Ohio's COVID-19 Populations Needs Assessment

Minimizing the Disparate Impact of the Pandemic and Building Foundations for Health Equity

This document contains excerpts from the full report, which can be found here: https://go.osu.edu/inequitable-burdens-covid-19

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Findings Relevant to the CDC's Public Health Strategies to Combat COVID-19

Healthcare Access (Topic H): Integrated Findings Across Population Groups

In the findings below, key Ohio population groups that repeatedly mentioned each item are indicated by the following abbreviations:

BA: Black and African American
AS: Asian and Asian American
RU: Rural
HL: Latino and Hispanic
IR: Immigrant & Refugee
DI: Living with Disabilities

Key Barriers to Healthcare Access

These categories represent the barriers that most commonly challenge the ability of key Ohio populations to access primary healthcare, mental healthcare, and substance use treatment to help minimize the impact of COVID-19.

Lack of healthcare access

In all the populations studied, many individuals have no health insurance coverage, which severely limits their ability to access any healthcare (BA, AS, RU, HL, IR, DI). Many do not know where to get healthcare without insurance (BA, AS, HL) and cannot afford to do so (BA, AS, RU, HL, IR). In all the populations studied, many individuals do not have a primary care provider (BA, AS, RU, HL, IR, DI). Some communities and neighborhoods lack enough primary health providers, nurses, and mental health providers for the population (RU, DI), and the healthcare that does exist may be overbooked (RU). In rural areas, primary care providers and free clinics may struggle financially because they do not receive federal funding (RU). Some healthcare and mental health services have closed due to COVID-19 (RU, DI), and individuals who need care may not know which facilities are still operating (AS). Some insurance plans do not cover telehealth appointments (DI). Undocumented immigrants do not qualify for Medicaid or Medicare (HL).

Mistrust of healthcare systems and government

Many members of the populations studied do not trust the healthcare system, due to a history of structural racism, medical experimentation on minorities, and personal experience of poor treatment by providers (BA, AS, HL, IR, DI). Contemporary racism and direct targeting of minority populations in the COVID-19 crisis increases reluctance to use healthcare facilities (BA, AS, HL). Lack of racial and ethnic diversity among healthcare providers, as well as lack of cultural accommodation by healthcare providers, adds to these problems (IR). Undocumented individuals fear that accessing healthcare could expose them to immigration authorities, ICE, imprisonment, and deportation (AS, HL, IR), and could create difficulties for their family members and communities (HL, IR). Some individuals who are eligible for Medicaid do not apply because they do not want to be on a government list (HL). Many members of rural communities do not trust health advice from government leaders, don't believe COVID-19 is a serious issue, and have concerns about confidentiality (RU).

Lack of personal transportation

Members of most of the populations studied lack private means of transportation and can therefore access healthcare only when it is on a public transportation route (BA, AS, RU, HL, IR). Additionally, public transportation and ride-shares are sometimes unaffordable and/or unsafe (BA, AS, RU, IR, IR).

Lack of technology

Many Ohioans rely on telehealth as a substitute for in-person healthcare that is not available during the COVID-19 pandemic, but telehealth use is severely limited for members of the studied populations when they lack access to smart phones, computers, Internet, broadband, and WiFi (BA, RU, IR). Some individuals have no reliable access to a telephone at all (RU).

Language barriers

Language barriers limit the ability of some community members to utilize healthcare (AS, HL, IR). Many healthcare settings provide care only in English, with no access to translators or multilingual staff (AS, HL, IR). The need for care provision in the languages spoken by communities applies to physical healthcare, mental healthcare, and substance use treatment (HL). In addition to limiting the ability of patients and medical providers to communicate effectively, language barriers can create fear and anxiety (AS).

Gaps in education, information, and understanding

Lack of up-to-date health information about COVID-19 can impede appropriate use of healthcare (AS, IR). It can also be difficult for individuals with low general levels of education or low health literacy to understand the information provided (RU, HL, IR). Some community members are exposed to misinformation and false news (and misinformation spreads more easily because accurate information is inaccessible); this further limits their understanding of appropriate healthcare use both in general and relevant to COVID-19 (AS, RU, IR). Some communities lack understanding of how and where to seek care (RU, HL), or how to use telehealth services (HL, IR, DI). Inconsistent information from regulatory agencies and hospitals exacerbates these problems (RU, IR).

Cultural norms and attitudes

Members of many communities experience stigma around mental healthcare and around COVID-19 (AS, HL, IR). Some community members prefer to use alternative medicinal practices instead of Western healthcare (AS, IR).

Other barriers - relevant to specific populations

- Fear of being exposed to COVID-19 at the doctor's office (BA)
- Necessary providers, advocates, and caregivers may not be allowed at medical appointments during the pandemic (DI)
- The lack of providers trained to treat people with disabilities is more acute during the pandemic (DI)

Commonly Proposed Solutions to Facilitate Healthcare Access

These categories represent our respondents' commonly proposed solutions to the barriers that impede use of primary healthcare, mental healthcare, and substance use treatment by Ohio populations.

Provide access to healthcare directly

Increasing access to healthcare involves both reducing financial barriers and improving the availability of services (BA, RU, AS, HL, IR). For many of the studied populations, direct measures to provide free and widespread healthcare access would be most helpful (BA, RU, AS, HL, IR). This could include providing more free clinics in small and underserved communities (RU, AS), offering free access to existing health services (RU), making prescriptions free (RU), and creating lists of clinics and hospitals providing these services (HL). Universal health insurance or less expensive health insurance would help substantially (AS, RU), as would assistance finding and enrolling in insurance programs (RU). Many communities need additional healthcare sites that are open and accepting patients (RU, AS); mental health services are particularly sparse (RU). Many individuals would benefit from continued and expanded telehealth options through clinics and Federally Qualified Health Centers (FQHCs) (AS, IR, DI) and help scheduling telehealth appointments (AS). Re-opening in-person services, providing mobile treatment options, and providing services at home could also help (RU, HL, IR).

Improve transportation

Improving public transportation and providing additional transportation options would facilitate use of healthcare in several of the populations studied (RU, AS, IR, DI).

Partner with trusted community members, leaders, and organizations

Public health authorities should work directly with trusted community members, leaders, and organizations to improve healthcare access (RU, IR). This could include hiring community members as community health workers or health navigators to connect people to appropriate care and payment mechanisms (RU, AS, HL, IR). Local FQHCs are trusted by many communities and could be helpful partners for improving healthcare access (AS).

Improve access to technology

Widespread – and affordable or free – access to cell phones, broadband, and Internet services would increase individuals' access to telehealth (RU, DI).

Provide information and services in multiple languages

Providing health-related information and services in multiple languages – or translators in healthcare settings – would help improve healthcare access (HL, AS, IR). Members of local communities can be hired to do this work (HL, IR).

Other recommendations - relevant to specific populations

- Provide education about mental health and drug use issues (IR)
- Provide education about COVID-19 and relevant healthcare (DI)
- Increase disability-related competencies among healthcare professionals (DI)
- Increase the availability of interpreters or interpretation technology in healthcare facilities (DI)
- Allow caregivers or trusted companions to accompany people with disabilities to medical appointments (DI)