Background

South Heartland District Health Department (SHDHD) conducted 10 focus groups to explore use of and access to health care by their constituents living in the 4 counties that comprise the South Heartland District (including Nuckolls, Webster, Adams and Clay). Based on the recent Public Health Accreditation Board (PHAB) submission, SHDHD wanted to focus on the Access to Care within their service area for these focus groups.

During the month of July 2018, SHDHD held a total of 10 focus groups, of which 6 targeted users/consumers of health care and 4 targeted leaders of local organizations/businesses, including representation from schools, law enforcement, banks, insurance agencies, YMCAs and similar community-based organizations, hospitals, etc., within the South Heartland District. Participants of the focus groups were recruited by SHDHD and partnering hospitals (Brodstone Memorial Hospital, Mary Lanning Memorial Hospital, and Webster County Community Hospital). Two of 6 focus groups targeting users/consumers of health care were comprised of Spanish-speaking community members living in and around the Hastings and Harvard communities. These focus groups were conducted by a bilingual facilitator from SHDHD. All other focus groups targeted English-speakers and were conducted by a facilitator from SHDHD. The Nebraska Association of Local Health Directors was contracted to scribe at all English-speaking focus groups. Table 1 defines the target population, location, number of participants and characteristics of each focus group.

Table 1. Focus group characteristics

Users of Health Care		
Location	**Number of Participants**	**Characteristics**
Clay Center, NE First Congregational Church	10	3 Men 7 Female English-speakers
Harvard, NE Harvard Public School	7	2 Men 5 Women Spanish-speakers
Hastings, NE Hastings Library	7	2 Men 5 Women Spanish-speakers
Hastings, NE Mary Lanning HealthCare	14	6 Men 8 Female English-speakers
Red Cloud, NE Webster County Community Hospital	8	4 Men 4 Women English-speakers
Superior, NE Brodstone Memorial Hospital	12	4 Men 8 Women English-speakers
Leaders of Health Care		
Location	**Number of**	**Participants' Gender**

	Participants	
Clay Center, NE First Congregational Church	14	7 Men 7 Women English-speakers
Red Cloud, NE Webster County Community Hospital	8	3 Men 5 Women English-speakers
Superior, NE Brodstone Memorial Hospital	5	3 Men 2 Women English-speakers
Hastings, NE Mary Lanning HealthCare	43	11 Men 32 Female English-speakers

Focus groups lasted for two hours. In each of the focus groups, participants were given the background of SHDHD and the community health assessment process followed by discussion of 7 questions. The leader group in Hastings, NE, given the number of participants, followed a different format than all other focus groups. The facilitator presented the same background of SHDHD and community health assessment process followed by 7 questions. However, the facilitator managed the focus group through use of small and large group discussion. Participants self-selected their seats at one of eight tables thus creating the small groups. Each small group selected a scribe and leader to capture the discussion and to keep the conversation moving along. The facilitator brought the small groups together for large group discussion around 4 questions. Additionally, the SHDHD and Mary Lanning Memorial Hospital decided to send a survey to invitees that could not make the Hastings Leader Focus Group to elicit more responses. The survey had one respondent. The notes for the questions not discussed in large group format during the Hastings Leader Focus Group and the survey response were included for analysis of focus groups.

Results

The focus groups centered around 7 questions. This section provides themes pulled from the focus group discussions across counties within the South Heartland District by question.

Where do you (or your contingency) go for healthcare?

User group (English-speakers)
Accessing healthcare through telehealth services and providers/services outside of the community were two themes that were mentioned in all focus groups within the South Heartland District.   Each focus group discussed that telehealth services (either through an app on their cell phone or as a part of a clinic) was used to access emergency care, blood pressure checks and/or specialty care by endocrinologists and oncologists. Healthcare services were accessed outside the community because people established care in another community or needed specialty care (i.e. Children's Hospital, eye doctor) that was not available in their community. Seniors with Medicare insurance and Veterans are

populations who access healthcare outside of the community in which they reside. Participants from focus groups in counties other than Adams mentioned they access healthcare in Aurora, Geneva, Hastings, Superior and Grand Island.

Half of the focus groups mentioned utilizing healthcare through the following: 1) the local health department (for follow-up from preventative screenings and/or for vaccinations and physicals), 2) physical therapy (mainly among student athletes), 3) hospital/emergency services/urgent care services (services are typically cheaper, faster, and convenient/fits within the participant's schedule than seeing a doctor—in some cases community members will stop by an EMT's off-duty, full-time job to get blood pressure checked, etc.), 4) physicians within the community, and 5) employer-based health opportunities, including health fairs and screenings. Additionally, not seeking care or self-diagnosing by researching on the internet was mentioned. Participants mentioned that people who have high deductibles or large premiums avoid care and use the internet to self-diagnose and/or use home remedies in place of care.

Other ways to access healthcare (mentioned in 1 focus group) include: 1) alternative medicine (such as acupuncturist, chiropractor, etc.), 2) pharmacy for screenings (including blood pressure checks, immunizations), 3) dental and 4) community-based organizations, such as Lions Club for eye checks.

User group (Spanish-speakers)
Participants mentioned that they avoid accessing healthcare as much as possible. Participants expressed that they receive screening tests (e.g. colonoscopies and mammograms) and some dental services in Mexico. However, if they do access healthcare locally, they go to the following places:

- Mary Lanning Healthcare,
- Family Care,
- Harvard Convenient care Monday's and Thursdays,
- Hastings Community Health Center in Hastings,
- Hastings Convenient Care,
- Urgent care,
- SHDHD,
- Sutton Clinic (they said its more economic).

Leader group
Accessing healthcare through hospitals and clinics (within and outside of the community) was the predominant theme that emerged from all leader focus groups within the South Heartland District.   In almost all counties, the hospital was mentioned as a place to access healthcare services (i.e. flu shots and emergency care). In counties other than Adams County participants mentioned that when seeking doctors and providers, many people go out-of-town to Hastings, Kearney and Grand Island (specifically for childbirth, pediatric care, and health services for Veterans). In Adams County, participants mentioned there were several places to access healthcare (i.e. doctor's offices, Mary Lanning Hospital, urgent care, Third City Clinic, Community health center and emergency rooms).

A few focus groups mentioned that telehealth services were used to access health services (i.e. health care services for older population and mental health services).   Telehealth is used because: 1) it is convenient (younger population is more comfortable with technology and online services) and 2) hospitals/clinics have expanded services to include telehealth (older population live in rural areas

without providers and have mobility restrictions making it more difficult to travel to another town for services). Other places to access healthcare include: assisted living facilities (specifically, a local pharmacy gives flu shots at the assisted living facility and in another county younger people receive care at the assisted living facilities); workplace (website, wellness coaching and employee assistance programs); community-based organizations (schools, pharmacies, health fairs, health department, parish nurses, and faith-based helps with mental health care); community college for dental services. Self-diagnosis/medicating (use the internet to get information, seek medications in Mexico for self-diagnosed condition, self-medicating for addictions due to lack of providers, and do not seek care due to cost/lack of insurance) was mentioned as well.

Some participants mentioned using pharmacists as a link between the provider and patients to increase and assure continuity of care and utilizing the faith-based community as a point of access for people to receive treatment (health care or mental health care) in areas with provider shortages.

When focus group participants were asked how accessing health care has changed over time, responses included: 1) insurance reimbursement/structure and cost of health insurance (i.e. there are more billing/reimbursement demands on providers, so they do not accept some insurances, and people cannot afford health insurance); 2) a more mobile and less connected community. People are used to travelling more so accessing services outside of the community is not a big deal which can potentially decrease the availability of providers in a community that suffers from current provider shortage. Additionally, people without reliable transportation cannot get to appointments because they do not have a support network (neighbors they can rely on and/or family members) within the community and rely on ambulances as taxis and/or do not seek care.

Where do you (or your contingency) get most of your (their) health information?

User group

Internet (including WebMD, Mayo Clinic, and sites recommended by workplace wellness programs) and family/friends were mentioned most frequently as the place people get their health information across all focus groups followed by doctor/providers (in 3 out of 4 focus groups). Participants trusted the WebMD and Mayo Clinic websites mainly due to the branding and reputation of these websites. Other places where health information was accessed include: 1) pharmacies (specifically pharmacists), 2) health fairs, 3) schools (specifically health classes and Educators Health Alliance), 4) chiropractor, 5) beauty shop, 6) health apps and wearable technology (i.e. Fitbit), 7) workplace (through in-services and trainings), 8) UNL Extension office (i.e. print materials and website), 9) nursing on-call services, 10) insurance company and 11) media—specifically newspapers and drug ads on TV. In one focus group, participants talked about the underground or black market of prescription drugs. Some people on pain medications will hold a few pills from a full bottle to take right before they go to their check-up, so they will have a positive urine analysis. The rest of the pills are sold on the black market.

Participants mentioned that information from hospitals/doctors' offices need to be more health literate. In some cases, participants had to take home information from the hospital and read it on their own, and another participant experienced a situation where loved one did not understand the Do No Resuscitate and signed it when hospitalized. Additionally, focus group participants involved with schools indicated that kids come to school with inhalers (or other medicine) and do not know how to use them because no one has showed them.

The internet, TV shows, community health workers (specifically Head Start) and programs through the SHDHD and YMCA were ways participants from Spanish-speaker user focus groups accessed health information.

Leader group

Internet (including Facebook, WebMD, Mayo Clinic, CDC online, and Google), media (including print and TV ads, TV shows starring doctors), and friends/family were mentioned most frequently as the place people get their health information across all focus groups. Other ways people receive healthcare information are from pharmacies, doctors/providers, workplace, and social circles (i.e. wellness programs/support groups, in-home parties, and hair stylists). Focus group participants mentioned the following considerations: 1) health information needs to be health literate and appropriate for diverse cultural audience, 2) there is a need to educate people about Medicare benefits. Access and availability of technology and internet has allowed a shift from getting information from doctors/providers (or other traditional sources of healthcare) to the internet and media.

What are the biggest concerns you (or your contingency) have about health care?

User group

Across all user focus groups (including Spanish-speaking), **cost of healthcare** (from medical bills to health insurance to senior care/nursing home care) was the biggest concern. Many participants shared stories about family members who are financially strapped because of an unexpected health condition and related medical bills and cost of care for family members. One participant shared that his aunt had a form of pancreatic cancer and had the financial means to try experimental treatments. However, if his

> *"I'm young but I don't feel that scared about it [cost of healthcare]…I worry more about them [my parents] to be able to raise 3 kids and be able to pay for healthcare they need." ~participant who was 20-30 years of age*

parents experienced something like this, they would not be able to afford the experimental treatments.

In some cases, participants had family members who retired (in their 40s) from full-time jobs to take care of spouses who had health issues (i.e. Multiple Sclerosis and liver transplant). People become "medically poor" quickly even with health insurance. Another participant had a quintuple heart by-pass survey at age 60 and before this survey, he did not go to doctors. The ability to retire has been put on hold due to this heart surgery and the amount of money it took to maintain good health status after surgery.

Medications for these serious health conditions are life-sustaining and costly.

> *"And you take risks. I take my Xarelto every other day—not every day [as prescribed]." ~participant who was 80+ years of age*

> *"…$250,000 surgery and I was responsible for 20% of it. That's a lot of money. It changed our lifestyle. Whatever we saved is gone." ~participant who was 80+ years of age*

5

Other concerns included:

1) **sexually transmitted infections (STIs) among LGBT population** (in Adams County). Participants stated that LGBT population do not know where to go for trusted health information. Health classes in high school were taught in a way that did not seem relevant to LGBT students. LGBT students in high school did not feel safe asking questions about risky behaviors and therefore did not know how to protect themselves from getting STIs.

2) **transportation** (to get to appointments/providers). With provider shortages in rural counties and accessing healthcare outside of the community, transportation is costly and a barrier to accessing care for some. Moreover, in rural counties, residents use the ambulance service as a taxi service to access healthcare.

3) **delayed rescue**. The Emergency Medical Services (EMS) is a volunteer force in most rural areas. Recruiting and retaining volunteers is hard due to increased training requirements. Rural areas experience a shortage of EMS volunteers due to pre-existing commitments (i.e. family, work, other). Additionally, in rural areas, seniors are concerned if hurt they will not be found right away.

4) **availability of quality senior care**. Seniors worry about where to go when they cannot live at home. Additionally, some participants indicated that nursing home facilities in smaller communities are not adept at handling Alzheimer patients.

5) **out-of-town care**. Participants expressed that when providers leave the community they are required to travel to another community to receive care. With transportation barriers (mentioned above), this can be difficult for community members.

In addition to the aforementioned concerns, participants indicated that they are concerned about missing out on new technologies that are only available in certain parts of the State; there is no family support for seniors at appointments; hospitals/providers do not stay open after-hours for on-call in rural communities; caregivers do not have support (respite care); school staff need better training to handle students physical, mental and behavioral health needs; individual habits, such as unhealthy eating and lack of sleep, impact long-term health outcomes.

User group (Spanish-speakers)
In addition to the cost of healthcare, regulating health conditions, such as diabetes, high blood pressure, etc., was a concern.

Leader group
Themes among the leader focus groups mirror the user groups with cost of healthcare, availability and affordability of insurance, quality of care, out-of-town care, transportation, and education to prevent health issues as biggest concerns. In addition to these concerns, lack of mental health services and resources for youth, schools and Veterans was a concern for a rural county. Lastly, education to prevent health issues in a multicultural and health literate manner was important in Adams County.

The high cost of healthcare and medication decreases the ability to save money, and some insurances (i.e. Medicare) does not cover the cost of basic services. This high cost makes some people fearful to seek care. Participants stated that constituents work more than one job to have insurance (i.e. farmers), and some constituents go without health insurance all together. The older generation is not retiring

because they need the health insurance. Some small operations are forming "corporations" and hiring one employee to get insurance.

Constituents do not want to travel out of the community for care, and in smaller communities when clinics close, providers have limited hours (office hours 1 time a week). This makes it harder to get appointments when needed; to spend quality time with patients because of high volume of patients; to get prescription medication refills.

Participants gave the following reasons when asked how the biggest concern has changed over time: 1) costs of healthcare are rising; 2) the way healthcare is delivered (i.e. doctors refer out to specialists more than they used to, [patient] has to have an appointment instead of calling [the doctor] when something is wrong, longer wait times to see doctor, doctors not seeing patients for regular check-up/preventative care, pre-authorizations [for services], availability of doctors and relationships with patients, etc.); 3) social isolation; 4) Burn our of healthcare providers, EMTs, etc. because of high demand.

What kinds of health care services are used (or not used) by people you know?

User group
Services utilized by people vary by county and include:

- Mental health services at school—middle and high school students access counselors; college students look for the availability of these services when selecting colleges
- Health fairs/biometric screenings through workplace and at hospitals
- Home health
- Immunization clinics

Services <u>not</u> utilized by people vary by county also and include:

- Chiropractic care—participant mentioned she did not access this during pregnancy because insurance did not cover this service
- Dental care—participants mentioned insurances are not taken everywhere
- Health savings plan—can act as a deterrent to care
- Support groups
- Services offered through workplace, such as counseling services and employee wellness benefits

User group (Spanish-speakers)
Services utilized by people vary by county and include:

- Chronic disease self-management programs—offered through SHDHD and YMCA around blood pressure and diabetes
- Health check-up—every 6 months with local clinic
- Pain clinic
- Doctor
- Ambulance
- Hospice
- Home health
- Medications and remedies access from Mexico or Mexican groceries stores

Preventative care was mentioned in across all focus groups as services used by people. Services utilized include school physicals, gym, health fairs for lab draws, immunization clinics, fitness facilities at workplace, vision/dental, school nurse, SHDHD, YMCA classes for cooking, college fitness centers.

In some counties, mental health services are used by people, and in some counties, mental health services are not used. Reasons cited for not accessing mental health services include services not being covered by insurances, wait list to see provider, and crisis-driven system. Services utilized include school nurses/counselors, licensed mental health provider, UNMC telehealth for behavioral health, geriatric mental health services through telehealth at Mary Lanning, ASAP drug prevention through schools, CASA/SASA services, banker who works with numerous ag loans act as a counselor.

> *"As an ag lender you become a counselor [to farmers in times of farming stress, drought]…" ~banker who works with numerous ag loans.*

While mental health services are accessed by some people, youth/schools, older and Veteran populations remain areas of concern to some leaders. Youth and the over access to technology may result in an increase of internalizing of feelings and issues. Schools may not have staff or training to handle mental/behavioral health issues. Parents need tools to help manage their youth's access to technology. Older populations in some counties do not have access to therapy, only psychiatric medication administration. Some Veterans may not be eligible for services at the Veterans Administration and may need mental/behavioral healthcare due to addictions.

Other services utilized by people include: 1) occupational therapy/physical therapy at schools and in community; 2) telehealth services to help with multilingual clients—however, leaders are not seeing use of telehealth through employer-issued insurance; 3) alternative medicine (i.e. massage, chiropractor, essential oils)—these services are cheaper than going to a physician and may be a good place for education; 4) dental care among college students; 5) socialization—just being able to talk and listen; 6) medical services (i.e. primary clinics, ambulatory/surgical services, emergency rooms, urgent care, community health center); 7) workplace programs (i.e. Employee Assistance Programs and wellness programs).

Services not utilized by people include: 1) dental care—limited providers with Medicaid, requires cash up front; 2) services for Veterans. Reasons cited for Veterans not using services were lack of awareness about benefits and how to access the Veterans Administration.

What kinds of health care services do you use to prevent health problems?
User group

Services utilized by people vary by county and include:

- Dental care
- Preventative screenings—such as mammograms
- Walking community trails and/or at community pool

- Wellness programs—such as workplace-based health screenings and programs, Tai Chi and Yoga through hospital
- Fall prevention
- Fitness Centers
- Biking in community
- Cardiac Rehab
- Eye care
- Vitamins
- Regular physicals
- Healthy weight
- Home blood pressure kit
- Fitbit
- Massages
- Immunizations
- Community facilities—such as outdoor activities, baseball,
- Good everyday habits and practices (i.e. ergonomic ways to sit and bend, etc.), and
- Social gatherings at the Community Club.

Services accessed by some participants and that are not located in their community included:

- Sand volleyball, and
- Gymnastic classes.

Lastly, in one community, the county sprays for mosquitos.

User group (Spanish-speakers)

Services utilized by people vary by county and include:

- Preventative screenings—such as mammograms, pap smears, project Homeless Connect for vision screening
- Massages
- Health fairs
- Immunizations
- Self-management programs for diabetes and blood pressure
- Home remedies, and
- Healthy eating.

Leader group

Accessing preventative services in community-based and school-based settings was mentioned across most focus groups. These services included immunization clinics, chronic disease self-management programs, church sponsored screenings/classes, playgrounds, fitness centers, food pantries, edible school yards (greenhouses), and so on. Other services mentioned fell into the following groups:

1) Groups—Yoga, Tai Chi, Zumba, social groups, friends advertising healthy activities, fitness classes, Mary Lanning Health Classes, YWCA after school programs, Zone/education classes through Revive, Inc.

2) Primary care—Every Woman Matters, primary care settings perform depression/substance abuse/tobacco screenings, family planning services
3) Alternative care/holistic
4) Workplace—health fairs, employee wellness programs
5) Policy/environmental/systems supports—walking and biking trails to make communities walkable/bikeable, waiver/care management services, DHHS Medicaid applications, Clean Indoor Air Act and education about smoking, kids' acceptance of seatbelt use, wellness incentives
6) Individual—cooking at home with healthy foods vs processed foods, use of organic/non-GMO foods, vitamins, supplements, look for healthy items when eating out, activity tracker (i.e. Fitbit), smart moves, budget management services, car seat installation, gyms
7) Mental health—opportunity house (offers day services/Alcoholics Anonymous/Narcotics Anonymous, South Central Behavioral Services, senior citizens mental health grant through Sunny Side
8) Education—Encourage families to be active and limit sedentary activities, education to families, teach patients how to prevent recurring hospital visits at home health care visits, scrubby bear, healthy beginnings (parenting programs), education and prevention start with youth throughout lifespan
9) Tech-free center

In some focus groups, participants mentioned that health fairs are ways to get folks screened but recognize there may be some gaps to treatment, i.e. health fair participant's responsibility to share results with their providers, at employer-sponsored health fairs—employees may not have the resources to understand the results.

What do you view as strengths of our local health care?

User group

Strengths of the local healthcare system vary by county and include:

- Churches—in the way of health ministry and community care. People read tidbits through church bulletins every week and attend health screening/blood pressure screening events that are linked with their faith.
- Local hospitals—working to expand services and offering a wide range of professionals/providers
- Doctors/providers
- Clinics and other health services—clinics to get basic services
- EMT services
- Value of the community caring for each other—strong community connections
- Senior center
- 4H extension office.

On the other hand, in one county participants noted that there is a gap in Mental Health services and not a lot of connection between providers.

User group (Spanish-speakers)

The Adams County focus group noted the following strengths of the local healthcare:

- Doctors/providers
- Pain Clinic
- Acupuncture.

The Clay County focus group noted there were not strengths in this community, and there was a lack of local healthcare.

Leader group

Leaders in most focus groups indicated that schools and community connectedness were strengths of local health care. Schools offer meal programs (on a free and/or reduced basis) and were engaged in most counties. Community connectedness was mentioned as being present through community volunteering, some provider and patient relationships, and healthcare systems collaboration and networking. Other strengths vary by county and included:

- Hospital/primary care/clinics (mainly in Adams County)
- Safe community
- Access to outdoor activities

In addition to the strengths mentioned above, strengths mentioned in Adams County included:

- Employer-based wellness programs
- Workforce development
- Community-based programs
- System for services to interact—networking opportunities, non-profits good at referring to each other and staying connected, communication between agencies unless regulations get in the way, Electronic Medical Records, great collaboration, centralized database for access to information, good network/communication, technology brought into hospital, easy to work within community.

What do you view as future demands of our local health care system?

User group

Participants in most focus groups indicated that the future demands of the local healthcare system included an increasing aging population, accessing healthcare outside their community, and unmet mental health needs.   Regarding the aging population, participants noted the need for affordable healthcare, quality care with qualified professionals, and more providers and facilities. As populations shrink from rural counties, healthcare providers and services leave the community. Most focus group participants indicated they would not travel for services outside of the community and wanted affordable healthcare services locally. Additionally, most focus groups indicated there were unmet mental and behavioral health needs, especially after State closed hospitals and clinics. With youth experimenting with drugs at an earlier age, addictions are more prevalent. There is a need for preventing mental health issues vs. reacting to mental health crises.

Other demands on the local health care system in the future vary by county and included:

- Culture shift towards being physically active and healthy eating over a lifetime—educate younger children and families as habits start early; school PE classes shift focus from weight lifting to get in shape for sports to other options to be physically active (i.e. juggling); school

sports are competitive in nature and do not focus on lifetime fitness. For example, when kids go out for sports expensive equipment is needed, and at times, kids do not stick with sport (losing the lifetime fitness approach) because they did not succeed at the sport.

- Obesity—big problem in the future, connected health issues, obesity problem is growing and starts with families, current incentives around obesity reduction focus on person vs. family unit.
- Multicultural and multilingual needs for healthcare and mental health services—not only for race/ethnicity but also gender, age, sexual orientation, impairments (i.e. deaf people have a hard time accessing health care and hearing aides are often not covered by insurance and are costly). LGBT population experience depression when "coming out" to family and friends. They do not know who to go to with questions and services. Education LGBT population receives in school around prevention of sexually transmitted infections and other health issues is not relevant. LGBT population is a higher risk population that does not have access to relevant health information and do not know where to access this information.
- Job/Economic issues—many people are working more than one job to make ends meet and are not able to afford healthcare, young community members are not motivated to work at jobs in the community, no access to major medical [insurance] policy, self-employed
- Veterans—increasing number of veterans returning to rural communities, VA reports that there are not enough resources for returning Veterans
- Prevention with families who are struggling to make ends meet—families received services, Child Protection Services does not help, how to reach these families about health issues (i.e. nutrition, hygiene, mental health issues, early intervention)
- Financial literacy—starting with youth
- Outreach and education needs—educate people about services to engage public in services that are offered, connecting people to services, improved education and wellness systems
- EMS/EMT burnout—volunteer service
- Crime rate increasing—due to addiction and law enforcement unable to address it
- Drinking water shortage

Recommendations to meet mental health needs from focus groups included utilizing churches to connect with people as possible support in mental health and train people to provide suicide prevention and mental health first aid at points of non-traditional access (businesses, bankers, etc.). Additional comments included that lifestyles have become so busy that it is difficult to slow down and relax.

User group (Spanish-speakers)
The following are future demands of the local healthcare system indicated by participants:

- Low-income emergency department/clinic/convenient care, pharmacy
- Dentist that accept Medicaid
- Gym for kids and parents to prevent illness
- Food pantry like the one at Catholic Social Services
- Medical interpreter for vision clinic
- Transportation
- Bilingual medical doctors and staff in every clinic

Leaders in most focus groups indicated that workforce development and aging populations were the future demands of the local healthcare system. Workforce development needs included:

1) Maintaining and recruiting health care providers and Emergency Medical Services (EMS). Providers/doctors have experienced increased workloads and a decrease in funding. The EMS system is requiring more education (Continuing Education Credits) and training for licensed EMTs and people to become EMTs. These requirements have decreased the number of people who are interested in becoming EMTs. In turn, rural areas struggle with recruiting new volunteer EMTs which is needed with the current aging out of EMS volunteers. Additionally, there are limited resources and funding for EMS in rural areas. All these reasons have lengthened response times when an emergency is called.
2) Delivering multicultural and multilingual care. The South Heartland District has experienced an increase in minority populations. Providers and health care system need to be responsive to different cultures and languages. YMCA experienced difficulties finding bilingual staff.

Demands to meet the aging population include the need for affordable and quality age-appropriate care and facilities.   There are children of aging people who take the responsibility for the care and finances of their parents. In cases where family support does not live close by, there is a need for affordable, quality Independent living/retirement. Considerations for communication styles for aging population is needed. Lastly, non-traditional community living for ages 45-65 who cannot live independently is a demand.

Other demands on the local health care system in the future vary by county and included:

- Collaborating/connecting as a community—to enhance services and availability. Engage faith-based organizations, use advocacy programs (i.e. zone program) and utilizing retired volunteers.
- Decreasing and aging populations in counties
- Providing mental health care/services—shortages of providers, addictions/drugs/break-ins, youth experimenting with drugs/marijuana at younger age, detox, anger issues
- Sharing trusted information about local services
- Closing of clinics in rural counties
- Using technology—using apps and alerts on cell phone to reach more population; doing outreach via technology; widening gap between those who can access care through technology
- Focusing on prevention—decrease chronic disease, decrease cost of healthcare, educate about how to take care of self and preventative care, focus on family and social networks vs individuals, treatment of chronic patients in emergency room instead of a treating a true emergency
- Accessing healthcare services/system—educate people on how to access healthcare and the process on getting into the system with doctors taking (or not) new patients; find out motivation to access or engage in established health care, encourage engagement with own health care, incentivize (lower deductibles or premiums), make process easier to access health care, expand healthcare hours, prevent patients from falling through the cracks, low-income populations, minority populations.
- Medication costs
- Teen pregnancy

- Prolonging life vs death
- Shopping for health care instead of family physician