

Knowledge Delivery Services, LLC

Community Health Care Needs Assessment for North Central Iowa Counties

Results of Surveys and Focus Group Research Carried Out Between April and September 2010.

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Introduction

This report details the findings from investigations into the health care needs of individuals who work or reside in and around the north-central region of the state of Iowa. A total of three surveys and focus-group interviews on three selected groups of residents provide the data for this report. The data collection took place between April and September 2010.

The first part of the report details the findings from a survey of employees of Mercy Medical Center – North Iowa. The survey was delivered to a total of 3,663 employees through e-mail distribution. Of these 682 employees completed and submitted the survey. Most employees are residents of Cero Gordo County where the medical center is located. A significant number of them also came from surrounding counties and cities. The survey questionnaires were distributed to the employees online through e-mail. The employee survey data collection started around the beginning of May and ended in June.

The second part of the report details the results of a random sample survey of community members of 14 counties in the region. The sampling design of the community survey used the entire 14 counties as a population of reference while at the same time giving Cero Gordo county (i.e., the county in which Mercy – North Iowa is located), a special focus by over representing its population in the sample selection process. The sample size for the survey was determined to be 600 respondents. This estimation was arrived at by taking into consideration historical situations (levels of need established in prior surveys), available resources for the data collection and the margin of error of plus or minus three percentage points. Based on the past history of non-response rates of similar surveys an oversampling by about 80% of the required minimum sample size was used to augment the statistical power. The final number of residents that were selected to respond to the survey was therefore 1,000. The sampling frame for the selection was obtained from a marketing database provider. The final tally of the results of the community survey is based on 328 responses (i.e., about 55 percent of the minimally required sample size that was calculated by design). The survey questionnaires were distributed to the sampled individuals through mail. Majority of the responses (about 50 percent of the required sample size), came as a response to the mail delivery. The rest, about 5 percent were solicited through telephone interviews.

The third survey was delivered to the physicians that are in practice in the region and members of the clergy. The physician/clergy survey, like the employee survey, was delivered online through e-mail distribution. The main goal for the clergy and physician survey was to gain some understanding of their perceptions of the local health needs and to solicit ideas for improvement. The survey contained three questions including (a) community health improvement ideas, (b) their awareness of the type of struggles among the local population, and (c) their awareness of Mercy-provided social and health service benefits to the needy. A little over 300 individuals were sent the survey and about 23 percent of

them responded. The proportion of clergy who responded to the survey was slightly less than that of the physicians (21 percent was the response rate for the clergy vs. 24 percent for the physicians).

In addition to these three surveys three focus group interviews were performed targeting seniors at the Senior Citizen Center, Mason City, lunch-time participants at the Mason City Community Kitchen, and gatherings of Hispanic women from the nearby community of Hampton. The informal interviews in Hampton took place in April 2010 and the two formal focus groups were conducted May 10, 2010.

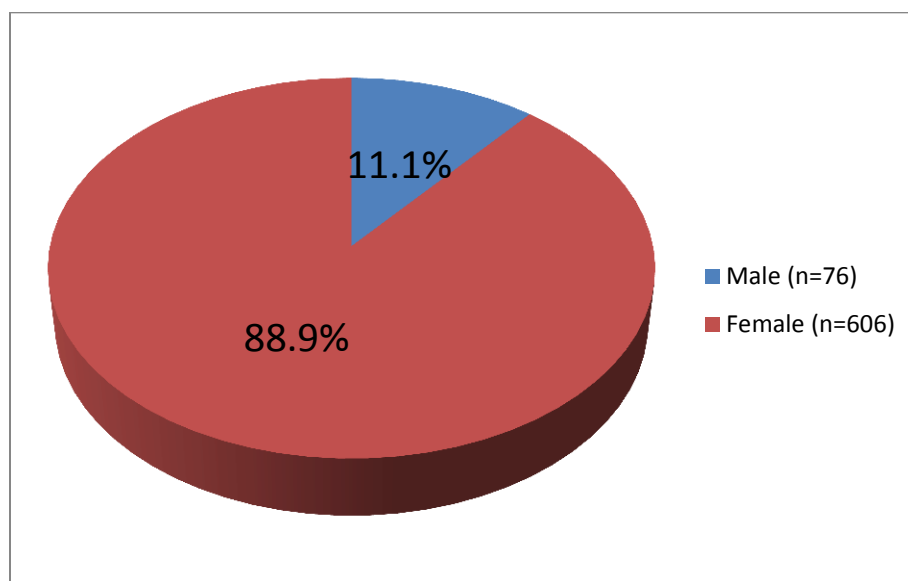
The Senior Citizens Center participants consisted of 11 adults, ages 65 and above. Six of the focus group members were female, and five of them were male. The Community Kitchen participants consisted of ten adults, age 55+, and three adults in their late 20s. In terms of gender there were eight females and five males. Of the 17 Hispanic women interviewed, 14 were in the age bracket 25-39 and 3 were, 40-54.

Employee Health Care Needs Assessment Survey Results

Demographic and Socioeconomic Characteristics of the Surveyed Individuals

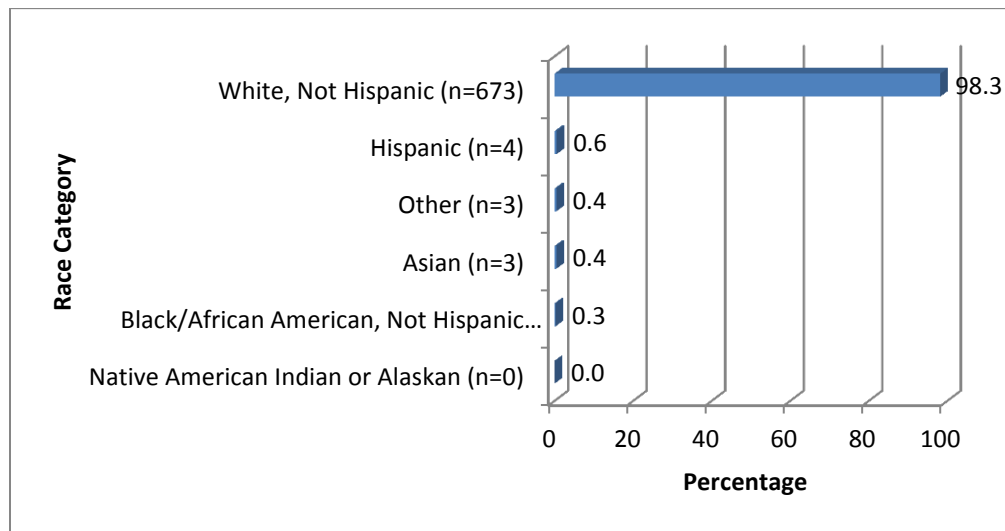
The Employee Needs Assessment Survey had 682 respondents. In terms of gender there were significantly more female respondents than male respondents. As shown in the chart below, nearly 89 percent of the respondents were female and only 11 percent were male.

Figure 1 Gender Characteristics of the Surveyed Employee



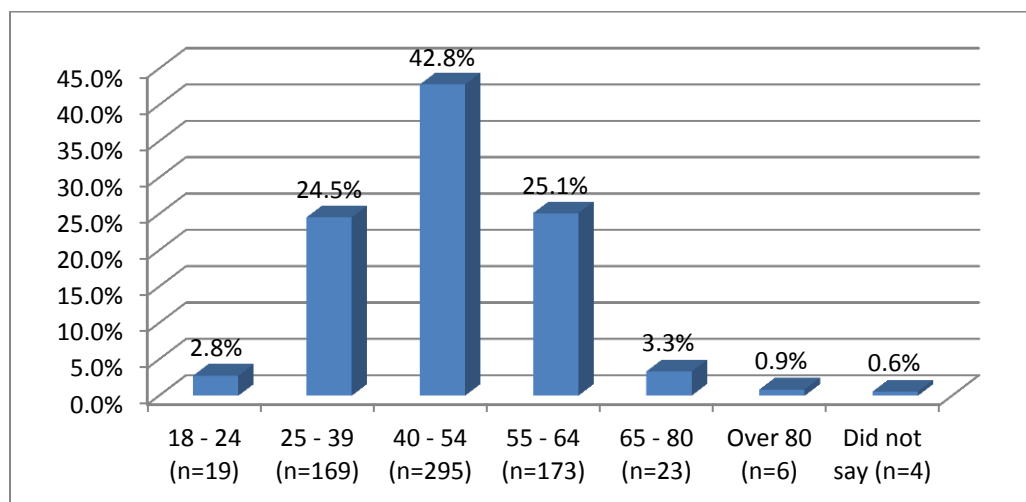
In terms of race or ethnicity, the survey population was largely White, Non-Hispanic, although there were small numbers of Hispanic, Asian, and African American individuals. The exact figures are shown below in Figure 2.

Figure 2 Race Characteristics of Respondents



The employee population was largely made up of middle-aged adults. Over 40 percent of respondents fell between the ages of 40 and 54. The next two largest age groups, each including around 25 percent of the respondents, were 25-39 and 55-64. Therefore, nearly 90 percent of surveyed employees were between the ages of 25 and 64. A detailed breakdown of age groups is illustrated in Figure 3.

Figure 3 Age Distribution of Respondents



Geographically, the respondents mainly lived in and around the Mason City metro area (Cerro Gordo County) and its neighbor to the east, Floyd County, had the second largest number of respondents living within its borders. Figure 4 illustrates population distribution on a map of northern Iowa counties.

Figure 4 Distribution of Respondents by Zip Code of Residence

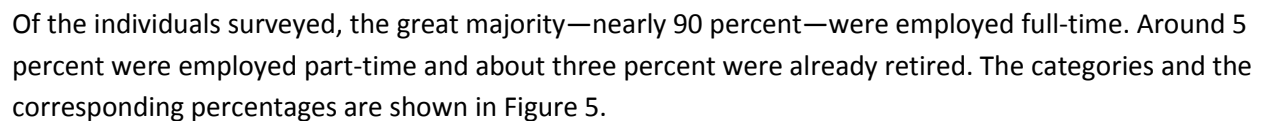
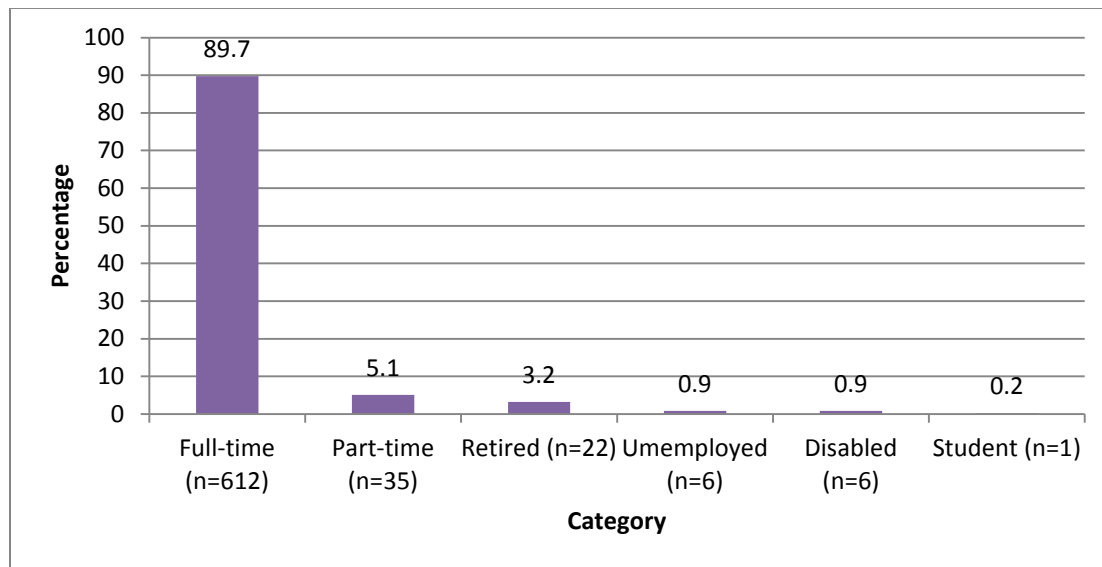


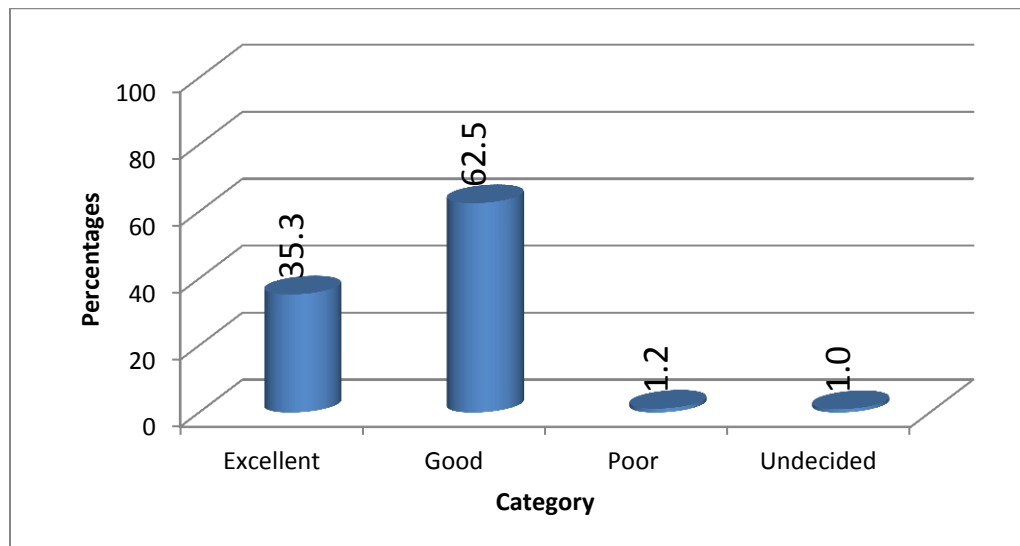
Figure 5 Employment Status of Respondents



Self-Assessed Health Status

The survey asked respondents to assess their own health, giving them the option of answering “Excellent,” “Good,” “Poor,” or “Undecided.” The majority—over 62 percent—of respondents characterized their health status as “good,” while only around one percent characterized their status as “poor.” On the opposite end of the spectrum, about 35 percent of respondents described themselves as being in “excellent” health.

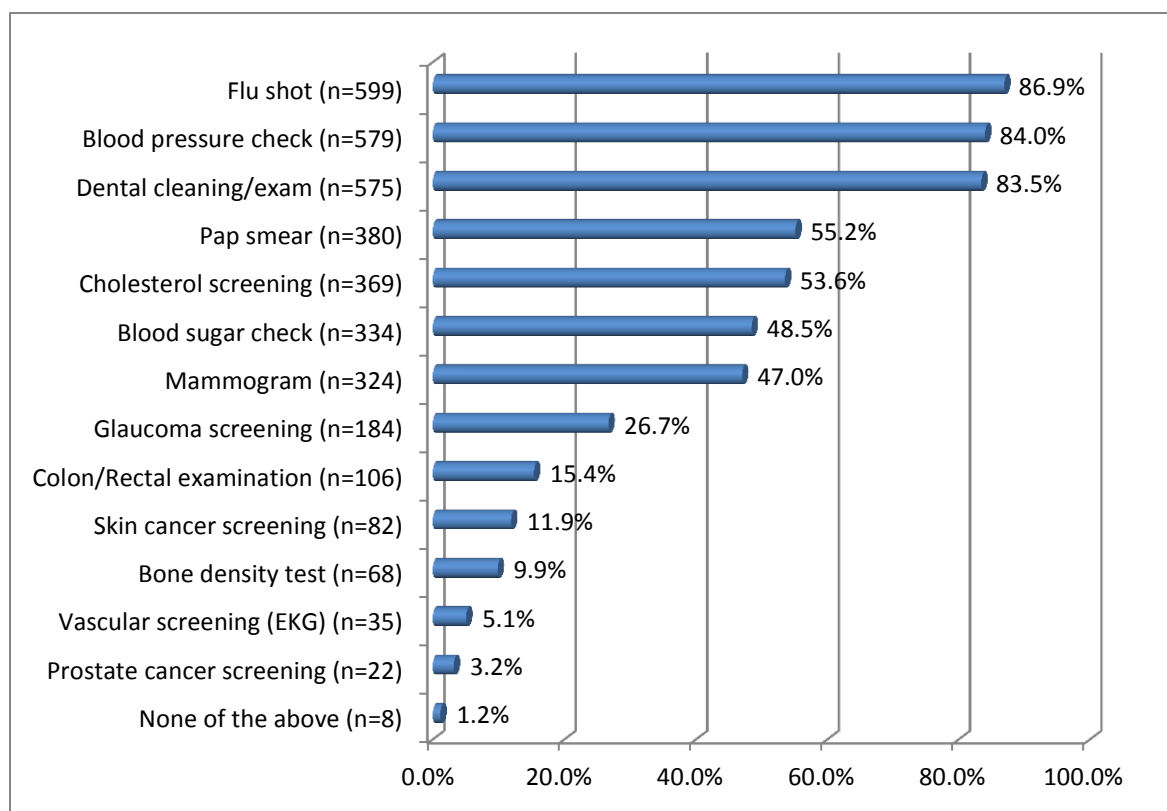
Figure 6 Self-Reported Health Status



Preventative Practices

The survey also asked respondents whether they had used any of 13 different health promotion and disease prevention services available to them. All but eight respondents checked at least one preventative service they had utilized over the previous year. The most common preventative practices—with over 80 percent of respondents utilizing each—were flu shots, blood pressure checks, and dental cleanings or exams, respectively. The least common preventative practices utilized by the respondents were bone density tests, vascular screenings or EKGs, and prostate cancer screenings, with less than ten percent of respondents utilizing each during the previous year.

Figure 7 Preventative Practices



The Presence of Health-Related Risk Factors

The survey presented six health-related risk factors or behaviors and asked the respondents to check any they had. Four hundred eighty one, or about 70 percent of the respondents, reported having at least one risk factor or risk behavior present. Although 208 individuals did not select any of the risk factors listed, only 178—about 26 percent—reported having none of the listed factors. Of the individuals who reported having at least one of the risk factors, 215 checked one, 142 checked two, and 77 checked three risk factors. Figure 8 shows the exact breakdown.

The most common risk factor checked by respondents was being overweight, with nearly 47 percent, or 323 individuals, describing themselves as possessing that risk factor. Stress was the second most common answer, with over 41 percent, or 286 individuals, describing themselves as stressed. Smoking was the least common risk factor checked by only by 50 respondents. The data for each of the seven risk factors is presented in Figure 9.

Figure 8 The Number of Risk Factors Reported

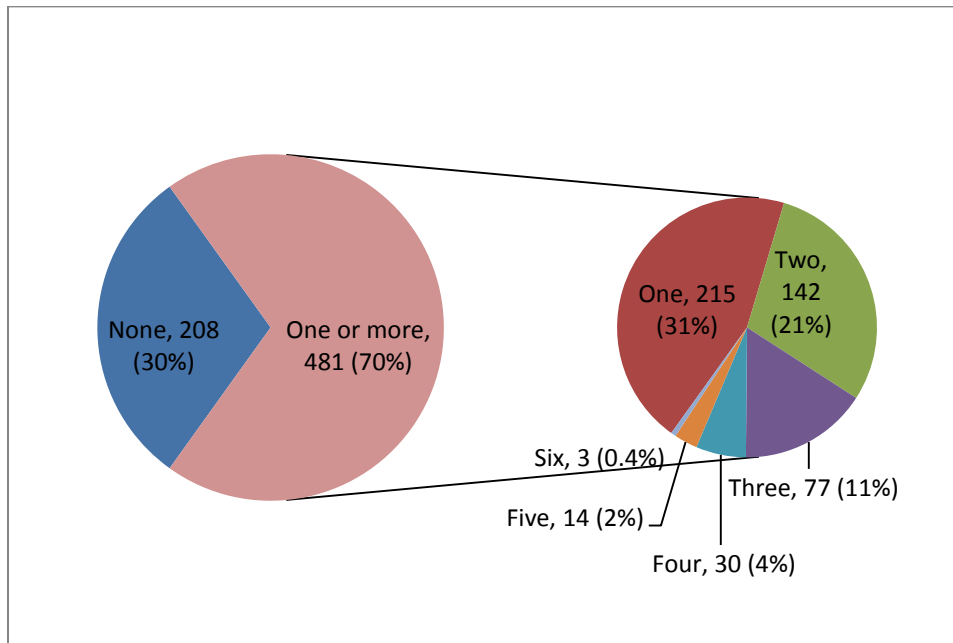
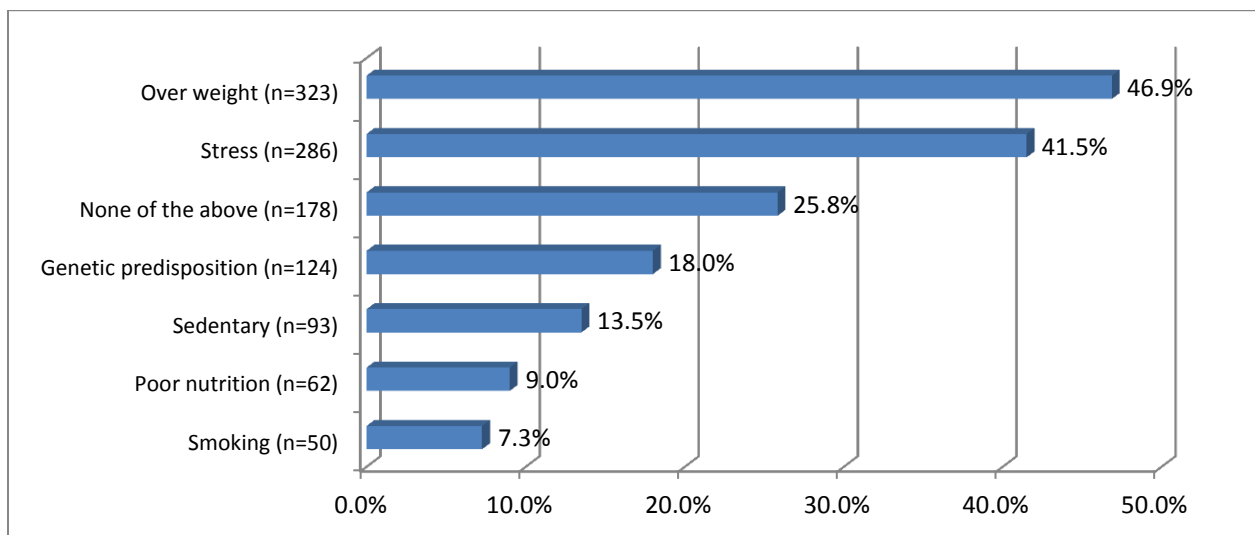


Figure 9 Types of Risk Factors Reported



Prevalence of Selected Health Issues

Next, the survey asked respondents if they had been diagnosed with any of 14 different illnesses or conditions. If a respondent had been diagnosed with a condition that was not listed, he or she was asked to check “other” and then specify the illness or condition. Seventy-four percent, or 498 respondents, reported having been diagnosed with one or more health issues. One-hundred-fifty-two of those had been diagnosed with one condition, and 130 had been diagnosed with two. Figure 10 shows the exact breakdown among respondents.

Although 181 of the respondents—or about 26 percent—did not report having been diagnosed with a health issue, only one respondent positively replied that none of the health issues listed applied to him or her and did not list any other condition. Figure 11 presents the prevalence of different conditions by the proportion of respondents. The most common issue selected was being overweight. Around 37 percent, or 254 individuals, selected it as an issue for themselves. The second and third most common health issues—each selected by about 35 percent of respondents—were high blood pressure and high cholesterol, respectively. The least common were stroke and alcoholism or another addiction. Eleven people, less than 2 percent of respondents, selected each of these two health issues.

Figure 10 The Number of Health Issues Reported Per Individual Respondent

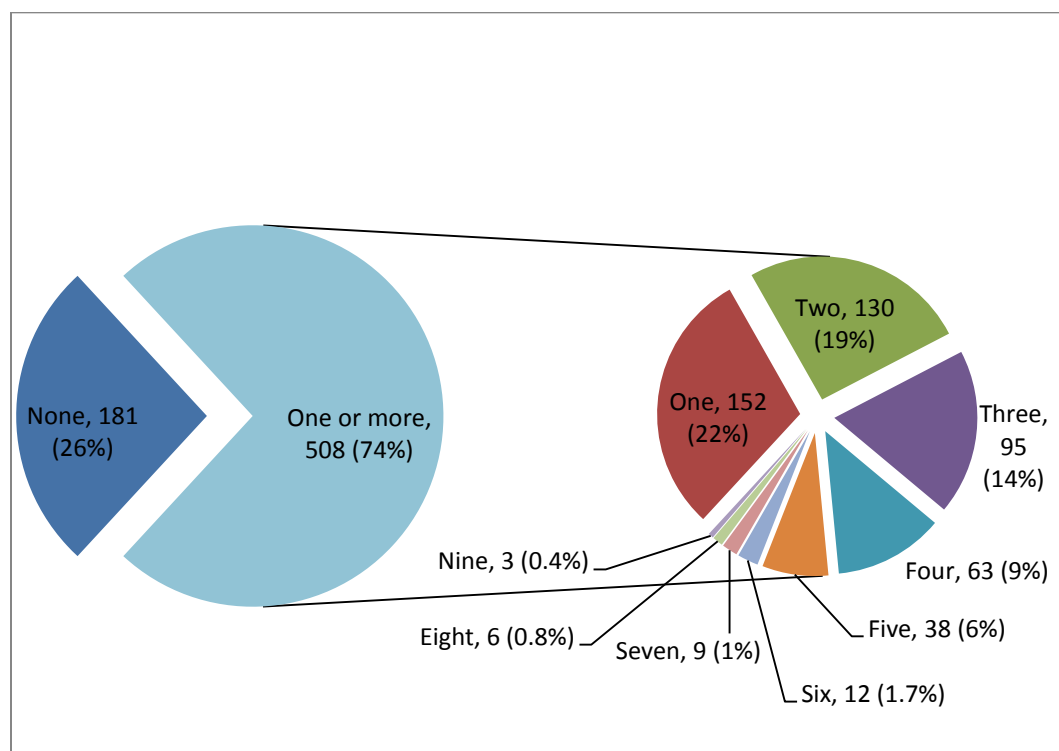
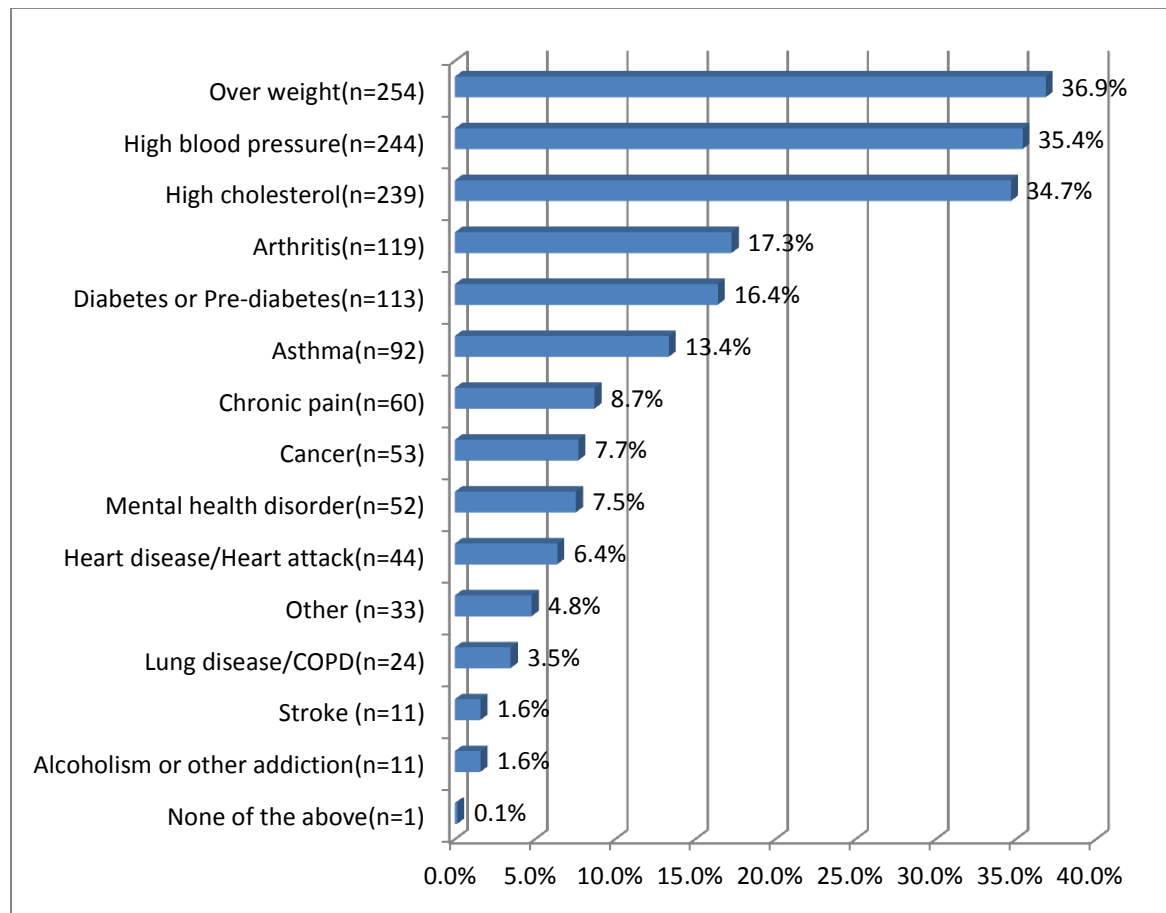


Figure 11 The Types of Health Issues Reported by Respondents



The 33 individuals who reported other conditions than presented in our list provided a total of 33 conditions. Because of the lengthiness of the listed conditions, they are reported on the appendix of this report.

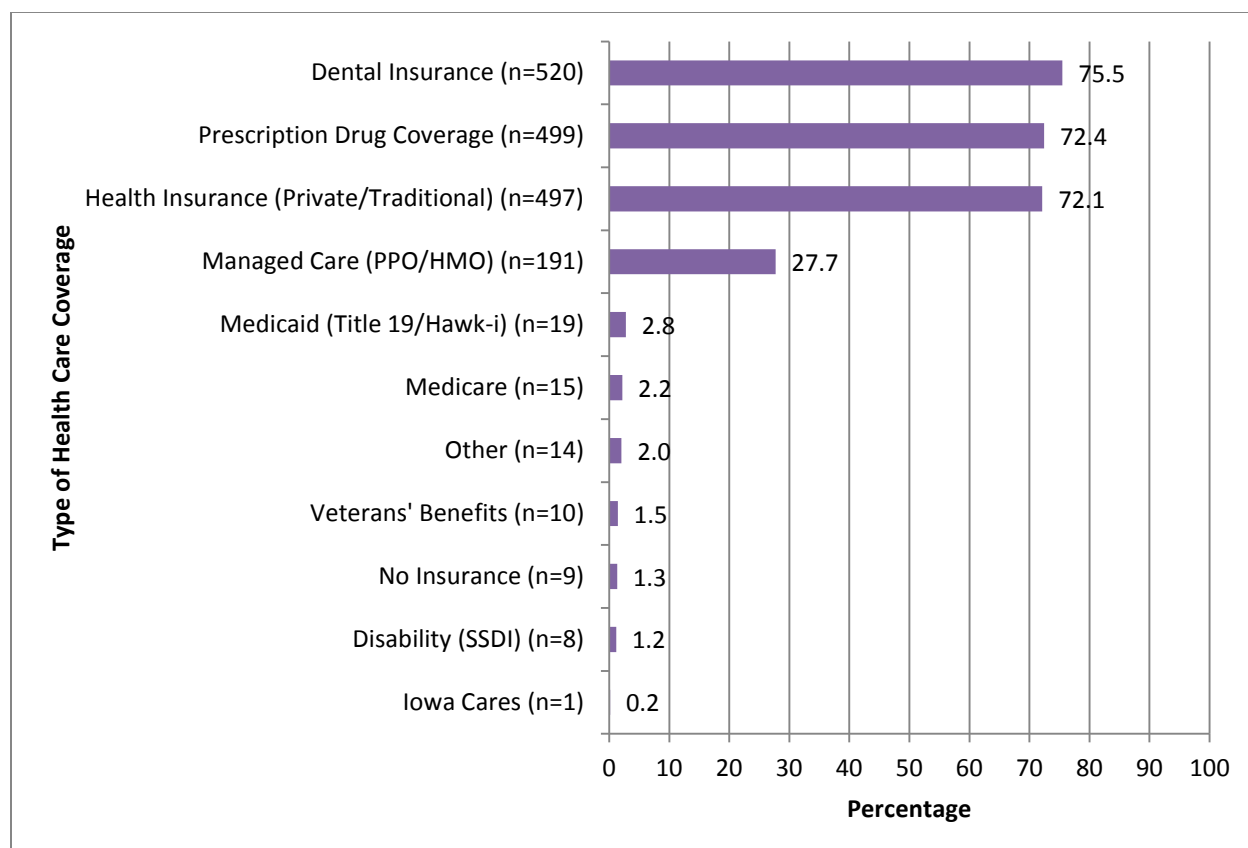
Health Care Coverage and Utilization

Health Care Coverage

The survey asked respondents whether they had health care coverage and then requested they check which, if any, of nine listed health care options they were covered by. “Other” and “No insurance” were options, as well. Nine employees reported not having any type of health coverage. Over 70 percent of respondents, or 497 individuals, had traditional private health insurance. Fifty-three respondents reported having some kind of public health care coverage, whether it was Medicaid, Medicare, Veteran’s Benefits, Disability insurance, or a state program. The type of health care coverage utilized by the most individuals was dental insurance, with over 75 percent, or 520 individuals, reporting that they possessed some form of dental coverage. Out of 14 individuals who responded having “other type of insurance” a little over half (11 individuals) reported having eye or vision insurance. Three individuals

reported having supplemental insurance coverage (“Tri-Care”, “insurance from work”, and “AFLAC and combined supplemental”).

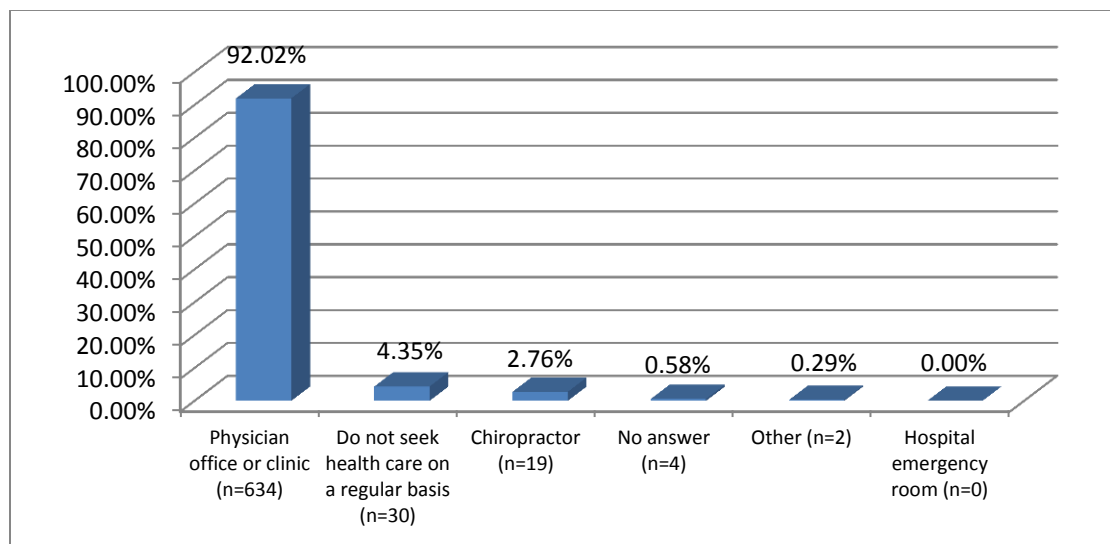
Figure 12 The Types of Health Insurance Coverage Reported



Routine Health Care Service Source

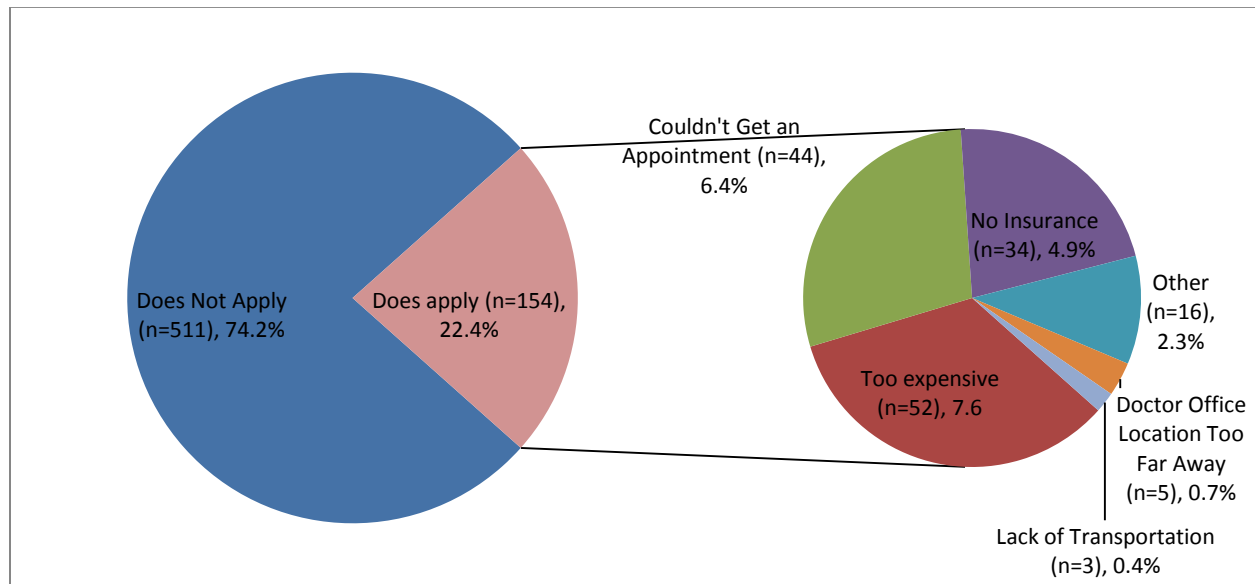
The survey then asked respondents what type of health care service they utilized on a regular basis. Significantly, over 92 percent—or 634 respondents—saw a physician in an office or clinic on a regular basis. Less than five percent, or 30 respondents, did not seek any form of health care on a regular basis. No respondents used the hospital emergency room routinely as their primary form of healthcare. The responses are illustrated in Figure 13.

Figure 13 Visits to Professional Healthcare Providers for Routine Care



Next, the survey asked respondents why they (or someone in their household) may have been unable to visit a physician when they needed to do so, if such a situation had ever occurred to them or someone in their household. Seventy-four percent answered that the question did not apply. But 22 percent, or 154 individuals, answered that they had been unable to visit a physician when they needed to. They were given five reasons for not visiting a physician—with the additional option of “other”—and asked to identify the one that best applied to their situation. The most common reason was the expense of the visit. Fifty-two respondents said they couldn’t afford to see a physician. Inability to get an appointment and lack of insurance were the next most common reasons for not visiting a doctor in a time of need. It is also important to note that 24 individuals did not respond to this question in any form. Graph below shows the responses and the exact figures associated with them.

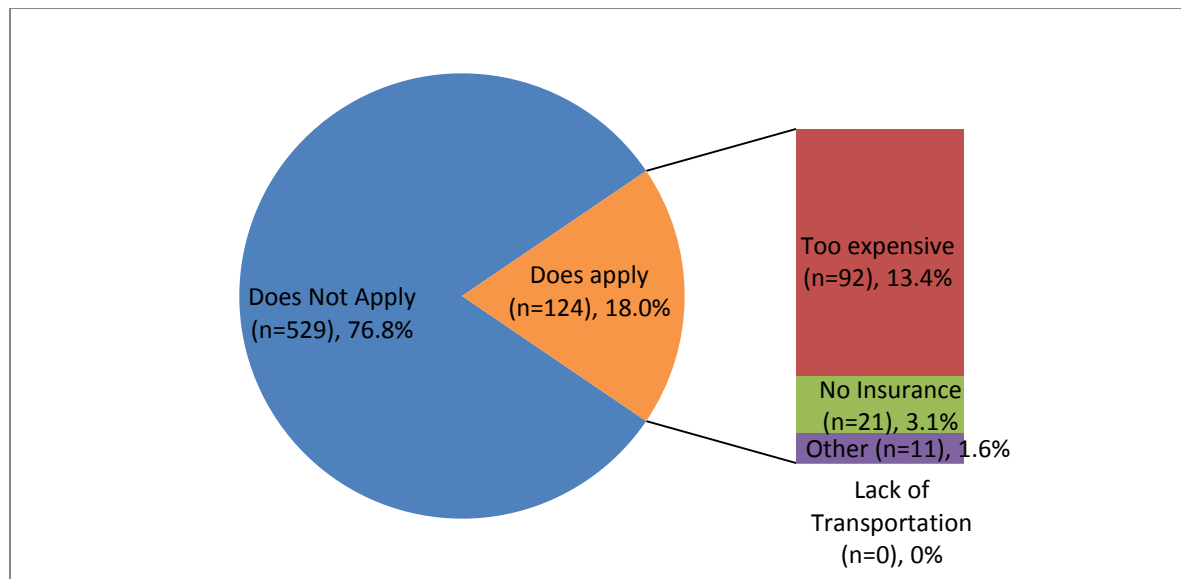
Figure 14 Reasons for Not Visiting Professionals for Routine Health Care (There are 24 non-responses.)



Reasons for inability to fill prescriptions

The survey next asked respondents why there were unable to fill prescriptions, if such a situation applied to them. Of the employees surveyed, 529, over 76 percent, answered that the question did not apply to them. Eighteen percent of respondents, or 124 individuals, said the situation did apply. They were given three reasons for their inability to fill prescriptions—with the additional option of “other”—and asked to select the reason that best described their situation. The most common reason was the expense of the prescriptions. About 13 percent, or 92 respondents, said they couldn’t fill prescriptions because they were too expensive. Twenty-one respondents chose lack of insurance as the reason for their inability to fill prescriptions and 11 individuals, or less than 1.6 percent, chose “other.” Figure 15 shows the responses and the exact data.

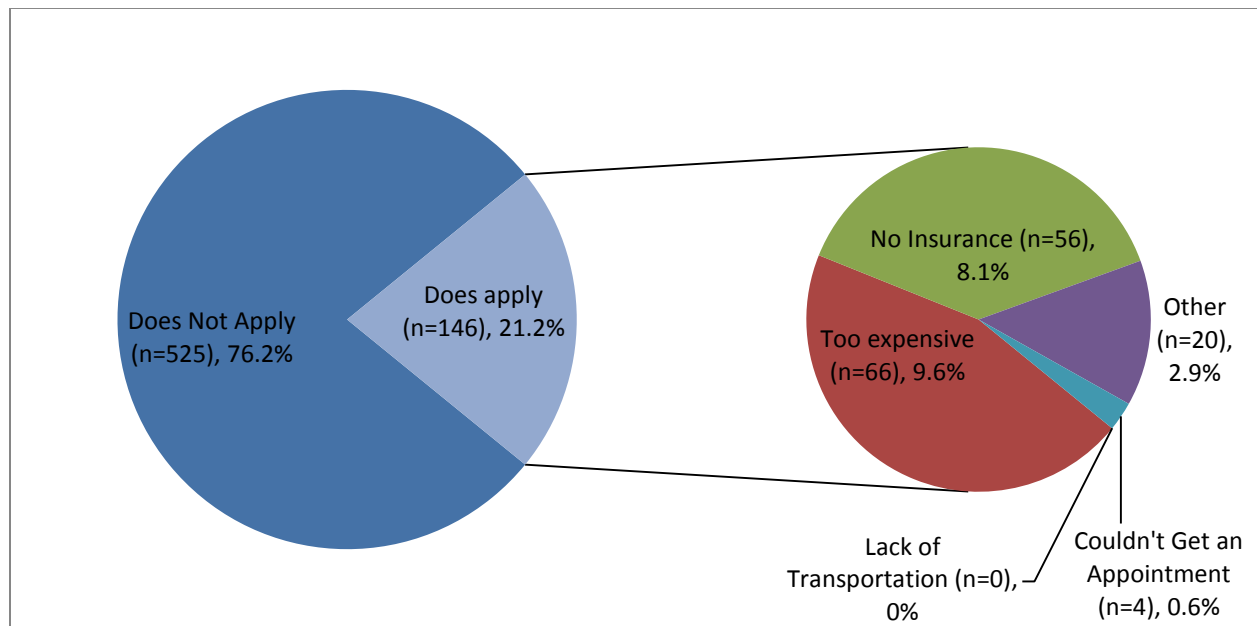
Figure 15 Reasons for Inability to Fill Prescriptions



Reasons for not visiting a dentist

Next, the survey asked respondents why they had not visited the dentist when they needed to do so, if such a situation had ever applied to them. About 76 percent of respondents—525 of them—found that the question did not apply. But 146 individuals, about 20 percent, responded that the question did apply to them. They were given three reasons for why they had not visited the dentist—with the additional option of “other”—and asked to select the reason that best described their situation. The most common reason for not visiting the dentist was the expense. Nearly ten percent, or 66 respondents, said visiting the dentist was too expensive for them. Lack of insurance was the second most common reason. About eight percent of respondents chose “no insurance” as the reason they had not visited a dentist when they needed to do so. Figure 16 shows the details of the responses.

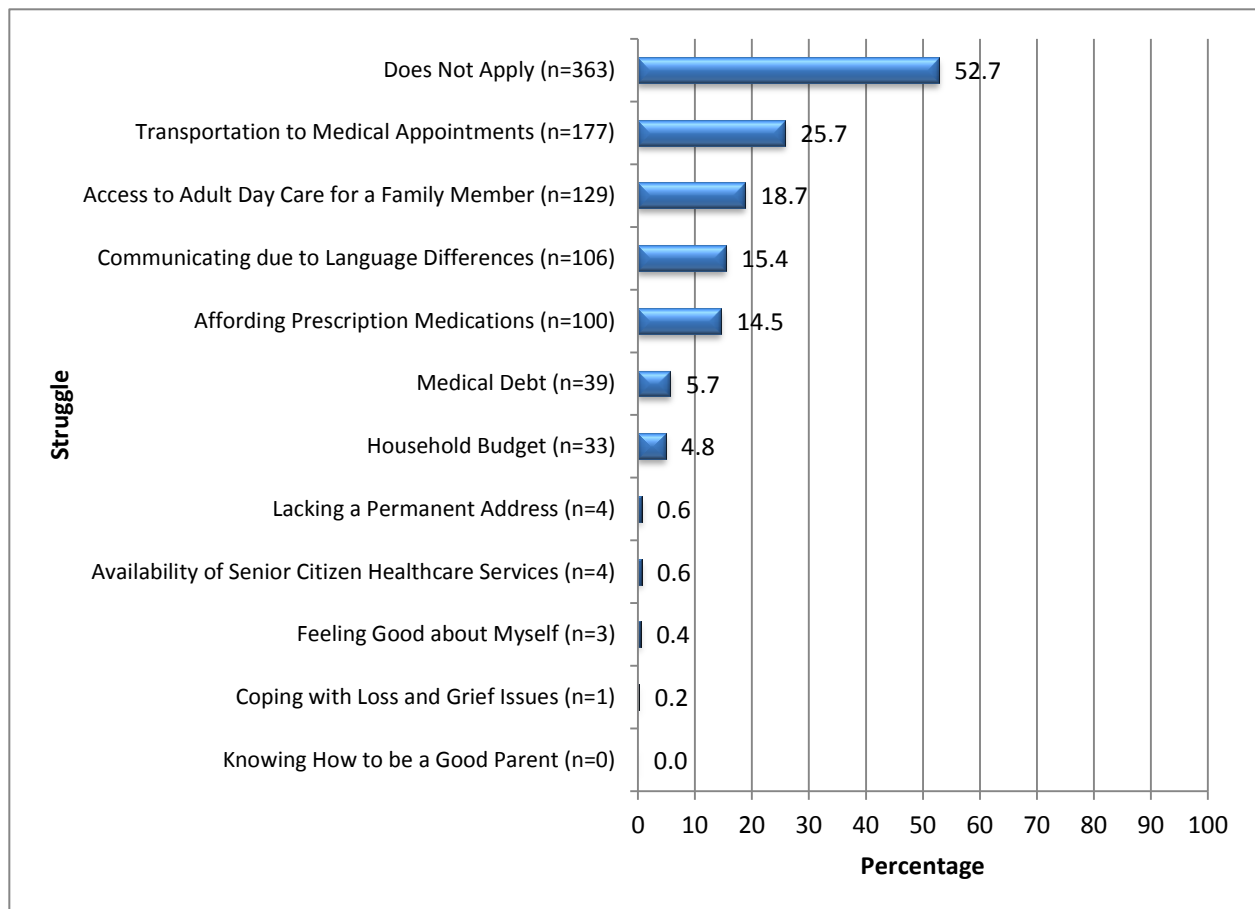
Figure 16 Reasons Given for Not Having Regular Dental Care



Daily Struggles

The survey also asked respondents what kind of daily struggles they encountered concerning their physical and mental health. The respondents were given a list of eleven struggles and asked to select any they felt that they dealt with in their daily lives. Over 50 percent of respondents, or 363 of them, said that the question did not apply. The struggle selected by the largest number of respondents was transportation to medical appointments. About 25 percent of individuals found it to be a daily struggle. About 18 percent of respondents said access to adult day care for a family member was a daily struggle, and around 15 percent of respondents chose communicating to be a struggle, due to a language difficulty. On the other hand, no respondents chose knowing how to be a good parent as a daily struggle, and only one respondent selected coping with loss and grief. Figure 17 shows detail of the responses.

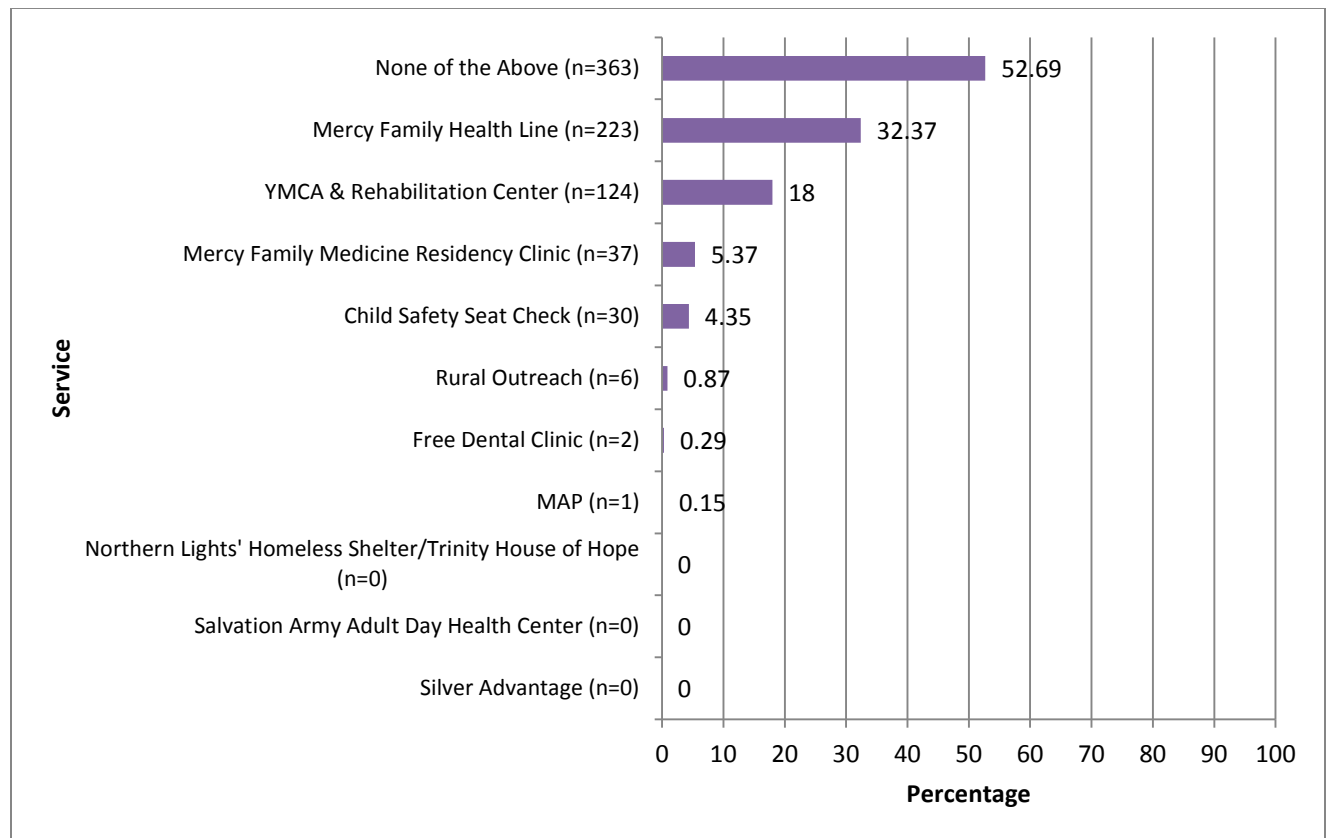
Figure 17 Daily Struggles



Awareness/Use of Available Services

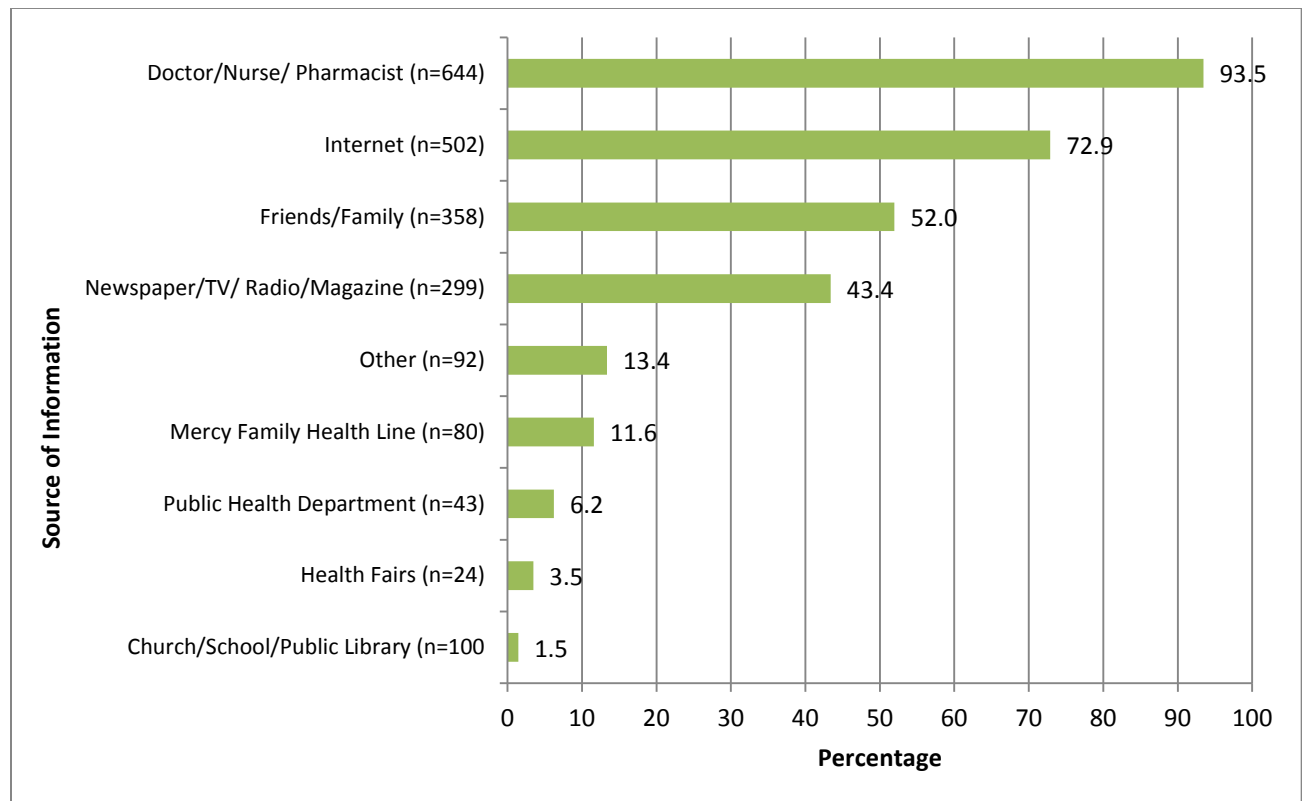
The survey then gave respondents a list of ten Mercy-related services, and asked which, if any, they had ever used. About 52 percent, or 363 respondents, selected the option “none of the above.” The most common social service used was the Mercy Family Health Line, with about 32 percent of employees responding that they had used it. The next most common social service used by respondents was the YMCA Rehabilitation Center; about 18 percent of individuals checked this service. None of the respondents said they used the services Silver Advantage, Salvation Army Adult Day Health Center, and Northern Lights’ Homeless Shelter/Trinity House of Hope. All of the services, along with the percentages of individuals who used them, are listed in Figure 18.

Figure 18 Services Known to or Used by the Employee Survey Participants



The survey respondents were also asked about where they normally get health related information. They were given a list of eight sources of information—with the additional option of “other”—and asked to select any of the sources they used to learn about social services. About 94 percent of individuals said they received information from their doctor, nurse, or pharmacist. And around 73 percent said they used the Internet to learn about social services. The least common sources of information used by respondents were their church, school, or public library and health fairs, with 1.5 and 3.5 percent of respondents choosing these sources, respectively. The exact breakdown of responses is shown in Figure 19.

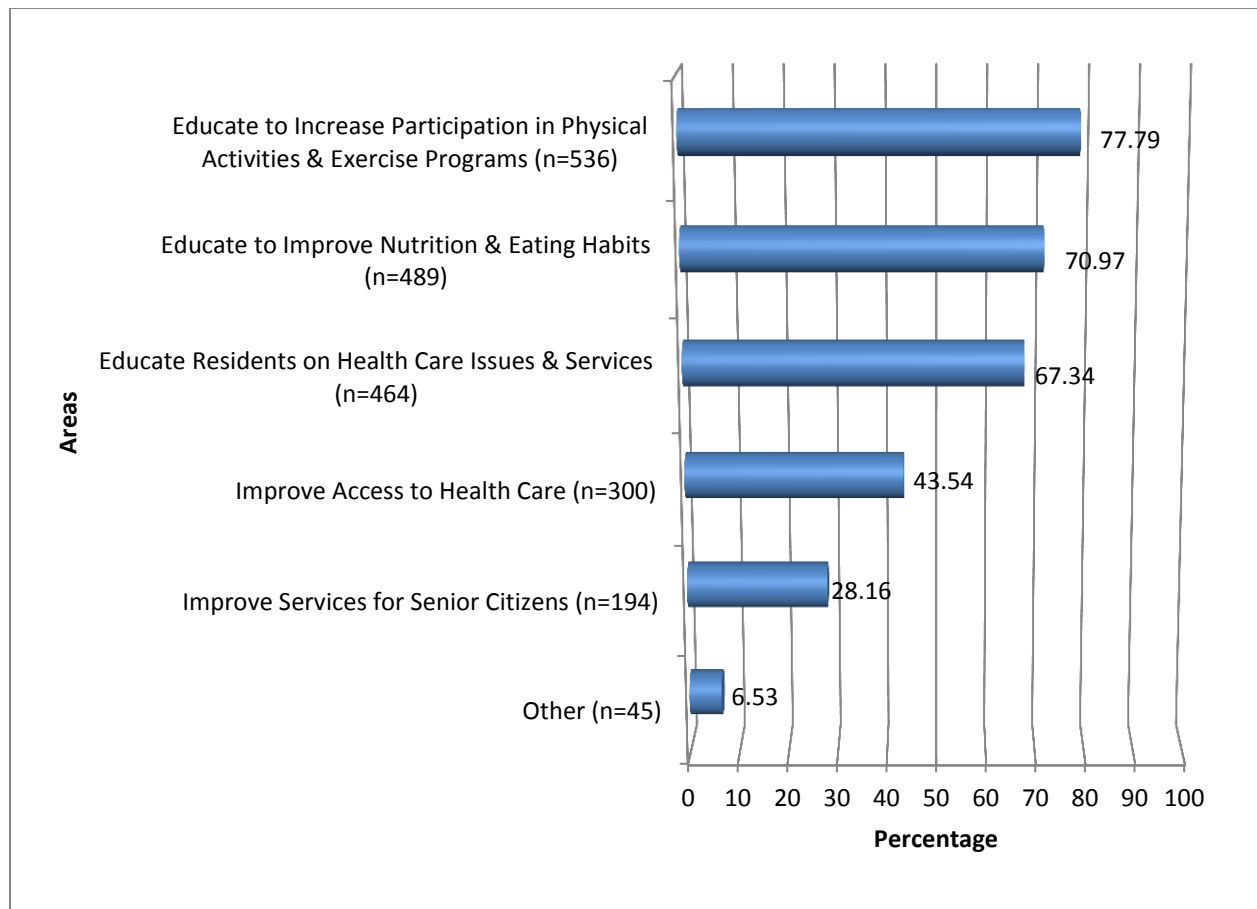
Figure 19 Sources of Health Information Reported by Respondents



Areas most important to improve

Lastly, the survey asked respondents what areas are most needed to improve in order to make the residents of their community healthier. They were given a list of five options—with the additional option of “other”—and asked to choose any three of the areas they thought needed improvement. Around 78 percent, or 536 respondents, thought that more education was needed to increase participation in physical activities and exercise programs. About 71 percent thought education to improve nutrition and eating habits was needed and about 67 percent believed educating citizens about health issues was important. The area that respondents felt needed the least improvement was services for senior citizens. The choices and the breakdown of percentages are listed in Figure 20.

Figure 20 The “Top Three Areas” Identified By Respondents According to The Proportion Who Selected Each

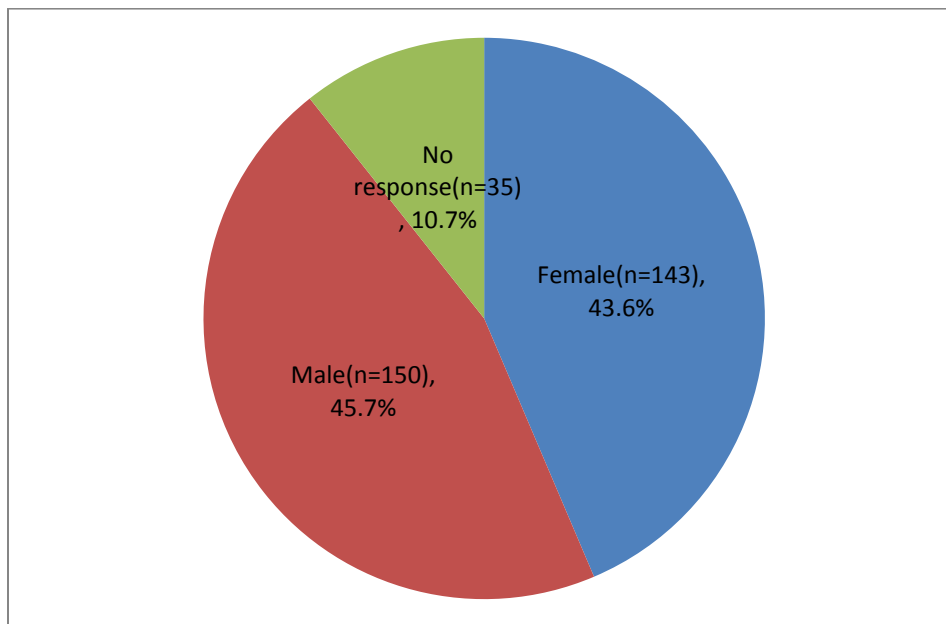


Community Health Care Needs Assessment Survey Results

Demographic and Socioeconomic Characteristics of the Surveyed Individuals

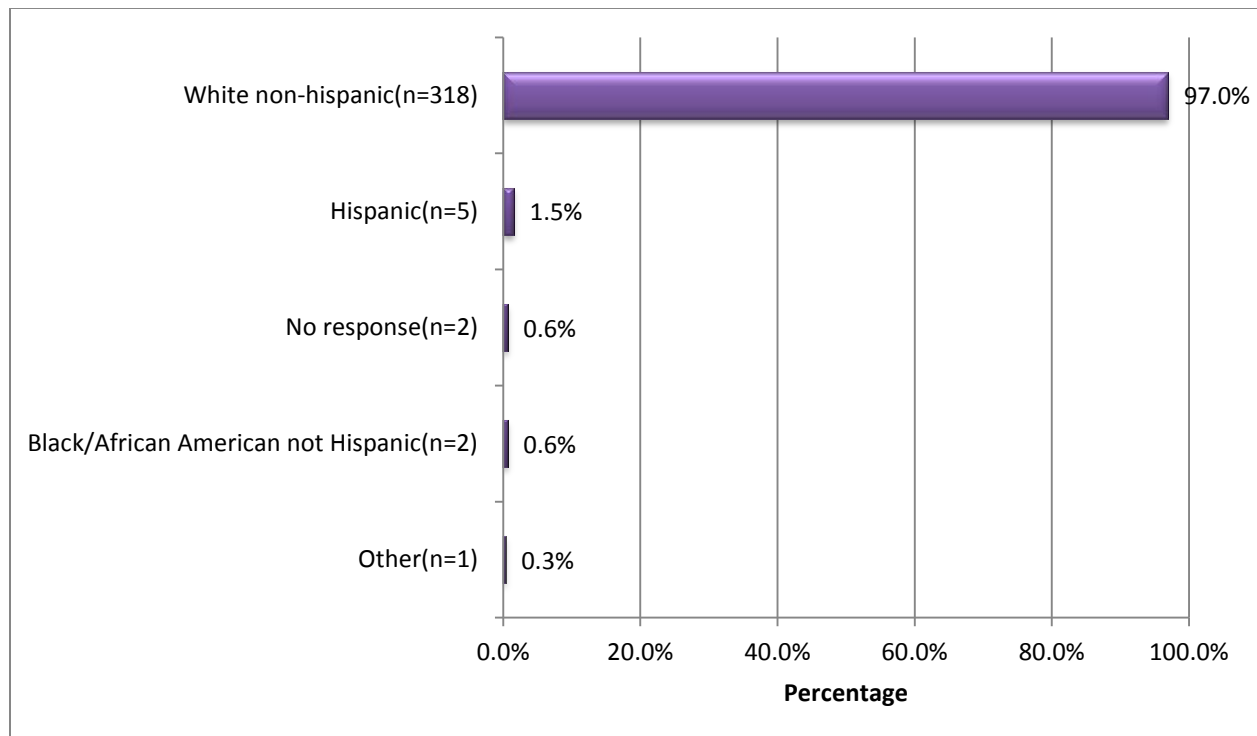
The Mercy North Community Needs Assessment Survey had 328 respondents. The population was about 44 percent female and 46 percent male, with over ten percent not responding to the question about gender. In exact figures, there were 143 female respondents, 150 male respondents, and 35 respondents of unknown gender. Unlike the Employee Needs Assessment Survey, this survey had more male respondents than female and was much closer to an equal distribution of gender.

Figure 21 The Gender Distribution of Survey Participants



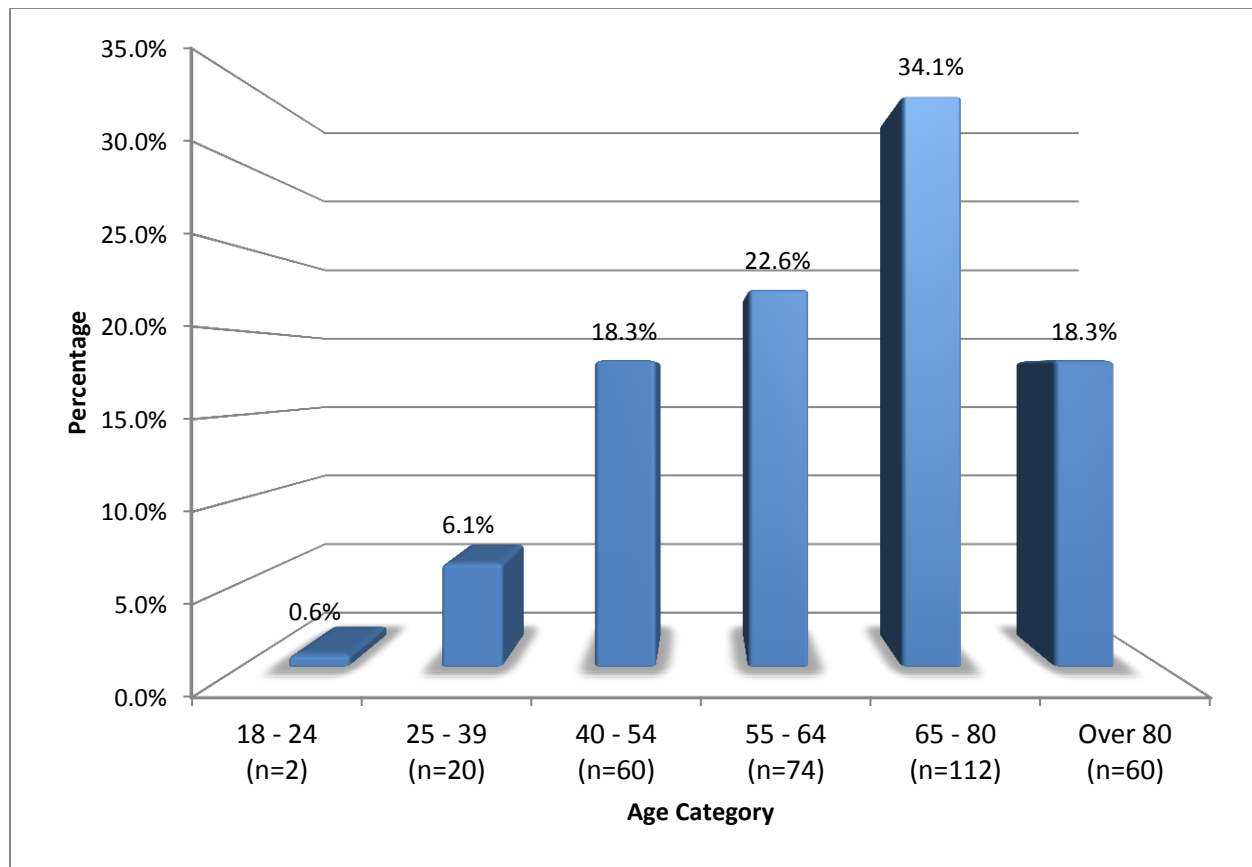
Racially, the survey population was largely White, Non-Hispanic, although there were small numbers of Hispanic and African American individuals—less than two percent each. Exactly 97 percent of respondents were White, Non-Hispanic. One respondent chose “Other” as his or her race/ethnicity, and two individuals did not respond to the question. The exact figures are shown in the graph below.

Figure 22 Race/Ethnicity of Survey Participants



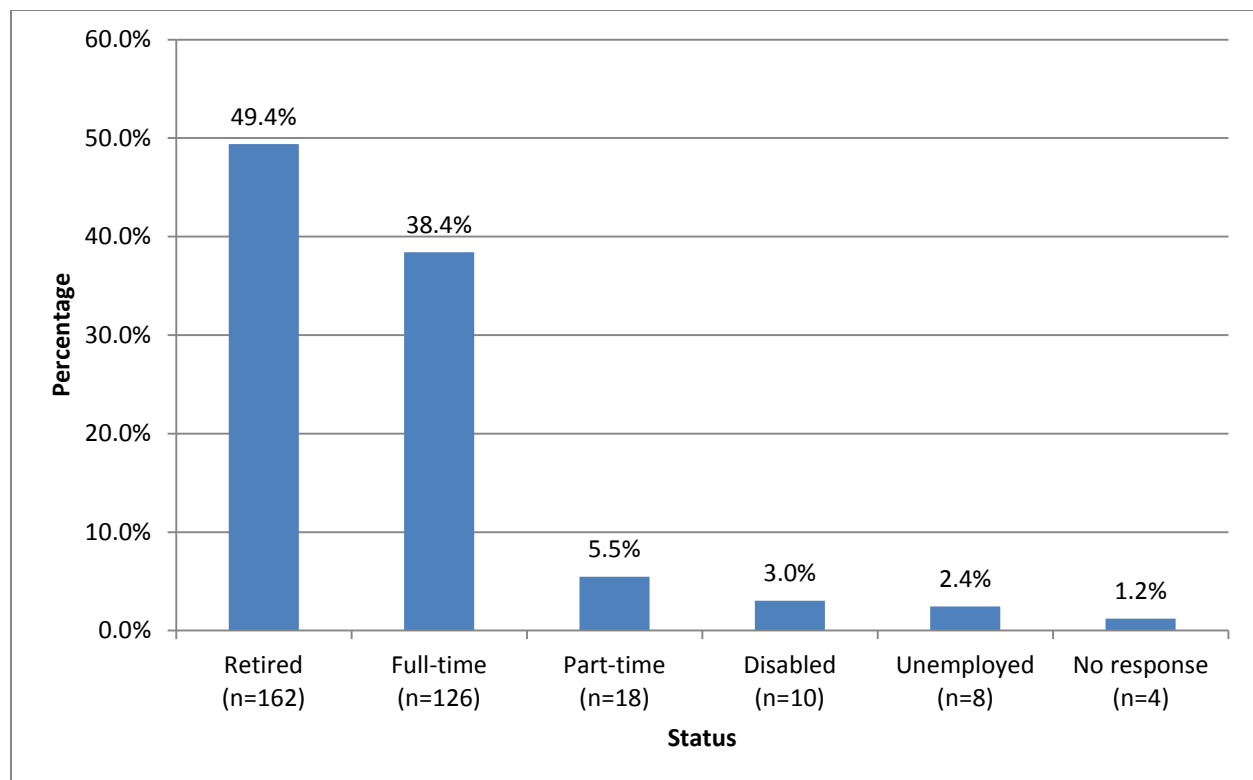
The Community Needs survey population was significantly older than that of the Employee Needs survey, where nearly 90 percent of the population was between the ages of 25 and 64. In the Community Needs survey, over 90 percent of the respondents were over the age of 40. And over 50 percent of respondents were seniors, age 65 or older. Individuals under 40 made up less than seven percent of the survey population. The largest age group was 65-80; about 34 percent, or 112 respondents, fell into this category. The second largest age group was 55-64, and the next two largest, each capturing 18.3 percent of the population, were 40-54 and over 80. See the graph below for a more exact age breakdown of the respondents.

Figure 23 Age Distribution of Respondents



Since more than 50 percent of the survey respondents were age 65 or older, it is no surprise that nearly 50 percent, or 162 individuals, were retired workers. Still, nearly 40 percent of respondents were employed full-time. Part-time workers made up less than six percent of the surveyed population. And together, the disabled and the unemployed also made up less than six percent of the population. Four individuals, or 1.2 percent of respondents, gave no answer to the question about employment status. Figure 24 shows the exact data.

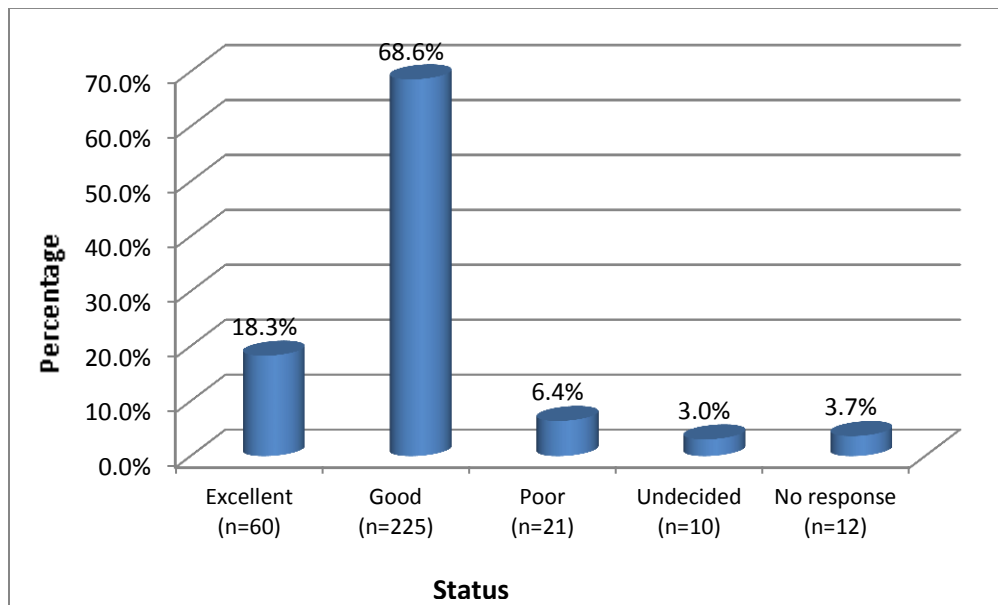
Figure 24 Employment Status of Respondents



Self-Assessed Health Status

The survey asked respondents to assess their own health, giving them the option of answering “Excellent,” “Good,” “Poor,” or “Undecided”. Sixty respondents (about 18 percent), described their health as “excellent.” However, the large majority, almost 70 percent, described their health as “good.” More than six percent of respondents characterized their health as “poor,” which is about five percent more of the population than did so in the Employee Needs survey. The larger number of respondents describing their health as “poor” could be due to the survey’s older population, since more than 50 percent of the respondents were seniors. Also, nearly seven percent of the respondents either answered “Other” or did not respond to the question. The graph below illustrates the exact figures for each response.

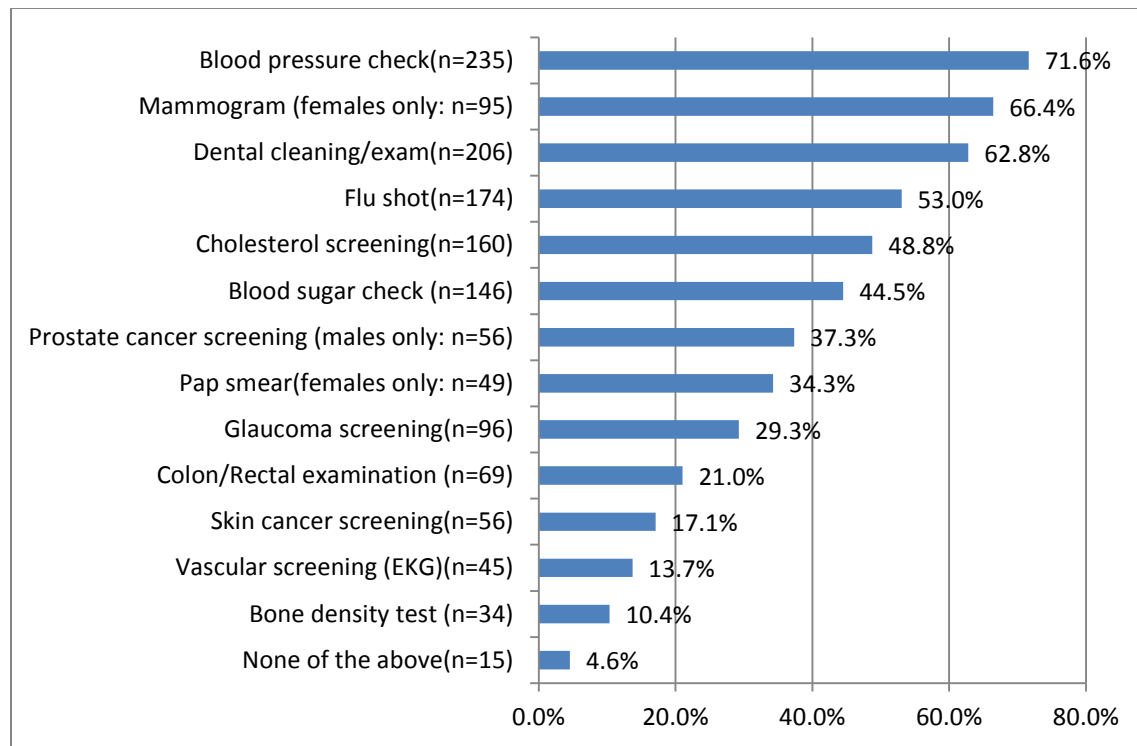
Figure 25 Self-Assessed Health Status of Respondents



Preventative Practices

Next, the survey asked respondents whether they had used any of 13 different health promotion and disease prevention services available to them. All but 15 respondents checked that they had used some type of preventative practice over the previous year. The most common practices used by the respondents—with over 60 percent utilizing each—were blood pressure checks and dental cleaning/exams, respectively. Also, more than 66 percent of female respondents had received a mammogram during the previous year. The least common preventative practices used were vascular screenings, or EKGs, and bone density tests, respectively—with less than 15 percent utilizing each. Figure 26 lists all 13 preventative services.

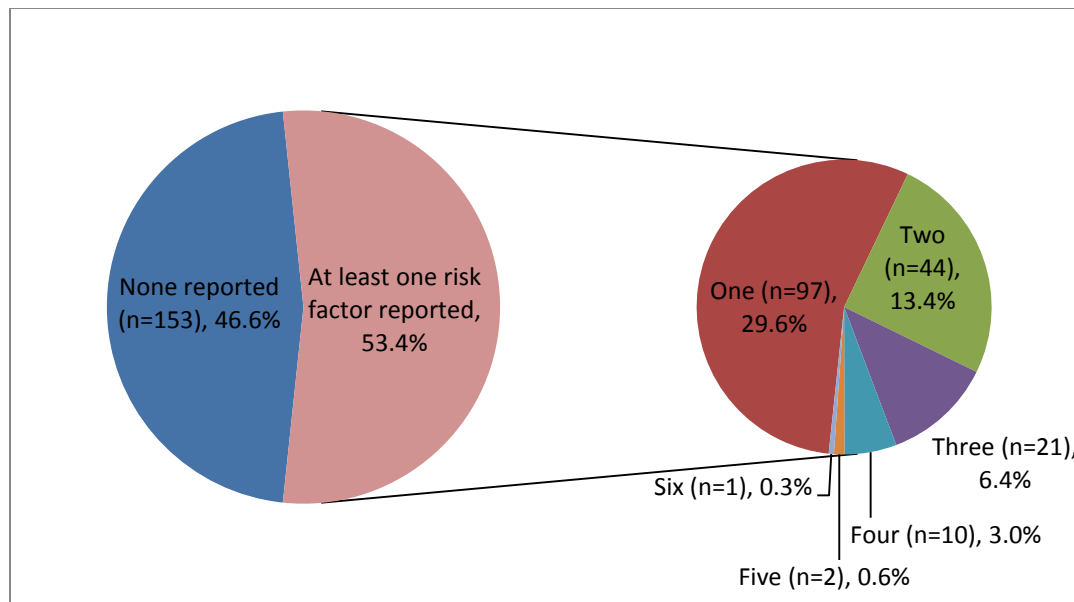
Figure 26 Self Reported Preventative Practices By Respondents



The Presence of Health-Related Risk Factors

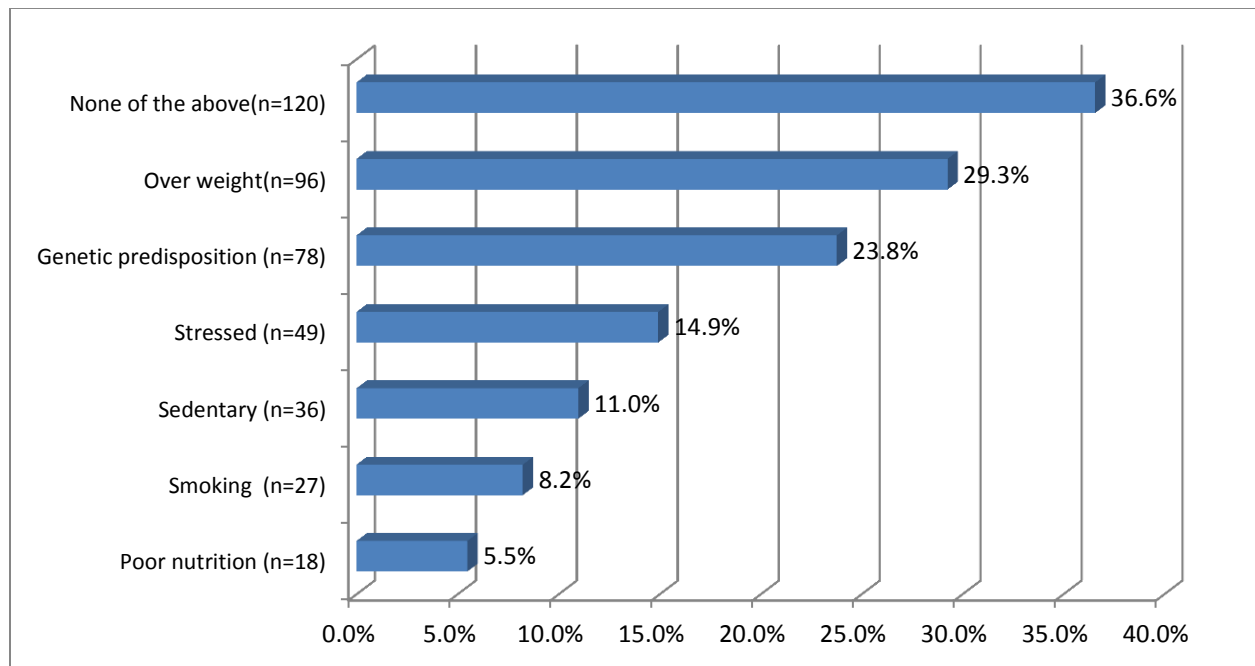
The survey then presented six health-related risk factors and behaviors and asked respondents whether they possessed or exhibited any of them. More than 46 percent of the surveyed population, or 153 individuals, did not report having any of the listed risk factors. But the majority—about 53 percent of respondents—reported having at least one of the risk factors. Of these individuals, almost 30 percent reported just one risk factor, while about 13 percent, or 44 people, reported having two of the risk factors. Twenty-one respondents, or 6.4 percent, reported having three risk factors. The exact breakdown, along with the figures for those reporting four, five, and six risk factors, is illustrated in the graph below.

Figure 27 Number of Self-Reported Health Risk Factors by Individual Respondents



The list of risk factors and behaviors the respondents were asked about is given below in the next figure. About 47 percent of respondents did not check any risk factors. The most common risk factor respondents reported was being overweight—with nearly 30 percent, or 96 individuals, selecting that risk factor. The second most common was a genetic predisposition, and the third most common was stress. Poor nutrition was the risk factor least selected by respondents. It is also important to note that 120 respondents, about 37 percent, checked “none of the above,” an answer that should be differentiated from not checking any of the risk factors listed.

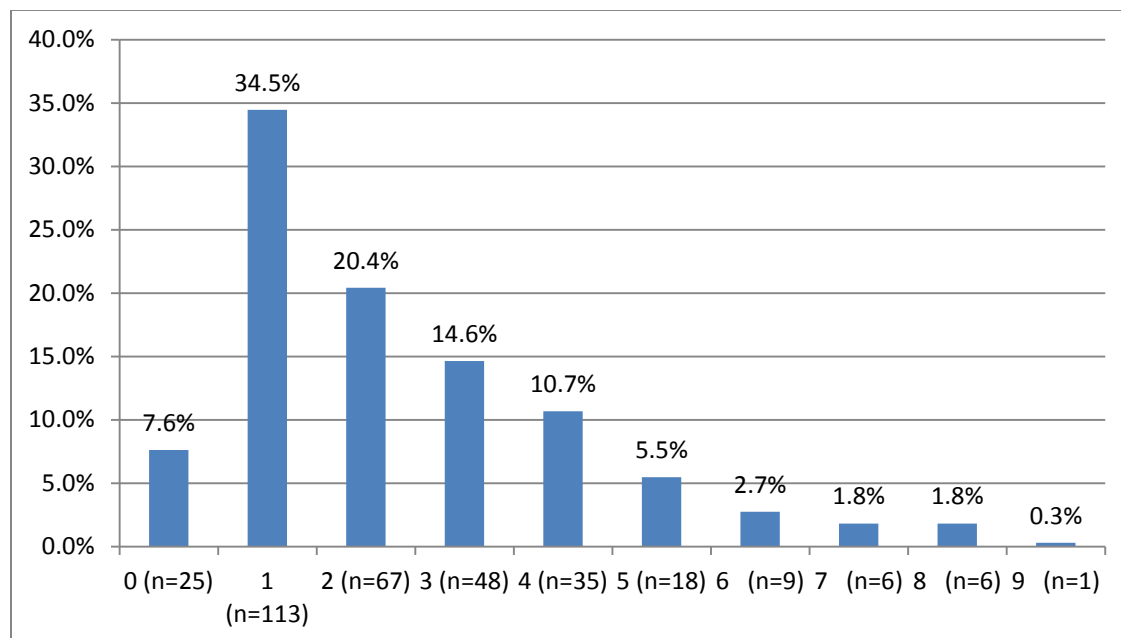
Figure 28 Self-Reported Risk Factors Present Among the Survey Respondents



Prevalence of Selected Health Issues

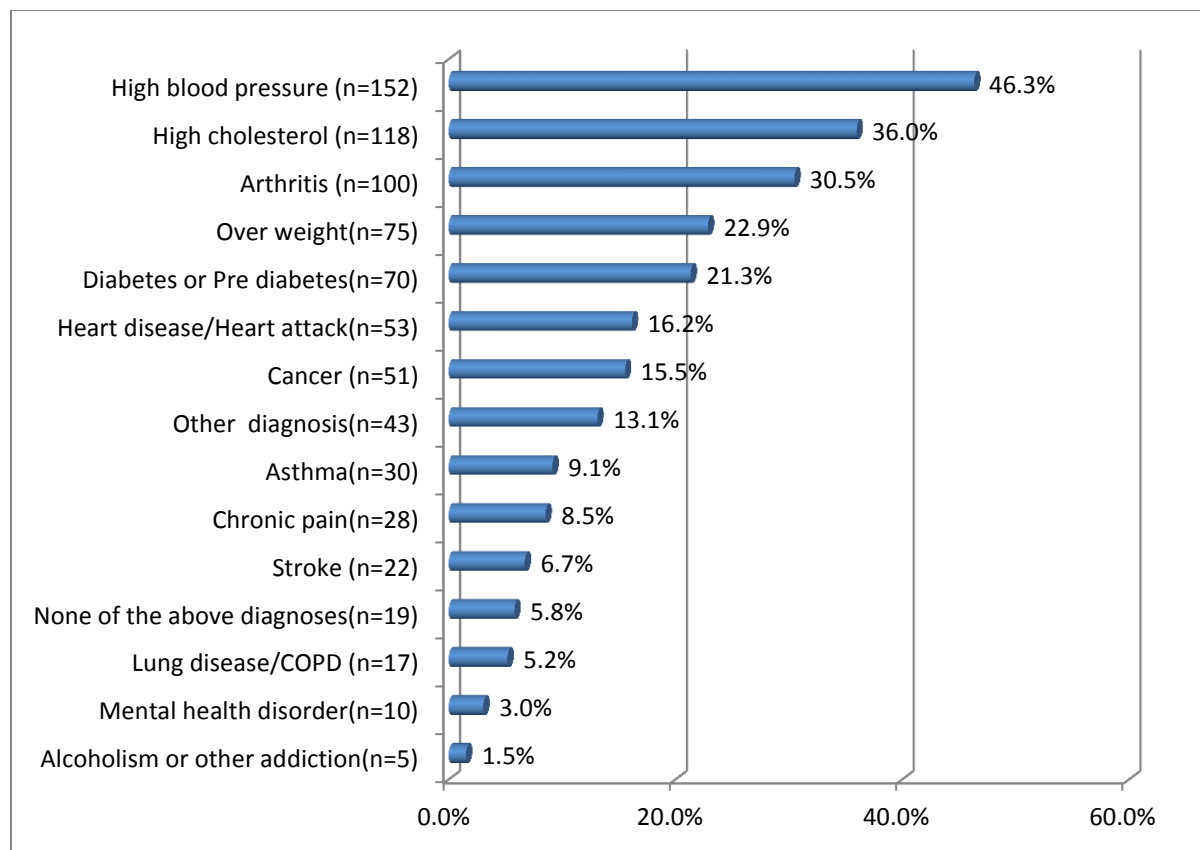
After risk factors, the survey respondents were asked about any actual health issues they had been diagnosed with. Fourteen different health issues were listed—with the additional option of “other diagnosis”—and the respondents were asked to check all the conditions they had, if any. Less than eight percent of respondents did not report having a health issue, which means that more than 92 percent reported having been diagnosed with at least one condition. Nearly 35 percent, or 113 respondents, reported having just one issue. About 20 percent reported having been diagnosed with two issues, and around 15 percent reported having been diagnosed with three. See Figure 29 for the exact breakdown.

Figure 29 Number of Issues Reported Per Each Respondent



The list of 14 health issues and conditions is shown in the Figure 30. The most common issue selected by respondents was high blood pressure. Around 46 percent, or 152 respondents, checked that option. High cholesterol and arthritis were the next most common health issues selected, each chosen by at least 100 respondents. Next, 75 respondents (or about 23 percent), reported being overweight. Although this is not in itself a health condition, it is likely to lead to other serious health issues. It is also important to note that 19 individuals, or nearly six percent of the surveyed population, checked “none of the above,” an answer that should be differentiated from not checking any option. Also, 43 respondents reported having a health condition not listed in the survey. Although the survey provided space in which to respond the type of health issue, these respondents failed to specify what health issue they had.

Figure 30 Types of Health Issues Reported

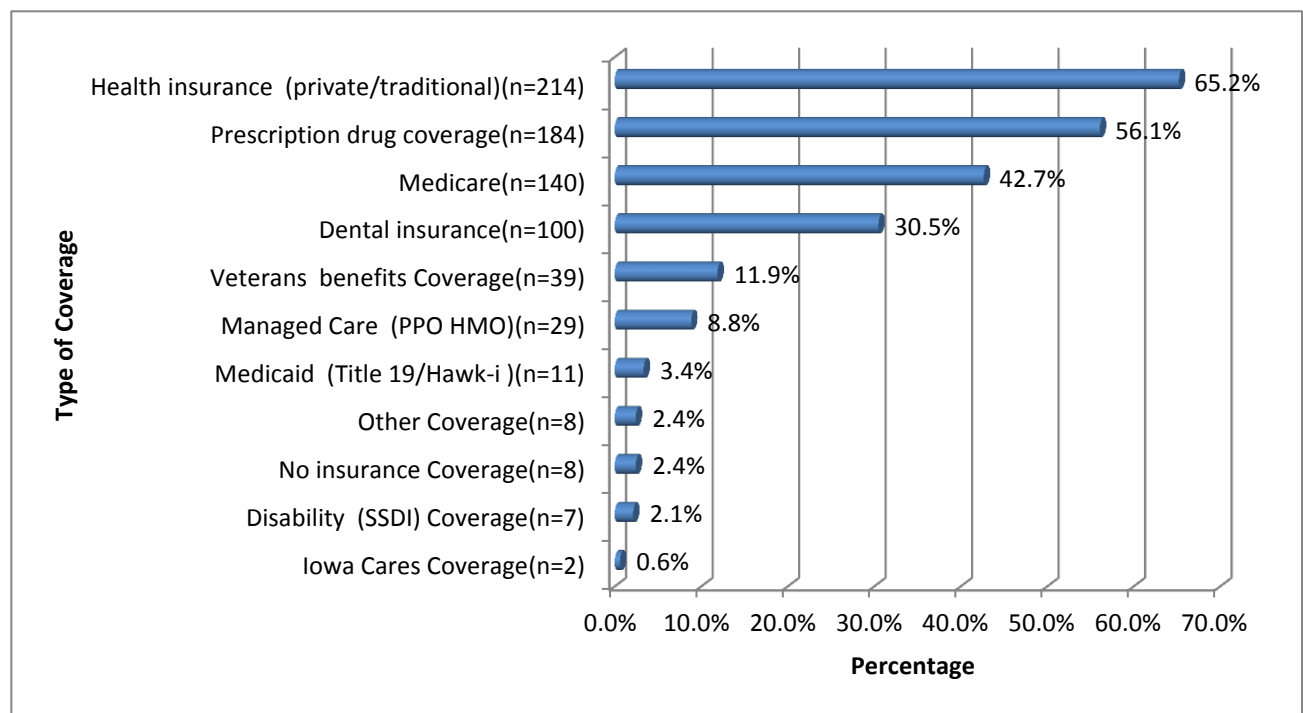


Health Care Coverage and Utilization

Health Care Coverage

The survey respondents were next asked about their health care coverage and how they used health services. The first question in this series concerned the type of health coverage, if any, the respondents possessed. Nine options were listed—along with the options of selecting “Other coverage” and “No insurance coverage”—and the respondents were asked to check all that applied. Eight respondents reported having no health care coverage at all. The majority—about 65 percent—had traditional private health insurance. A majority—about 56 percent—also reported having prescription drug coverage. And nearly 43 percent reported receiving Medicare coverage. This is a much larger percentage than reported receiving Medicare in the Employee Needs Survey; only about 2 percent of the employees surveyed received Medicare. This difference is most likely due to the advanced age of the Community Needs survey population. Figure 31 lists all the health care coverage options the respondents could choose from and the number of respondents that selected each.

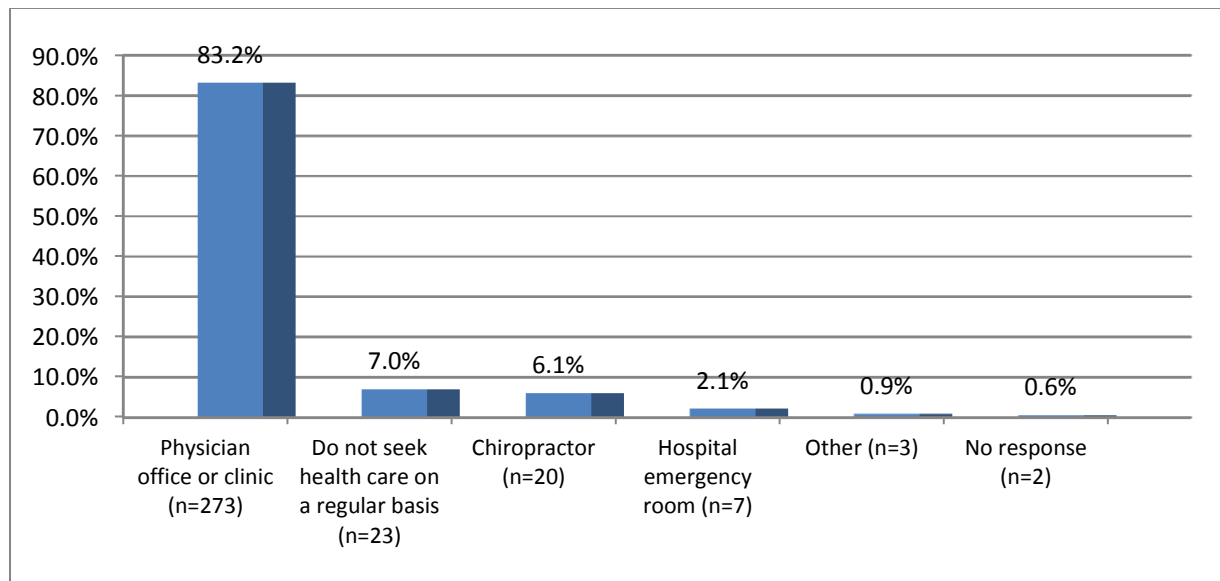
Figure 31 Health Care Coverage



Routine Health Care Service Source

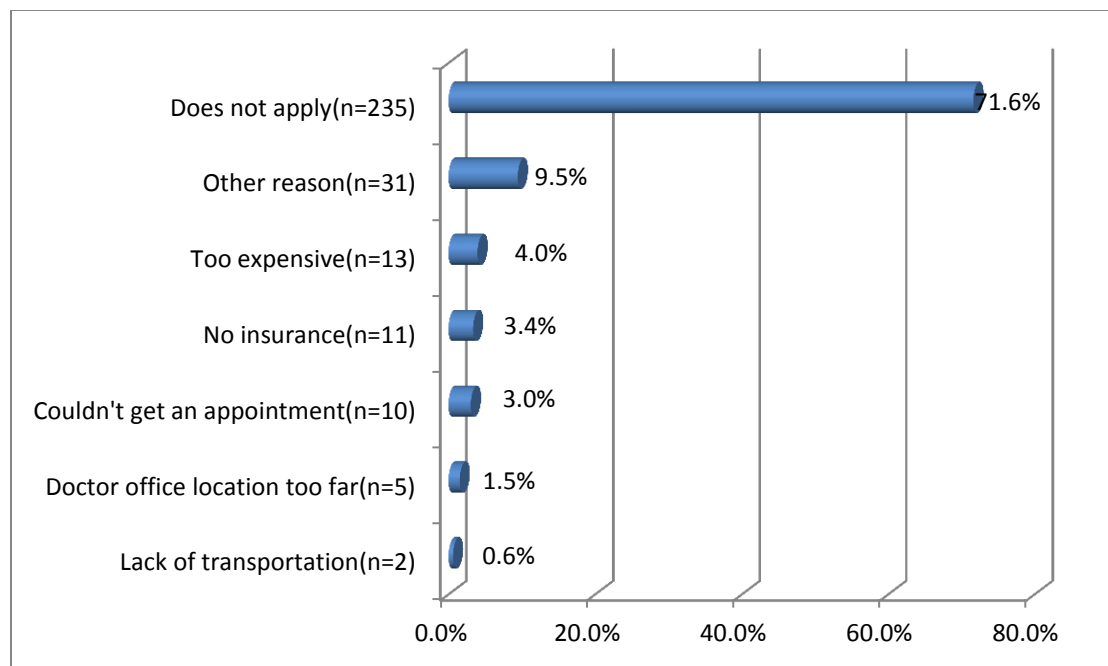
The next question in this series about health care coverage and utilization concerned the kind of routine health care the respondents used. The large majority—more than 83 percent—went to a physician’s office or clinic on a regular basis. But seven percent, or 23 respondents, did not seek any type of routine health care. About six percent saw a chiropractor and around 2 percent went to a hospital emergency room on a regular basis. Less than one percent of respondents used some other type of routine health care, and less than one percent did not respond to the question. Exact figures are given in the graph below.

Figure 32 Visits to Professional Health Care Providers for Routine Care



In addition, the respondents were also asked if they or someone in their family was unable to utilize routine health care service, what caused them make such decisions. More than 70 percent of respondents found that the question did not apply to them. It is worth noting here that this proportion is about the same as is reported in the employee survey earlier. Four percent of respondents said that routine health care was too expensive, and 3.4 percent stated their reason for no routine care was lack of insurance. But the most common reason chosen by respondents for not seeking routine care was “other.” See the figure below for the complete list of reasons and the number of respondents who selected each.

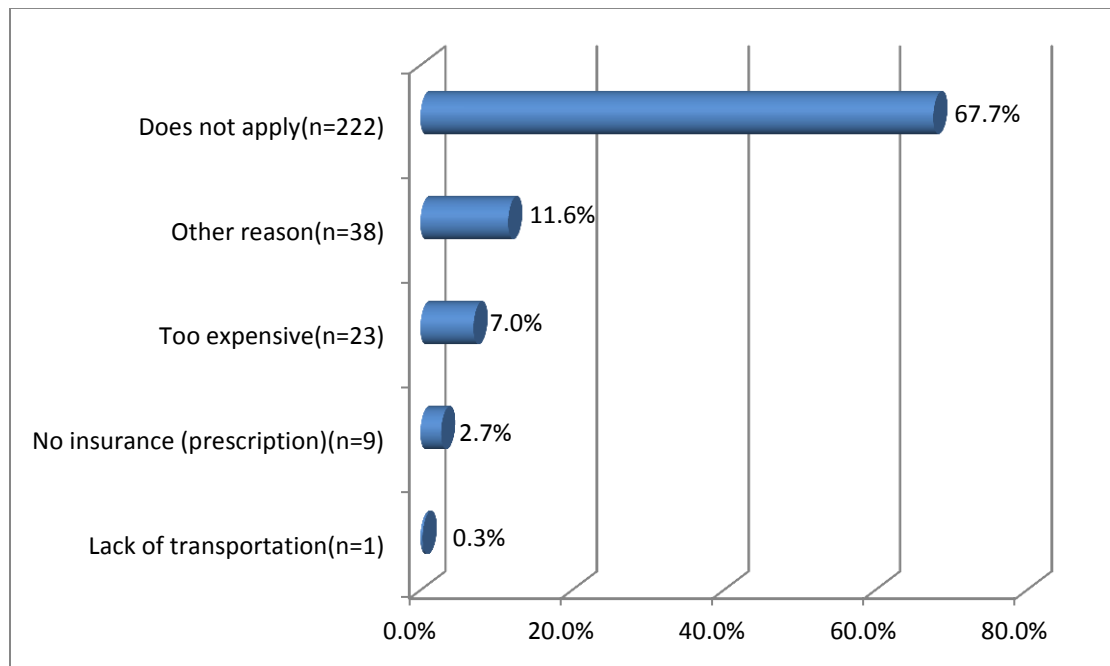
Figure 33 Reasons for Not Visiting Professionals for Routine Health Care



Reasons for inability to fill prescriptions

The survey respondents were next asked about their reasons for not having prescriptions filled, if such was the case. About 68 percent of the surveyed population, or 222 individuals, reported that the question did not apply to them. But seven percent of respondents reported that having prescriptions filled was too expensive, and 2.7 percent said that their reason for not getting prescriptions filled was lack of insurance for prescriptions. The most common reason chosen for not having prescriptions filled, however, was “other.” The complete list of reasons, along with the breakdown for each, is given in Figure 34.

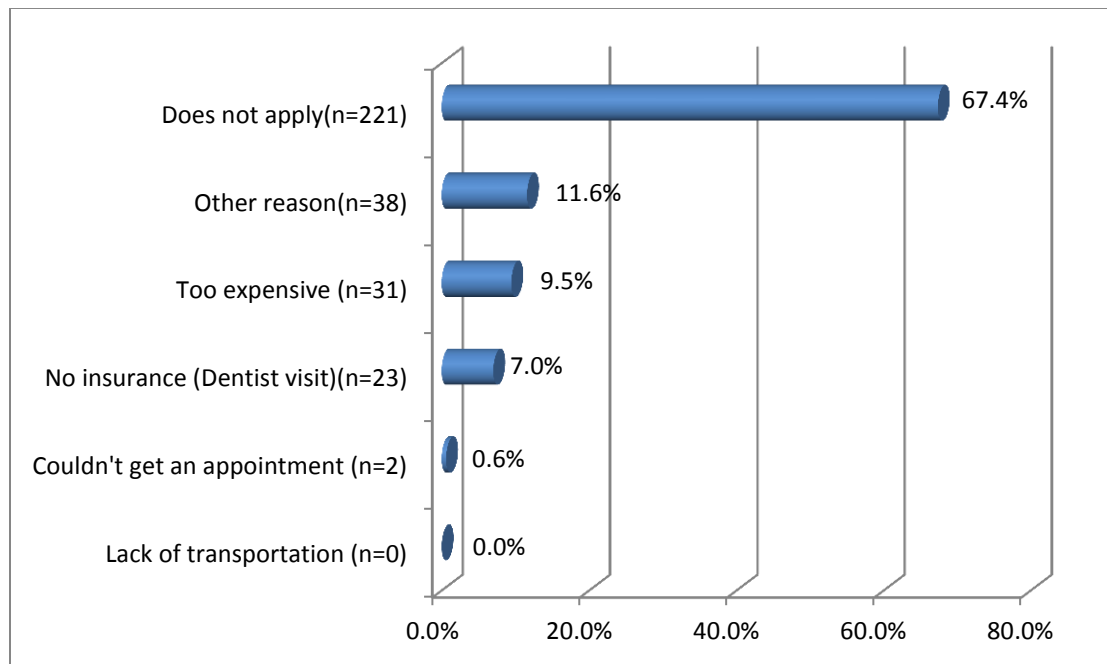
Figure 34 Reasons for Inability to Fill Prescriptions



Reasons for not visiting a dentist

The last question about health care coverage and utilization probed respondents' reasons for not receiving dental care (when such a situation applied to them). Around 67 percent of respondents said the question did not apply. Almost ten percent said that dental care was too expensive, and seven percent said lack of insurance for a dentist visit was a reason for not receiving dental care. See the figure below for the complete list of options and the exact breakdown of responses.

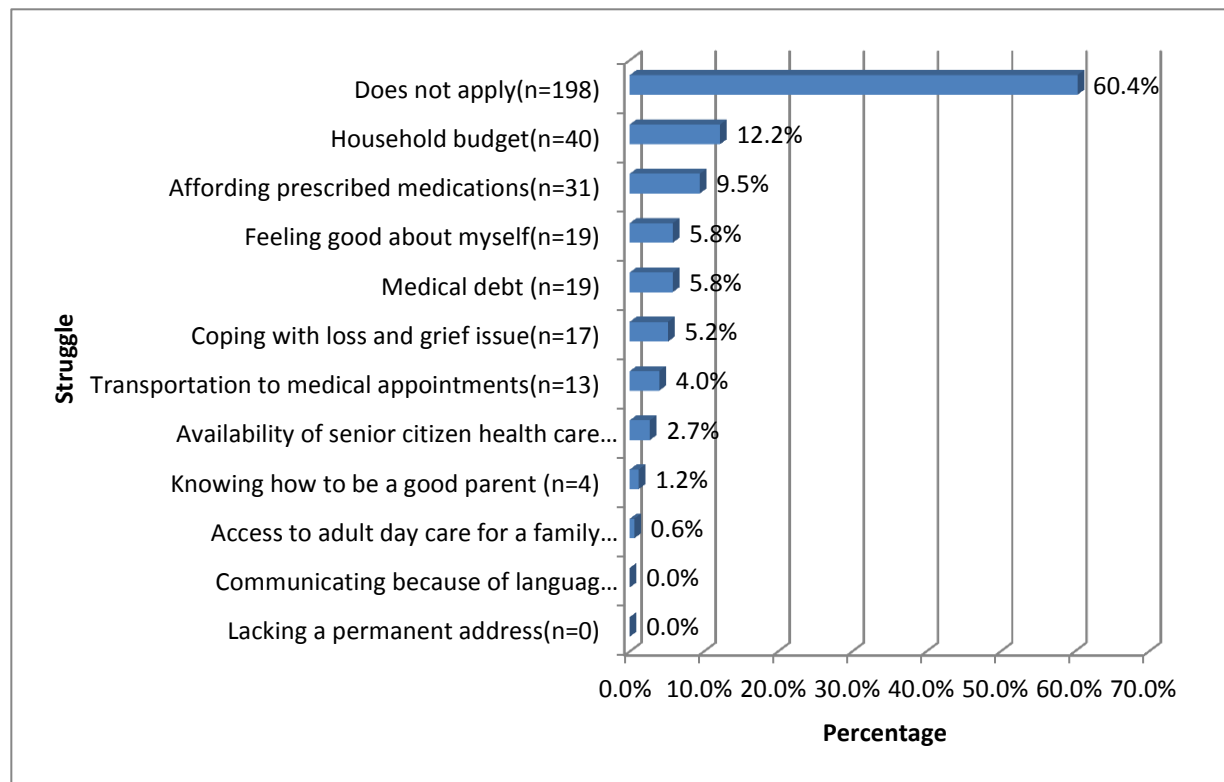
Figure 35 Reasons for Not Having Regular Dental Care



Daily Struggles

In the next section of the survey, respondents were asked about the daily struggles they encountered that might affect their physical or mental health or that of their family members. They were given a list of 11 struggles and asked to check any they dealt with on a daily basis. About 60 percent of respondents found that the question did not apply to them. The most common struggle listed—with 12.2 percent, or 40 individuals, selecting it—was household budget. The next three most common, in respective order, were affording prescribed medication, feeling good about themselves, and medical debt. No respondents chose “communicating, because of language differences” and “lacking a permanent address” as daily struggles. Figure 36 shows the complete list of struggles the respondents had to choose from and the exact breakdown of responses.

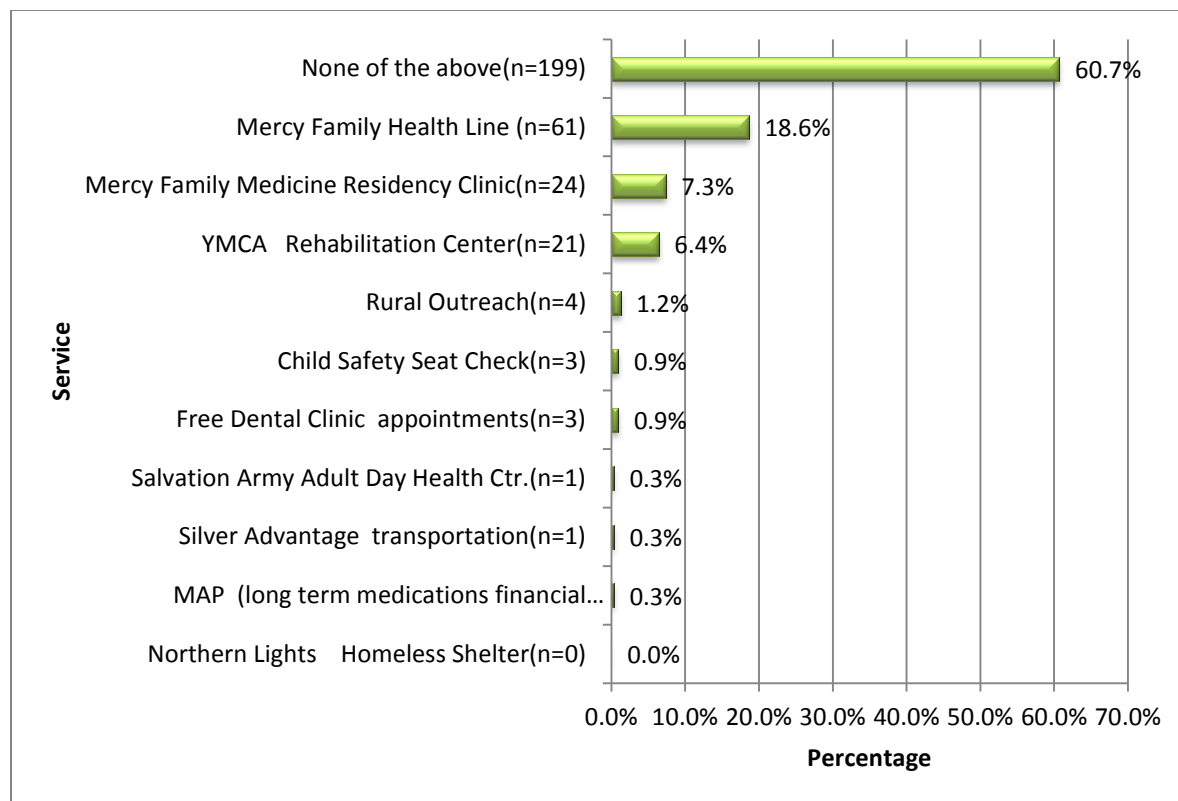
Figure 36 Daily Struggles



Awareness/Use of Available Services

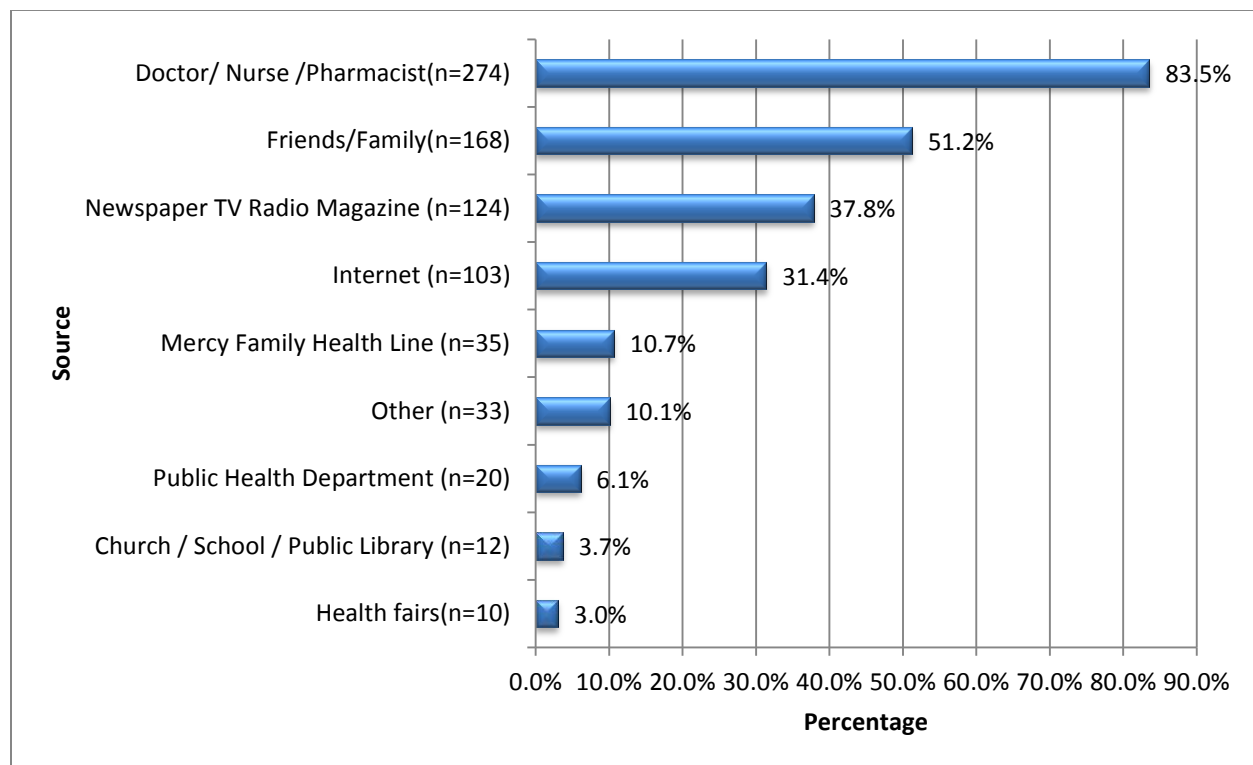
The survey respondents were then asked about their knowledge and utilization of Mercy-related services in their area. The first question in this section concerned what services were used by survey participants. The respondents were given a list of ten services in their area and asked to select any they had used. About 60 percent of respondents said the question did not apply to them. The most common social service used by respondents was the Mercy Family Health Line—with 61 individuals, or about 19 percent, selecting that option. The next most common services—each used by 6 – 8 percent of the survey population—were the Mercy Family Medicine Residency Clinic and the YMCA Rehabilitation Center. No respondents reported having used the Northern Lights Homeless Shelter. The complete list of social services and the number of respondents who selected each is given in the graph below.

Figure 37 Services that the Respondents Reported Knew Existed or Have Used Sometime In the Past



Respondents were then asked where they learned about health-related information in their area. They were given eight health information sources—with the additional option of “other”—and asked to select any three they had used to acquire health information. A doctor/nurse/pharmacist was the most common source of information; about 84 percent of respondents gained information from this source. A majority—around 51 percent, or 168 respondents—also used their family or friends as a source of health information—followed by media sources (i.e., TV, newspaper etc...). More than 37 percent reported using the media as a source of health information. The least used sources of information—each selected by less than four percent of respondents—was a church, school, or public library and health fairs. See the figure below for the complete list of sources and the breakdown of responses.

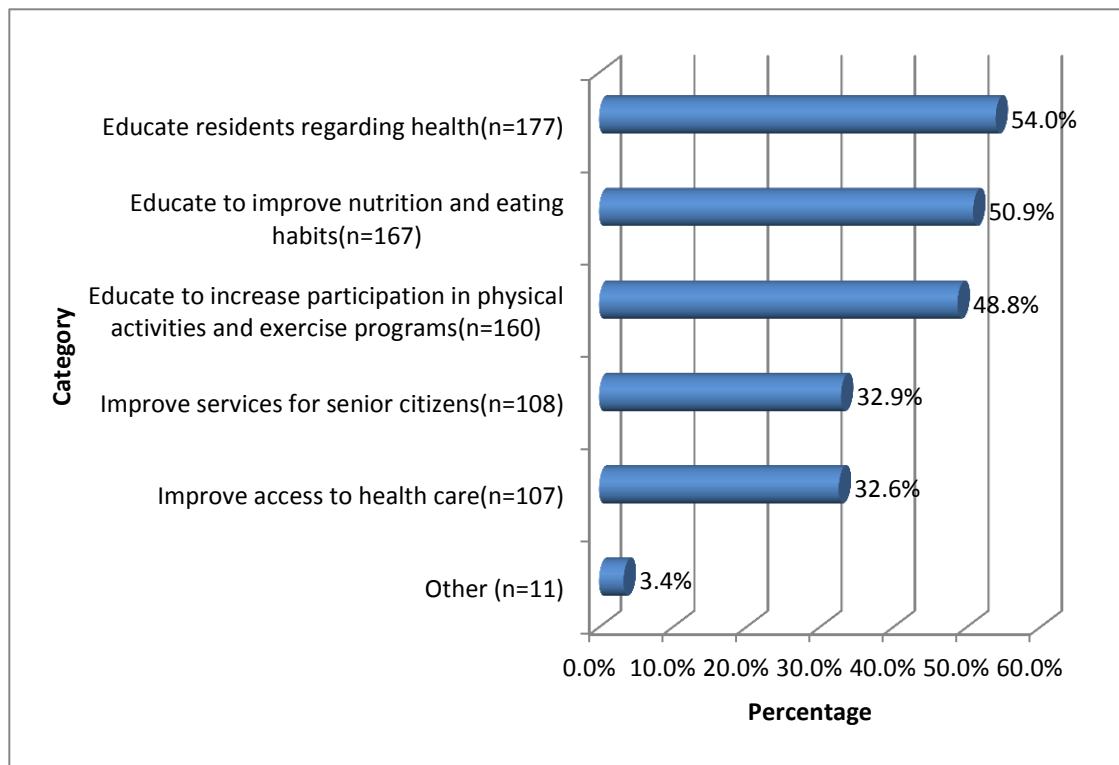
Figure 38 The Top 3 Sources for Health Information



Areas most important to improve

Finally, the survey respondents were asked what they thought was most important for community health care improvement. They were given five options—with the additional option of “other”—and asked to select any three they thought important for health care improvement. The area most selected by respondents was education regarding health for residents. Fifty-four percent of the surveyed population selected this option. The next two most selected areas—each checked by around 50 percent of respondents—were education to improve nutrition and eating habits and education to increase participation in physical activities and exercise programs. About three percent of respondents chose “other.” Figure 39 shows the complete list of areas needing improvement and the number of respondents who chose each.

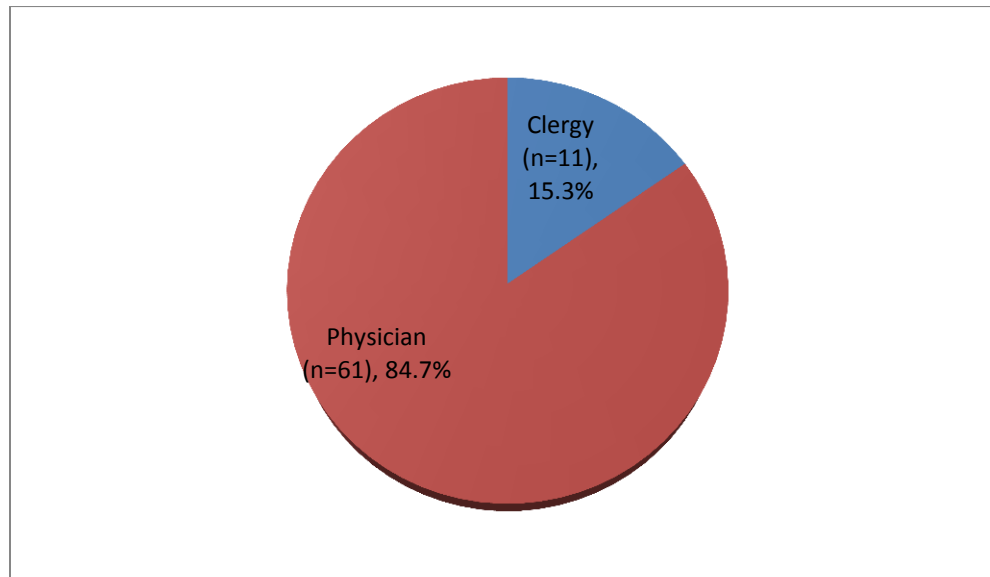
Figure 39 Suggestions for Community Health Care Improvement



Clergy/Physician Survey Results

Seventy-two individuals responded to the clergy/physician survey. As the pie chart below shows (Figure 40), the survey results that are tabulated in this report come from 11 clergy and 61 physicians.

Figure 40 The Proportion of Responses from the Clergy vs. Physician Groups



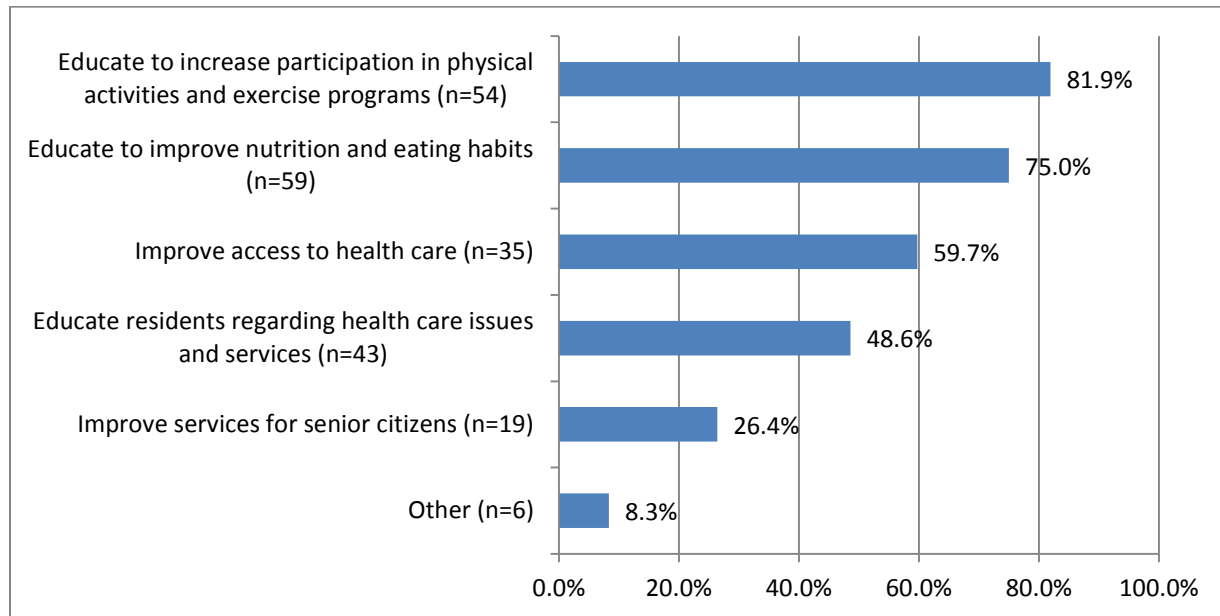
Community Health Improvement Ideas

The first question in the survey asked the respondents to select the top three areas out of five that they think are most important to make the residents of their community healthier. The three prominent choices were “educate to increase participation in physical activities and exercise programs (about 82 percent), educate to improve nutrition and eating habits (75 percent) and improve access to health care (about 60 percent). Educating residents regarding health care issues came next. The least chosen option (just like in the other two surveys), was improve services for senior citizens. Six individuals chose the “other” option among their choices and provided the following list of services to be important:

- Advocate for better nutrition and activity for our residents. Not sure education alone does it; there need to be changes in things like meals served in schools and nursing homes.
- Education doesn't work; you need active programs to be involved in.
- Improve access to dental care.
- Really just the nutrition and eating habits...we are TOO FAT!!!!
- Small group involvement in community.
- 'Y' enrollment (optional) for 3 to 6 months a year!

Figure 41 shows the details of suggestions made.

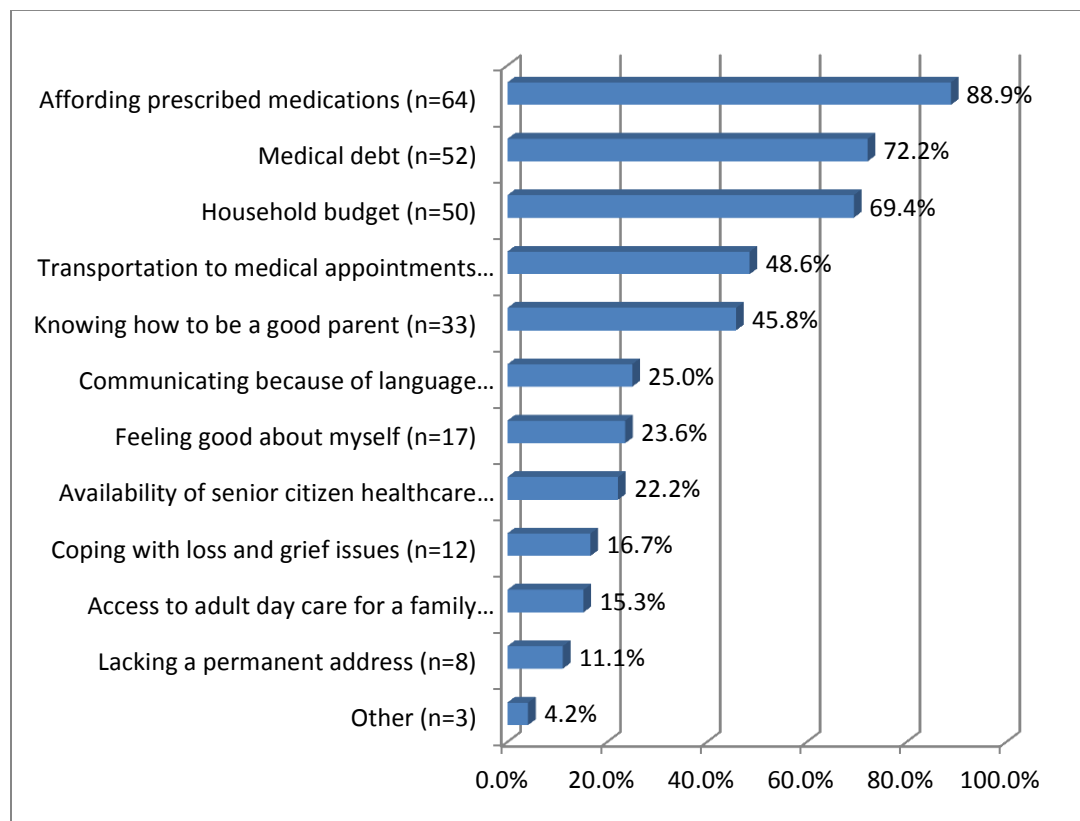
Figure 41 Suggestions for Community Health Care Improvement



Awareness of the Daily Struggle of Community Members

Next the survey participants were presented with 11 items consisting of daily struggles that community members may be having. They were asked to identify all the items that they felt represent the struggles of the uninsured and under-insured residents of North Iowa. These items were, of course, the same “daily struggle” items that were presented to the employee and the community members in the prior surveys. Figure 42 will detail the responses.

Figure 42 Daily Struggles



The two most frequently identified daily struggles by the physician/clergy were medications related (affording medications – about 89 percent and medical debt—72 percent. Household budget came third (69 percent) followed by transportation to medical appointments (49 percent). At the bottom are coping with loss and grief (16 percent), access to adult daycare for families (15 percent) and lacking of permanent address (11 percent). Finally, three “other” sources of struggle are identified by the survey respondents. They are:

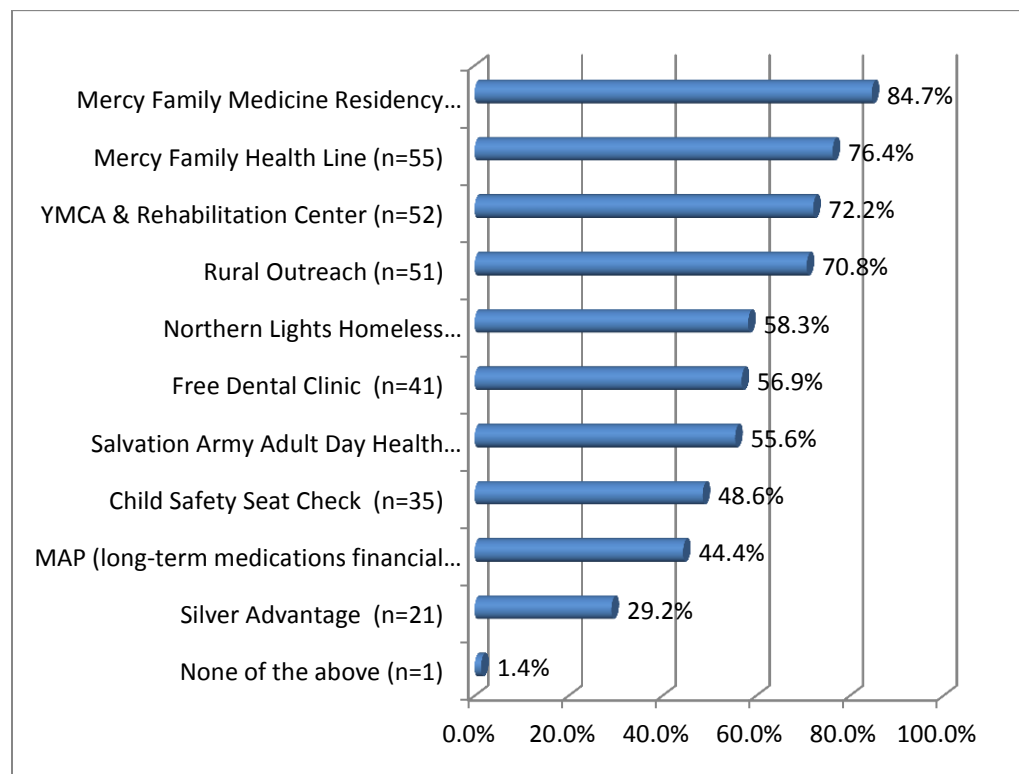
- Access to health care
- Having access to medical care other than the emergency room. Having to travel to Iowa City for medical care and
- Hesitation to come in, get appropriate tests.

Awareness of Available Services

The next question asked the clergy and physicians to identify the social and/or health care services that they knew Mercy provided to the needy within the community. The majority of them responded that they knew seven of the ten services listed. Most (85 percent) were aware of the Mercy Family Medicine Residency Clinic. This is followed by Mercy Family Health Line (76 percent), YMCA Rehab Center (72 percent), Rural Outreach (70 percent), Northern Lights (58 percent), Free Dental Clinic (58 percent), and Salvation Army’s Adult Day Health Center (56 percent).

Slightly less known are child safety check by the fire department (49 percent), MAP (44 percent), and Silver Advantage (29 percent). One respondent reported not knowing the existence of any of the social/health care services that were listed. See Figure 43 for additional details.

Figure 43 Services that the Clergy or Physicians Were Aware of



Open Comments

Finally, an open ended question was placed at the end of the clergy/physician survey to solicit any ideas that they may wish to share with us. Accordingly seven respondents provided the following suggestions/ideas.

- access to services in outlying areas is even much worse
- I am a physician 50 to 75 miles away, so mostly we are aware of more local services.
- I appreciate knowing about the services available for people in Mason City. This however, other than the Family Health Line and Rural Outreach, does not help us in the outlying areas very much. I feel like we are left to fend for ourselves. I suspect that there are numerous patients who are referred to the medical center on a daily basis that could benefit from many of the above services if they were available in the 'hinterlands'.
- Set hospital fees more in line with what the payers are paying. The 'rack rate' is unaffordable for those without insurance and can lead to bankruptcy.
- Thanks for all you do already.

- The above are not in my community of Ackley.
- When a person is diagnosed with a chronic or acute illness, they should be given education about the disease, nutritional guidance, exercise guidance and financial guidance. What does MAP mean and how does Rural Outreach tie to financial assistance for people who live in Mason City. How does Silver Advantage tie to transportation? Names need to be more descriptive of function.

Focus Group Research

Senior Citizen and Community Kitchen Focus Groups

Results

It was clear from the proceedings of the focus group interviews that the two focus groups represent populations within the Mercy community that have very different needs. The general populace that frequents the Community Kitchen is at high risk for unemployment, homelessness, health issues, and transportation needs.

According to the focus group participants, this indigent population's income level is based on intermittent employment opportunities that are short-term - low pay - no benefits. Amanda Ragan, the program director, concurs that, "most of those who enter here are unemployed and uninsured." She cited survey findings from 18 months ago, which revealed that, 98 percent have income levels under \$20,000; a further breakdown shows that 79 percent make less than \$10,000 per year, and the single men are not eligible for Medicaid. They are clearly stressed over their current living situation, feel isolated, alone and helpless to change their circumstances. Many are at the point of not knowing where help will come for rent, meds, nutrition, dental, eye care and serious health care needs. They are using every available resource known in the area, but very often simply do without.

"People not getting jobs, health care - - unbelievable what a person sees at Community Kitchen - - not a good situation."

"When I do have a job, I don't make much money and many times I don't get insurance with the job, so hard to afford prescriptions or healthcare."

"No insurance, in between jobs . . . "

The Senior Citizens Center group expressed having stable living conditions and are, at present, able to afford insurance and meet other obligations and needs. They did acknowledge that there may be some within their ranks that have need of assistance, but this is never talked about since this is considered very personal. They voiced that this community looks out for one another, and while they politely

answered our queries, they did feel that the nature of our questions often broached upon very private matters. They were curious about what Mercy plans to offer for community benefits, expressing that if their situation changed and they were not able to afford their health care insurance, that their answers would be very different. According to Val Sliger, the Director, most of the population has an adequate pension, but there are some who exist on Social Security alone, whose financial situation is more fragile. The Senior Citizens Center does offer benefits, such as on-site health screenings, wellness activities, and social gatherings for improved social and mental health.

Health Care Service Needs

For the purpose of Community Benefit planning, the general information received from the Senior Citizens Center session is not as powerful as the very specific needs heard at the Community Kitchen. There are many unmet needs for those who are unaware of the programs, or who have reached benefit limit and are no longer eligible.

When asked about past use of health care, the lack of financial resources was the most common barrier. It appears that Mercy is not actively advertising community benefit services because they are already utilized far beyond capacity. However there are many unmet needs for those that are unaware of the programs, or who have reached benefit limits and can no longer access the system. For the Community Kitchen populous, basic needs trumps health care every time.

Health Care Utilization

- Regular physician clinic visits do occur, with those who have insurance. Those who are not insured are less likely to visit the doctor due to costs. Access to Cerro Gordo County Free health Care Clinic is a concern, as well as even knowing there is a free clinic available.
- As a general rule, ED [Emergency Department] is not an option because of the lack of affordability.

Health Care Gaps

- At present the Free Dental Clinic does not have the capacity to meet all the demands. As of the time of this report, the clinic is no longer accepting new appointments. There is also a gap in dental benefits offered; the clinic will perform teeth extractions, but there is no financial assistance for dentures or partials. Not having teeth impacts the ability to communicate effectively, and it adds to the concern of the nutritional health of the individual. Again there were some that did not know of the Free Dental Clinic's existence.
- Eye exams and assistance with the purchase of glasses for the indigent does not exist.
- The focus group reported that meds are commonly not refilled and doses are omitted. That is true for even the less expensive medications and for those whose only barrier to getting a refill is minimal co-pay. Rural Outreach has a limit on what each applicant is eligible for. Once that limit is reached no other assistance is offered. This population is unaware that Mercy pharmacy debt can be considered for charity care, or that there are many other indigent programs directly through the individual pharmaceutical companies. It would be useful to have a portion of the Community Case Management program replicated, or a Social Worker available for the purpose of assistance with paperwork to help access other indigent programs.

Impact on Lifestyles - Hardship stories included

- Having to choose between medications or rent.

- Living with pain and/or disabilities, hindering employment.
- Lack of evening or night shift childcare. Lack of appropriate care for a special-needs child. Situations that prevent parents from working.
- Not having \$4 to pay a co-pay for medication.
- Lack of affordable transportation to Iowa City for health care (also lack of transportation to Waterloo for dental care under Title XIX).
- Lack of assistance for young adults with disabilities.

Summary of the Two Focus Group Findings

The Senior Citizens Center group appears to be stable and at low risk. They have no unmet needs that they were willing to discuss. They do compare and shop around for the best prices, and buy generic meds whenever possible. They are frugal and budget carefully. There is some apprehension that at some point in the future, the cost of living and the ongoing reductions in Medicare coverage will eventually erode their stability. However, at present they are able to remain living independently and are very private about their personal lifestyles. They have become a closed community that seeks out and looks after their own. Mercy's affiliation with community benefits has no weight on their health care choices. They either were unaware of Mercy's involvement, or it was simply a curiosity. They were very complimentary of Mercy and noted the value of having a quality health care facility in the community.

The Community Kitchen population is at high risk. They have long ago given up their dignity, privacy, security, and have settled for substandard living arrangements. It isn't a question of what health care they can afford -- they can't afford much of anything. They are struggling to meet their most basic needs and often have to choose between immediate necessities or long-term health. Various levels of functionality have been compromised due to unmet health care needs. At present, the general belief is that there are no other options to help with their situation, and health care has become a luxury they simply can't make allowances for.

"Medical expenses are low priority – getting children to school, food and shelter is more important."

Suggestions: Eye and oral health care screenings, assistance with eye glasses and dentures, expansion of Rural Outreach assistance, child care for evening and night shifts, help for younger adults with disabilities, and increased information regarding indigent community programs.

"Could Mercy point us in the right direction to where services are available for free medical, dental, parenting, prescriptions, etc."

Hispanic Focus Group Results

In April of 2010, 17 members of the Hispanic community in Hampton, Iowa were surveyed about their health care needs and experiences. Hampton is a small town in the northern part of the state with a population under 5,000. The results of the focus group are outlined in this section of the report. The demographics of the focus group are as follows: All of the 17 individuals surveyed were female. Fourteen of them were between the ages of 25 and 39, and three were between the ages of 40 and 54.

The Hispanic Focus Group members were first asked to select any of the thirteen preventative measures that were presented to those who took the community survey. They were asked which preventative service they had had during the previous year. All respondents selected receiving at least one of the options. The most common preventative service that the respondents reported having was Pap smear test; seven individuals reported having had one during the previous year. The next most common was a blood sugar check. Three group members selected this option. Two respondents each said they had a flu shot, a dental cleaning/exam, or a blood pressure check. Only one woman reported having had a mammogram during the previous year. The following seven procedures were not selected by any of the focus group members: cholesterol screening, glaucoma screening, skin cancer screening, vascular screening or EKG, bone density test, prostate cancer screening, and colon/rectal examination.

The focus group participants were next asked whether they, or anyone in their household, had been diagnosed—by a doctor or health professional—with a medical condition. They were provided with a list of 13 different conditions—with the additional option of reporting any other condition. Most significantly, eight of the respondents said they or someone in their household had been diagnosed with diabetes or pre-diabetes. Five individuals selected high blood pressure, two selected asthma, and one selected high cholesterol.

The focus group members were then asked where they went for routine health care. Ten focus group members said they received routine health care at a physician's office or a clinic. But four said they did not seek any type of health care on a regular basis. Other options included the hospital emergency room—selected by two individuals—and the chiropractor—selected by one individual. No respondents chose the option of "Other."

Next, the Hispanic Focus Group members were asked how often they, or anyone in their household, had used a hospital emergency room for care during the previous year. Six of the respondents said they had not used it even once. Five individuals said they had used the emergency room only one time. Two individuals responded that they'd used the emergency room 2-3 times during the previous year. None of the respondents said they had used the emergency room more than three times. However, four individuals did not respond to the question.

The survey participants were then asked why they, or anyone in their household, had not been able to visit a doctor when they needed to during the previous year, if such a situation applied to them. All members of the focus group answered the question, and none answered that the question did not apply. The respondents were given five reasons for not visiting a doctor—with the additional option of "Other"—and asked to select all that applied. All respondents said they or a member of their household

did not visit the doctor because of a lack of insurance. And 17 said visiting the doctor was too expensive. Two respondents selected lack of transportation as a reason for not visiting a doctor, and one said the doctor's office was located too far away. None of the respondents selected the options of "Other" and "Couldn't get an appointment."

Similarly, the respondents were next asked why they, or someone in their household, had not been able to fill a prescription or had skipped doses during the previous year, if such was the case. No respondents answered that the question did not apply. The respondents were given three reasons for not filling a prescription or skipping doses and asked to check all that applied. Ten individuals said filling prescriptions was too expensive. And eight said that a lack of insurance deterred them from filling prescriptions. Two gave "lack of transportation" as their household's reason for not filling a prescription. No individuals chose the option of "Other."

Along the same lines, the focus group members were then asked why they, or someone in their household, had not been able to visit a dentist when they needed to during the last year, if such a question was relevant. Again, no respondents answered that the question did not apply. Significantly, 17—or all of the respondents—said a visit to the dentist was too expensive. Eight respondents said their household's reason for not visiting a dentist was lack of insurance. Two selected lack of transportation as a reason. None of the survey participants selected the options of "Other" and "Couldn't get an appointment."

After being asked about health care utilization, the respondents were asked about coverage. The focus group members were given a list of 11 health care coverage options—with the additional option of "other"—and asked to select all the types they had at the current time. Significantly, 15 of the respondents chose "other" and wrote in that they had Medicaid for their children. And eight individuals said they had no type of insurance at all. Only one participant had traditional private health insurance. Two were on Medicaid while pregnant. The health care options not selected by any of the participants are as follows: managed care (PPO/HMO), dental, prescription drug coverage, Medicare, Medicaid (while not pregnant), Iowa Cares, Veteran's benefits, and Disability.

The Hispanic Focus Group members were next asked about their fiscal, mental, and emotional struggles. They were given a list of ten options and asked to select any they felt they struggled with. None of the participants responded that the question did not apply to them. Significantly, all 17 of the respondents said affording prescribed medications was a struggle. The next most common struggle was communicating, due to language differences; nine individuals selected this option. Eight respondents said medical debt was a struggle. And two respondents each selected transportation to medical appointments and coping with loss and grief issues as struggles. None of the respondents selected the following options as struggles: availability of senior citizen health care services, household budget, knowing how to be a good parent, access to adult day care for a family member, feeling good about themselves, and lacking a permanent address.

Lastly, the survey asked participants about Mercy-related services they used. Respondents were given a list of ten services available in their area and asked to select any they had used. The service most

commonly used was the Mercy Family Medicine Residency Clinic; ten individuals selected this option. The next most commonly used service was the Mercy Family Health Line (641-422-7777 or 800-433-3883). Five respondents reported having used this service. Four respondents said they had used the Child Safety Seat Check put on by the Mason City Fire Department. And three individuals used the Free Dental Clinic and made appointments through Sister Carmen, Special Populations Outreach Coordinator. One respondent each used Rural Outreach for short-term financial assistance for medications and the Northern Lights' Homeless Shelter/Trinity House of Hope. None of the survey participants selected the following services: MAP, which provides long-term financial assistance for medications; Silver Advantage, which provides transportation to medical appointments; the Salvation Army Adult Day Health Center; the YMCA & Rehabilitation Center; and the Free Dental Clinic (making appointments through the Mercy Family Health Line). No survey participants chose "none of the above" as their answer to this last survey question.

Overall Summary and Conclusions

This study reveals mostly overlapping yet sometimes distinct opinions, perceptions and needs of the interviewed individuals. Given the diversity of the respondents this should not be surprising. In evaluating the results of this survey several issues need to be taken into consideration – the chief of which is that whereas the community survey targeted the general population of the region, the rest of the data collection efforts targeted specific populations.

The composition of the surveyed individuals is such that, for example while the community respondent's age closely paralleled the local populations' aging age structure the group of employees that were surveyed had a younger average age. Whereas the community members' gender distribution was about even (46 percent male and 43 percent female), the surveyed employees were overwhelmingly female (89 percent of them were female). Occupation wise, the surveyed employees were mostly full-time employed (89 percent) whereas only 38 percent of the community survey respondents are fully employed (about half of them were retirees).

When we look at self-assessed health status of the two groups, 98 percent of the employees self-assessed their health status as either "good" or "excellent". The proportion of the community survey respondents who self-assessed their health status as "excellent" or "good" is 86 percent. Preventative practices are on the average more prevalent among the employee respondents as compared to the community respondents. This is especially evident from the reported none-utilization of preventative services (one percent of the employees vs. five percent of the community respondents reported having no preventative procedure over the previous year).

In terms of self-reported health related risk factors, 70 percent of the employee respondents reported having one or more risk factors, whereas only 53 percent of the community respondents reported having one or more health related risk factors. The proportion of respondents who reported not having any risk factors is also higher among the community respondents as compared to the employee respondents who reported having *no* risk factors. Overweight is the top-most reported risk factor

between both groups (47 percent among the employee group but 29 percent among the community respondents). Stress is the second most reported risk factor among the employees whereas genetic predisposition is the number two concern among the community respondents. The community respondents were also more likely to respond that they had no risk factors as compared to the employee respondents. The pattern and magnitude of health issues between the two groups are closely identical – with high blood pressure and high cholesterol on the top three ranks.

The responses given to the “daily struggles” question is somewhat interesting. Only 52 percent of the employees reported that the “daily struggles” question did not apply to them. Among the community respondents 60 percent responded that these questions did not apply to them. The reported daily struggles that pre-occupy most in the two groups are clearly not identical. Among the community respondents household budget, affording medications and feeling good about self are the top three concerns. Among the employee respondents transportation to medical appointments, adult day care (presumably for household members) and language differences stood out as the top three. The clergy/physician survey respondents’ perception closely approximates the community members “daily struggles” but not the employees’ struggles.

Majority between both groups get their health information from doctors/nurses (94 percent among the employees and 84 percent among the community members). More employee respondents relied on the Internet (72 percent) than the community respondents (31 percent). This rather significant discrepancy in the level of reliance on the Internet for health information between the two groups is perhaps a consequence of the discrepancy in the age structure of the groups. About the same proportion of community respondents (54 percent) and employee respondents (51 percent) relied on friends and family members for health information.

The employee respondents, the community respondents, and the clergy/physician respondents all seem to agree that the three most important community improvements should include educating citizens to be more physically active, educating citizens about proper nutrition and providing general health education to the public. The only exception to this general statement is that a more significant majority in the clergy/physicians group (as compared to the other two groups) expressed the importance of improving access to health as one of the top three priorities.

Appendix

Other Health Issues Reported by Employees
atrial fib
PMR
Chronic dry eyes
Allergies
DVT'S
ADHD
allergy issues
hypothyroidism
Crohn's disease
ITP, osteopenia
TN
Muscular Dystrophy
schizoid personality disorder
Depression
prolactinemia
UC
Neurological/Behavioral disorders
ALS
ulcerative colitis
Ulcerative Colitis
Osteoporosis
Degenerative Disc Disease - Back
anxiety
post TBI
hypothyroidism
fibromyalgia, degenerative disc disease, corneal dystrophy
hypothyroidism
SLE (Lupus)
Crohns Disease
Epilepsy and Aortic Aneurysm
immune deficiency
depression
SVT, mitral and aortic valve regurgitation
Hypothyroidism

Other Reasons Provided by Employees for they or Someone in their Household Not Having Needed Physician Visit Over the Previous Year
They ask for the co-pay and I cannot afford the co-pay and my children do not have health insurance. The looks I receive from the receptionist makes me feel like a bad parent.
Husband needs monitoring of heart disease (stent in 1997), and rx of prostate cancer, but doesn't want to take time off work to go in for preventative checks or tests.
NO time, changed physicians
time schedule, making an effort
work nights, not an optimal time to get an appointment
Bad providers in area
Can't trust the dr.
Work would not let me off when the appointment was scheduled. Happens alot!
No time, monitor my own B/P
could not get off work.
had to sit and wait over 1 hr to see Dr. I left I shouldn't have to wait that long to see the Dr.
haven't taken the time
I could not get time off of work because we have been short staffed.
no issues
time
specialist was out of our insurance network/insurance didn't approve visit
Not convenient office hours; evening hours would be nice.

Other Reasons Provided by Employees for they or Someone in their Household Not Having Prescription Medications Filled Over the Previous Year
Medco refused to release until tried to get cheaper prescription that didn't work
Pharmacy is not open on Sundays
pharmacy failure to send
Couldn't get doctor office to get prescription refill in a timely manner
weather
Not covered by insurance plan
too soon for insurance to cover
no issue
Forget to take doses

forgot

Prescription ran out- Need to see Dr. before it can be re-filled

Other Community Health Service Improvement Suggestions Made by Employees

cooking classes

I don't know why I have to select 3 options. None of these would help my community. We need more translators. Making it easier to have access to exercise equipment.

Veterans able to see specialist in there own area instead of traveling

make health care more affordable

more doctors to take and make more appointments

educate on pharmacies-what they can provide

Alternative health care options: aromatherapy, massage, Reiki, herbals, etc.

Make health care more affordable for people

patients with lowa care need transportation now...not 3 month waiting list

make it more affordable

cost

improved transportation services

Increase quality of practitioners in the area

Kangan water system

young adults need access to health care

Case management for geriatric patients with ongoing chronic illnesses.

educate title 19 pts. on when to go to ER vs. clinic

shorter wait times between appts.

health care payable on sliding scale to wages

Access to appts in timely manner

Need more mental health therapists so they don't have to wait so long to get in.

need for activity center

financial coverage

reduce cost

access to mental health services

Low cost exercise activities

need national health care for everyone

affordable access to exercise facility.

children with no insurance aged > 18

I hear from most people it is the cost of health care ins. as well as the charge at the office.

Economy - need more/better paying jobs in this area - we are a poverty pocket in the Midwest.

more education regarding the importance of going to a routine physical and dental
better help with paying the bill, have more nurses available to assist when calling Family Health Line.
non compliance, non citizens, generational system abusers
extended clinic office hours for people who have jobs to make it more convenient so they do not have to miss work to make a doctor's appt.
make preventive care more affordable
Improve access to mental health care
NEED TO IMPROVE SERVICES - HELP LINE AND ER ARE NOT GOOD
Hold patients accountable to work on the above and be an active participant in their health maintenance.
Alternative Health Care
Let people with no insurance know what is available to give them help to see the doctor. My sister can not even have her med check without it costing a fortune. She has no insurance and needs her meds but will not go because of the cost. So worry about her health.
Clinics opened during evening hours for routine examinations, i.e. physicals and medication re-fills
Reduce cost of health care
more access for md appointments
The facilities and the knowledge are available for people to make the right health choices. They just choose not to. There's nothing we can do about that.