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Introduction

The goal of the Safety Net Snapshot Project (SNSP) was to examine the current condition of the health care safety net in Ohio. The concern is that Ohio's distressed economy is placing an increased burden in terms of service capacity and resources upon the health care safety net. The findings of surveys, interviews, and data collection from the SNSP exhibited that:

(1) The need for the health care safety net is not concentrated, but spread throughout the state,

(2) More uninsured and underinsured are seeking care through the health care safety net,

(3) Private physicians are seeing more economically distressed, uninsured, and underinsured patients,

(4) Hospitals are seeing more Medicaid and less privately insurance patients,

(5) The need for basic primary care for impoverished Ohioans is acute, especially among working-aged Ohioans,

(6) Financial resources to Ohio's health safety net have not kept pace with the level of increased demand,

(7) Professional resources, the number of health care providers to the health care safety net, specifically primary care physicians, dentists, and mental health professionals, have not kept pace with the level of increased demand,

(8) Recruiting new providers, particularly providers who have experience with the issues of impoverished populations, is difficult, and

(9) The geographic distribution of health care safety net providers are clustered around Ohio's primary and secondary metropolitan centers – mirroring prior research relating to the distribution of medically underserved areas in Ohio.

The consensus among health care safety net organizations is that the economic downturn and the changing landscape of health care delivery (e.g., lessening rates of private insurance in Ohio) are stressing the health care safety net. However, many health care safety net organizations believe that recent health care reform legislation (the Patient Protection and Affordable Care Act [PPACA] and the American Recovery and Reinvestment Act [ARRA]) will moderately strengthen the primary care presence in many of Ohio's medically underserved areas.

To present these Safety Net Snapshot Project findings and to gain additional input on key topic areas relating to the health care safety net, the SNSP research team held five forums in distinct areas of Ohio (Columbus, Cincinnati, Rootstown, Lima, and Glouster). Most of the attendees at these forums found the SNSP results to be of concern, but not surprising. A summary of feedback from these forums is presented in what follows and are categorized into (1) capacity issues, (2) health care safety net future expectations, (3) potential impact of PPACA, and (4) gaps in capacity relative to need.

I. Capacity Issues

I-a. Service capacity was stressed prior to the 2008 economic downturn and is becoming more stressed as the economic downturn continues – particularly for Ohio's rural areas. The forum participants reported that plentiful capacity has not historically been the normal state of affairs for most health care safety net providers. A message was delivered that historically, skilled personnel are difficult to recruit and retain, and that many health care safety net organizations compete to secure skilled personnel and often recruit practitioners from different health care safety net organizations ("predatory" recruiting). The main reasons given for stressed practitioner capacities were: (1) financial limitations, (2) skilled personnel "burn-out", (3) the location of many health safety net facilities are not enticing to lucrative practices, and (4) a statewide lack of overall primary care physicians, dentists, and mental health professionals who serve the impoverished. The overall perception is that a situation that was worrisome in the earlier part of this decade is now more acute. An exception given to this provider stress is emergency departments, which reported a level demand for safety net services.

I-b. Many attendees reported administrative systems within health care safety net organizations are underpowered. Those representing organizations reported that advanced information systems and tracking mechanisms are needed to better serve patients. Many of their current systems are outdated and inadequate. The attendees reported a strong desire to have better health information technology and telemedicine options. The consensus of participants was that better electronic health system integration would lessen service stress through more efficient operations.

I-c. Most attendees stated that, given a growing need for health safety net services, government and private financial constraints will continue to curtail service offerings for the impoverished. With the exception of FQHC and hospital representatives, most attendees reported that decreasing state and local sponsorship of health care safety net services will equate to less service capacity in the face of increasing demand. The FQHC and hospital representatives believe that prior service expansion incentives and federal health care reform will enable more health care safety net services to be available through their organizations. However, representatives of free-clinics, local public health departments, and other types of health care safety net providers believe that lessened resource capacities at local foundations and charities, combined with less government sponsorship, will result in less services being offered – particularly in rural areas. The feedback from the forums accentuates that there is a difference in perception concerning the impact of provider stress via financial constraints for FQHCs, look-alike clinics, and hospitals, on the one hand, and free-clinics, community health centers, dental clinics and ancillary health care safety net service providers. The latter reporting more economic stress.

I-d. Many attendees believe that health provider associations, training centers, and business groups do not emphasize serving the health care safety net. Many attendees noted that the limited supply of primary care, mental health, and dental providers to the health care safety net is by design. Their belief is that professional associations, training institutions, and provider business groups encourage medical provider business plans that emphasize higher reimbursement and prestige practice locations for their members, resulting in the de-emphasis of health care safety net organizations. At all forums the issue of resetting licensure rules in Ohio for advanced practice nurses, advanced physician assistants, and advanced pharmacists as a way to rebalance capacities was raised. The comments concerning licensure adjustment were

mixed, with most physicians providing feedback in opposition to licensure adjustment due to concerns of service quality.

II. Health Care Safety Net Future Expectations

II-a. The future for the overall health care safety net is expected to be characterized by financial limits and a growing need for services, except for those receiving assistance from federal health care reform. The consensus of the regional forum participants was that Ohio's health care safety net will continue to be financially and practitioner capacity stressed. These opinions were held despite a belief that more resources will come to FQHCs and look-alike clinics via federal health care reform. First, many participants expressed that federal health care reform will primarily benefit FQHCs and look-alike clinics, rather than the full spectrum of health care safety providers. Second, while there are incentives in federal and Ohio health care reform to enable statewide redistribution of primary care physicians and other health care providers, the consensus of attendees is that these reforms will not result in noticeably more health care providers in their facilities. A majority of attendees expressed that health care reform will not rebalance the medical professional supply-side.

II-b. The development of a tiered system of health care access and quality will continue to stress Ohio's health care safety net. While applauding federal and Ohio health reform expansions of Medicaid, employer-sponsored health insurance to adult dependents, and preventive services, a common theme expressed was that the overall health care system is tiered into quality categories for those with adequate employer-sponsored and private insurance, and those with government-sponsored or charity health care access. This situation is expected to worsen and is expected to result in less quality care for those enrolled in Medicaid or frequenting the health care safety net. Examples are the reports of a growing number of primary care physicians refusing to see Medicaid patients, a lessening of volunteer providers, and a lessening of referral partners – particularly in rural areas. While most health care safety net providers expressed that they try hard to provide quality services, many expressed frustration with their limited access to professional partnerships (e.g., labs, specialist) and access to the general health care infrastructure.

II-c. The potential contraction of services for many health care safety net organizations is considered a problem. Several forum attendees noted that due to federal health care reform, many hospital and urgent care systems will "cherry pick" their insurance covered or reimbursed/paying clientele. Examples included the taking of primary care service patients and the off-loading of usually low reimbursable/income losing dental and preventive services to health care safety net organizations. A critique of federal health care reform is that it will enable this trend to accelerate. A caution is that if "cherry picking" ends up not making business sense, larger health systems will pull out of these expansion regions, resulting in a weakened health care safety net infrastructure. This caution was strongly expressed in the rural forums.

III. Potential Health Care Reform Impact

III-a. Most attendees believe that recent reform legislation (the Patient Protection and Affordable Care Act [PPACA] and the American Recovery and Reinvestment Act [ARRA]) will increase the number of Federally Qualified Health Centers, look-alike facilities, and hospital expansions. The consensus among attendees was that reforms contained in legislation will increase the number of FQHCs and look-alike facilities due to federal incentive funding, and will assist the expansion of hospital offerings to the impoverished via targeted demonstration grants and programs. Representatives from other types of health care safety net organizations such as

dental clinics, free-clinics and other types of community-specific providers expressed that, beyond the expansion of Medicaid, health care reform will probably not significantly increase their operational capacities.

III-b. The consensus of attendees is that Medicaid expansion to 138% of the Federal Poverty Level ($30,429 annual income for a family of four in 2010) will greatly assist their clientele. Of particular note is that Medicaid expansion moves beyond the "child introduction" for adult enrollment, defined as the requirement of having a child in the household as an adult qualification for Medicaid enrollment. With PPACA Medicaid expansion, any person at or below 138% FPL is eligible for Medicaid enrollment. This more open criterion was believed to be significant to the health of adults in employment transition, the chronically uninsured, and those who cannot afford private health care coverage. It was also believed that Medicaid expansion will help financially stressed health care safety net organizations by lessening the demand for charity care, which was reported to be on the rise for most attendees.

III-c. The attendees addressed the potential impact health reform might have on the shortage of medical practitioners to health safety net organizations. The general input is that health reform legislation may moderately assist access to care for health care safety net organizations in Ohio's urban and suburban areas, but will probably not result in an equivalent increase of practitioners in Ohio's rural regions. There was disappointment expressed that federal reform did not strongly address the need to reform medical professional licensing. This issue was specifically targeted to the expansion of practice relating to advanced practice nurses.

IV. Gaps in Capacity-to-Need Realignment

IV-a. A major finding of the SNSP is that the areas of highest concentration per county of poverty, poor health, and uninsured have less health care safety net capacity than do Ohio's metropolitan areas. When mapped, most of the state's health care safety net locations are within proximity of Ohio's metropolitan counties and within the proximity of Ohio's medical hubs. Ohio's rural medically underserved areas are stressed for health care safety net capacity. When presented with this finding, few forum attendees were surprised. Some attendees expressed that it would be "naive to think that the situation would be otherwise."

IV-b. A common theme in the forum discussions and in written feedback was the need for "realignment" of medical services to counties in most need. These discussions included suggestions for enhancing hospital services and the need for attracting more dentists, mental health providers, obstetricians, dermatologists, oncologists, physical therapist, and health educators. The stated reasons for this misalignment included financial, cultural, and ease of practice issues. A majority of attendees thought that any realignment brought by health care reform would include FQHCs and hospitals. Many attendees strongly expressed that realignment should start with community planning that includes health care safety net providers partnered with large providers.

IV-c. A discussion held at the rural forums (Glouster and Lima) was the need for the health care safety net to have more modern and better-equipped facilities. Comments included the need for assistance in bringing many health care safety net facilities "up to modern standards in terms of structure, computers, and equipment and supplies." A physician in a rural forum noted that often the facilities to serve those in most need do not compare to private practice facilities – "Sometimes the spirit and hope for medical care is lessened as soon as a patient walks through the doors." The reinvestment into facilities was considered sensitive in that investment in facilities can equate to less charity services for the most impoverished. Accordingly, many attendees believe that reinvestment in facilities should be assisted by government sponsorship.