide both mental health and alcohol and substance abuse services (AOD). Mental health services

Unintentional drug overdose Montgomery County, 2012

- 162 unintentional overdose deaths
- 145 residents of Montgomery County
- 15 residents of other Ohio counties (2 from other states)
- 59 percent were heroin related, compared to 35 percent of deaths in 2011
- 45 percent used prescription opioids; down from 62 percent in 2011 and 74 percent in 2010

at these agencies range from treatment for depression to caring for those with severe mental illness. A range of AOD services also are provided by various agencies, and range from alcohol abuse counseling and groups to treatment for addiction to heroin.

A 17.8% increase occurred in the number of people served from 2008 to 2011. However, estimates show there are more than 32,000 adults in Montgomery County who are severely depressed, and more than 35,000 who have used illicit drugs within a month of being surveyed. As will be discussed later in this document, there are documented shortages

– or at least a maldistribution of behavioral health professionals – in Montgomery County, with larger deficiencies evident within the more urban neighborhoods of Dayton and a greater surplus in various suburban areas such as Kettering.

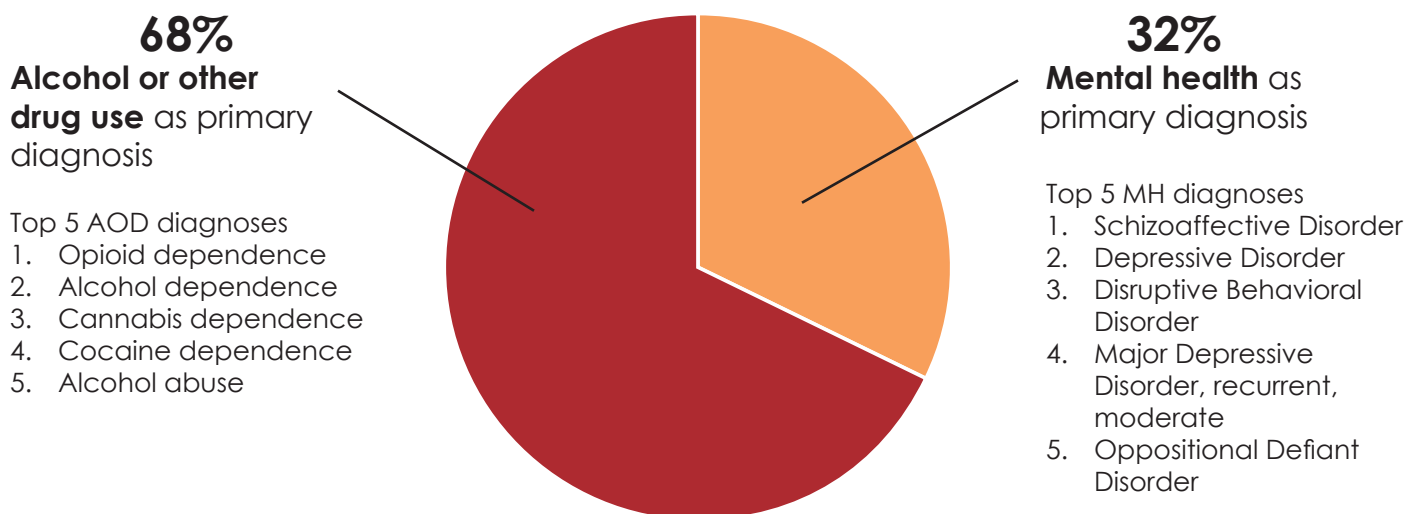
The major intake point for the system is CrisisCare, a division of Samaritan Behavioral Health. CrisisCare's primary role is to provide a gateway for those who need alcohol and drug treatment and/or treatment for severe mental illness/disability. However, others who need mental health care often are referred first to CrisisCare. Licensed therapists are on staff 24-hours daily and available for walk-ins or calls on the crisis line.

More than 7000 diagnostic assessments were done in 2012, and 30% of all clients were covered by Medicaid while most of the remainder were uninsured.

The figure below shows the types of assessments conducted by CrisisCare and the most prevalent diagnoses.

CrisisCare publishes a wait-time report, which shows that in 2012 the average wait time for CrisisCare to get a referral into an agency for general mental health care was

Samaritan CrisisCare diagnoses, 2012



Qualitative Research Findings

The wait-time study indicates that few ADAMHS-funded provider offices will make an appointment with an individual who calls them directly. Only two offices made an appointment within two weeks; another four told the caller to contact CrisisCare for a referral first. Although offices are encouraged to make direct appointments, it is not always possible, as they must employ people who are certified in clinical assessment. Consumer and provider focus group experiences with the behavioral health system have been mixed and no consensus about any particular issue emerged.

22.5 days. Wait times vary by agency, but overall the director of CrisisCare reports these have been decreasing over recent years. For instance alcohol and other drug (AOD) intensive outpatient has a 30-day wait for an appointment at one agency and 17-day wait at another. For non-AOD or severe mental illness (SMI) concerns, individuals can go

directly to one of the ADAMHS agencies.

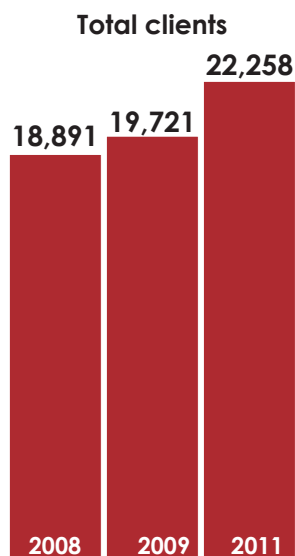
Despite the comprehensive network of behavioral health services, access needs still remain and the hospital emergency department often becomes one of the points of entry. CrisisCare reports that one-third to one-half of all individuals who present in the hospital EDs for a behavioral health reason have not been to a behavioral health provider at any time previously. Indeed depressive state, anxiety and alcohol abuse are common reasons for a visit to the hospital EDs in Montgomery County.

Overall within the ADAMHS system, its nearly 30 agencies provided 1.85 million units of services in 2011; an overall four-year increase of 4.7% compared with 2008. The areas with the greatest increases were mental health counseling/therapy, which increased by 40% over the four years, and heroin treatment which went up by 33.7%.

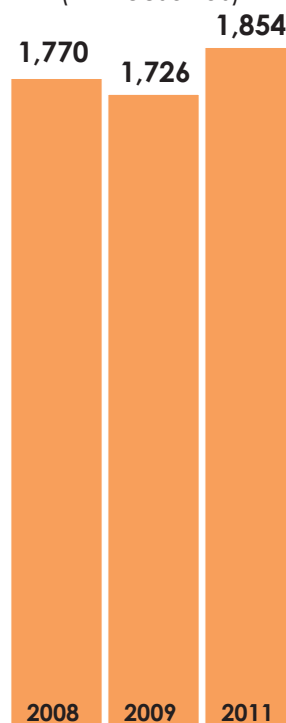
ADAMHS system redesign

Looking to the future, ADAMHS is exploring

ADAMHS service delivery



Total units of service (in thousands)



changes to how the system functions. Currently the system operates under a silo-based model of care, with each agency in the system operating in relative isolation from the others. This is particularly challenging when many clients in the ADAMHS system are dual-diagnosed (AOD and mental health diagnoses). Although additional resources may be needed to support growing demand for services, a realignment of the people and resources also is important.

Key changes being examined include better information-sharing, including maximizing available technology, and moving from a “flat” grant-dependent system to a system of funding based on service reimbursement. Additional focus on tracking progress and outcomes will be critical, as will be new tools

for early identification of behavioral health issues in children. Once better integration is achieved within the ADAMHS system, improved integration with medical providers is a next stage.

In terms of point of access, the system is moving toward a “no wrong door” approach, which would look at agencies across the system as being the entry points and lessen the demand on CrisisCare as the main entry and intake point. This would allow CrisisCare to focus more on being the 24-hour center for behavioral health emergencies and less the primary entry point for the behavioral health system.

Earlier sections of this report note general staffing and workforce shortages faced by

Is the healthcare workforce adequate?

Montgomery County safety net providers. As part of the environmental scan, we include an assessment of the overall healthcare workforce in Montgomery County, summarized in this section. (See Appendix F for additional workforce maps.)

Key themes of this analysis include:

- While workforce shortages exist, maldistribution of providers may be a more significant problem than overall shortages.
- The distribution of the healthcare workforce in Montgomery County follows the same general pattern across physical, dental, and behavioral health sectors, leaving areas of the county consistently underserved.
- The Montgomery County health care workforce is aging; a factor that must be taken into account when planning for how to meet anticipated increased demand.
- Efforts to address primary care workforce shortages must extend beyond the primary care workforce to the specialty physicians and allied healthcare workforce that are vital members of team-based care.

Primary care workforce

To better understand the current maldistribution of primary care workforce in and around Montgomery County, we first looked statewide to determine other areas that state level resources also may be targeting. Taking this comprehensive perspective helps gauge how responsive the state will be to requests for additional funding or shortage designation status.

Using an average annual per person physician usage rate developed by The Robert Graham Center,²³ NCAHD has calculated that the state of Ohio's primary care workforce maldistribution costs the state \$2.6 billion annually and over 67,000 jobs.²⁴ In addition, Ohio needs an additional 2,925 primary care physicians to meet the need in current widespread shortage areas, as shown in Figure 1 on the next page.

Although the state map indicates areas within and around Montgomery County are in surplus or meeting their primary care physician needs,

A note about methodology

This workforce analysis was led by the National Center for the Analysis of Healthcare Data (NCAHD). NCAHD has been collecting state licensure data on physicians and 18 other non-physician providers over the last six years for use in analysis and research such as this analysis conducted for Montgomery County. Its data normalization process includes validating the address to the provider's practice location and only includes those actively practicing in the workforce and not those in research/administration. Because providers frequently change the number of hours they work during the course of a year, each provider is counted as one full-time equivalent (FTE).



RECOMMENDATION E

Strengthen primary care, oral and behavioral healthcare workforce capacity

Maldistribution and insufficient numbers of providers contribute to healthcare workforce shortages within Montgomery County and within the region. Not only does this create access barriers for vulnerable populations, it also carries a loss of economic benefits to the wider community. The Task Force should make strengthening health care workforce capacity a top priority, focusing on shortage areas. Suggested strategies include:

- Engage health and civic leaders from surrounding counties to address workforce and access issues on a regional basis
- Strengthen incentives for serving in shortage areas, including seeking all available HPSA designations
- Partner with medical, dental and allied health training programs to develop strategies to meet short and long-term needs, including strengthening and supporting community-based training

there still exists a shortage within the county at a cost of \$164 million in revenue and 4,209 in jobs,²⁵ as shown in Figure 2.

The shortage areas (shown in red), indicate a need for 183 additional primary care physicians in Montgomery County.²⁶ Some of these communities have had longstanding workforce distribution challenges, which may complicate the process for establishing or expanding healthcare delivery services.

A closer look at the distribution of primary care physicians within Montgomery County, as seen in Figure 3 on the next page, reveals that the highest density is located within the southeast portion of Dayton and of the county, leaving shortage areas in the northeast portion of the county as well as in much of Dayton and neighborhoods to the west of the city.

This same pattern is consistent with the distribution of mid-level physician extenders within Montgomery County, namely, nurse practitioners and physician assistants, as shown in Figure 4 on the next page.

In addition to the current maldistribution of primary care providers within the county, the aging of this workforce must be taken into account. The table on the next page shows the average age of primary care providers and dentists, compared to both national and state averages.

The average age of these primary care providers is generally lower in Montgomery County compared to Ohio and the U.S. However, whether or not the aging healthcare workforce will remain in the healthcare delivery system if Medicaid expansion

Figure 1.

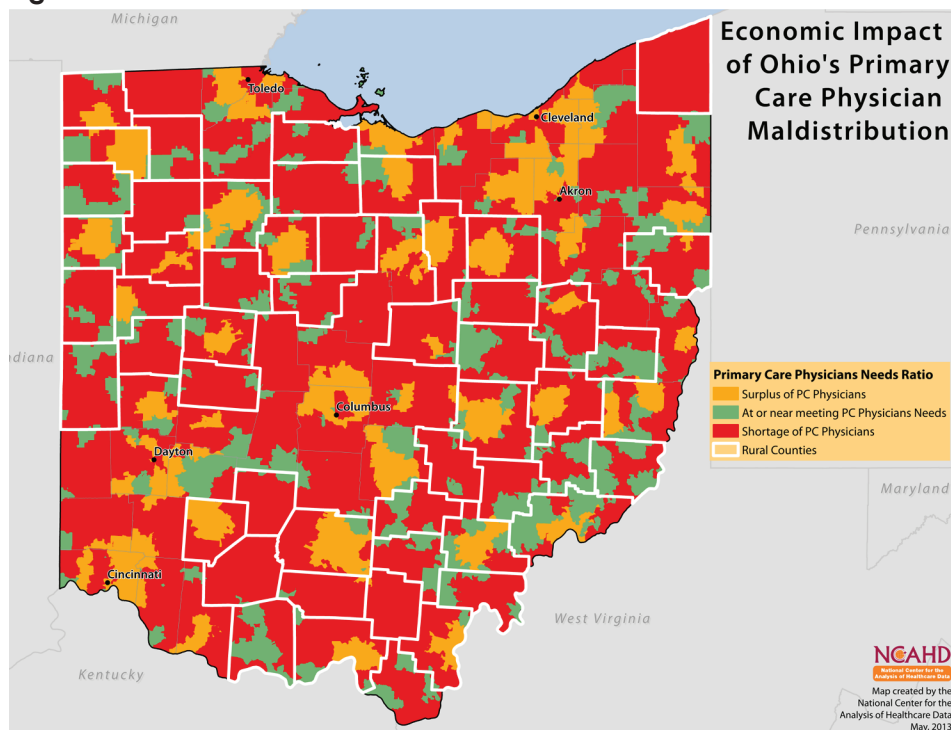
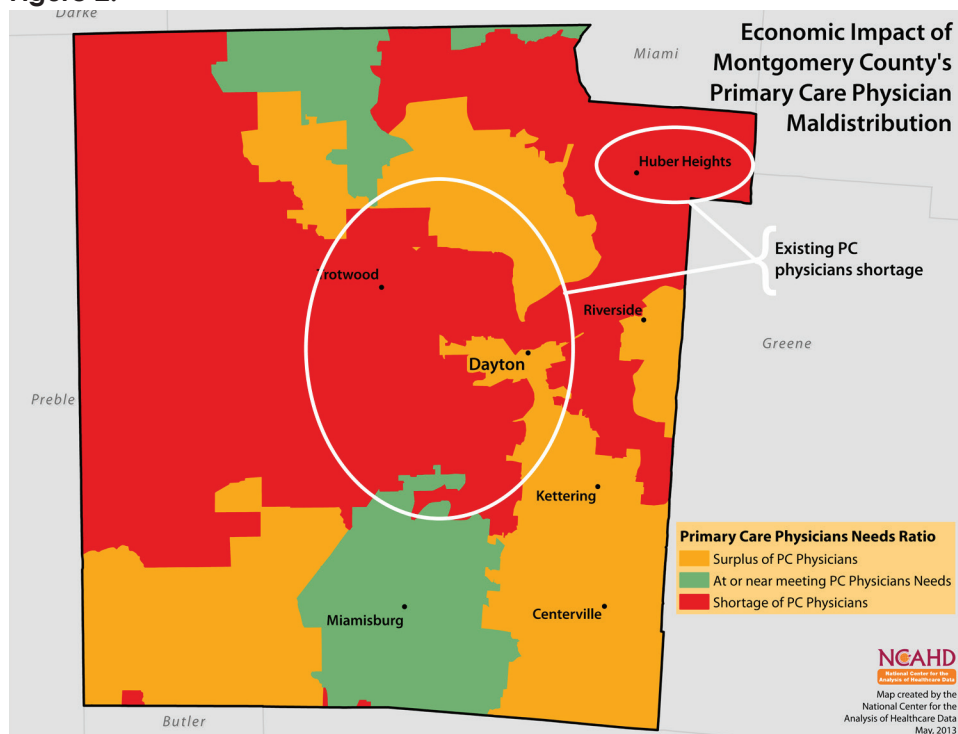


Figure 2.



occurs is of concern. Understanding the proximity of aging healthcare workforce to areas where there are high concentrations of potentially eligible populations can be helpful for targeting recruitment by provider training programs.

Healthcare workforce average ages

Provider (Group)	National*	Ohio**	Mont. County
Primary Care Physicians	52	43	45
Nurse Practitioners	56	47	48
Physician Assistants	51	45	43
Dentists	62	58	48

* 2012 NCAHD's State Licensure

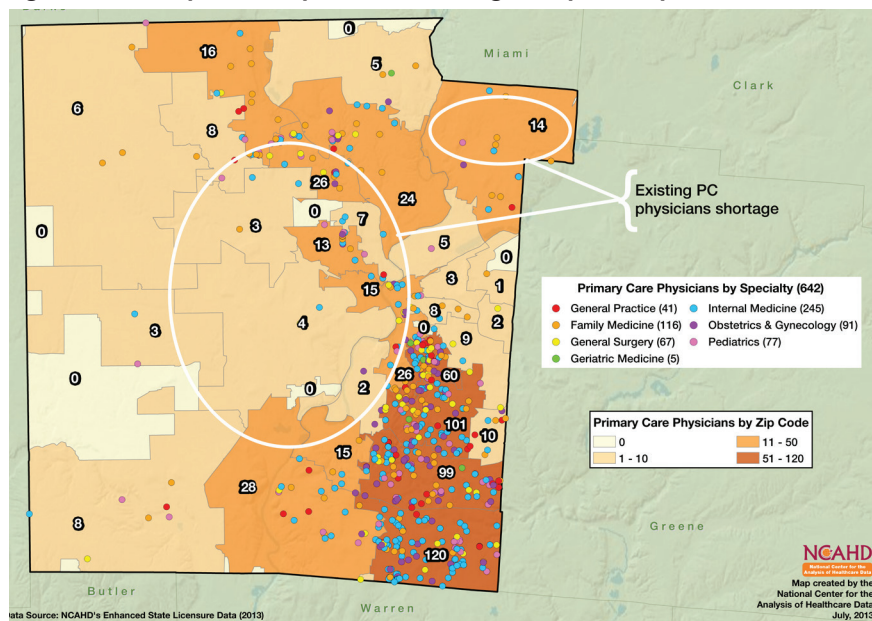
** 2013 NCAHD's state Licensure

Dental workforce

As noted earlier, dental provider shortages are evident for low-income populations in Montgomery County, particularly for those living within low-income Dayton neighborhoods; two of which, East Central Dayton and West Dayton, represent the county's designated Dental Health Professional Shortage Areas.

This is not surprising given the distribution of Montgomery County dentists as shown in Figure 5 on the next page. The distribution of additional dental workforce, including dental hygienists and enhanced function dental auxiliaries, follows the same general pattern. See map in Appendix E.

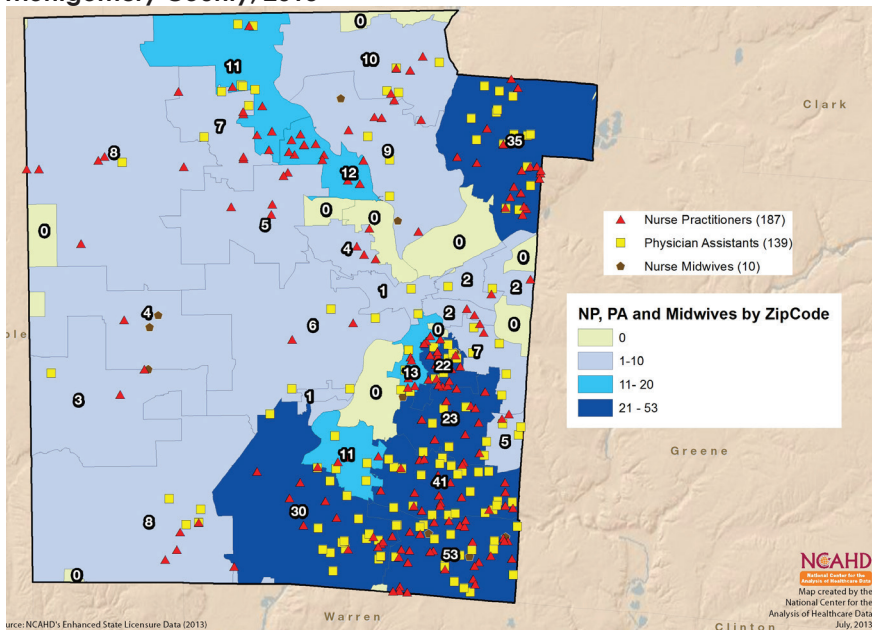
Figure 3. Primary Care Physicians in Montgomery County, 2013



Like the primary care workforce, the dental workforce is aging. As noted earlier, the average age of dentists in Montgomery County is less than that of the country; however, as a whole dentists represent the highest average age among healthcare professions.²⁷

In addition to the maldistribution of dentists, a particular challenge is the limited number of dentists who accept new Medicaid patients, as confirmed in the focus group research, wait-time study audit, and evidence of a lack of dental claims by those enrolled in Medicaid, all noted elsewhere. And, while that same research indicates dentists are willing to serve uninsured patients, the up-front payment that is required creates a barrier for many.

Figure 4. Nurse practitioners, nurse midwives and physician assistants in Montgomery County, 2013



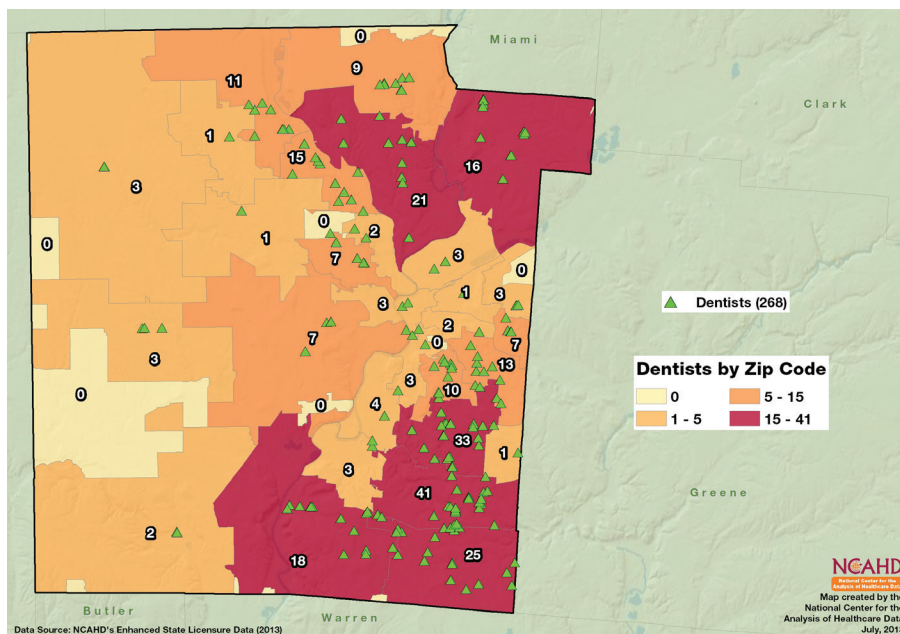
Behavioral Health

The environmental scan includes an analysis of the number and distribution of key behavioral health professionals as identified by the ADAMHS Board of Montgomery County. Understanding the number and distribution of behavioral health professionals is important as stakeholders work to strengthen the integration of mental health and addiction services with primary care.

Figure 6 highlights psychiatrists and psychologists within Montgomery County, confirming the challenges that many communities face regarding shortages of psychiatrists.

Figure 7 on the next page shows

Figure 5. Dentists in Montgomery County, 2013



mental health professionals, both counselors and social workers. We have included those professionals in process of obtaining licensure, referred to as “pipeline,” to indicate future capacity.

Figure 8 on the next page examines workforce working within the chemical dependency and addiction services. Interestingly, chemical dependency counselors in the pipeline outnumber those currently practicing.

Workforce conclusions

Training additional health providers has been a priority for Ohio with several programs directly benefiting Montgomery County. For example, in Montgomery County alone, there are fourteen specific residency programs primarily associated with the Boonshoft School of Medicine at Wright State University, a physician assistant program, a dental hygienist and a physical therapist training program. As team-based primary care

training continues to be embraced in Montgomery County, encouraging the inclusion of behavioral health training will be key to ensuring integration of care provides the results patients need.

While the overall analysis clearly points to some health care workforce challenges for Montgomery County, there are several key strengths. The safety net healthcare delivery system, medical school and residency programs, and other health provider training programs provide an infrastructure that can be grown to help

accommodate the additional needs of the county. Additionally, most of the safety net programs and medical school curricula embrace team-based care training modules already, so as graduates move into the delivery system, they will be prepared to work in team-based environments, possibly better than their peers who did not benefit from such training.

Figure 6. Psychiatrists and psychologists in Montgomery County, 2013

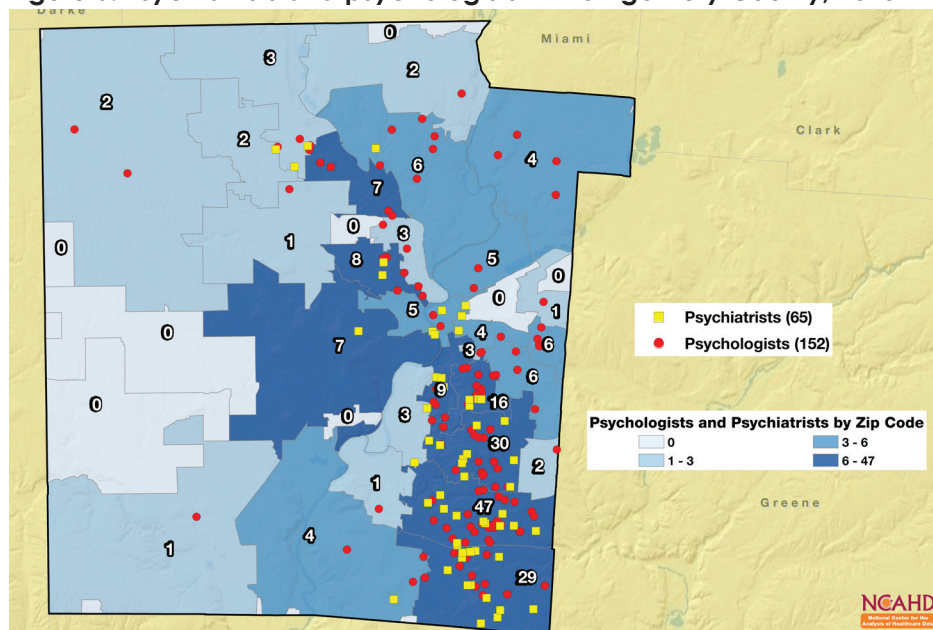


Figure 7. Mental health professionals in Montgomery County, 2013

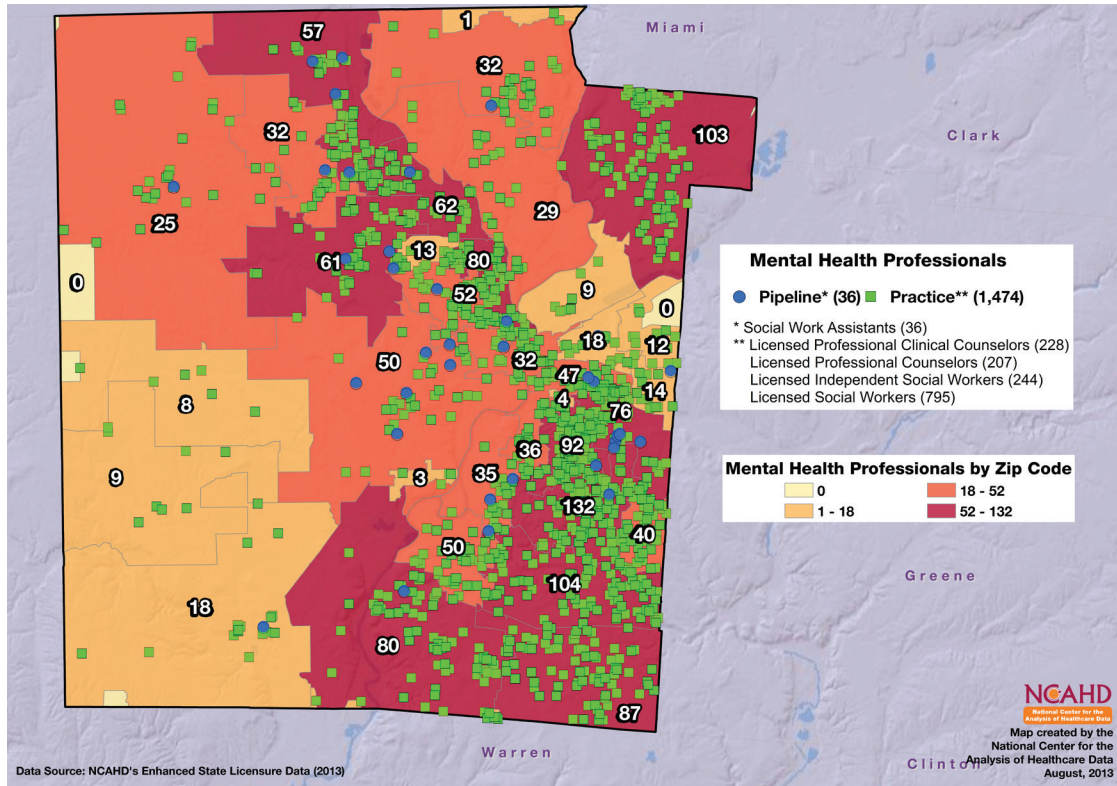
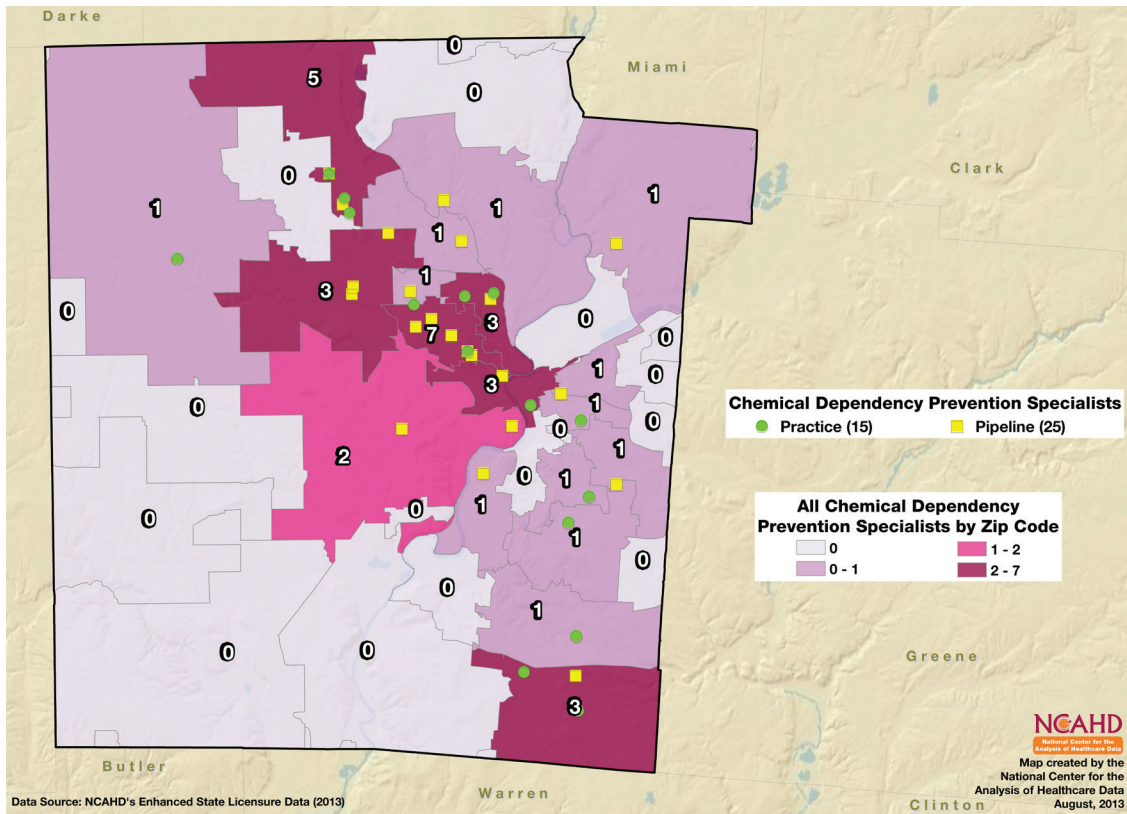


Figure 8. Chemical dependency prevention specialists in Montgomery County, 2013



Health Professional Shortage Areas

Health Professional Shortage Area (HPSA) Designations recognize a lack of primary care capacity within largely low-income urban communities as well as rural and small town areas. HPSAs are administered by state health departments in partnership with the Health Resources Services Administration (HRSA) at the federal level. HPSAs may be primary care (medical), dental or mental health HPSAs.

HPSA designations may represent:

- a defined geographic area based on several census tracts that meet the designation criteria; such as in a city or town
- a portion of, or an entire, rural county that meets the criteria
- a special population within a defined area that lacks access to primary care
- facilities that serve primarily low-income populations and meet certain other criteria (Currently, three health centers in Montgomery County have facilities that are designated as HPSAs.)

In the past there have been geographic primary care HPSAs in Dayton. However, these designations dissolved several years ago and currently Montgomery County is the only urban county in Ohio that lacks a geographic primary care HPSA. (The city of Dayton does have two communities designated as Dental HPSAs, noted elsewhere in this report.)

HRSA's Bureau of Health Professions, which administers the federal scholar and loan repayment programs, requires a geographic HPSA in order to place providers in an area. For the state loan repayment program, administered by the Ohio Department of Health (ODH), an active HPSA is not required in all circumstances, but ODH gives preference to an area that has a HPSA. The HPSA both defines the severity of the need, and also allows ODH to take advantage of federal matching dollars for loan repayment purposes. Thus the lack of a HPSA hinders recruiting efforts; an issue that could become more challenging as the demand for services increases as a result of expanded coverage under the ACA. In addition, primary care physicians who serve Medicare beneficiaries in areas designated as primary care geographic HPSAs by HRSA, as of December 31 of the prior year, are eligible for a 10% Medicare HPSA bonus during the current year. Psychiatrists who practice in an area designated as a mental health HPSA qualify for the same bonus for Medicare patients.

In Ohio, the HPSA process requires that an entity in the community be responsible for initiating the application and collecting survey data from all primary care physicians within the proposed HPSA area. Several Montgomery County entities have initiated a HPSA application, but the application continues to lack all of the information needed for ODH to complete the preliminary scoring and prepare an application to HRSA.

ODH recommends the following for securing a HPSA:

- Define the primary care service area (use census tract boundaries)
 - The most logical boundaries may not be those that were previously designated
- Appoint a single entity to take the lead
 - Consider appointing a "neutral party" that does not receive direct benefit from the HPSA designation
- Obtain a list of primary care physicians
- Use the one-page ODH survey to collect information
- Conduct physician surveys by phone, in person at their offices, and/or at medical society meetings
- Collect and report data by census tract, not zip code, to align with federal and state criteria

How will ACA implementation impact the Montgomery County safety net?

Shifts in payer mix

As the Affordable Care Act is fully implemented in 2014, the vulnerable populations (low-income, Medicaid, and underserved communities) served by Montgomery County's safety net may not fundamentally change, but their sources of coverage will change. As a consequence, financing for safety net providers who care for these populations is expected to shift, driven by such factors as:

- Enrollment in qualified health plans through the new Health Insurance Marketplace²⁸
- Increased enrollment in Medicaid, especially if the proposed expansion is adopted
- Reductions in Disproportionate Share Hospital funding (DSH)

As more among the vulnerable populations gain coverage, the biggest access challenge will likely evolve from financial barriers to capacity issues. Changes in economic circumstances and family status will lead some of these vulnerable populations to cycle through different coverage sources – Medicaid and qualified health plans – and even through periods of no insurance coverage. Safety net providers can play a significant role in providing consistent care even as coverage status changes. But to do so, safety net providers must be positioned and able to obtain reimbursement from different payers.

Health Insurance Marketplace

Open enrollment for Ohio's federally-facilitated Health Insurance Marketplace will start October 1, 2013 for coverage that begins January 1, 2014. Individuals and small businesses will be able to shop for coverage through a web-based system that enables comparison across plans and benefit levels. Premium subsidies will be available to those with family incomes between 100% - 400% of the federal poverty level; cost-sharing subsidies are available for those with family incomes up to 250% of the federal poverty level. Only people who are not covered by Medicaid or Medicare, who are under age 65, and who do not have access to affordable employer-sponsored insurance that meets minimum benefit requirements are eligible for these subsidies.

In Montgomery County, nearly 42,000 currently uninsured adults are estimated to be eligible for premium subsidies for coverage purchased

Key informant insights

Predictions about changes to the payer mix as a result of the ACA varied among key informants. Several voiced concerns that the beginning of the process will be "chaotic", and employers are unlikely to make many changes in 2014. Some expect that some employers (particularly in sectors where employees are easy to find, making insurance less of an incentive for employment) may begin to shed their insurance in 2015 and require their employees to buy it on the Marketplace. While many people would buy insurance for themselves or their families, some may choose to go without since the penalty is not very large. Some key informants also predicted that more employers may drop spouse insurance.

Another common concern is that many people who will be buying insurance through the Marketplace, or who would be eligible for Medicaid expansion, are those without a great deal of "health literacy", an understanding of how to properly use the healthcare system. As one person said, "A small number of people account for the greatest costs. They tend to be the least educated about healthcare and the most needy."

"When people get better education, they understand their own bodies and know how to connect with service providers and they get better outcomes," said another key informant. A few interviewees commented about the need for not only more education, but for a shift in culture in how some low-income people access the healthcare system away from using emergency departments for primary care and toward understanding the worth of primary care and preventive medicine. "The vulnerable populations know how to work the current system -- they just go to the emergency department," noted another key informant. "We need to get them to start using primary care effectively. Without incentives to change, they'll wait until they get sick, and at that point there's not a lot of healthcare management that can occur."

through the Marketplace.²⁹ This estimate is likely conservative as it assumes Medicaid expansion to 138% FPL and includes only uninsured adults between 150% - 400% FPL. An estimated 3,000 uninsured children may enroll in subsidized coverage and some currently insured adults may transition from their current coverage to subsidized coverage.³⁰

The adjacent map shows the geographic distribution of currently uninsured adults eligible for subsidized Marketplace coverage.

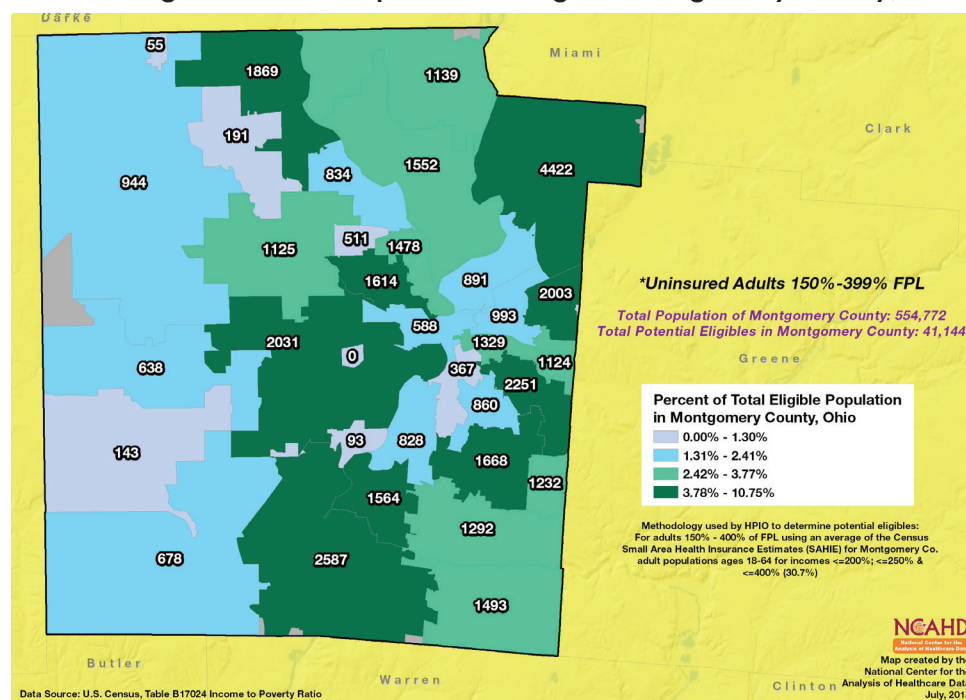
Current Medicaid growth

The number of Montgomery County residents insured through Medicaid grew by nearly 15% during the 18-month period of January 2012 through June 2013, from 108,300 to 124,300.³¹ This growth translates into a higher volume of applications and cases that are processed by the Montgomery County Department of Job and Family Services.

In addition, it means that more low-income residents are gaining health coverage, although how many were previously insured vs. previously uninsured is not known. The impact on safety net providers of growth in Medicaid enrollment varies. Some providers only serve uninsured, meaning those current clients who gain Medicaid coverage no longer meet eligibility and may have to seek care elsewhere. For community health centers, uninsured clients who gain Medicaid coverage can remain a patient and move from self-pay to insured status, bringing the enhanced Medicaid payment for which FQHCs qualify.

However, as noted earlier, some who will gain

Potential eligibles for marketplace coverage in Montgomery County, 2013



Medicaid coverage are currently insured. In settings other than community health centers, the reimbursement associated with these clients may decrease given Medicaid's low reimbursement rates compared to commercial insurance.

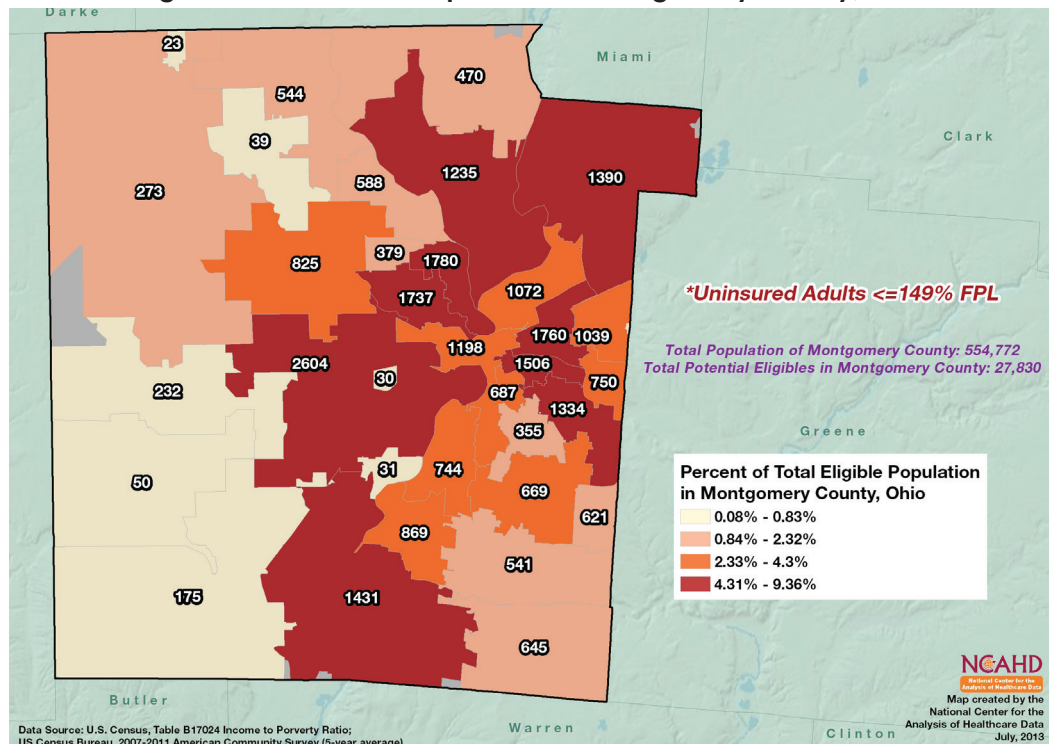
Proposed Medicaid expansion

As of September 2013, Ohio policymakers are still debating whether or not to expand Medicaid eligibility to 138% of the federal poverty level, as provided for in the Affordable Care Act. If Ohio expands Medicaid, an estimated 29,000 newly-eligible Montgomery County residents would enroll in Medicaid,³² a 24% increase over the 2013 average monthly enrollment to date. An additional unknown number of currently eligible residents would enroll as a result of the "welcome mat" effect, driven by such factors as the individual mandate, and increased public education and outreach.

Nearly 10,000 of those expected to enroll in Medicaid are estimated to currently have insurance.³³ Where they will seek care once enrolled in Medicaid is hard to predict. Regardless, as more people gain Medicaid coverage, more are expected to seek care and likely a good portion will seek care from the safety net.

The adjacent map shows the geographic distribution of currently uninsured adults who will be newly eligible for Medicaid coverage if Ohio expands. As might be expected, the areas with the highest concentration of newly eligible Medicaid coverage is similar to the areas with the highest concentration of those eligible for subsidized coverage through the Health Insurance Marketplace.

Potential eligibles for Medicaid expansion in Montgomery County, 2013³⁵



Medicaid Expansion Projected Revenue

A Medicaid expansion would generate new revenues at the state and county level, some of which could be invested back into the safety net to ensure care.

Montgomery County revenues (in 2015) are estimated to be:³⁴

- Managed care sales tax revenue:
\$150,000
(based on expansion in 2014; similar amounts would be generated annually thereafter)
- New local general sales tax revenue:
\$773,000
(based on expansion in 2014; similar amounts would be generated annually thereafter)

The need for outreach, education and consumer assistance

The need for community outreach, education and consumer assistance regarding new coverage options arose throughout the environmental scan. Concerns that the

public does not have adequate information and does not understand what is available are consistent with national, state and local findings. For example, in Fall 2012, Enroll America focus groups found that over 70% of participants lacked awareness of new options for insurance;³⁶ in Spring 2013, focus groups sponsored by CareSource found that 75% of respondents were not familiar with health insurance marketplaces;³⁷ and in Summer 2013, 87% of respondents to a Medicaid Outreach Client/Patient Survey sponsored by the Medicaid Outreach Consortium in Montgomery County reported that they were not aware of and/or understand the Affordable Care Act and what it may mean for their family.³⁸

Our research indicates that no one entity in Montgomery County is coordinating outreach, education and consumer assistance efforts, although a number of people recognize the need for a coordinated strategy.

The figure on the next page provides an overview of resources that can support efforts, including specific funding sources that are dedicated to Montgomery County.

Outreach, education, enrollment resources

Community Health Centers outreach and enrollment grants*

- Community Health Centers of Greater Dayton
- Samaritan Homeless Clinic

Navigators

- Helping Hands of Dayton
- Ohio Association of Foodbanks/ local partners

Navigators will be listed at www.healthcare.gov and www.OhioForHealth.org

Certified application counselors

Certified application counselors will be listed at www.healthcare.gov and www.OhioForHealth.org

Agents & Brokers

A list of agents and brokers certified to sell qualified health plans on the marketplace will be available at the Ohio Department of Insurance website, www.insurance.ohio.gov

* FQHC look-alikes are not eligible for these grants. As a result, Samaritan Homeless Clinic will partner with Five Rivers in this effort.



RECOMMENDATION F

Ensure eligible Montgomery County residents access new coverage options by developing and supporting a coordinated strategy for outreach, education and consumer assistance

Local, state and national research confirms that many consumers do not know how the Affordable Care Act may impact them or their families, nor if they may be eligible for new coverage options beginning in 2014.

Montgomery County leaders should ensure that the community develops and supports a coordinated strategy for outreach, education and consumer assistance. A neutral entity may be best to coordinate this effort and should include those entities that have a formal role (Navigators, Certified Application Counselors, community health center outreach and enrollment grantees, Job and Family Services, among others) as well as the wider group of interested stakeholders who want to ensure that their constituents have accurate, timely information.

In addition, the strategy could include consumer education and assistance in how to access and utilize health care effectively to stay healthy and prevent/manage illness.

Notes

1. 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
2. The United States Census Bureau Small Area Health Insurance Estimates, The United States Census Bureau. <http://www.census.gov/did/www/sahie/>
3. Average monthly enrollment for January – August 2013. Montgomery County Department of Job and Family Services, Control D Report GRP525RA; additional calculations by HPIO
4. Desai, Anand, Ph.D., Greenbaum, Robert, Ph.D., Hayes, William, Ph.D., Rohling McGee, Amy, Cui, Renhao, and Saksena, Michelle. "Expanding Medicaid in Ohio, County-Level analysis," March 2013. Available at www.hpio.net. Note: This estimate is for 2015, assuming expansion occurs in 2014
5. Ibid
6. Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2010 on CDC WONDER Online Database, released January 2013. Data are compiled from Compressed Mortality File 1999-2010 Series 20 No. 2P, 2013
7. Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2010 on CDC WONDER Online Database, released 2012. Data are from the Multiple Cause of Death Files, 1999-2010, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program (Source for Diabetes, Heart Disease and Female Breast Cancer)
8. Centers for Disease Control and Prevention; Behavioral Health Risk Factor Surveillance System, compiled/reported by Public Health – Dayton & Montgomery Co., 2012
9. Ohio Department of Health, Vital Statistics, 2007-2011, compiled and analyzed by Public Health – Dayton & Montgomery Co.
10. Health, United States, 2010, Table 67. Hypertension and high blood pressure, calculated using BPHC-approved extrapolation method based on race/ethnicity of the population in the neighborhoods, calculated by Gilbert Consulting, LLC for Five Rivers Health Centers
11. Ohio Department of Health, Vital Statistics, 2007-2011, compiled and analyzed by Public Health – Dayton & Montgomery Co.
12. 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)
13. 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
14. Centers for Disease Control and Prevention; Behavioral Risk Factor Surveillance System, compiled/reported by Public Health – Dayton & Montgomery County
15. Ibid
16. This reflects the definition of hospital uncompensated care developed by the 2008 Healthcare Safety Net Task Force, which includes the following: net uncompensated care costs from hospital emergency departments, inpatient and outpatient; net uncompensated care costs from hospital clinics; emergency department payments for on-call physicians; and net Medicaid shortfall Data provided by the Greater Dayton Area Hospital Association, 2013.
17. HPIO analysis using Ohio Hospital Association; Statewide Clinical and Financial Database; special data runs by Greater Dayton Area Hospital Association (GDAHA), July & August, 2013
18. Avalere Health analysis of American Hospital Association Annual Survey data, 2011, for community hospitals; US Census Bureau National and State Population - reported by H.J. Kaiser Family Foundation; and HPIO analysis using Ohio Hospital Association; Statewide Clinical and Financial Database; special data runs by Greater Dayton Area Hospital Association (GDAHA), July & August, 2013
19. HPIO analysis using Ohio Hospital Association; Statewide Clinical and Financial Database; special data runs by Greater Dayton Area Hospital Association (GDAHA), July & August, 2013
20. Data from UDS Mapper, Community Health Center reporting system, 2011, and American Community Survey (ACS) 2007-2011 five-year estimates at the ZIP Code Tabulation Area (ZCTA) level. Note: the community health center system includes Federally Qualified Health Centers (FQHCs) and the Health Center Look-alikes.
21. Ohio Department of Health, Oral Health Section, July 2013
22. Ohio Department of Health, Oral Health Section analysis of Ohio Medicaid claims data provided by the Ohio Department of Job and Family Services, 2013
23. In 2012, The Robert Graham Center calculated the average annual per person primary care physician usage rate at 1.6 visits per year, and the number of visits a primary care physician could handle annually at 2,237. NCAHD multiplied that rate to the population in each zip code and divided by 2,237 to obtain the number of primary care physicians needed. NCAHD subtracted current supply to determine primary care physician shortage. For more information, see "Projecting US Primary Care Physician Workforce Needs (2010-2025)," www.annfammed.org/content/10/6/503.full.pdf
24. Based on economic impact information from the National Center for Rural Health, one primary care physician generates approximately \$1.5 million in revenue, \$0.9 million in payroll, and creates 23 jobs in both the physician's practice setting and the hospital. See www.ruralhealthworks.org for more information.
25. See sources and methodology cited in footnotes 2 and 3
26. Ibid
27. Dolan, D. A., (2005). Access to dental care among older adults in the United States. *Journal of Dental Education*, vol 69, 961-974. Retrieved from <http://www.jdentaled.org/content/69/9/961.full>
28. Established in the Affordable Care Act, Health Insurance Marketplaces (also known as Affordable Insurance Exchanges) facilitate the purchase and sale of qualified health plans in the individual market and in the small group market (through the Small Business Health Options Program (SHOP)). The aim of the Marketplace is to reduce the number of uninsured, increase transparency in the insurer marketplace, provide consumer education and assist individuals with access to health insurance, premium assistance and cost-sharing reductions.
29. US Census, Table B17024 Income to Poverty Ratio. Calculated by HPIO for Adults 150% - 400% of FPL using an average of the Census SAHIE for Montgomery Co. adult populations ages 18-64 for incomes <=200%; <=250% & <=400%
30. US Census, Table B17024 Income to Poverty Ratio 2007-2011 American Community Survey 5-Year Estimates Calculated by HPIO for Children age 17 & under: 200% - 400% of FPL
31. Montgomery County Department of Job and Family Services, Control D Report GRP525RA; additional calculations by HPIO
32. Desai, Anand, Ph.D., Greenbaum, Robert, Ph.D., Hayes, William, Ph.D., Rohling McGee, Amy, Cui, Renhao, and Saksena, Michelle. "Expanding Medicaid in Ohio, County-Level analysis," March 2013. Available at www.hpio.net. Note: This estimate is for 2015, assuming expansion occurs in 2014
33. Ibid
34. Desai, Anand, Ph.D., Greenbaum, Robert, Ph.D., Hayes, William, Ph.D., Cui, Renhao, and Saksena, Michelle. "Expanding Medicaid in Ohio, County-Level analysis part 2: Local economic impact on employment and general sales tax revenues." April 2013. Available at www.hpio.net.
35. The proposed Medicaid expansion in Ohio under the ACA would go up to 138% of federal poverty level (FPL). This map looks at the estimated number of adults up to age 64 that would qualify in each zip code based on household poverty and lack of health coverage. The US Census income/poverty tables do not perfectly align with the Small Area Health Insurance Estimates (SAHIE), which estimates the percentage of adults ages 18-64 who have incomes up to 138% of federal poverty level and are uninsured at the county and state level. The income/poverty categories used by the Census (which can be captured by zip code) break only at 124% of FPL and 149% of FPL; we chose the higher break-off in our calculations with knowledge the figures would capture those who are uninsured and potentially eligible for Medicaid up to 138%. The SAHIE estimate for adults 18-64 with incomes up to 138% of FPL were applied to the number of adults in each zip code with incomes up to 149% of poverty; thus we acknowledge this would slightly over-inflate the figures by also including those who have incomes from 139% up to 149% of FPL. These are estimates and are intended to illustrate the geographic areas with highest overall numbers of eligibles.
36. "Informing Enroll America's Campaign, Findings from a National Study," Enroll America, February 2013. Available at www.enrollamerica.org.
37. "The Psychology Behind Effective Communication: the Ohio Expansion and Exchange Populations," CareSource presentation at Voices for Ohio's Children's Enrollment Summit, March 27, 2013. Presentation available at www.vfc-oh.org.
38. Unpublished Medicaid Outreach Survey results, shared via email correspondence, August 20, 2013.

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.

Federally Qualified Health Centers and FQHC Look-Alikes:

Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes, more commonly referred to as Community Health Centers, provide care to underserved populations. Community Health Centers provide comprehensive primary and preventive care including (but not limited to) medical, dental, mental health, substance abuse and vision care services.

Health Insurance Marketplaces: Established in the Affordable Care Act, Health Insurance Marketplaces (also known as Affordable Insurance Exchanges) facilitate the purchase and sale of qualified health plans in the individual market and in the small group market (through the Small Business Health Options Program (SHOP)). The aim of the Marketplace is to reduce the number of uninsured, increase transparency in the insurer marketplace, provide consumer education and assist individuals with access to health insurance, premium assistance and cost-sharing reductions. Ohio decided not to pursue a state-based marketplace but continues to perform insurance regulatory functions through the Ohio Department of Insurance. Open enrollment for coverage in 2014 runs from October 1, 2013 through March 31, 2014. Information about Ohio's Marketplace is at www.healthcare.gov.

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.

Integrated care: the systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs. (From SAMHSA Center for Integrated Health Solutions)

Patient-Centered Medical Home (PCMH): The Patient-Centered Medical Home model of care is one that facilitates partnerships between individual patients and their personal healthcare providers 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. (Ohio Department of Health, PCMH webpage)

Primary Care: Health services related to family medicine, general internal medicine, general pediatrics, obstetrics, or gynecology that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives; including

- diagnostic laboratory and radiologic services;
- preventive health services, including--
- prenatal and perinatal services;
 - appropriate cancer screening;
 - well-child services;
 - immunizations against vaccine-preventable diseases;
 - screenings for elevated blood lead levels, communicable diseases, and cholesterol;
 - pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;
 - voluntary family planning services; and
 - preventive dental services;
- emergency medical services;
- mental health and substance abuse services; and
- pharmaceutical services

(Adapted from Health Resources Services Administration/ Public Health Service definition for health centers)

Safety net providers: Safety net providers are defined as health care providers who serve a significant portion of patients who are classified as uninsured, enrolled in Medicaid, or other vulnerable populations, and those living in underserved rural or inner city areas.

Safety net population: Consists of three broad subgroups of individuals who reside in a geographic location and disproportionately depend on the safety net):

1) uninsured people, 2) Medicaid beneficiaries, and 3) vulnerable populations—including adults and children with disabilities, the frail elderly and disabled, low-income individuals, the mentally ill, substance abusers, HIV/AIDS patients; and the homeless. (Institute of Medicine)

Appendices

- A.** List of stakeholder meetings
- B.** Focus groups report
- C.** Wait call audit report
- D.** Key informant interviews report
- E.** Workforce analysis report
- F.** Data synthesis report, including:
 - Models of collaboration/access/innovation
 - Key Affordable Care Act Provisions and Resources

Appendix A. List of stakeholder meetings

DATE	STAKEHOLDERS	PURPOSE
5/13/2013	Core leadership team	Discuss and affirm proposed work plan
5/23/2013	Greater Dayton Area Hospital Association	Discuss available data
5/23/2013	ADAMHS Board	Discuss available data
5/23/2013	Public Health Dayton and Montgomery County	Discuss available data
5/28/2013	ADAMHS Board (conference call)	Discuss available data
5/31/2013	Samaritan BH/CrisisCare (call)	Informational/data gathering interview
5/31/2013	Community Health Centers of Greater Dayton (call)	Information gathering
6/7/2013	Montgomery County Care (conference call)	Discuss focus group participation
6/19/2013	Core leadership team	Review progress to date; gather input and direction
6/19/2013	Five Rivers Health Center	Informational/data gathering interview
6/19/2013	ReachOut of Montgomery County	Discuss focus group participation
6/19/2013	Dr. Gary Ensor	Discuss dental safety net
6/19/2013	Community Health Centers of Greater Dayton	Informational/data gathering interview
6/20/2013	Montgomery County Care (conference call)	Informational/data gathering interview
6/26/2013	ReachOut of Montgomery County	Informational /data gathering interview
6/26/2013	Good Neighbor House	Informational/data gathering interview
7/2/2013	Greater Dayton Area Hospital Association (call)	Discuss data gathering
7/3/2013	Public Health Dayton and Montgomery County	Discuss population-based data analysis
7/3/2013	ADAMHS (conference call)	Discuss wait-time survey
7/3/2013	Samaritan Homeless Clinic (conference call)	Informational/data gathering interview
7/11/2013	Montgomery County Medicaid Outreach Consortium (conference call)	Informational/data gathering interview
7/11/2013	Montgomery County Indigent Care Consortium (call)	Informational/data gathering interview
7/15/2013	Greater Dayton Area Hospital Association (call)	Information gathering
7/15/2013	ADAMHS Board	Discuss behavioral health workforce analysis
7/24/2013	Core leadership team	Present initial data findings; review progress to date; gather input and direction
7/29/2013	Ohio Department of Health, Oral Health Section (call)	Informational/data gathering/analysis
7/31/2013	Co-Chairs	Discussion re: Task Force process, project timeline
8/1/2013	ADAMHS Board	Behavioral health wait time study training
8/9/2013	Ohio Department of Health,	Information/recommendations related to Health Professional Shortage Areas
8/23/2013	Co-Chairs (conference call)	Discuss agenda and presentation for 8/28 MCACATF meeting
8/28/2013	MCACATF	Presentation and discussion of research findings and initial priorities
9/10/2013	ADAMHS Board (call)	Discuss/clarify referral process
9/17/2013	ADAMHS Board (call)	Informational interview
10/8/2013	Co-Chairs (conference call)	Review and accept final report

An Environmental Scan of the Montgomery County Safety Net for the Montgomery County Affordable Care Act Task Force

Focus Group Report

Prepared by Health Policy Institute of Ohio (HPIO): Rachel Holbert, Usable Research, and Mary Wachtel, HPIO
September 2013

Research Objective

Conduct consumer and provider focus groups to assess how vulnerable populations currently access health care.

Background

In order to incorporate the experiences of those who are uninsured or who have Medicaid, and providers who work directly with these populations, into the overall picture of health care access for poor and vulnerable populations, HPIO proposed to conduct three focus groups. Two were to be of health care consumers, and one of direct providers. While the consumer groups took place, it was not possible to recruit providers for a focus group. Instead, researchers spoke separately with five providers and were able to glean valuable information using brief individual interviews.

Additionally, researchers held a focus group with six behavioral healthcare administrators, and while they were asked a different set of questions (related to the key informant study), some of their answers are more relevant to health care provision.

In general, we found that the focus groups confirmed what one provider stated: "Having Medicaid is way better than being uninsured." Medicaid consumers reported a relatively easier time finding someone who would serve them and were able to more easily negotiate their way through the health care system. Further, most Medicaid consumers we spoke to reported that they have a personal physician, while most uninsured consumers did not. Finally, Medicaid consumers were much more likely to have visited a dental clinic within the past three years than the uninsured consumers.

One issue is shared, however: aside from the cost of healthcare, the biggest access challenge is transportation. Only two of 15 consumers interviewed owned a car. So while the experience of Medicaid patients is different from those who are uninsured, it is not without challenges.

The physicians we interviewed include several types of medical practitioners. While all work with the safety-net population, some work full-time in a safety net clinic, while others largely do not see poor or uninsured patients except for their volunteer activities. Some are primary care physicians, while others are specialists. In general, they are aware of their patients' problems with transportation and with finding specialists, dentists, and/or mental health professionals. They also expressed a great deal of uncertainty related to how the Affordable Care Act (ACA) and proposed Medicaid expansion will affect them and their patients.

Methodology

The focus group of uninsured patients was held on July 30, 2013 at Good Neighbor House near downtown Dayton. Participants were recruited through Reach Out of Montgomery County and Good Neighbor House, and were provided with a box dinner before the start of the focus group, and a \$25 Visa gift card at the end. In addition to answering the focus group questions, each participant filled out a one-page survey about themselves. All participants signed an informed consent form, and the conversation was audio-taped. Nine participants attended; several were currently staying in a homeless shelter. Consequently, the focus group may have under-represented the working poor.

The focus group of Medicaid patients was held on August 1, 2013 at the Charles Drew Health Center, part of Community Health Centers of Greater Dayton. All of the participants were recruited by staff members at Charles Drew, though several participants mentioned other primary care providers. As with the group of uninsured patients, these participants were provided with a box lunch and a gift card. The same protocol (informed consent form, survey, audio-tape) was also followed. Six adults participated in this group, one of whom accompanied his wife and was uninsured.

Although the most efficient way to recruit focus group participants was to work through established clinics, it also ensured that the participants had recently been in a clinic to see a provider. As a result, many of the focus group participants reported that they have a relationship with a provider, and almost none complained about being unable to make appointments with provider offices. This contradicts the evidence presented in the wait time audit survey report, as well as statements from the provider interviews below.

In all, 15 people participated in the focus groups, including ten women and five men. Eleven were African-American and four were white; none were Hispanic or any other ethnic group. Ages of participants ranged from 24 to 63; the median and average age were both 42. All but one uninsured participant had been without insurance for more than five years. About half the participants rated their health "good"; the rest chose "very good" or "fair", with no real difference between Medicaid and uninsured participants. Six participants stated that there is someone they consider to be their personal doctor or nurse, four of whom have Medicaid. Six participants (three of whom have Medicaid) stated that they have been to an emergency department instead of a doctor's office within the past year. Participants were asked to list the year that they last went to the dentist; of the 11 participants who answered (some answered "never" or "years" and were thus excluded), eight have been to a dentist within the past five years. Finally, five participants answered that they have been to the emergency department for dental reasons sometime in their lives.

Because of small sample sizes, this focus group research may not be representative of all consumers who are uninsured or covered by Medicaid. However it provides insights into consumer experiences and a degree of local context for data provided elsewhere in the environmental scan.

Consumer Focus Group Results

Uninsured participants cited paying up-front for services as their principal access challenge, while Medicaid patients noted that certain provider offices require long wait times from the time they arrive to the time they are seen by a practitioner. Beyond those obstacles, the most immediate access issue, regardless of whether the patient is uninsured or has Medicaid, was transportation. Only two people out of 15 (a married couple) owned a car. One participant spoke of calling the Medicaid referral line to find a dentist, and she was referred to three offices in Miamisburg, which is not a route covered by public transportation. "At least give me something on public transportation," said another participant. Another participant expressed frustration about being dependent on the bus system. "I can't control if the bus is late, or if people act up and the driver has to pull to the side of the road and take care of the situation. Now I've missed my appointment, and I can wait and see if someone else doesn't show up and they'll squeeze me in. I can get the bus downtown then look to see when the next bus is, it'll say the bus will be here in 5 minutes, then in 5 minutes it will say the bus will be here in 8 minutes. Buses are always late."

These findings are consistent with four low-income consumer focus groups that were conducted for Five Rivers Health Centers in 2012. Many participants identified the cost and time needed for public transportation as a barrier to healthcare. Participants also mentioned long wait times in the doctor's offices once they arrived, being charged additional amounts for lab work and x-rays for which they were unprepared, and being rushed through appointments once they are seen.

Most participants reported that if they needed subsequent appointments with their doctor or a specialist, the appointment process went

smoothly. Participants told how their provider offices made specialist appointments for the patient and for the most part, the specialists were prepared with the patients' medical files. "I've had that experience with Miami Valley. It's all computerized. It all comes up – what medicines I'm taking, what doctors I've seen," said a Medicaid participant. An uninsured participant had a similar story: "I was referred to a specialist by Reach Out. It went really smooth. Reach Out made the first appointment for me."

Participants agree that finding dental care is a challenge, whether or not they have Medicaid. Although some people had been to a dental appointment recently, others reported that it has been "years" since they have seen a dentist; the average focus group participant had not been to a dentist for more than three years. An uninsured participant commented, "You have to pay something upfront, and more if you need more done." Uninsured participants (most of whom were not working) understood their choices – Miami Valley Dental Clinic or Sinclair Community College.

A Medicaid participant noted, "It's hard to find a good dentist because of our insurance. You have to call the back of the card to get help in finding who will take the insurance. Then you have to look up those people. They'll give you those random places and you're like, where is that?" Another Medicaid participant described his experience trying to make an initial appointment with Miami Valley Dental Clinic: "I go to the dentist like clockwork now that I'm with Miami Valley. It's like getting in to the Masons or the Mob, once you're in, you're in – it's just getting in. I would call and they would say, 'Call back in six months.' So I would call back and they would say, 'Call back in six months.' But I've had a great experience since then." There is also evidence that even people with Medicaid do not choose preventative dental care. "I haven't been to the dentist in forever, but I don't have any problems so I'm fine," said a Medicaid participant. These findings regarding dental care again are similar to those in the Five Rivers study, in which several people stated that cost prevents them from seeking dental care. The Medicaid group discussed the

unavailability of emergency dental care. "There are no dentists in the emergency room. You can go down there and sit in the emergency room and then finally they'll tell you that there's no dentist. They could have told me that rather than let me sit here and wait," said one participant. Another agreed, saying, "I went to one hospital, there's no dentist there. They say 'Go to (a different hospital),' which is across town, and then there's no dentist there too." Five Rivers focus group participants also reported that hospital emergency departments will give pain medications for a dental emergency, but will not treat the problem.

This conversation transitioned into a discussion of medications and assumptions that participants believe are made about Medicaid patients. "They'll give you Motrin, no pain medication," said one participant. A few participants had stories about medical professionals assuming they were coming to the emergency department to receive narcotics they would then sell. "Certain people in the medical profession assume that everyone coming into the hospital is looking for drugs, on drugs, using them or selling them. And that hurts regular people. I had someone assume I was using drugs because I got a rub mark from my crutches on my arm," said a participant. "It's the most embarrassing thing," agreed another.

When asked about their experiences with the mental health/substance abuse field, the uninsured participants reported mostly positive experiences and Medicaid participants reported primarily negative experiences. An uninsured participant stated, "I go to Eastway to talk to a psychiatrist there. I've been going since last year." Another noted that his cousin went into rehab two years ago and even though she was uninsured, "They took her in and got her the help she needed; it was real smooth." However, another uninsured participant said, "If you don't have insurance to begin with, they don't want to help." A Medicaid participant told the group that she had post-partum depression when her first child was born. "You could be long gone before you get help," she said. Another Medicaid participant reported that "I told my doctor about my depression. He

put me on some medication and I couldn't function (so I had to go off it)," she said. The Medicaid group also told stories of relatives who had reached out for help through a clinic, CrisisCare, and a suicide hotline and did not receive the help they felt was needed. It appeared they had a negative impression of the mental health care system.

There was widespread agreement among both groups that finding healthcare has become more difficult in the past three to five years. "It's gotten more difficult, since I used to have CareSource (and no longer do)," said one uninsured participant. "There are only certain places that will take you," another agreed. A participant with Medicaid mentioned that her mother, who is diabetic and has high blood pressure, has insurance through Montgomery County Care, but "it only goes so far." Another participant said, "It's not like it used to be. I used to make my own choices, and the doctors would accommodate you because they knew you had a job. Now you get whatever time they're willing to give. Beggars can't be choosers." To sum up, one uninsured participant related, "It's harder. If you don't have insurance, forget it. I can't get hurt, I can't get sick. If I go to the ER, they scoff at me."

When asked whether they had tried to apply for Medicaid, one participant said that she was currently trying to gather the paperwork and had been told it would be about six months to a year until she would be insured. Others agreed when another participant stated, "You really don't know if you'll get it and they want all this proof and you get frustrated and don't even want to try."

Provider Focus Group Results

Most of the providers acknowledged that the biggest access challenge for poor and vulnerable populations is finding doctors who will take Medicaid or uninsured patients. "There are not enough providers for Medicaid and uninsured patients," said one doctor. In a somewhat different take, another said, "It's universal that people cannot get appointments if they don't have established relationships with a primary care provider." Another doctor related a story about a woman who called her office and

said that office was 25th on her list of offices that accept Medicaid. She had only seven more providers on the list and had yet to make an appointment. (The wait-time audit study of primary, dental, and behavioral health provider offices also suggests that new patients with Medicaid or without insurance will find difficulty making an appointment.) A behavioral health administrator acknowledged, "People without insurance who have substance abuse problems are totally left out of the loop of care."

Other challenges providers mentioned include the wait time between making an appointment and the appointment date; transportation; translation for non-English speakers, and finding specialists. One doctor noted, "Specialists don't understand the trials and tribulations of this population. If patients don't arrive on time or don't get the testing done ahead of time, specialists won't accept them." Consequently, stated one doctor, "Primary care providers end up doing things that are not within their specialty area of practice. Not very many specialists will see patients without insurance." Interestingly, none of the consumer focus group participants seemed to experience any problems with specialist appointments. That could be because the primary care provider offices are making the appointments for the patients, and they have to deal with finding a specialist who will take the patient with Medicaid or who is uninsured.

Most of the providers also agreed that "(Having) Medicaid is way better than being uninsured," as one provider asserted. Medicaid patients can get testing done and many prescriptions filled without paying for them, and they may have access to some assistance with transportation. One doctor said that uninsured patients are more likely to have mental health or substance abuse problems, along with more advanced diseases. "I had an uninsured patient with uncontrolled hypothyroidism – you wouldn't see that with Medicaid patients," he reported.

Some provider clinics are able to deal with the issues of transportation and translation. Those with Medicaid can be transported to a primary care office through their Medicaid

managed care plan, but the transportation reservation has to be made at least 48 hours in advance. (None of the Medicaid focus group participants mentioned this benefit.) One doctor noted that one problem that does occur on occasion is that if the patient needs to be transferred from the provider office to the hospital, transportation becomes an individual responsibility. So just at a time when the patient's condition must be acute (or they would not be going to the hospital), they need to figure out how to get to a hospital that may or may not be close by. That doctor also mentioned that sometimes staff members give patients bus money from their own pockets. Another doctor tries to accommodate as many late patients as possible each day. "There is no one answer," he said. "It depends on how busy we are and other factors."

Two doctors also mentioned that they work with translation services that are able to provide translators within 24 to 48 hours of the initial appointment, so the patient has to return. One doctor noted that non-English-speaking patients are given the same amount of time for an appointment as English speakers, and the schedule is usually thrown off for cases with translators as everyone in the room tries to ensure that both the provider and patient understand each other.

Most providers lamented the lack of dental care available for uninsured and Medicaid patients. "Dental isn't a problem as long as you have really good insurance and lots of money – and no problems," said one doctor. "I don't know which problem is worse – the inability to pay, or the lack of available dentists. If you can't pay, it doesn't matter how many providers there are out there. I've seen people whose teeth break off and are in really bad shape." Three providers mentioned the Miami Valley Dental Clinic, two of whom noted that there can be long wait times to get an appointment (or the patient has to call at 8:00 a.m. to make a same-day appointment). Like some consumers, a provider mentioned that there is no dental capability available at area emergency departments. "Patients are given pain medication or antibiotics and told to make an appointment the next day," said that doctor. Aside from the dental care shortage, one doctor acknowledged other barriers

even for those with Medicaid: "Some patients do not realize that they have that medical benefit, some have had bad experiences with dentists, and others are overwhelmed by the degree of work they need to have done."

Providers reported a variety of experiences with the mental health and substance abuse treatment system for their patients. "In my 25 years of practice, the state of mental health care in Dayton has gone down significantly," said one family physician. He attributes the problem largely to a lack of psychiatrists, so "they don't have to deal with what they don't want to," including substance abuse issues, he said. Other providers paint a different picture. One commented, "I call the behavioral health team and get [the patient] plugged in. Dayton could be better but it's ok." Another reported that his patients' experiences have varied, depending on what they need and are looking for.

Behavioral healthcare administrators painted a dismal picture of access for poor and especially, for uninsured people. "If you have no insurance, it's extremely hard to get your foot into any sort of treatment," said a participant. One administrator noted that access declined in 2008 with the closing of Twin Valley Behavioral HealthCare state hospital (now reopened as a for-profit mental health facility that is not an ADAMHS-contracted provider). Another administrator said that people with substance abuse issues often co-present with other mental health issues, and "if you have both, there are no resources for that population."

The issues of electronic medical records (EMRs) and provider communication receive mixed comments. One doctor reported that some specialists and hospitals provide information about patient visits, while others do not. Her clinic is affiliated with a hospital, and she is not sure she receives much information if her patient goes to another hospital. On the other hand, another doctor said, "It's a lot better than it used to be." He shared the concern that the two main hospital systems may not share information.

Behavioral healthcare administrators struggle with EMRs and sharing of data with outside

providers. In particular, some noted that they can get primary healthcare information, but not in real-time because systems don't "speak" to one another, or some providers do not have EMRs, or there are privacy concerns that inhibit instantaneous sharing of data. One participant commented, "We haven't had many problems coordinating with providers, but it's very taxing administratively." Another participant told the group that at times a provider from that facility will accompany the patient to a primary healthcare appointment, where everything can be shared face-to-face.

Providers shared a great deal of uncertainty related to how the ACA and Medicaid expansion will affect their work and patients' access to healthcare. All of them said that they were not sure how it would all work out,

noting that there is not enough capacity for this population already. There was no clear agreement, however, about how to solve the provider capacity issue. One noted that the problem is not as much a Dayton-only issue as much as it is a national issue. Some suggested starting to recruit from medical schools early on, particularly students who are originally from the Dayton area. Two providers related that it is also primarily an economic issue, since other doctors, including emergency department doctors, get paid more than primary care doctors. "People follow the money," said one. They suggest continuing to find ways to incentivize becoming a primary care provider, though they also mentioned that it has to be the right fit for the students.

Conclusions

A few clear conclusions can be drawn from this sample of healthcare consumers and providers:

- Uninsured people have very few primary care options.
- The providers interviewed appear to be more aware of the mismatch between supply of and demand for primary health care providers than the consumers who came to the focus groups.
- Transportation is key to healthcare access. Further, safety net providers have to be located on or near public transportation stops, or many patients will be unable or unwilling to find them.
- Dental care, while theoretically available, is functionally scarce. Medicaid will pay for dental care, but few providers will take Medicaid. On the other side, dental providers will accept payments up-front for care, but most are priced too high to be functionally accessible (see wait-time audit report).
- Behavioral health care appears to be a mixed bag from the "ground level."

While patients were largely pleased with the level of communication among their providers due to electronic medical records, providers see room for improvement.

Finally, the degree of integration of medical care depends on (a) whether the person has Medicaid and (b) the medical care systems included in the analysis. People with Medicaid appear to experience a good degree of integration between primary and specialty care. Even uninsured people who used specialty care reported that the path was fairly seamless from the primary care provider's office to the specialist's.

However, integration does not extend very far into dental and mental health care. If a patient is seen at a primary health care clinic that is affiliated with a dental care clinic, the records will be integrated. Beyond that, a dental surgeon may call a patient's primary care provider to obtain a medical history prior to surgery, which seems like integration to the patient but not to the provider. As noted above, the behavioral health clinics and offices also are not integrated with primary care.

An Environmental Scan of the Montgomery County Safety Net for the Montgomery County Affordable Care Act Task Force

Wait Call Audit Report

Prepared by Health Policy Institute of Ohio (HPIO): Rachel Holbert, Usable Research, and Mary Wachtel, HPIO
September 2013

Research Objective: Test availability of and wait time for primary care appointments across physical, behavioral and oral health providers.

Background

Although several members of the MCACATF had heard anecdotally that people with Medicaid or who are uninsured struggle to find providers who will accept them as patients, they wanted outside validation. Using established research protocols and guidance from a leader in the field of wait-time audits, Dr. Karin Rhodes, HPIO developed a test of physical, dental, and behavioral health provider offices to determine not only whether a new uninsured or Medicaid patient could get an appointment, but the number of days between the date of the call and the date of the appointment, as well as the ease and accessibility of making appointments with provider offices.

Audit studies, health care's "mystery shoppers"

The term "audit study" is the scientific name for "mystery shopper"-type techniques, in which trained callers pose as potential new patients. It is a powerful method of detecting whether appointments can be made, the length of time between the call date and appointment date, and if other criteria are met. These techniques have been used extensively to determine factors such as housing and employment discrimination. In health care, Karin Rhodes, M.D., an emergency department doctor, has been on a number of teams that have studied disparities in appointments among patients with private insurance, Medicaid, or who are uninsured. Dr. Rhodes, who provided HPIO with scenarios and guidance, found through a nationwide audit study in 2002-2003 that privately insured "patients" were almost twice as likely to secure a prompt appointment (within one week) than were Medicaid "patients."¹

More locally, 120 Montgomery County primary

care providers (excluding the traditional safety net providers) that provide services to Medicaid and uninsured patients were surveyed as part of a 2012 health care needs assessment for Five Rivers Health Centers. The assessment found that only 15 percent of the offices accepted Medicaid patients and 44 percent accepted "self-pay" (uninsured) patients at that time.² That same assessment conducted a similar survey of 88 area dental care providers that accept Medicaid or self-pay patients and found that 15 percent accepted new Medicaid patients.

Methodology

Rather than survey provider offices, in consultation with MCACATF co-chairs, HPIO opted for the audit study approach of primary care, dental care, and behavioral health care offices in order to ensure accuracy. The universe of providers for this study was defined as follows:

Physical health: The universe was the 65 community clinics and private practice offices that were listed as accepting new Medicaid patients in the online provider directories of the two Medicaid managed care companies operating in Montgomery County at the time (CareSource and Molina Healthcare).³

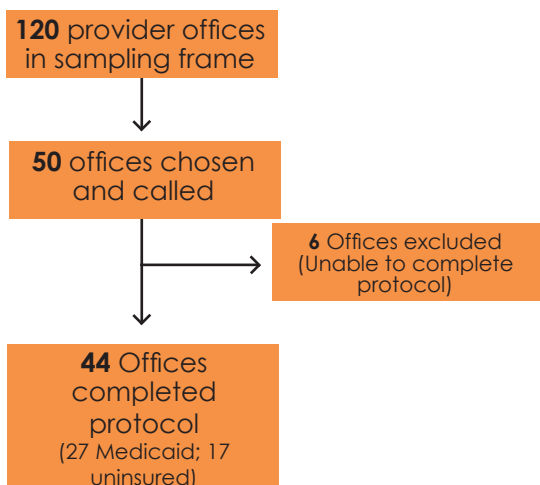
Dental health: Similar to physical health, the universe was the 50 dental provider offices listed as accepting new Medicaid patients in the online directory of CareSource and Molina Healthcare.

Behavioral health: Because of their smaller number, all behavioral health provider offices that receive funding from the Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) Board of Montgomery County and provide direct services to clients were called.

Once the sampling frame was determined, provider offices largely were selected randomly using an internet-based program, except to ensure that traditional safety net providers (community health centers and a free clinic) were included when necessary. More provider offices than needed were

chosen in case some were excluded due to wrong phone numbers or other reasons. If a provider office was excluded, to the extent possible, another was added to the list (this was not possible for the behavioral health provider offices).

Figure 1. Survey sample



Trained callers asked whether they could make an appointment, given their insurance status (Medicaid or uninsured/self-pay). They used scenarios provided by Dr. Rhodes and the ADAMHS Board, all of which were based on the caller's purported emergency department visit the previous evening and on a need for urgent follow-up care: hypertension for the primary care calls, severe tooth pain for dental offices, and depression and/or alcohol/prescription drug use for behavioral health calls. (See Attachments 1 and 2 for forms and scenarios).

Callers were instructed to try to make an appointment within two weeks of their call at the very latest. Because other studies had noted difficulty with speaking to a live person, or being put on hold for inordinately long periods of time, callers kept track of various data points on a standardized form, such as whether a live person or automated machine answered; the date and time of their appointment, or the reason they could not make an appointment; the amount they would need to pay, if uninsured; and other data. A few provider offices were taken off the call

list if the call was transferred directly to an answering machine or we found that they do not provide actual services as listed. If an appointment could be made, callers would cancel the appointment before hanging up to allow someone else to use that time. If an appointment could not be made, the caller would determine the reason and ask whether there was anywhere else she could be treated.

Because we did not call all provider offices with both the Medicaid and uninsured scenarios, the information provided below is not representative and is meant only to provide a degree of local context for the data provided elsewhere in the report.

Physical Health Call Results

Of the original 65 primary care provider offices listed, we called 18 (27.7 percent) of them, including four community health centers (either from the Five Rivers Health Centers or the Community Health Centers of Greater Dayton) and 14 private-practice offices. We did not find any problems with speaking to a receptionist (sometimes after an automated answering machine, which is more or less standard for large medical practices) or with excessive hold times. Table A1 shows the number of provider offices called, the success rate with making appointments, and the most prevalent reasons for denying an appointment within two weeks.

Table A1: Physical health appointment rates and reasons for failed appointments

Physical Health Offices			
	Medicaid	Self-pay	Total
Total provider offices called	12	6	18
Appointments made (%)	2 (17%)	0 (0.0%)	2 (11%)
Co-pay range for self-pay	\$35 - \$160		
Total failed appointments	10	6	16
Primary reasons for refusal*			
Appointment offered > 2 weeks (%)	3 (33%)	1 (17%)	4 (25%)
Does not take Medicaid/self-pay (%)	4 (40%)	2 (30%)	7 (44%)
Not accepting any new patients (%)	2 (14%)	1 (17%)	3 (19%)

***Note:** There are many reasons that callers failed to make an appointment; the reasons listed above are the most popular ones. Consequently, the reasons listed above will not necessarily add up to the total number of failed appointments.

According to Table A1, we were able to secure an appointment within two weeks for only two (11 percent) of 18 providers. Although no self-pay appointments were made within two weeks, when appropriate the caller asked about self-pay amounts, which ranged from \$35 to \$160 for the visit. No provider offices tried to assess the urgency of the caller's situation; in fact, only one provider office asked what the caller wanted to be seen for. Hence, the scenario was largely unimportant and not relevant to whether or not the provider office would make an appointment within a certain time.

The most common reason for failed appointments (44 percent) was the provider office's unwillingness to take Medicaid or self-pay consumers. Some provider offices (25 percent) did offer appointments during the course of the call, but the appointment ranged from one month to three months from the date of the call. A few provider offices stated that they were not accepting new patients at all at that time. These provider offices did not ask the insurance status of the caller before announcing their "no new client" rule, so this does not appear to be related to insurance or lack thereof. Two provider offices had particular processes that did not allow the caller to make an appointment that day but an appointment could have been secured if the caller had called back on the appointed day or filled out and sent back paperwork ahead of time. While these are relatively simple barriers, it still stands that the caller could not make an appointment that day. Finally, only three of the seven provider offices that were unable to make an appointment (43 percent) could provide any specific advice about other provider offices that accept Medicaid and/or uninsured patients.

Dental Health Call Results

We called 15 dental health provider offices, using ten Medicaid and five uninsured scenarios. We did not find any problems with speaking to a receptionist or with excessive hold times. Table A2 shows the number of dental provider offices called, the success rate with making appointments, and the most prevalent reasons for denying an appointment within two weeks.

Table A2: Dental health appointment rates and reasons for failed appointments

Dental Health Provider Offices			
	Medicaid	Self-pay	Total
Total provider offices called	10	5	15
Appointments made (%)	5 (50%)	5 (100%)	10 (75%)
Co-pay range for self-pay	\$29 - \$84		
Total failed appointments	5	0	5
Primary reasons for refusal*			
Appointment offered > 2 weeks (%)	0 (0%)	0 (0%)	0 (0%)
Does not take Medicaid/self-pay (%)	3 (60%)	0 (0%)	3 (60%)
Not accepting any new patients (%)	0 (0%)	0 (0%)	0 (0%)

***Note:** There are many reasons that callers failed to make an appointment; the reasons listed above are the most popular ones. Consequently, the reasons listed above will not necessarily add up to the total number of failed appointments.

We were able to secure most of the appointments we tried to make, and all of them were within two weeks. However, these numbers may look better, particularly for self-pay/uninsured clients, than they actually are. All but one of the five provider offices that made appointments for uninsured patients required an up-front payment of at least \$75 for the first appointment, which generally includes a basic exam and in some cases, X-rays, but not necessarily treatment for the problem about which the call was made. The one provider office that is more affordable divides the exam, X-rays, and cleaning into two appointments, and neither includes actual treatment. One provider office charges \$75 for an urgent visit, but it will treat the problem, if possible, that day. In other words, dental provider offices are more willing to take uninsured patients as long as they can pay the full charge up front. These charges can be prohibitive to low-income patients, who may choose not to make an appointment and thus really have very few options.

Three provider offices stated that they do not take Medicaid patients, or have taken all the Medicaid patients they can right now. One receptionist reported that her provider office has tried unsuccessfully to be taken off the insurer's list for three years. As with physical health calls, the dental scenario was largely irrelevant. Only one office attempted to assess the problem over the phone, asking how long

the caller had been in pain, whether she was sensitive to heat or cold, and whether she was having difficulty sleeping.

Behavioral Health Call Results

We successfully completed calls to 11 behavioral health provider offices that provide direct treatment services to clients, from counseling to in-house treatment. Some provider offices only handle mental health issues, some only substance abuse issues, and some handle co-occurring problems, so with the help of the ADAMHS Board we created three scenarios. We did not find any problems with speaking to a receptionist or with excessive hold times. Table A3 shows the number of treatment centers called, the success rate with making appointments, and the most prevalent reasons for denying an appointment.

Calls to the behavioral health treatment centers paint a different story. None of the five calls with a Medicaid scenario were able to make appointments, and three of those five were referred directly to CrisisCare, an assessment services for those with mental health and substance abuse needs. Two of the self-pay callers were able to make appointments within two weeks, while one made an appointment more than two weeks away, one was told that the provider office does not take self-pay clients, and one was referred to CrisisCare. Of the three remaining provider offices, one required information the caller could not provide (a Medicaid number) and two others sent the caller to an answering machine of a counselor or nurse.

Sending callers to be assessed through CrisisCare can be the appropriate step to take for behavioral health providers, if the caller is uninsured or if the provider office does not employ a staff member who is licensed to conduct clinical assessments. The ADAMHS Board is moving toward a policy of "no wrong door" to behavioral health treatment, but CrisisCare continues to be the primary assessment organization for now. Of the three provider offices where appointments were made, one offered counseling sessions for \$20 each while the other required an up-front payment of \$120

Table A3: Behavioral health appointment rates and reasons for failed appointments

Behavioral Health Provider Offices			
	Medicaid	Self-pay	Total
Total provider offices called	5	6	11
Appointments made (%)	0 (0%)	2 (30%)	2 (18%)
Co-pay range for self-pay	\$20 - \$120		
Total failed appointments	5	4	9
Primary reasons for refusal*			
Appointment offered > 2 weeks (%)	0 (0%)	1 (25%)	1 (11%)
Does not take Medicaid/self-pay (%)	0 (0%)	1 (25%)	1 (11%)
Not accepting any new patients (%)	0 (0%)	0 (0%)	0 (0%)
Sent to CrisisCare (%)	3 (60%)	1 (25%)	4 (44%)

***Note:** There are many reasons that callers failed to make an appointment; the reasons listed above are the most popular ones. Consequently, the reasons listed above will not necessarily add up to the total number of failed appointments.

for an assessment, \$120 for a visit with a doctor, and an uncertain amount thereafter for treatment. The receptionist of the other provider office was uncertain about self-pay prices and sent the caller to the Finance Department's answering machine. Only one provider office receptionist tried to make any assessment regarding the severity of the caller's condition.

Conclusions

In all, we successfully completed calls to 44 provider offices that are identified in some way as serving Medicaid and/or uninsured people. Even with such a targeted approach, callers were able to make appointments within two weeks with only 20 percent of the physical and behavioral health care provider offices. This is about the same as the Five Rivers assessment, though our number of office calls was fewer so the results may not be comparable. Further, while it appears that there is a good deal more access to dental care, uninsured patients usually have to be prepared to spend \$75 or more just for an initial check-up. So while the dental appointments appear to be accessible, poorer patients or those without severe symptoms may opt out of the appointment. Even though our sampling frame (the total number of possibilities) was specifically focused on provider offices that were listed as accepting new Medicaid and/or uninsured patients, our callers still found 13 providers

that were unwilling to accept new Medicaid/ uninsured patients, or any new patients at all. In a one-on-one interview, a family physician told a story relating to the frustration of those without private insurance. As a sole practitioner, his office turns away many people who have Medicaid or are uninsured each week, including a woman who said that she was working through a list she had been given and his office was 25th out of a total of 32.

Concerns about callers being put on hold for long periods of time or sent to an answering machine instead of a receptionist appear to be unfounded. We also found that

the scenario behind the call was almost inconsequential; callers were asked about their condition only twice. When callers asked the receptionist if there was somewhere else they could make an appointment, half the offices were prepared with the name and phone number of a community provider office or other office that might be able to help.

With the exception of dental care, the study, while small, leaves questions as to whether timely access to appointments and follow-up care is currently available to this population, even before the Marketplace is implemented or Medicaid is expanded.

How to Replicate the Wait Call Audit

In the case that an organization would like to conduct a similar study in the future, these are the steps to take for the physical health and dental health wait time audits*:

1. Gather the universe of provider offices that accept new Medicaid patients, according to Medicaid managed care plans' "find a doctor" websites.
2. Using www.random.org or another random number generator, choose 20 provider offices.
3. Choose 15 of those provider offices to call, with five set aside in case of wrong numbers or other issues.
4. Fill out an audit call form for each provider office, with name of office, phone number, and type of health care.
5. Revisit and refresh the scenarios, if necessary. Practice the scenario a few times; other offices not chosen could be used for practice. Choose a name and phone number. Decide how to handle social security numbers. (In this audit, callers encountered a number of offices asking for social security numbers. While Dr. Rhodes' protocol instructed the caller to end the call if asked for a social security number, we decided to use one that was real, but not one that would be in any database in Dayton.)
6. Decide whether or not the same level of data needs to be collected, such as whether the caller encounters an answering machine, the receptionist asks about the caller's condition, and so forth.
7. Find a relatively large block of time, either before or after lunchtime, and conduct as many calls as possible at once. This helps with consistency. Write answers on the forms.
8. When finished with all wait time calls, input information into a spreadsheet for easier analysis.

See Attachments 1 and 2 for the forms and scenarios that were used in this wait call audit.

* As noted earlier, all behavioral health provider offices that receive funding from the Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) Board of Montgomery County and provide direct services to clients were called. Other than the need to generate a random set of providers for physical and dental health, the same process outlined above can be used to replicate this wait time audit.

Notes

1. Asplin, Brent R., Karin V. Rhodes, Helen Levy, et. al. "Insurance status and access to urgent ambulatory care and follow-up appointments." *Journal of the American Medical Association* 294, no. 10 (1248-1254).
2. Gilbert Consulting, LLC, "Health care needs assessment report." Report to Miami Valley Hospital and Life Connection of Ohio Dayton Health Centers dba Five Rivers Health Centers. May 2012.
3. As of July 1, 2013, three insurers have been added: Buckeye Community Health Plan, Paramount Advantage, and United Health Care Community Plan of Ohio.

Attachment 1

Appointment wait time protocol

(Fill out this section before dialing)

Date: _____

Name of Office: _____

Medical Condition: _____

Insurance: _____

Phone #: _____

At beginning of call:

Dropped line/wrong number?

YES

NO

Did you reach (circle correct choice)

An automated message?

A live person?

An answering machine?

If automated message, did it allow you to choose a language?

YES

NO

Spanish

Other _____

Were you put on hold?

YES

NO

How long? (# minutes) _____

Can I get an appointment?

YES

NO

Date _____ Time _____

Why can't I be seen?

_____ Urgent care/Walk-in clinic only (no fixed appointments)

_____ Condition not treated here

_____ Does not take Medicaid/self-pay patients

_____ No new patients at all

_____ Need information I couldn't provide

_____ Social security #

_____ Specific other Medicaid information needed

_____ Other _____

If beyond 7/14 days: The ER doctor said I needed to be followed up right away, within a week/2 weeks. Can't I be seen sooner?

Date of sooner, fixed appointment: _____

Can NOT get sooner appointment: Why can't I be seen sooner? _____

Payment issues:

Will I need to pay for anything when I come in? NO YES Must bring \$ _____

I'm kind of short on cash right now, could you bill me later? YES

NO

Where else can I go?

If cash is needed: I think I better try another clinic, where else can I go?

If appointment beyond a week: The ER doctor wanted me to be seen within a week. Where else can I go?

_____ Doesn't apply/got an appointment in a week

_____ Name of office/clinic only provided

_____ Name & address or phone provided

_____ Vague info provided

_____ No advice

_____ Back to ER

_____ Told to check plan list

_____ General referral phone #

_____ Other _____

Cancel appointment before hanging up: "I'm sorry, I forgot I have to be somewhere else that day. I'll have to call you back."

Post-call questions

Did a nurse or other medical person speak to you? YES NO Don't know

Comments _____

Was any attempt made to assess the severity or importance of your condition?

YES NO Comments _____

Were you asked what the emergency department recommended? YES NO

If yes, explain: _____

Is there anything else you would like to add about this call? _____

Attachment 2

Physical Health Scenario Script – Hypertension

Appointment script:

Hello, I would like to make an appointment. I went to the ER last night for a cut on my hand. The doctor told me that my blood pressure was really high. He wanted me to follow up so I need to make an appointment.

Is it ok if I have CareSource/Molina/don't have insurance?

Is there a co-pay? How much money do I need to bring?

Medical questions:

Who is your primary doctor?

I don't really have one. I haven't been to the doctor in a long time.

Which ER did you go to?

Some hospital in Columbus. I was in Columbus yesterday.

How high was it?

I don't know exactly what the reading was, but the bottom number was 110, I think. The doctor said it was very high.

Do you have any other symptoms?

No.

Did the ER doctor start any medication?

Yes. I was started on a medication. It's some long name I can't pronounce – hydro something or other. (Hydrochlorothiazide)

What did the ER doctor say/recommend?

He just said I needed to follow up with a doctor within a week.

Insurance work-arounds:

What is your health insurance?

CareSource Molina
I don't have any insurance right now.

What is your account number?

I don't have the card on me right now/I'm not sure where it is.

Call back when you have the card information.

Can I call you back after I make the appointment? The ER doctor said I needed to be seen within a week.

Cancel appointment before hanging up: "I'm sorry, I forgot I have to be somewhere else that day. I'll have to call you back."

Other questions

What is your name?

Create one using <http://random-name-generator.info/random/>.

What is your address?

5610 N. Main Street, Apartment 2C, Dayton OH 45415
(Be sure to find zip code if you change addresses.)

What is your phone number?

(Should be one that is not able to be traced to an actual patient or identifies an office through Caller ID.)

What is your birth date?

December 28, 1985 (or other appropriate date).

Dental Health Scenario Script

Appointment script:

I'd like to make an appointment with a dentist.

My mouth is in a lot of pain. I went to the ER, but they said there's nothing more they could do and I should follow up with a dentist as soon as possible.

Is it ok if I have CareSource/Molina/don't have insurance?

Is there a co-pay? How much money do I need to bring?

Medical Questions:

Who is your primary doctor?

I don't really have one. I haven't been to the doctor in a long time.

Which ER did you go to?

Some hospital in Columbus. I was in Columbus yesterday.

Where does it hurt?

The lower left side of my mouth, below my teeth.

How much does it hurt?

It's really uncomfortable. I had a hard time sleeping last night. It can't stay like this.

Insurance work-arounds:

What is your health insurance?

CareSource

Molina

I don't have any insurance right now.

What is your account number?

I don't have the card on me right now/I'm not sure where it is.

Call back when you have the card information.

Can I call you back after I make the appointment? The ER doctor said I needed to be seen within a week.

Cancel appointment before hanging up: "I'm sorry, I forgot I have to be somewhere else that day. I'll have to call you back."

Other questions

What is your name?

Create one using <http://random-name-generator.info/random/>.

What is your address?

5610 N. Main Street, Apartment 2C, Dayton OH 45415
(Be sure to find zip code if you change addresses.)

What is your phone number?

(Should be one that is not able to be traced to an actual patient or identifies an office through Caller ID.)

What is your birth date?

December 28, 1985 (or other appropriate date).

Behavioral Health Scenario Script – Depression

Appointment script:

I'd like to make an appointment with someone who can help me. I was in the ER last night. I went there because I've been feeling really sad and can't sleep at night. The ER doctor wanted me to follow up with someone as soon as I could.

Medical Questions:

Who is your primary doctor? I don't really have one. I haven't been to the doctor in a long time.

Which ER did you go to? Some hospital in Columbus. I was in Columbus yesterday.

How long have you been feeling that way?

About 3 months. I finally went to the ER because I can't sleep, so I've skipped work a few times and my boyfriend is getting worried. He insisted that I go.

Did the ER doctor prescribe any medication?/Are you taking any medication? No

Have you ever had problems with depression before? No

Have you had thoughts about hurting yourself or others?

No, I just don't have any energy, I feel sad all the time, but I can't sleep.

Insurance work-arounds:

Have you called CrisisCare?

I did, but they weren't very helpful so I thought I'd call you directly.

What is your account number (if Medicaid)?

I don't have the card on me right now/I'm not sure where it is.

Call back when you have the card information.

Can I call you back after I make the appointment? The ER doctor said I needed to be seen within two weeks.

Other questions

What is your name? (choose a name, or create one using <http://random-name-generator.info/random/>)

What is your address? 5610 N. Main Street, Apartment C, Dayton, 45415

What is your phone number?

(Should be one that is not able to be traced to an actual patient or identifies an office through Caller ID.)

What is your birth date? November 2, 1956 (or other appropriate date)

What is your Social Security number?

(Have to decide whether to use someone's number, make one up, or hang up if asked.)

Behavioral Health Scenario Script – Co-occurring MH-AOD

Appointment script:

I was in the ER last night. I went there because I've been feeling really sad and can't sleep at night. So I've been drinking and taking some other drugs to help me sleep. The ER doctor wanted me to follow up with someone as soon as I could.

Medical Questions:

What substances have you been taking? Alcohol and sometimes Vicodin

Who is your primary doctor? I don't really have one. I haven't been to the doctor in a long time.

Which ER did you go to? Some hospital in Columbus. I was in Columbus yesterday.

How long have you been feeling that way?

About three months. I finally went to the ER because sometimes I drink too much and can't get up and go to work the next day. My boyfriend is getting worried. He insisted that I go.

Did the ER doctor prescribe any medication?/Are you taking any medication? No

Have you ever had problems with depression before? No

Have you ever a substance abuse problem before? No

Have you had thoughts about hurting yourself or others?

No, I just don't have any energy, I feel sad all the time, but I can't sleep. Drinking makes me feel better and so do the pills.

Insurance work-arounds:

Have you called Crisis Care?

I did, but they weren't very helpful so I thought I'd call you directly.

What is your account number?

I don't have the card on me right now/I'm not sure where it is.

Call back when you have the card information.

Can I call you back after I make the appointment? The ER doctor said I needed to be seen within two weeks.

Other questions

What is your name? (choose a name, or create one using <http://random-name-generator.info/random/>)

What is your address? 5610 N. Main Street, Apartment C, Dayton, 45415

What is your phone number?

(Should be one that is not able to be traced to an actual patient or identifies an office through Caller ID.)

What is your birth date? November 2, 1956

What is your Social Security number?

(Have to decide whether to use someone's number, make one up, or hang up if asked.)

Behavioral Health Scenario Script – AOD Abuse

Appointment script:

I was in the ER last night. I went there because I think I've been drinking too much. Well, and taking some other drugs sometimes, too. The ER doctor wanted me to follow up with someone as soon as I could.

Medical Questions:

What substances have you been taking? Alcohol and mostly Vicodin, but sometimes Xanax, too.

Who is your primary doctor? I don't really have one. I haven't been to the doctor in a long time.

Which ER did you go to? Some hospital in Columbus. I was in Columbus yesterday.

How long have you been using?
I've drank alcohol as long as I can remember. It didn't bother me until about six months ago when I started drinking so much that I can't get up and go to work the next day. I was so nervous about losing my job, I started taking pills to calm my nerves. My boyfriend is getting worried. He insisted that I go.

Did the ER doctor prescribe any medication?/Are you taking any medication? No

Have you ever a substance abuse problem before? No

Do you drink first thing in the morning when you wake up? Sometimes

Have you had thoughts about hurting yourself or others?
No, drinking just makes me feel better and so do the pills.

Insurance work-arounds:

Have you called CrisisCare?
I did, but they weren't very helpful so I thought I'd call you directly.

What is your account number?
I don't have the card on me right now/I'm not sure where it is.

Call back when you have the card information.
Can I call you back after I make the appointment? The ER doctor said I needed to be seen within two weeks.

Other questions

What is your name? (choose a name, or create one using <http://random-name-generator.info/random/>)

What is your address? 5610 N. Main Street, Apartment C, Dayton, 45415

What is your phone number?
(Should be one that is not able to be traced to an actual patient or identifies an office through Caller ID.)

What is your birth date? November 2, 1956

What is your Social Security number?
(Have to decide whether to use someone's number, make one up, or hang up if asked.)

An Environmental Scan of the Montgomery County Safety Net for the Montgomery County Affordable Care Act Task Force

Key Informant Report

Prepared by Health Policy Institute of Ohio (HPIO): Rachel Holbert, Usable Research, and Mary Wachtel, HPIO
September 2013

Research Objective: Analyze current Montgomery County health care delivery system for vulnerable populations, including extent of integration of physical/behavioral/oral health care, timeliness, availability, and impact of payer mix.

In order to gain the perspective of community and healthcare leaders about these and other issues, we interviewed 18 people through August and mid-September, 2013. We spoke with businesspeople, lawmakers, and leaders in healthcare, insurance, community organizations, post-secondary education institutions, and other organizations. Some are members of the Montgomery County ACA Task Force, while others are not.

Methodology

Along with generating its own list, HPIO accepted suggestions for key informants from members of the Task Force and from other interviewees. After a list of 22 people was constructed, HPIO received an invitation to conduct a group interview of behavioral health leaders during a regular meeting time at the ADAMHS Board, which was accepted. That group interview added six more people to the total. Care has been taken to ensure that this report does not over-emphasize behavioral health given the number of people in that field who were interviewed. Some of that interview material is also used for the focus group report when applicable. The rest of the interviews were completed over the phone and lasted between 20 and 30 minutes.

Interview Results

Positive attributes and challenges

The creation of Montgomery County Care and the Community Health Centers of Greater Dayton as outcomes of the Safety Net Task Force were lauded. Several key informants also mentioned the development of the Five Rivers Health Centers, along with the Community Health Centers of Greater Dayton, as recent positive changes for Montgomery County. A few also mentioned how the Human Services

Levy dollars go toward the care of poor and vulnerable populations.

Several of Montgomery County's access challenges could be summed up with one phrase: "not enough." Many key informants mentioned that there are not enough primary health care providers or specialists, not enough clinics to handle all of the Medicaid and uninsured patients who need help, and/or not enough resources in general to support the organizations that are trying to help these populations. One key informant commented, "Information is getting out to people about the clinics, and whoever falls through the cracks goes to Reach Out. But they are maxed out already and need to expand." Another said, "People who are uninsured and unemployed, like young men and women without children, but who are not homeless are falling through the cracks." Echoing that comment, another said, "Some people have figured out the system, they know where to go. But there are so many who don't. We don't have enough availability of doctors or clinics. It's a growing problem."

The lack of specialists is seen as another issue: "Sometimes finding specialty coverage for Medicaid and other patients, especially in certain areas, is difficult," said one key informant. The least available specialties, according to that interviewee, are pain management, neurology, mental health, and endocrinology. "It's difficult to recruit people," he said. "There's just not enough of them out there." A key informant affiliated with the dental profession noted that there is a lack of both dental facilities and practitioners. The need for psychiatrists and other mental health specialists was echoed during our provider interviews (see Focus Group Report). A behavioral health leader also pointed out that hospital beds for those with a mental illness or substance abuse problem decreased in 2008 with the closing of Twin Valley State Mental Hospital.

A final concern shared among many key informants is the lack of “health literacy” by the ACA’s target population. One part of this problem is that “they don’t understand that their behaviors are contributing to their illnesses,” as one key informant said. Consequently, “a small number of people account for the greatest costs. They tend to be the least educated about healthcare, and the most needy,” said another. On the other hand, the poor and uninsured have developed usage habits that need to be redeveloped. “The vulnerable populations know how to work the current system – they just go to the emergency department. We need to get them to start using primary care effectively. Without incentives to change, they’ll wait until they get sick, and at that point there’s not a lot of healthcare management that can occur,” said another. A community leader summed up: “I do know that when people have better education, when they understand their own bodies and know how to connect with service providers and services, they get better outcomes.”

Health Insurance Marketplace and Medicaid Expansion

As a group, key informants made the following predictions about the upcoming implementation of the Marketplace, and Medicaid expansion, if it occurs:

- More people will have healthcare insurance of some kind, although there will always be some people who are uninsured.
- The capacity of all types of providers will be even more of a challenge, as more patients compete for the current number of appointment times.
- Employers will not make any changes in 2014 and possibly even 2015, but after that some may drop their insurance, or drop it for spouses, forcing more people into the Marketplace.

Some people predict a “chaotic” or “confusing” beginning of the Marketplace program, particularly for members of the public who are trying to become insured, as well as for healthcare providers. One person pointed out that with a large proportion of uninsured Ohioans making less than 400% of the federal poverty level and therefore eligible for subsidies, there will be a lot of interest in the Marketplace. “Not knowing how it’s going to play out is kind of daunting,” said one key

informant. Another agreed, saying that there is still a lot of “apprehension” about what the reimbursement will be from some of the Marketplace products.

A few key informants suggested that a change in the payer mix for healthcare providers has already begun to occur, as people have heard more about the Medicaid expansion recently and realized that they may be eligible now. Specialists may notice that change in the payer mix only somewhat, since, as one key informant noted, the increase in Medicaid rates only applies to primary care providers.

Key informants had a variety of concerns about Medicaid expansion, both if it becomes enacted and if it does not. Several expressed doubt that there is enough primary or specialist provider capacity to meet the demand they would see as a result of Medicaid expansion. In particular, while primary care providers are reimbursed at the higher Medicare level (at least through 2014), specialists are not. “That has been an access issue for our current Medicaid population and it only stands to get worse,” said one key informant. An insurer predicted that clinics attached to retail establishments, such as the Minute Clinic, and online/telephone helplines would become more popular to help fill the need for provider capacity. Other key informants are more concerned that Medicaid expansion will not occur, leading to a gap in insurance coverage for those who cannot afford the Marketplace and are not covered otherwise.

Most people expressed a degree of uncertainty about the next stage of healthcare reform. “We’re all interested in what the real impact of the exchanges will be,” one key informant said. “Is the subsidy enough to support people at the lower income levels to allow them to buy into the exchange?” Administrators are also working with a great deal of uncertainty. One behavioral healthcare administrator said, “I don’t know what the reimbursement rates will be. They might allow some people who haven’t been in our system to enter the system, but we might not be able to help them because our unit costs are so high. If our unit costs are \$100 per hour and they reimburse at \$40 per hour, then we can’t accept those people into care.” Another healthcare administrator noted, “It’s kind of a shell game trying to figure out who’s going to land where

and what services will be most needed for them." Nonetheless, two people who work in healthcare and insurance agreed that their sectors are preparing as best they can.

Some employers and healthcare administrators are concerned that over the long run, employers may drop insurance coverage and pay the penalty. "Then the employees will elect to not get insurance or choose a plan with low premium costs but a high deductible, so they won't have the money to pay for their health care when they need it," said one key informant.

A final concern that some key informants expressed was the high expectations that previously uninsured patients may have regarding access to healthcare once they get insurance through the Marketplace. One businessperson made the point that access is far from perfect for people with private health insurance in terms of days between making the appointment and the appointment date and access to specialists. Given that the current system may be working beyond its capacity in the short run once the Marketplace is implemented, wait times could increase and provider appointments could be even more difficult to schedule. Several key informants mentioned the need for patient education not only in terms of expectations, but on understanding how the healthcare system works and managing their own healthcare.

Three key informants suggested that one way to bolster the supply of healthcare providers is to expand the use of mid-level practitioners such as physician assistants and nurse practitioners (though the dental health key informant said that there are enough, if not too many, dental hygienists and assistants). A few others suggested that more medical questions will be resolved via cell phone or computer in the future rather than a visit to the doctor.

Collaboration among Interested Organizations

When asked about the degree of cooperation among the healthcare, insurance, business, government and social service communities on strengthening the safety net, few key informants reported strong or ongoing efforts. "Up until the Task Force, there hasn't been much collaboration," said one key informant. "We haven't really talked to each other." Others mentioned that the process is just

beginning and did not mention any previous efforts. A behavioral health administrator noted that the local criminal justice system has done a good job of partnering with the mental health community. "Many of us have relationships or contracts that integrate with the criminal justice system," she said.

Some key informants had ideas for people and organizations that should be invited to collaborate:

- Healthcare providers — doctors, nurses, social workers, case managers
- A large, locally-owned employer
- "Regular citizens" — those with private insurance, Medicaid or are uninsured.

Electronic Medical Records, Patient-Centered Medical Homes, and Integration of Health Care

As noted in the focus groups report, the use of electronic medical records has increased considerably over the past several years, and patients have noticed increased integration of their healthcare as a result. One healthcare administrator commented, "It's definitely a way to enhance communication between providers. The safety-net population has received the most fragmented care in the past. Now we are able to facilitate communication between providers even when they don't know that their patients are seeing other providers. Previously, people might bounce around from health center to specialist to hospital Emergency Department. Not only do providers have access and have the notes, but they are able to talk back and forth to each other. Even the most sophisticated patients are not able to translate medical information for their doctors. So having the information available across the spectrum of care helps everyone."

Because healthcare integration is largely dependent on the use of electronic medical records, and because all healthcare providers do not use the same system, healthcare becomes less integrated between primary and dental care, and especially between primary and behavioral health care. If the primary healthcare system is linked to a dental healthcare system, then the patient experiences more integration — the dentist will know the patient's medical conditions, prescriptions, and so forth. Usually, however, this is still not the case. "A lot of it has to do with the electronic records systems that

hospitals and other large clinics use,” said one key informant. “They are not user-friendly for the dental community, and we haven’t found a tool to help us bridge that yet.”

Several key informants agreed that primary care and mental health care integration is even worse than primary care and dental care integration, and is complicated further by privacy concerns among professionals for mental health records. One reported that mental health providers are reluctant to keep electronic health records because of concerns that they will not be able to meet the legal requirements attached to privacy. Currently only a small percentage of mental health professionals are integrated into the major electronic health records systems and a key informant noted that a few have withdrawn from those systems. The behavioral healthcare administrators agreed that integration between primary and behavioral healthcare is “stalled,” but privacy concerns did not arise.

Instead, it was described as a resource issue.

Lack of resources was also brought up in discussions of patient-centered medical homes. Those key informants who had an opinion about this concept pointed out that while it is a good idea and can lead to efficiencies for both the patients and practitioners, it takes resources to develop up-front with uncertain savings in the longer run. One key informant stated, “We are moving toward population management rather than occurrence-based care. But we need reimbursement for population management.” A few key informants spoke of the need for incentives to develop patient-centered medical homes, or at least the ability to retain any savings from them in the future. Finally, another key informant mentioned that he does not believe there is a lot of buy-in from physicians yet.

Conclusions

Even when key informants work in the same field, they sometimes have such different perspectives that it can be difficult to reconcile them for each question asked. Nonetheless, some themes emerged:

- Despite the creation of the Community Health Centers of Greater Dayton and Five Rivers Health Center, key informants remain concerned about access to primary medical, dental and mental health care for poor and vulnerable populations.
- Many recognize the need for long-term education to train people about the appropriate use of primary care and emergency departments.
- Several key informants predict a chaotic start to the Marketplace and Medicaid expansion, if that occurs. In the longer run, they are concerned that access for the poor could become worse before it becomes better, as more patients vie for limited appointment slots.
- Most key informants do not think that the level of collaboration among groups and organizations with shared interests surrounding health care access was very high.
- Those who know about electronic medical records think that their use has been progressing over the past ten years, to the benefit of all patients. The concept and implementation of patient-centered medical homes seems a more contentious issue.
- Some key informants acknowledge the positive effects that various forms of telemedicine could have for this population in the near future. Employers are in favor of it and consumers appreciate the convenience.

Appendix E.

An Environmental Scan of the Montgomery County Safety Net for the Montgomery County Affordable Care Act Task Force

Workforce Analysis Report

Prepared by Health Policy Institute of Ohio (HPIO): Ann Peton, Director, National Center for the Analysis of HealthCare Data and Mary Wachtel, HPIO

September 2013

Research Objective

Conduct Montgomery County health care workforce capacity analysis to identify potential access strengths and gaps.

Background

The National Center for the Analysis of Healthcare data has been collecting state licensure data on physicians and 18 other non-physician providers over the last six years for use in analysis and research such as this analysis conducted for Montgomery County. Based on feedback from the Task Force Core Leadership team, we targeted 17 health professions across primary care, dental and behavioral health for this analysis.

Primary Care: Advanced Nurse Practitioners, Certified Nurse Midwives, Physician Assistants, Physicians (Allopathic and Osteopathic; including the following specialties: general practice, family medicine, obstetrics/gynecology, internal medicine, general surgery, and pediatrics)

Dental: Dental Hygienists, Dentists, Extended Functions Dental Auxiliaries (EFDAs)

Behavioral Health: Chemical Dependency Prevention Specialists, Licensed Professional Clinical Counselors, Licensed Professional Counselors, Psychiatrists, Psychologists, Social Work Assistants, Licensed Independent Social Workers, Licensed Social Workers

Other: Pharmacists, Podiatrists

Methodology

Annually, NCAHD works with state licensure boards to collect data for all providers. A

thorough data normalization process is then conducted which includes validating the address to the provider's practice location. Only those licensees that are validated as in-state and actively practicing are included in the analysis; those involved in research and administration are excluded. All out-of-state licensees are separated into a file for future reference. Those licensees that are licensed in multiple states are assigned to the state in which their license is sent assuming that this is their main practice site. Because providers frequently change the number of hours they work during the course of a year, each provider is counted as one full-time equivalent (FTE).

The final step for mapping purposes, is to run the data through geographic information systems (GIS) software (NCAHD uses ESRI) to conduct spatial analysis using the most up-to-date georeferencing file. (For this analysis, June 2013 files were used.)

Key themes of this analysis include:

- While workforce shortages exist, maldistribution of providers may be a more significant problem than overall shortages.
- The distribution of the healthcare workforce in Montgomery County follows the same general pattern across physical, dental, and behavioral health sectors, leaving areas of the county consistently underserved.
- The Montgomery County health care workforce is aging; a factor that must be taken into account when planning for how to meet anticipated increased demand.
- Efforts to address primary care workforce shortages must extend beyond the primary care workforce to the specialty physicians and allied healthcare workforce that are vital members of team-based care.

Findings

Understanding the existing healthcare workforce is vital in targeting healthcare education planning, healthcare delivery systems maintenance/expansion and policy development. Not only does accurate and current information aid in this regard, but making this information accessible to all partners will broaden the understanding of the significance of their decisions.

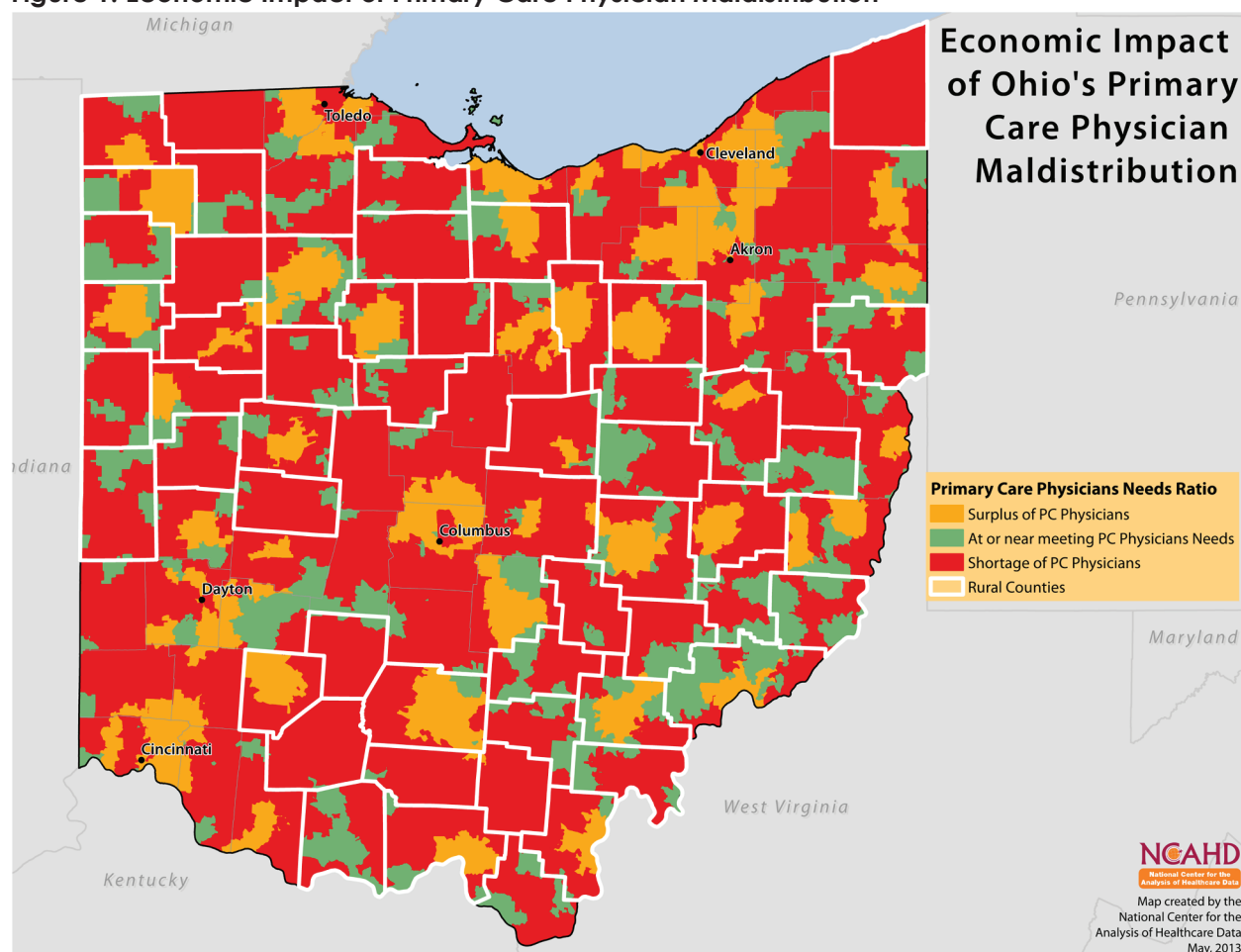
Much has been written about the potential impact of primary care workforce but in not fully embracing that the provision of healthcare involves so many other providers (e.g. physician specialists, mental health, allied health providers, etc.) the ability to recruit and retain the needed healthcare workforce in targeted areas can be challenging. Based upon NCAHD's state licensure data, the allied healthcare workforce represents nearly 60% of the total healthcare workforce.

In a recently published article on what factors influence choices where medical residents end up practicing, their level of debt had less influence than quality of life and the existence of other types of healthcare providers/ services to support.¹ When considering team-based care, it will be important to consider these relevant influences when looking at the expansion of primary care capacity. Primary care physicians are dependent upon specialists for the delivery of care and consultation and, often more importantly, the non-physician providers, mental health professionals and human services professionals needed to care for their patients.

Primary care providers

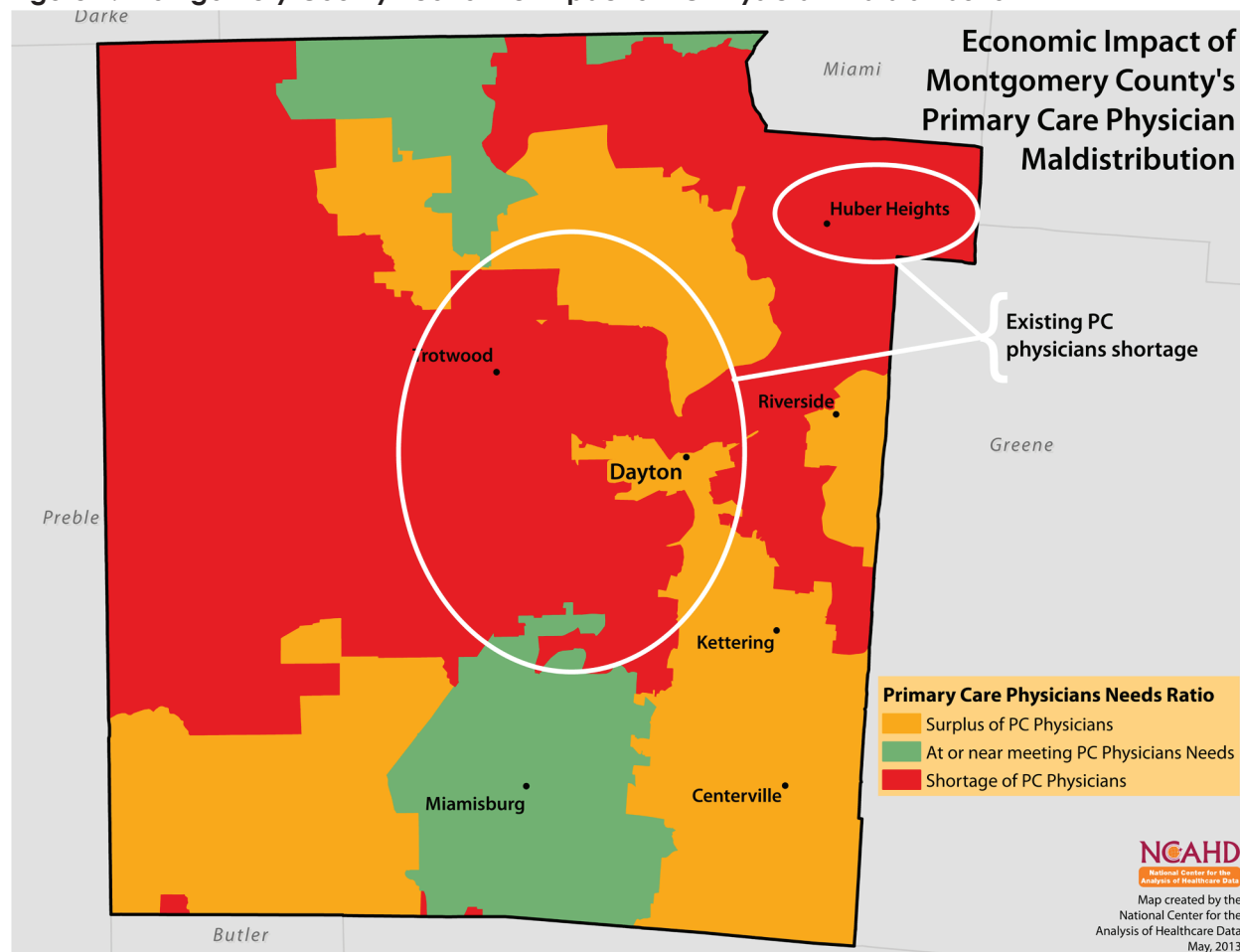
Understanding the current maldistribution of the primary care workforce in and around Montgomery County starts with looking statewide to determine other areas that state level resources may be targeting. Taking this

Figure 1. Economic Impact of Primary Care Physician Maldistribution



Data sources: NCAHD's enhanced State Licensure Data (2012); The Robert Graham Center (2012); National Center for Rural Health Works.

Figure 2. Montgomery County Economic Impact of PC Physician Maldistribution



comprehensive perspective helps gauge how responsive the state will be to requests for additional funding or shortage designation status.

Using an average annual per person physician usage rate developed by The Robert Graham Center,² NCAHD has calculated that the state of Ohio's primary care workforce maldistribution costs the state \$2.6 billion annually and over 67,000 jobs.³ In addition, Ohio needs an additional 2,925 primary care physicians to meet the need in current widespread shortage areas, as shown in Figure 1.

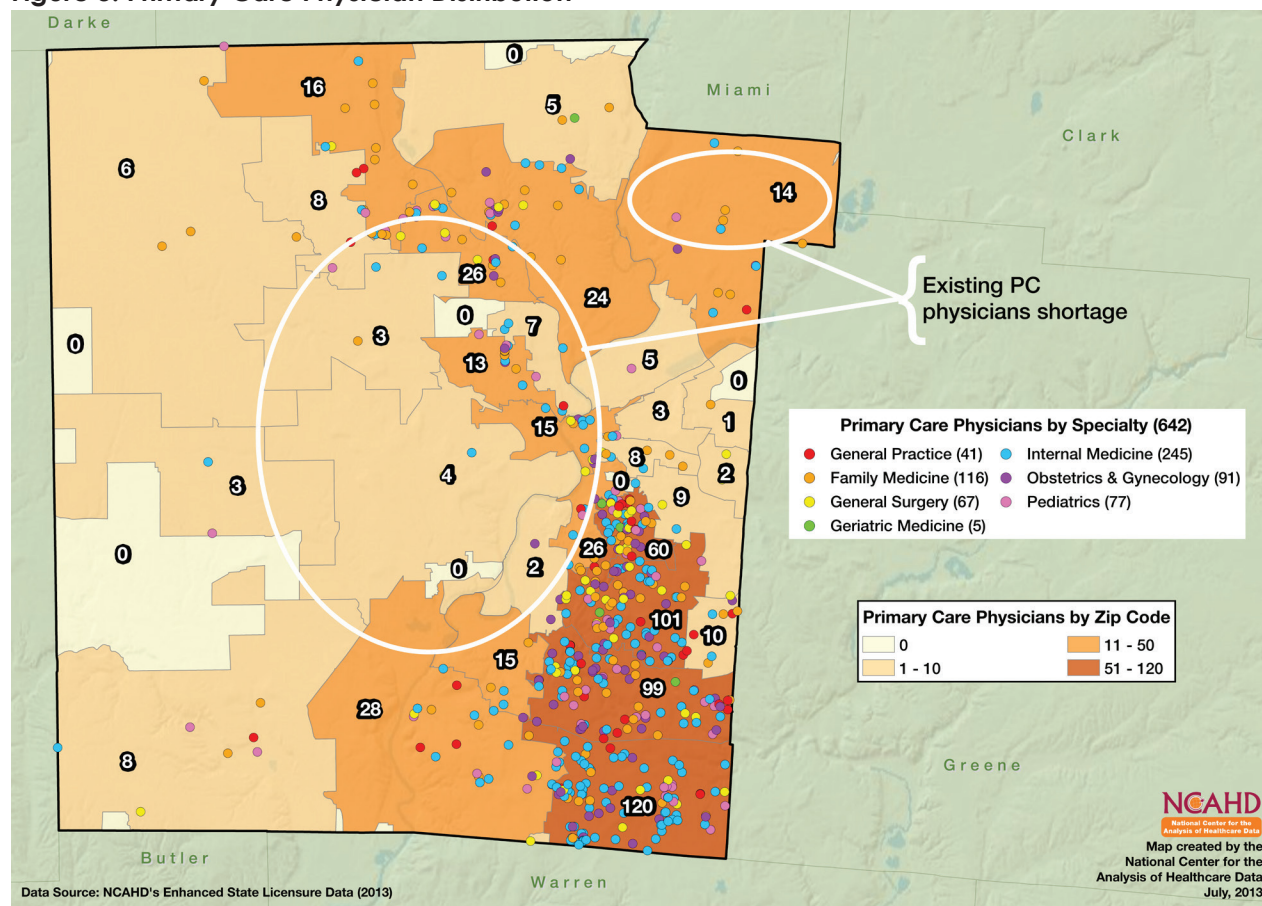
Although the state map indicates areas within and around Montgomery County are in surplus or meeting their primary care physician needs, there still exists a shortage within the county at

a cost of \$164 million in revenue and 4,209 in jobs,⁴ as shown in Figure 2.

The shortage areas (shown in red), indicate a need for 183 additional primary care physicians in Montgomery County.⁵ Some of these communities have had longstanding workforce distribution challenges, which may complicate the process for establishing or expanding healthcare delivery services.

A closer look at the distribution of primary care physicians within Montgomery County reveals that the highest density is located within the southeast portion of Dayton and of the county, leaving shortage areas in the northeast portion of the county as well as in much of Dayton and neighborhoods to the west of the city. (see Figure 3).

Figure 3. Primary Care Physician Distribution



This same pattern is consistent with the distribution of mid-level physician extenders within Montgomery County, namely, nurse practitioners and physician assistants, as shown in Figure 4.

In addition to the current maldistribution of primary care providers within the county, the aging of this workforce must be taken into account. The table to the right shows the average age of primary care providers and dentists, compared to both national and state averages.

The average age of these primary care providers is generally lower in Montgomery County compared to Ohio and the U.S. However, whether or not the aging healthcare workforce will remain in the healthcare delivery system if Medicaid expansion occurs is of concern. Understanding the proximity of aging healthcare workforce to areas where there are high concentrations of potentially eligible populations can be helpful for

Healthcare workforce average ages

Provider (Group)	National*	Ohio**	Mont. County
Primary Care Physicians	52	43	45
Nurse Practitioners	56	47	48
Physician Assistants	51	45	43
Dentists	62	58	48

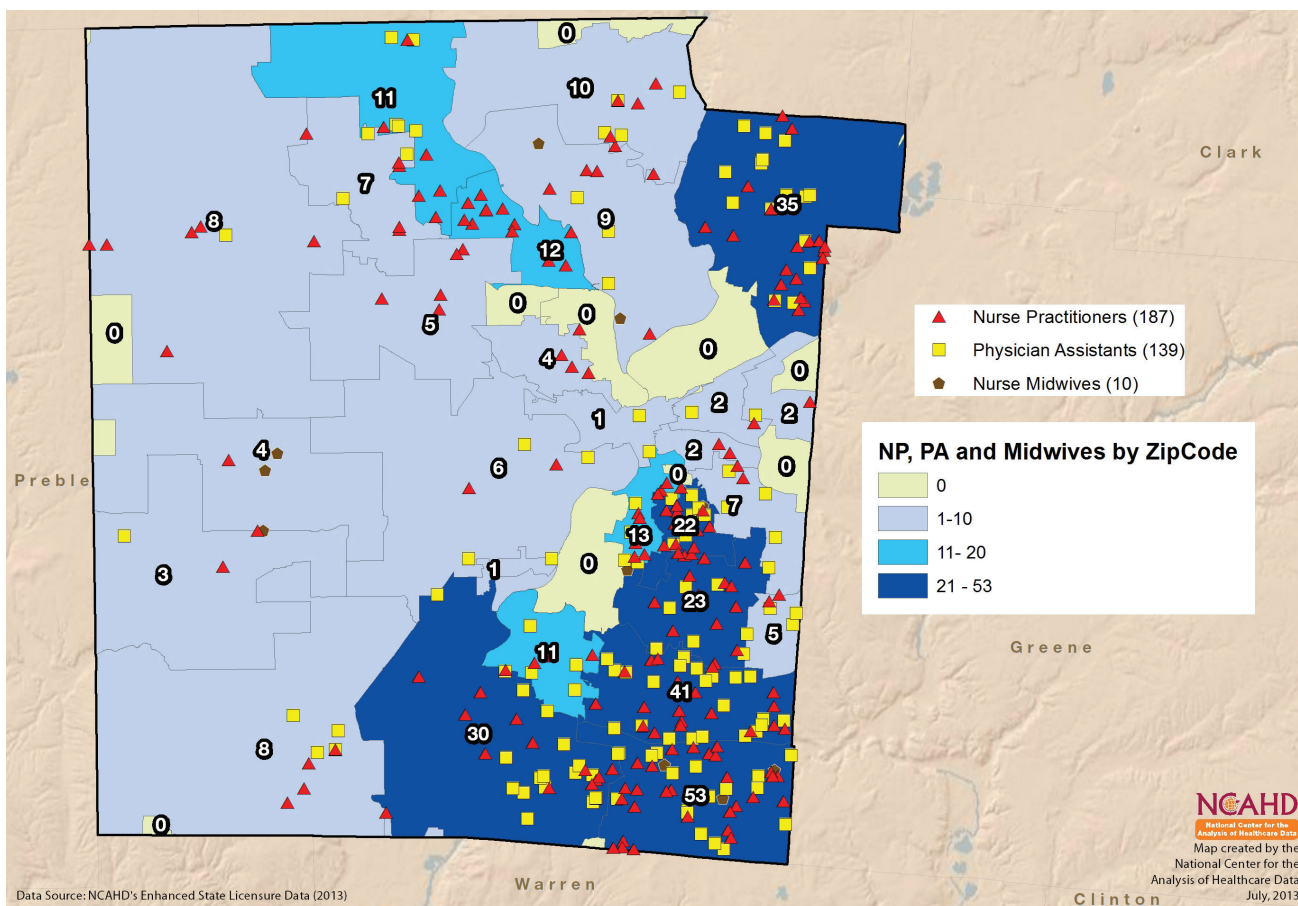
* 2012 NCAHD's State Licensure

** 2013 NCAHD's state Licensure

targeting recruitment by provider training programs.

Provision of healthcare services in the non-urban areas where there are not only shortages of providers but higher percentages of potentially eligible Medicaid enrollees should be addressed in both short and long term strategic planning.

Figure 4. Nurse practioners, nurse midwives and physician assistants in Montgomery County, Ohio (2013)



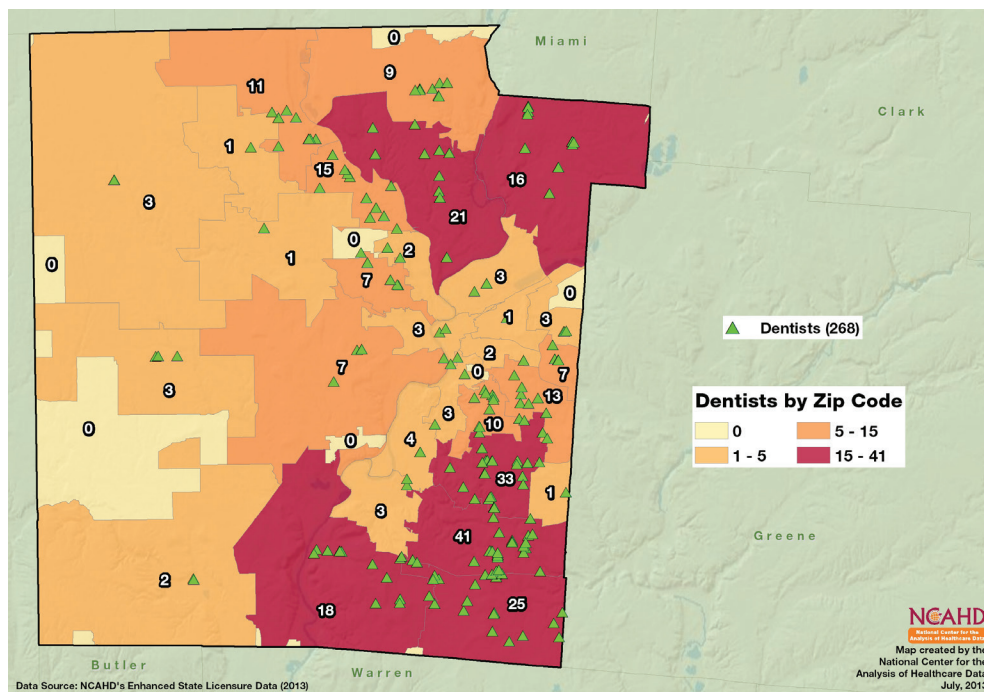
Dental workforce

As noted earlier, dental provider shortages are evident for low-income populations in Montgomery County, particularly for those living within low-income Dayton neighborhoods; two of which, East Central Dayton and West Dayton, represent the county's designated Dental Health Professional Shortage Areas.

This is not surprising given the distribution of Montgomery County dentists as shown in Figure 5. (The distribution of additional dental workforce, including dental hygienists and enhanced function dental auxiliaries, follows the same general pattern. See Attachments.)

Like the primary care workforce, the dental

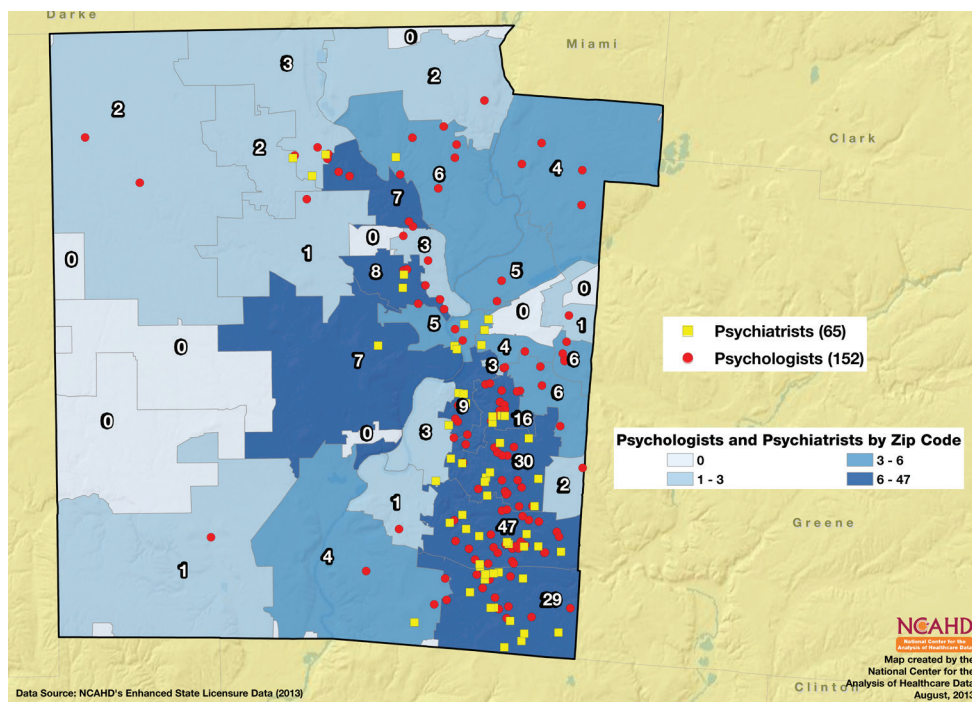
Figure 5. Dentists in Montgomery County, Ohio (2013)



workforce is aging. As noted earlier, the average age of dentists in Montgomery County is less than that of the country; however, as a whole, dentists represent the highest average age among healthcare professionals.⁶

In addition to the maldistribution of dentists, a particular challenge is the limited number of dentists who accept new Medicaid patients, as confirmed in the focus group research, wait-time study audit, and evidence of a lack of dental claims by those enrolled in Medicaid, all noted elsewhere. And, while that same research indicates dentists are willing to serve uninsured patients, the up-front payment that is required creates a barrier for many.

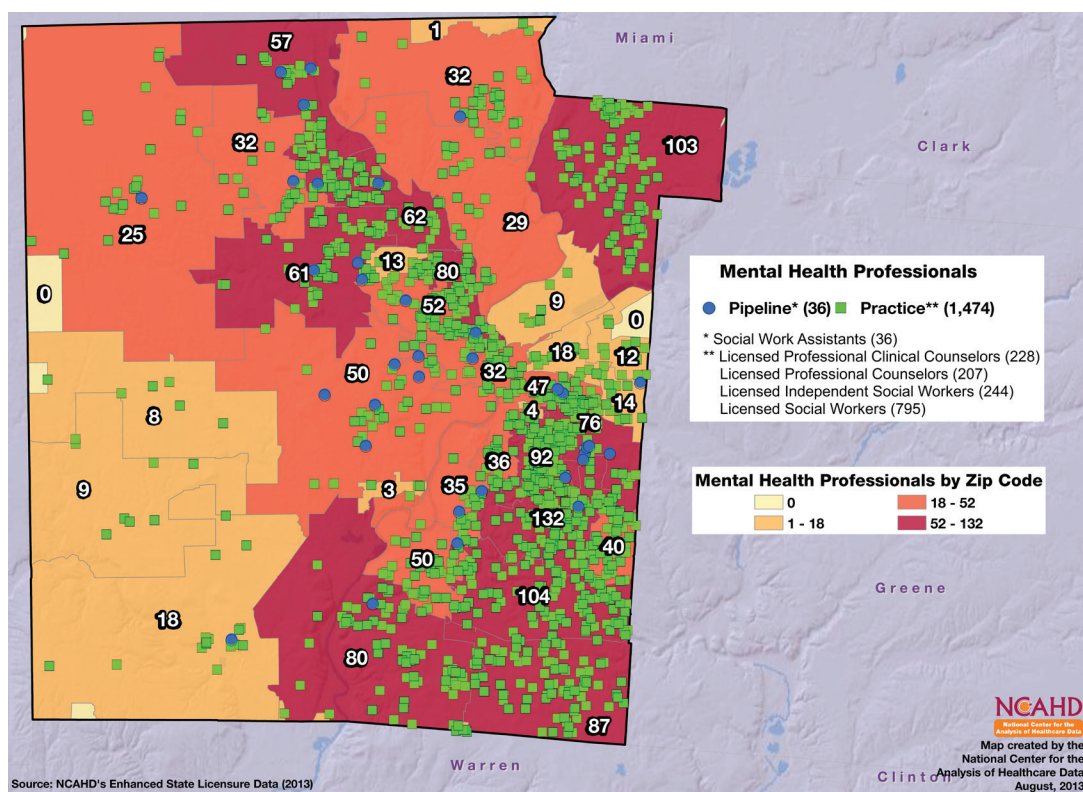
Figure 6. Psychologists and psychiatrists in Montgomery County, Ohio (2013)



Behavioral health workforce

It is generally accepted in the nation that mental health services are not as easy to access due to a pervasive shortage of providers. The importance of this speaks directly to the distribution of the multiple providers of mental health services and the ability for their services to be coordinated with primary care and other relevant specialty care providers. As team-based primary care training continues to be embraced in Montgomery County,

Figure 7. Mental health professionals in Montgomery County, Ohio (2013)



The environmental scan includes an analysis of the number and distribution of key behavioral health professionals as identified by the ADAMHS Board of Montgomery County. Understanding the number and distribution of behavioral health professionals is important as stakeholders work to strengthen the integration of mental health and addiction services with primary care.

Chemical Dependency Prevention Specialists

- Practice (15)
- Pipeline (25)

All Chemical Dependency Prevention Specialists by Zip Code

- 0
- 0 - 1
- 1 - 2
- 2 - 7

Map created by the National Center for the Analysis of Healthcare Data, August, 2013

NCAHD
National Center for the Analysis of Healthcare Data

Map created by the National Center for the Analysis of Healthcare Data, August, 2013

Figure 7 shows mental health professionals, both counselors and social workers.

Figure 8 examines the workforce working within the chemical dependency and addiction services. Interestingly, chemical dependency counselors in the pipeline outnumber those currently practicing.

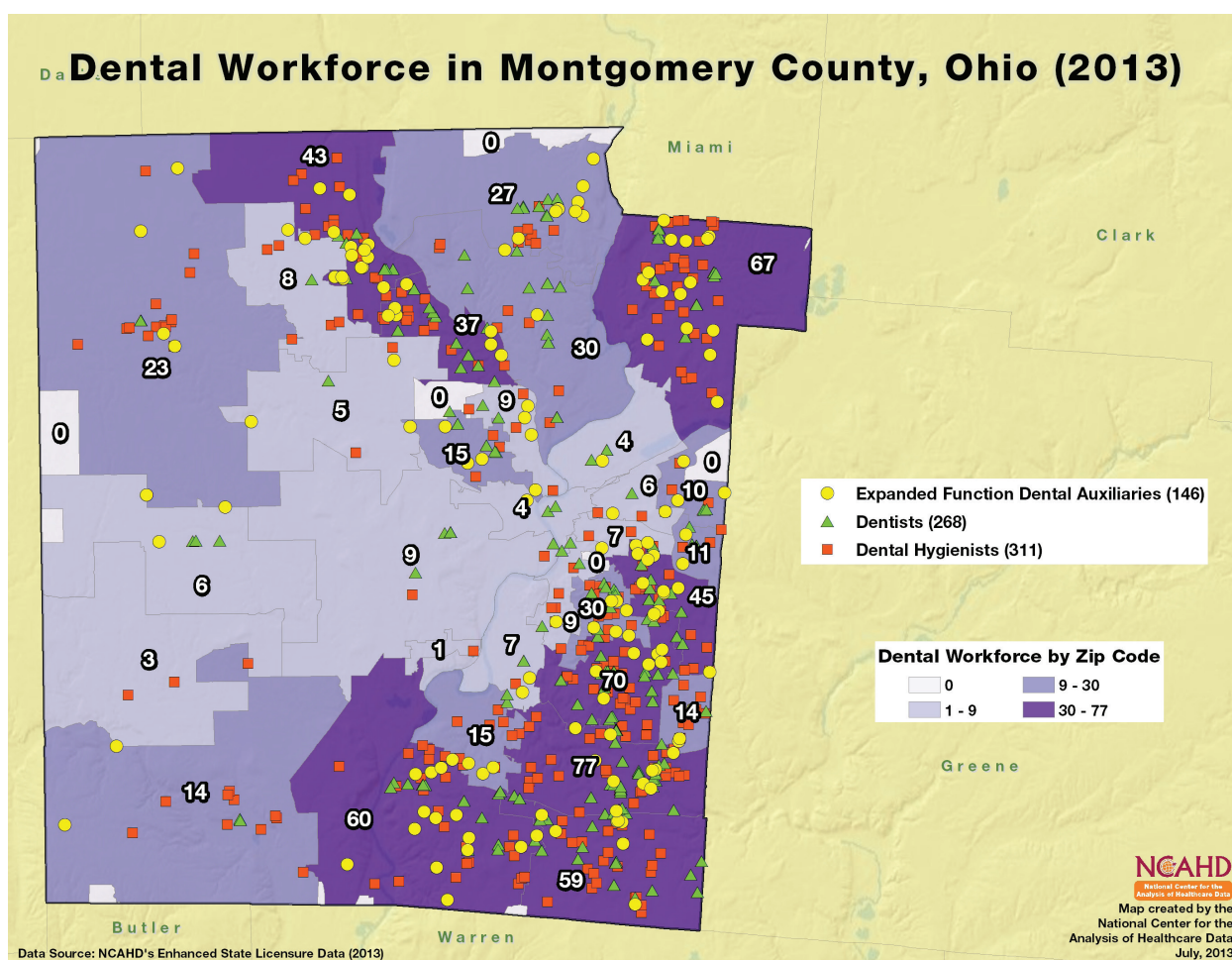
Training additional health providers has been a priority for Ohio with several programs directly benefitting Montgomery County. For example, in Montgomery County alone, there are fourteen specific residency programs primarily associated with the Boonshoft School of Medicine at Wright State University, a physician assistant program, a dental hygienist and a physical therapist training program. As team-based primary care training continues to be embraced in Montgomery County, encouraging the inclusion of behavioral health training will be key to ensuring the integration of care provides the results patients need.

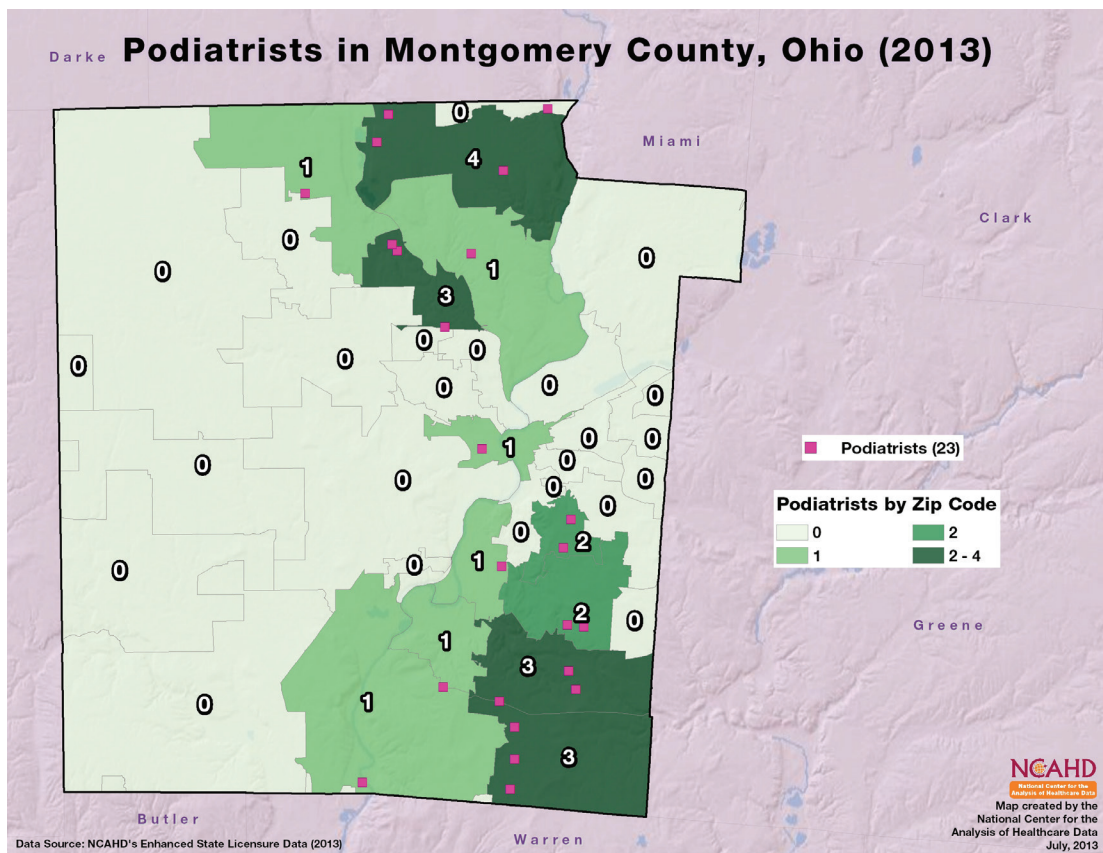
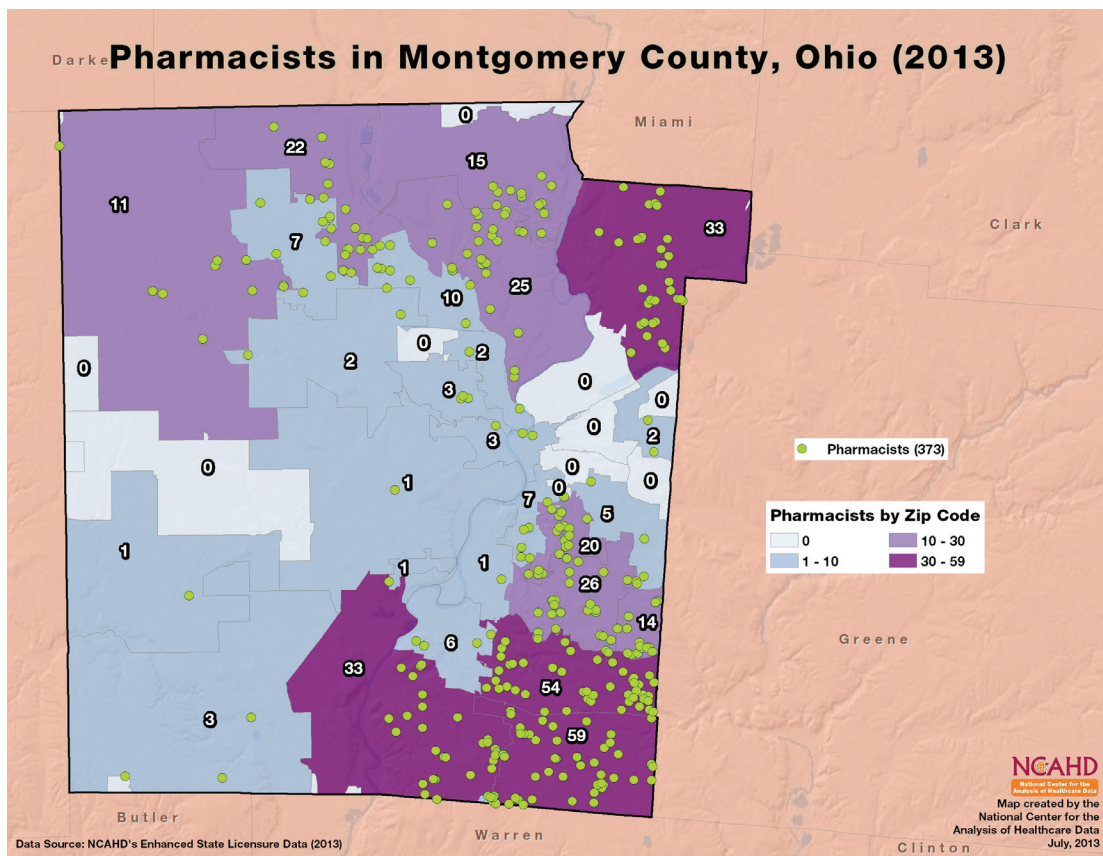
While the overall analysis clearly points to some health care workforce challenges for Montgomery County, there are several key strengths. The safety net healthcare delivery system, medical school and residency programs, and other health provider training programs provide an infrastructure that can be grown to help accommodate the additional needs of the county. Additionally, most of the safety net programs and medical school curricula embrace team-based care training modules already, so as graduates move into the delivery system, they will be prepared to work in team-based environments, possibly better than their peers who did not benefit from such training.

Notes

1. Phillips, R.L., et.al., (2009). *What Influences Medical Student & Resident Choices?* Josiah Macy Jr. Foundation monologues. Retrieved from: <http://www.graham-center.org/online/etc/medialib/graham/documents/publications/monographs-books/2009/rgcmo-specialty-geographic.Par.0001.File.tmp/Specialty-geography-compressed.pdf>
2. In 2012, The Robert Graham Center calculated the average annual per person primary care physician usage rate at 1.6 visits per year, and the number of visits a primary care physician could handle annually at 2,237. NCAHD multiplied that rate to the population in each zip code and divided by 2,237 to obtain the number of primary care physicians needed. NCAHD subtracted current supply to determine primary care physician shortage. For more information, see "Projecting US Primary Care Physician Workforce Needs (2010-2025)", www.annfammed.org/content/10/6/503.full.pdf
3. Based on economic impact information from the National Center for Rural Health, one primary care physician generates approximately \$1.5 million in revenue, \$0.9 million in payroll, and creates 23 jobs in both the physician's practice setting and the hospital. See www.ruralhealthworks.org for more information.
4. See sources and methodology cited in footnotes 2 and 3.
5. Ibid.
6. Dolan, D. A., (2005). *Access to dental care among older adults in the United States*. Journal of Dental Education, vol 69, 961-974. Retrieved from <http://www.jdentaled.org/content/69/9/961.full>

Attachments — Supplemental workforce maps





An Environmental Scan of the Montgomery County Safety Net for the Montgomery County Affordable Care Act Task Force

Data synthesis report

Prepared by Health Policy Institute of Ohio (HPIO): Eric Davies, Transformative Consulting, and Mary Wachtel, HPIO
September 2013

Research Objective: Review and synthesize existing data in order to establish a baseline understanding of Montgomery County's safety net, vulnerable populations, health status, access to care, integration of care, and possible impacts of proposed health coverage changes.

Background: In order to provide this data synthesis, HPIO researchers met with Montgomery County stakeholders and Task Force members to set priorities for the analysis, identify and gather local data, and discuss findings. In addition, researchers reviewed state and federal data and interviewed state officials as necessary.

This report includes an overview of key data indicators and their implications, an overview of the Montgomery County safety net, models of access collaboration and integration being implemented in other communities, and key Affordable Care Act resources.

Findings

Demographics

The trend in Montgomery County during the 10-year Census period (2000-2010) can be defined as a reduction in population, an aging of the overall population and more diversification of race and ethnicity. For instance:

- Median age increased from 36.4 to 39.2 years of age (7.69% increase)
- Under age 50 population decreased from 394,597 to 346,058 (12.3% decrease)
- Over age 50 population increased from 164,465 to 189,095 (15.0% growth)
- White population: 7.7% decrease
- Black/African-American population: <1% increase
- Asian population: 26.3% increase (7,341 to 9,273)
- Hispanic/Latino population: 71.6% increase (7,096 to 12,177)
- Some other race & two or more races: 50%+ growth in each

Although the largest percentage increases occurred among the Hispanic/Latino population, Asian population and those of some other race or two or more races, these also represented small overall numbers relative to the rest of the population. The county remains most heavily populated by a non-Hispanic white population and non-Hispanic Black/African-American population.

Health status

Health status, income, race/ethnicity, poverty by family and by community, and access to health care are all linked. In examining communities within Montgomery County, populations with the highest prevalence of health disparities, the greatest proportion of populations with chronic disease and racial disparities also correlates with those living in areas where healthcare workforce shortages, high poverty and the greatest share of populations needing access to primary care are present. These areas also tend to be the areas with the largest concentrations of adults who are uninsured, but would be eligible for Medicaid under an expansion to 138% of poverty.

To demonstrate linkages between health status and health coverage for low-income populations, a national study was done by several authors from various research institutions to compare the health status of populations currently covered by Medicaid with those who would be eligible for Medicaid under an expansion to 138% of federal poverty, but are currently uninsured.¹ The study, published in the June 26, 2013 edition of the *Journal of American Medical Association* (JAMA), looked at a number of health conditions related to health status, risk factors, chronic disease identification and control, and health care clinician utilization. The study's authors used the National Health and Nutrition Examination Survey (NHANES) 2007-2010, and includes low-income adults ages 19-64.

The study found the current Medicaid population, which tends to represent low-income pregnant women and children, very low-income parents and the severely disabled, overall has poorer health status than those individuals who are low-income uninsured — a group with at least somewhat higher incomes. In a comparison of health status, the study showed:

- 45.2% of Medicaid populations were obese compared with 34.4% of the low-income uninsured
- 27.4% of Medicaid recipients had hypertension compared with 19.6% of the uninsured group
- 12.7% of Medicaid enrollees had diabetes versus 6.6% of those who were uninsured

Yet the report also showed that when the uninsured did have a chronic disease, there was a better chance it had not been previously diagnosed, and even if it had been there was a better chance it was uncontrolled. For instance among those studied that did have a diagnosis of hypertension:

- 30.5% of those who were uninsured with hypertension did not know they had it compared with 17.6% of those on Medicaid
- 67.4% of the uninsured had uncontrolled hypertension compared with 40.1% of Medicaid enrollees

Similar results occurred for diabetes, hypercholesterolemia and among those with two or more co-morbidities. In terms of health access, more than one-third of the uninsured had not seen a doctor or other health professional in the past year while only 8% of Medicaid enrollees had not seen a health professional. For those with an identified health condition, 29.3% of those who were uninsured had not seen a health professional compared with only 5.6% of those covered by Medicaid. In addition, only 11.0% of Medicaid enrollees did not claim a usual place of care, but 46.1% of those who were uninsured did not have a regular source of health care.

Thus the recent study concluded the low-income uninsured population that would be eligible for Medicaid under an expansion to 138% of the federal poverty level is less

likely to have a chronic condition than those more traditional, currently enrolled Medicaid populations. However, the research also found the uninsured are more likely to have undiagnosed and/or uncontrolled chronic disease compared with the current Medicaid population. The uninsured also were less likely to have regular – or any recent – access to medical care. In considering the impact of health reform, the authors concluded the uninsured who seek more regular care once they receive coverage may have more intensive health treatment needs than those currently on Medicaid.

The JAMA report signals new challenges that may face treating a newly covered low-income population. However, it also illuminates the impact a lack of access to health care, as well as the linkages between poverty and health, can have on the health status of low-income populations. Looking at Montgomery County's low-income and underserved populations, those populations with highest proportions of chronic disease and health disparities also live in communities with less access to health care services where there is evidence of health professional shortages and larger non-white populations.

Racial and income disparities also are well documented throughout the United States, including in Ohio, and are very evident in Montgomery County. Population loss and an aging of the county's population both may have caused a greater adverse impact as the greatest outward migration has occurred by younger, and more middle and upper-middle class populations. While in a number of areas Montgomery County's health indicators are better than Ohio overall, in most areas the county's measures are worse than the state's across the board and fall short of the U.S. averages and benchmarks as well as Healthy People 2020 targets in most categories.

In a comparison of several measures, Montgomery County has worsened compared with the national statistics overall. For instance, in 2009 the proportion of adults who were obese was 3.3 percentage points higher than the nation's figure, but in 2011 the margin had grown to 4.6. The proportion of adults ever diagnosed with diabetes also increased in the

county relative to the nation from 2009 to 2011.

On a positive note, even though in 2009 and 2011 Montgomery County had a higher percentage of heart attacks, strokes and heart disease than the nation as a whole, in 2011 the county's figures for each of these indicators drew closer to the nation's figures by either decreasing, or at least increasing by a smaller percentage.

From 2009 to 2011, Montgomery County's percentage of the population vaccinated for influenza and pneumonia improved relative to the U.S. In 2009 the percentage of Montgomery County's overall population vaccinated for each condition was slightly behind the U.S., but in 2011 the BRFSS showed Montgomery County residents were vaccinated at a percentage that was actually slightly better than the U.S. for each of these preventable conditions.

Thus there are some positive trends to track. However, Montgomery County still has significant disparities, particularly when looking at factors such as income and race.

One measure of health status is death rates, including the overall death rate for all causes, which for Montgomery County is 861.7 per 100,000 versus 830.3 per 100,000 for Ohio overall.² The highest rate in the county is among the Black/African-American population at 1003.2 per 100,000, which is significantly higher than the state rate and when compared with the rate for whites in the county: 835 per 100,000.³

Among a number of select diseases, the Black/African-American population has a significantly higher rate of death compared with whites in the county related to diabetes (59.3 vs. 26.4 per 100,000 population), heart disease (256.9 vs. 210.7 per 100,000) and breast cancer (17.8 vs. 14.5) respectively.⁴

The Black/African-American population also has higher prevalence of risk factors. For instance 45.7% of the county's Black/African-

Note about changes in BRFSS Data methodology

The Behavioral Risk Factor Surveillance System (BRFSS) is a population-based health behavior survey that collects and reports data about chronic disease prevalence, lifestyle habits and behavioral risk factors. The survey is done by telephone, and provides data on local geographic areas to allow comparisons with state figures. The survey permits local counties and/or metropolitan statistical areas (MSAs) and states to examine comparisons against each other and the rest of the nation.

In 2011, the Centers for Disease Control and Prevention (CDC), which oversees the BRFSS, changed the methodology for how data is collected and analyzed by including cell phone numbers and by changing to a more advanced weighting system. Thus the comparisons between 2011 and later to 2010 and earlier years is not recommended. However, it is possible to compare data across variables using the same data collection and analysis methodology. Thus using data from a single year for a select measure, Montgomery County can be compared Ohio, to peer counties or to the nation even though exact trend comparisons cannot be made to years before 2011 due to the methodology changes.

While it is not possible to make BRFSS comparisons between current data and anything prior to 2011, it is possible to compare the status of Montgomery County relative to the state or nation on various indicators for periods before and after 2010. One way to do so is to look at Montgomery County's figure relative to the figure for Ohio or the nation consistent with the same reporting year. Thus the analysis in this report compares several county health indicators to those for the nation as a whole, and looks at whether or not between 2009 and 2011 Montgomery County's indicator improved or declined relative to the nation.

American population is obese compared with 32.3% of the county overall, 33.9% for Ohio, and 37.3% of the US population.

Compared to whites and the county, state

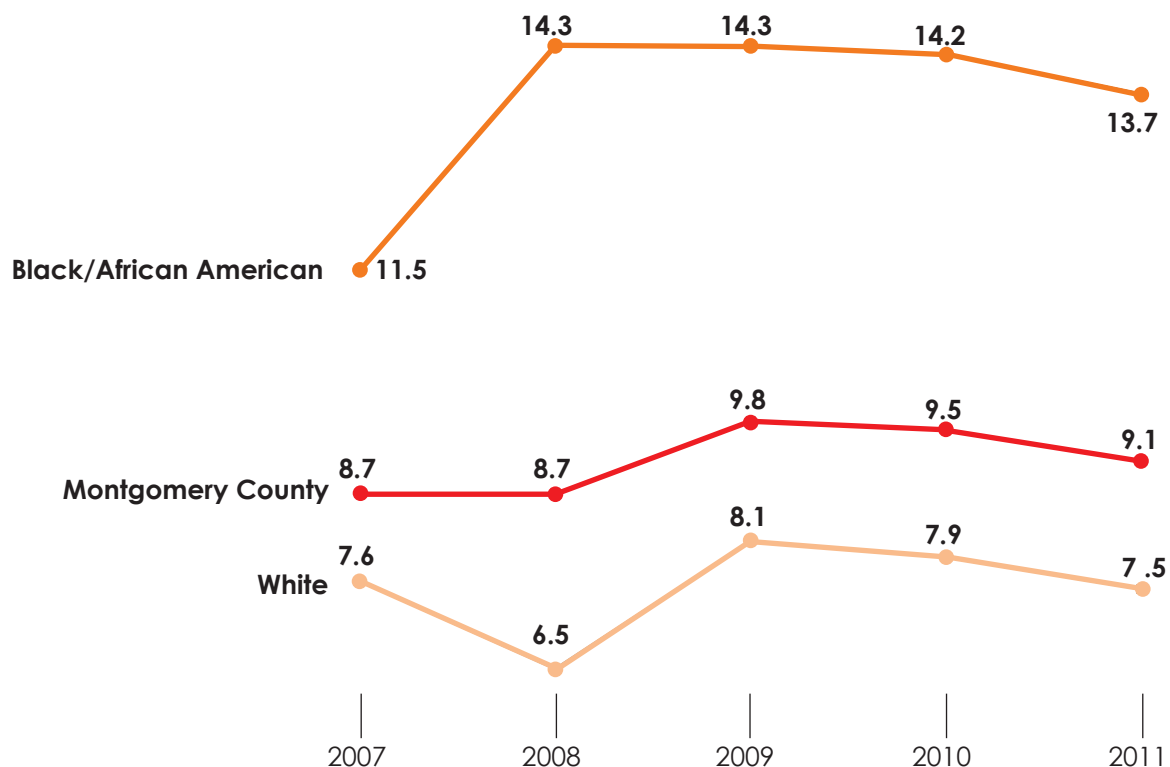
and nation overall, the Black/African-American population also has a higher rate of babies born at low birth weight and is more likely to access late or no prenatal care.

Heart disease-related mortality in Montgomery County (deaths per 100,000)



Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2010 on CDC WONDER Online Database, released 2012. Data are from Multiple Cause of Death files, 1999-2010, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

Low birth weight births in Montgomery County



Source: 2011-2012 vital statistics, Ohio Department of Health. Prepared by Public Health-Dayton & Montgomery County

In terms of mental health, the Black/African-American population reported an average of 4.8 poor days of mental health within the past 30 days compared with 3.8 days for the county's population overall. Income and poverty levels also impacted mental health; the percentage of low-income residents (incomes under \$15,000 per year) who reported a depressive episode or anxiety disorder was nearly double those figures for the county overall.

The JAMA report highlighted above points to higher utilization of health care by the lowest income individuals who are on Medicaid versus low-income uninsured. The data in Montgomery County seems consistent with these findings on two measures related to cancer prevention/early detection tests in 2012:

- Percent of women age 40+ who received mammograms: 63.7% of women with incomes between \$25,000 and \$35,000, but 74.4% of women with incomes below \$25,000 annually received timely screenings⁵
- Percent of women ages 18+ who received timely Pap tests: 51.0% of those with incomes between \$25,000 and \$35,000, and 82.2% of those with incomes below \$25,000 received timely tests⁶

However, the opposite was true for men who received PSA prostate tests: 43.9% with incomes from \$25,000 to \$35,000 had a PSA, but only 29.7% of men with incomes below \$25,000. It should be noted that very low-income men are less likely to have health coverage or Medicaid than very low-income women due to female pregnancies and the higher likelihood of females having dependents.⁷

Income and racial health disparities exist in Montgomery County. As will be evident in other portions of this report, the highest proportion of low-income populations and non-white populations also reside in areas where health professional shortages are more severe, where hospital ED utilization rates are highest, and where a larger portion of currently uninsured potential Medicaid eligible populations reside.

The Montgomery County safety net

Those entities known as the safety net that are primarily responsible for care of the lower-income and most vulnerable populations usually consist of medical and dental primary care clinics as well as behavioral health care agencies (including mental health and alcohol and substance abuse). In Montgomery County, the longevity and reach of the safety net varies. The nearly 50-year old federally-supported community health center system, which is a significant part of the safety net in many urban communities around the United States, is still somewhat in its infancy in the Dayton area with the exception of the Samaritan Healthcare for the Homeless clinic, which has existed since 1992. Two free clinics, a small dental safety net and the ADAMHS behavioral health agencies comprise the remaining components of what is known traditionally as the safety net.

Hospital Care and emergency department utilization trends

One entity that is a critical, but also overused component of the safety net, is the hospital emergency department (ED). A look at a few key hospital measures provides context related to overall health care needs and access. In particular the following three indicators can shed light on health care access and utilization of the primary care infrastructure:

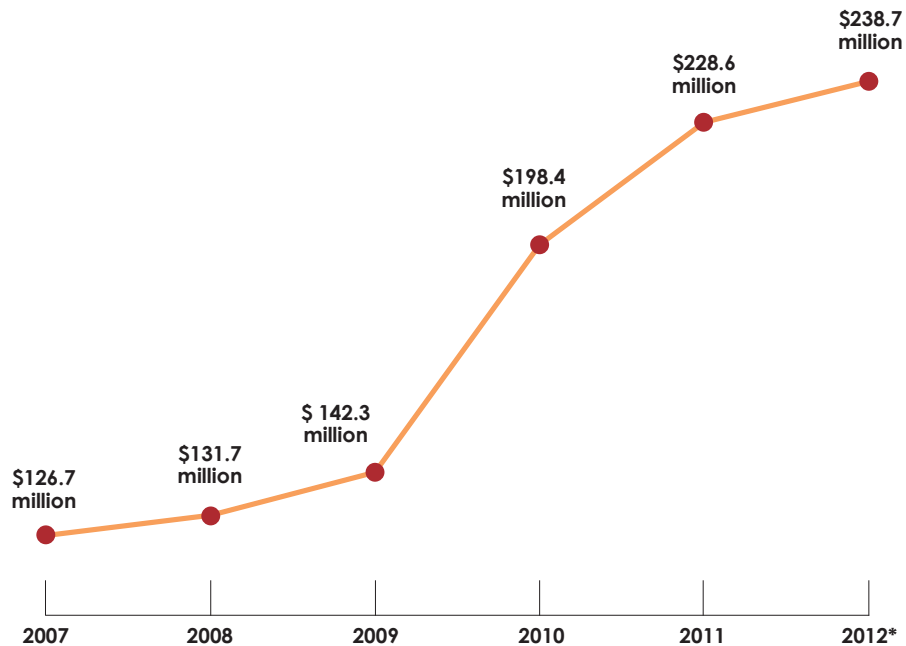
- Emergency department utilization
- Hospital Uncompensated Care Costs
- Admissions/discharges for conditions that were potentially avoidable (also known as Ambulatory Care Sensitive Conditions)

This assessment did not analyze hospital admissions and discharge data, and unlike states that continue to have Certificate of Need (CON) in place, Ohio's Department of Health does not collect and analyze this data since Ohio discontinued CON two decades ago.

One indicator of need – hospital

uncompensated care costs; i.e., the amount of money spent to care for uninsured/underinsured populations – most of whom are considered low income – has risen steadily over the past five years among Montgomery County hospitals: increasing from \$126.7 million in 2007 to \$238.7 in 2012.⁸

Hospital uncompensated care in Montgomery County



*based on first 6 months projection of 2012

Hospital ED visits and rates

In an analysis of Montgomery County hospital emergency department utilization several other trends were revealed:

- Hospital Emergency Department utilization has increased steadily over the past several years.
- At least seven of the top 10 reasons for visits to the emergency department were preventable — at least in many cases. Although nearly any situation can be classified as an emergency, most concerning is that several of the conditions regularly showing up would not be classified as an emergency in most cases, and/or more severe onset could have been prevented through care provided in an outpatient primary care and in some cases outpatient specialty service practice: e.g., headache, otitis media (earache), fever, sore throat, urinary tract infection, among others. The top 10 reasons comprised nearly 20% of all emergency department visits at

	Total ED visits (w/o Children's Hospital)	Total ED visits (including Children's Hospital)	Utilization rate (per 1,000 population, all hospitals)
2009	223,064	279,233	521 per 1,000
2010	221,460	280,068	523 per 1,000
2011	234,184	297,523	557 per 1,000
2012	224,317	317,268	593 per 1,000

Source: Ohio Hospital Association Statewide Clinical and Financial Database; special data runs by Greater Dayton Hospital Association (GDAHA), July and August, 2013

Rate comparison: 2011: U.S.= 415 per 1,000; Ohio=564 per 1,000 (American Hospital Association); Ohio is in the top five highest states nationally

the county's hospitals. Thus there is the opportunity to prevent some share of these through better primary care access and care coordination.

A study of ED utilization also revealed a steady increase in visits over a four-year period from 2009 through 2012. Total ED visits increased from 279,233 in 2009 to 317,268 in 2012; a nearly 14% increase.⁹ The ED utilization rate of 593 per 1000 population for the county's

hospitals is close to Ohio's, which is among the top five highest in the nation.¹⁰ A number of zip codes in central Dayton clearly boost this rate as several exceed ED utilization rates of 500 per 1000. These zip codes also coincide with those areas where a high number of individuals who are considered low-income, and not served by a community health center, reside.

The rate for Montgomery County hospitals also reflects an influx of patients from other surrounding counties where health care options are more limited. In 2012 a total of 21% of all patients in Montgomery County hospital EDs originated from other counties.¹¹ Thus the resources in the county take on a greater burden as a result of health care deficiencies in other counties, as well as the likelihood that a number of individuals feel more comfortable using larger urban hospitals where they may perceive they will receive better care compared with facilities in smaller towns.

Behavioral health

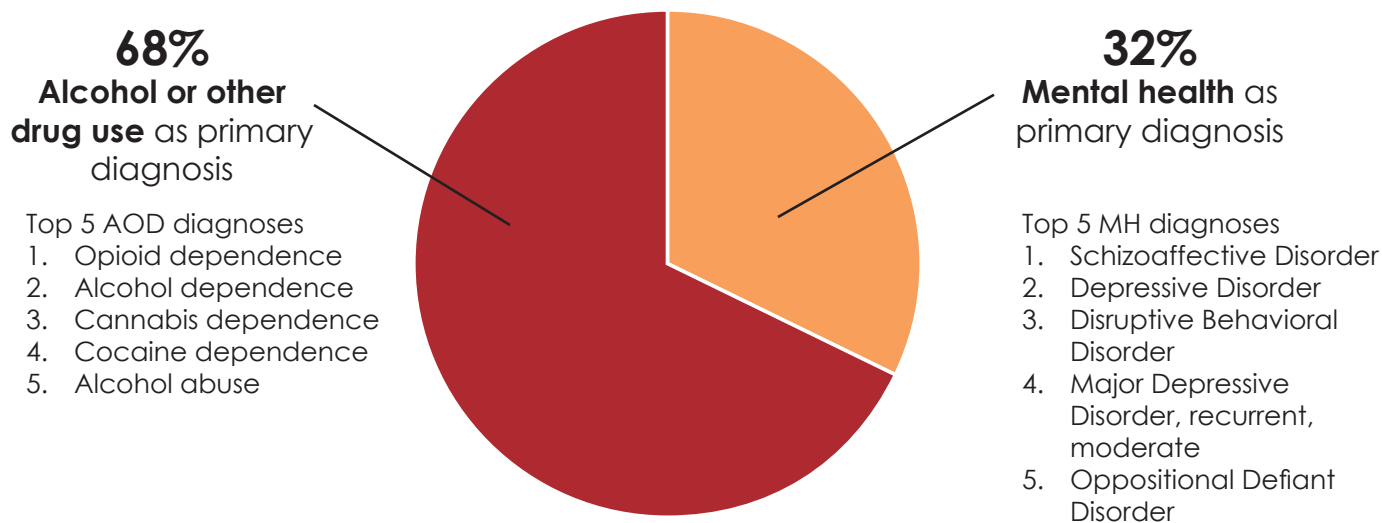
One of the most comprehensive safety nets within Montgomery County is the system of behavioral health care under the direction of the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board for Montgomery County. The ADAMHS Board oversees a network of nearly 30 independent behavioral health agencies that provide services throughout Montgomery County, with the largest concentration in Dayton.

The agencies serve outpatient and inpatient treatment to more than 22,000 low-income residents of the county and provide both mental health and alcohol and substance abuse services (AOD). Mental health services at these agencies range from treatment for depression to caring for those with severe mental illness (SMI). A range of AOD services also are provided by various agencies, and range from alcohol abuse counseling and groups to treatment for addiction to heroin.

A 17.8% increase occurred in the number of people served from 2008 to 2011. However, estimates show there are more than 32,000 adults in Montgomery County who are severely depressed, and more than 35,000 who have used illicit drugs within a month of being surveyed. There are documented shortages — or at least a maldistribution of behavioral health professionals — in Montgomery County, with larger deficiencies evident within the more urban neighborhoods of Dayton and a greater surplus in various suburban areas such as Kettering.

The major intake point for the system is CrisisCare, a division of Samaritan Behavioral Health. CrisisCare's primary role is to provide a gateway for those who need alcohol and drug treatment and those who are being screened or need treatment for severe mental illness/disability. However, others who need mental health care often are referred first to

Samaritan CrisisCare diagnoses, 2012



CrisisCare. Licensed therapists are on staff 24-hours daily and available for walk-ins or calls on the crisis line.

More than 7000 diagnostic assessments were done in 2012, and 30% of all clients were covered by Medicaid while most of the remainder were uninsured.

CrisisCare publishes a wait-time report, and in 2012 the average wait time for CrisisCare to get a referral into an agency for general mental health care was 22.5 days. Wait times vary by agency, but overall the director of CrisisCare reports these have been decreasing over recent years. For instance AOD Intensive Outpatient has a 30 day wait for an appointment at one agency and 17-day wait at another. For non-AOD or SMI concerns, individuals can directly go to one of the ADAMHS agencies.

Despite the comprehensive network of behavioral health services, access needs still remain and the hospital emergency department often becomes one of the points of entry. CrisisCare reports that one-third to one-half of all individuals who present in the hospital EDs for a behavioral health reason have not been to a behavioral health provider at any time previously. Indeed depressive state, anxiety and alcohol abuse are common reasons for a visit to the hospital EDs in Montgomery County.

Overall within the ADAMHS system, its nearly 30 agencies provided 1.85 million units of services in 2011; an overall four-year increase of 4.7% compared with 2008. The areas with the greatest increases were mental health counseling/therapy, which increased by 40% over the four years, and heroin treatment which went up by 33.7%.

Oral healthcare

Dental provider shortages exist for low-income populations in Montgomery County, particularly for those living within lower income Dayton neighborhoods. The greatest shortages are found within two dental health professional shortage areas (HPSAs) that exist in two of the more impoverished areas of the city of Dayton: East Central Dayton and West

Dayton. Within these two geographic areas alone, there is a dentist shortage of 10.5 FTEs, resulting in a population to dentist ratio of 11,741:1,¹² well above the shortage threshold ratio of 5000:1.

Overall, 65% of Montgomery County adults report having visited a dentist or dental clinic in the past year; this is not surprising given Ohio's overall rate is 67% and that more Ohioans lack dental insurance than lack health insurance. Even more concerning, the percentage of Montgomery County Black/non-Hispanic adults in who reported a dental visit was much lower at 45%.

Among Montgomery County residents of all ages enrolled in Medicaid, only 36% received dental care in 2011, suggesting that even with dental coverage, dental access is a challenge.

An analysis of Medicaid dental providers and visits in Montgomery County revealed the following:

- Similar to the county's hospitals, dental providers within Montgomery County are experiencing significant demand from other counties, as 31% of visits to Medicaid dental providers in Montgomery County were from out-of-county residents. This signals a regional shortage of dental care. ODH data also demonstrates regional dental capacity shortages, and thus the extent and impacts of this issue regionally warrants further exploration.
- 98% of Medicaid dental visits occurred in offices that accept more than 250 Medicaid patients. Most of these visits are to large private dental practices such as Aspen, ImmediaDent, and Small Smiles, as well as a handful of other private dentists who accept large numbers of Medicaid. Thus, most Montgomery County dental practices are not providing access for this population.

In addition, because of the limited capacity of the dental safety net only two percent of Medicaid dental visits occurred in settings such as hospital or community health center dental clinics.

Emergency departments and oral health

One effect of inadequate dental access is that hospital emergency departments have become the default safety net for oral health emergencies, even though they are not equipped or staffed appropriately to provide comprehensive dental care.

The Ohio Department of Health conducted a study of hospital ED utilization for dental concerns and found the following¹³:

- 4,016 emergency department visits by Montgomery County residents were for dental-related diagnoses
- The top three reasons accounted for 85% of these dental-related visits and all three are preventable and treatable in a primary care dental setting
 - 'unspecified disorder of the teeth and supporting structure'
 - 'dental caries'
 - 'periapical abscess without sinus' (otherwise known as dental abscess)
- Montgomery County's Medicaid population's rate of utilization compared to other urban counties in Ohio was among the lowest. However, Montgomery County's uninsured population represents a higher portion of all dental visits compared to other counties in Ohio (Montgomery Co. = 53% of ED dental visits were by uninsured patients vs. 44% in Ohio overall).

Similar to physical health, these data suggest that increasing dental capacity for vulnerable populations may result in fewer inappropriate emergency department visits for dental-related reasons.

Models of Collaboration / Access / Innovation

A variety of approaches are being taken to create innovative solutions to health care for vulnerable populations in many communities. Below are select models from communities that are using collaboration and integration to implement strategies focusing on those most at risk for poor health outcomes and other challenging issues posed by poverty and environmental factors.

1. Communities Joined in Action (CJA)

<http://cjaonline.net/index.asp>

Communities Joined in Action (CJA) is a national private, non-profit membership

organization of nearly 200 community health collaboratives. The organization's members are committed to improving health, improving access, and eliminating disparities in their communities by assisting these community health collaboratives to assure better health for all people at less cost.

2. Community Health Access Project (CHAP) and Pathways

<http://chap-ohio.net/>

The Pathways focuses on outcomes, and uses a community "hub" model and community health workers (CHWs) to address pathways to better health that focus on issues such as achieving better birth outcomes among at-risk populations. CHAP is a Mansfield, OH based organization that has developed and is advancing this model throughout Ohio and nationally.

The Agency for Health Research and Quality (AHRQ) has published a manual on how to build a community hub, which is partly authored by the CHAP leaders: "Connecting Those at Risk to Care: A Guide to Building a Community "HUB" to Promote a System of Collaboration, Accountability, and Improved Outcomes" <http://www.innovations.ahrq.gov/guide/HUBManualTOC.aspx>

3. Cincinnati's Health Care Access Now

<http://healthcareaccessnow.org/>

This nonprofit organization is chartered to turn the region's independent providers and payment sources into a high performing, integrated, health care delivery network able to provide access to care for all residents of nine (9) counties of Greater Cincinnati – Hamilton, Butler, Clermont, Adams, Brown and Warren in Southwest Ohio and Boone, Campbell and Kenton in Northern Kentucky. Key initiatives of HCAN include using community health workers (CHWs) to mentor and empower low-income pregnant women to ensure prenatal care and other approaches to better care and healthier births, and employing CHWs to target the most frequent users of hospital emergency departments among others.

4. **Access HealthColumbus (AHC)**

This non-profit, public-private partnership is working to improve delivery of local health care by coordinating collaborative improvement projects in central Ohio. AHC has convened learning sessions, seeded the development of a voluntary physician's care network and charitable pharmacy, convenes the central Ohio region's patient-centered medical home collaboratives, and supports other initiatives and innovative projects to improve the safety net and collaboration among health care entities.

5. **Muskegon Community Health Project (Michigan)**

<http://www.mchp.org/aboutus/mission.html>

The Muskegon Community Health Project (MCHP) is known as a national model for convening community groups and service agencies to form community collaborative coalitions that address barriers to access, reduce health disparities, and improve community health. The organization has used a collaborative approach to conduct outreach and enrollment and to create a single door enrollment for a variety of programs, and also use of CHWs.

Other key models/strategies include:

6. **Accountable Care Organizations**

Multiple providers such as hospitals, primary care providers, specialists, and others sharing risk to improve outcomes and reduce costs via coordinated care and collection and analysis of data. ACOs are designed to remove barriers to care and integration and to align payment incentives with quality outcomes and controlled cost growth.

The American Hospital Association put out report that synthesized the overall structure of the ACOs.

<http://www.aha.org/research/cor/accountable/index.shtml>

7. **Primary Care, Improved ED Throughput Are Keys to Reducing ED Overcrowding and Preparing for ACA Implementation**

<http://www.nphhi.org/Homepage-Layout/Featured-Publications/Research-Briefs/February-2013-NPHHI-ED-Throughput->

[Research-Brief.aspx?FT=.pdf](#)

This article in the February 2013 Research Brief from the National Association of Public Hospitals and Health Systems describes ways to address hospital Emergency Department (ED) over-utilization. Given Montgomery County's already high utilization rate, these strategies may be valuable particularly if projections of increased demands on the EDs materialize due to more people gaining access to coverage, but not appropriate care settings.

Models of Integration/Collaboration (hospitals/health centers/behavioral health)

The following links to models/programs/systems, presentations and studies provide insights into how partnerships can be developed and offer opportunities for more research/in-depth study as Montgomery County explores ways to improve its safety net.

1. **How Hospitals and Federally Qualified Health Centers Should Collaborate**

Article written by Health Care Attorney Susan Patton, for *HealthLeaders Media*, April 16, 2010, that outlines a multitude of ways FQHCs and hospitals can partner <http://www.healthleadersmedia.com/print/LED-249684/How-Hospitals-and-Federally-Qualified>

2. **Cherokee Health Systems (Tennessee)**

A multi-county regional Federally Qualified Health Center and Community Mental Health Center Network that serves as a national model for the integration of primary care and behavioral care <http://www.cherokeetraining.com/pdf/Clinical%20Model-Best%20Practices.pdf>

3. **Health Center Affiliations and Collaborative Arrangements**

Key guidance and policies related to the formation of informal and formal affiliations between FQHCs and other entities: <http://1.usa.gov/1b9MMpp>
<http://1.usa.gov/16ty3Hq>

Presentation by Health Care Attorney Jacqui Leifer on FQHC/Hospital

Relationships:

http://www.scha.org/files/developing_fqhc-hospital_relationships_in_a_changing_environment_-_j._leifer_and_t._hewson.pdf

FQHC/Public Health Collaboration:

<http://www.nachc.com/client/>

4. Holy Cross Hospital (Chicago) and FQHC Collaboration

An example of co-location of a health center at a hospital.

http://www.scha.org/files/innovation_-_fqhc_and_hospital_collaboration_-_holy_cross_hospital_0.pdf

5. Free Clinics in the United States: A Nationwide Survey

A study reported on the JAMA Network regarding free clinics in an era of health reform. The report discusses the future role of free clinics and suggests these entities should be more integrated into the overall health system and with other safety net providers.

<http://archinte.jamanetwork.com/article.aspx?articleid=416041>

Under the ACA Essential Community Providers (EHPs) are organizations that predominantly serve low-income, medically underserved individuals. These include entities such as Federally Qualified Health Centers, Ryan White (HIV/AIDS) grantees, and family planning among others. These organizations meet the 340B(a)(4) of the Public Health Service Act requirements and section 1927(c)(1)(D)(i)(IV) of the Social Security Act. Qualified Health Plans (QHPs) participating in the Marketplace must enroll "a sufficient number and geographic distribution" of the ECPs within a defined service. "Sufficient" is considered at least 20% of ECPs in a QHP's service area with at least one in each category in each county. CMS will use a non-exhaustive database of ECPs to determine the number within the market area of the QHP and use that number as the denominator. Thus the QHPs are not required to include all ECPs in their networks.

The following fact sheet offers tips on how ECPs can connect with Marketplace plans:

http://www.nashp.org/sites/default/files/ecp_tips.connect.marketplace.plans.pdf

Key Resources /Links for Provider organizations/Agencies/Health Consumers**1. Health Insurance Marketplace portal**

The main portal for the Health Insurance Marketplace: www.healthcare.gov

** This website serves as the HHS front door to the Marketplace for service providers and health care consumers.

2. Toolkit for Safety Net Providers

<http://www.hrsa.gov/affordablecareact/toolkit.html>

This online toolkit includes a range of resources and materials that clinicians and health care administrators can use to learn more about the Marketplace and educate patients about their new health care options, how insurance works, and the benefits of having insurance. It also includes materials for providers to learn more about the Small Business Health Options Program (SHOP).

3. HHS: Information on Essential Community Providers & Information

<http://www.cms.gov/CCIIO/Programs-and-Initiatives/Files/Downloads/ecp-listing-cover-sheet-03262013.pdf>

Montgomery County's Essential Community Providers (extracted from data.cms.gov)

AIDS Resource Center Ohio	15 West 4th Street Suite 200	Dayton
Community Health Centers of Greater Dayton	1323 W. 3rd St.	Dayton
Community Health Centers of Greater Dayton	165 S. Edwin C. Moses	Dayton
Dayton Health Center dba Five Rivers Health Centers	725 South Ludlow	Dayton
GOOD SAMARITAN HOSPITAL	41 CATHERINE ST	DAYTON
PLANNED PARENTHOOD SOUTHWEST OHIO REGION	224 N WILKINSON STREET	DAYTON
PUBLIC HEALTH DAYTON & MONTGOMERY COUNTY	117 S. MAIN STREET	DAYTON
Community Health Centers of Greater Dayton	2132 East Third St.	Dayton
Community Health Centers of Greater Dayton	2349 Stanley Ave.	Dayton
Dayton Health Center dba Five Rivers Health Centers	2345 Philadelphia Drive	Dayton
GOOD SAMARITAN HOSPITAL	819 S Edwin C Moses Blvd	Dayton
Dayton Health Center dba Five Rivers Health Centers	1 Apple Street	Dayton
Dayton Health Center dba Five Rivers Health Centers	1 Wyoming Street	Dayton
Dayton Health Center dba Five Rivers Health Centers	222 Philadelphia Drive	Dayton
MIAMI VALLEY HOSPITAL	ONE WYOMING STREET	DAYTON
CHILDRENS MEDICAL CENTER	ONE CHILDRENS PLAZA	DAYTON
ECPs that provide Dental Services		
GOOD SAMARITAN HOSPITAL	819 S Edwin C Moses Blvd	Dayton

such organization in the United States, designated by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services as the sole center to provide leadership, scholarship, evidence, coordination and national visibility to advance interprofessional education and practice as a viable and efficient health care delivery model.

By aligning the needs and interests of education with health care practice, the project aims to create a **Nexus** of new shared responsibility for better care, added value and healthier communities. The center is a public-private partnership created at the University of Minnesota in October 2012 through a cooperative agreement with HRSA and four private foundations: the Josiah Macy Jr. Foundation, the Robert Wood Johnson Foundation, the Gordon and Betty Moore Foundation and the John A. Hartford Foundation.

4. Workforce / Health Care professional development: The National Center for Interprofessional Practice and Education

<http://nexusipe.org/>

The National Center for Interprofessional Practice and Education leads, coordinates and studies the advancement of collaborative, team-based health professions education and patient care as an efficient model for improving quality, outcomes and cost. It is the only

Notes

1. Decker, Sandra L, Kostova, Deliana PhD, Kenney, Genevieve M, Long, Sharon PhD. Health Status, Risk Factors, and Medical Conditions Among Persons Enrolled in Medicaid vs Uninsured Low-Income Adults Potentially Eligible for Medicaid under the Affordable Care Act, JAMA. 2013; Vol. 309: pgs. 2579-2686.
2. Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2010 on CDC WONDER Online Database, released January 2013. Data are compiled from Compressed Mortality File 1999-2010 Series 20 No. 2P, 2013. The rate used is age-adjusted per 100,000 population.
3. Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2010 on CDC WONDER Online Database, released January 2013. Data are compiled from Compressed Mortality File 1999-2010 Series 20 No. 2P, 2013. The rate used is age-adjusted per 100,000 population.
4. Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2010 on CDC WONDER Online Database, released January 2013. Data are compiled from Compressed Mortality File 1999-2010 Series 20 No. 2P, 2013. The rate used is age-adjusted per 100,000 population.
5. Centers for Disease Control and Prevention; Behavioral Health Risk Surveillance System, compiled/reported by Public Health – Dayton & Montgomery Co., 2012
6. Centers for Disease Control and Prevention; Behavioral Health Risk Surveillance System, compiled/reported by Public Health – Dayton & Montgomery Co., 2012
7. Centers for Disease Control and Prevention; Behavioral Health Risk Surveillance System, compiled/reported by Public Health – Dayton & Montgomery Co., 2012
8. Figures reported by the Greater Dayton Area Hospital Association for Montgomery County Hospitals, 2007-2012
9. HPIO analysis using Ohio Hospital Association; Statewide Clinical and Financial Database; special data runs by Greater Dayton Area Hospital Association (GDAHA), July & August, 2013
10. Avalere Health analysis of American Hospital Association Annual Survey data, 2011, for community hospitals; US Census Bureau National and State Population - reported by H.J. Kaiser Family Foundation; and HPIO analysis using Ohio Hospital Association; Statewide Clinical and Financial Database; special data runs by Greater Dayton Area Hospital Association (GDAHA), July & August, 2013
11. HPIO analysis using Ohio Hospital Association; Statewide Clinical and Financial Database; special data runs by Greater Dayton Area Hospital Association (GDAHA), July & August, 2013
12. Ohio Department of Health, Oral Health Section, July 2013
13. Ohio Department of Health, Oral Health Section analysis of Ohio Medicaid claims data provided by the Ohio Department of Job and Family Services, 2013.