Hardin County Needs Assessment

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Abstract

This Clinical Improvement Project (CIP) was a needs assessment regarding the need for a free/low-cost medical clinic in Hardin County, Iowa. There is an increasing need to bridge the gap of health care inequity all over America, and Hardin County Iowa is no different (The Dahlen Company, 2012; Davis, 2003; Institute of Medicine, 2002; Iowa Fiscal Partnership, 2010). There are a large number of people in this community who are unemployed, living in poverty, and/or lacking insurance or the funding for health care. Many small businesses owners are not able to afford to pay for health insurance for their workers; others are not able to afford to buy insurance for their own families. A needs assessment was performed to determine if the development of a free/low-cost medical clinic is something that would be of value to this community. The plan surrounding the implementation of this needs assessment is discussed in detail within the context of this clinical inquiry proposal.

Hardin County Needs Assessment

In order to make the most of limited resources, before new services are created, such as a free/low-cost medical clinic, a thorough assessment of the community for this type of service was completed. The author recruited members of the community with the intention of holding two similar focus groups. The purpose of the focus groups was to help determine if a need for a free/low-cost medical clinic existed, and if the community saw this as its highest priority.

Description of the Problem

Not much is known about what the preventative and/or wellness service needs are of the residents in the primarily rural county of Hardin. Although the services such as before school exercise programs for elementary students are currently in place, and are used routinely, Ellsworth Municipal Hospital and other Hardin County organizations were interested in expanding, revamping, or adding additional preventative and/or wellness services to the county. Medical needs were currently being met with the assistance of the local hospital, six primary care clinics, and multiple specialty outreach clinics located in Iowa Falls, all services situated in Hardin County and created without using any formal community assessment data. Conducting a thorough assessment could help evaluate what services were needed and where funds could be allocated in order to create a program that would positively impact the community and also easily be sustained. It was important to identify what resources were currently available to the community, in order to avoid unnecessary duplication of resources.

Hardin County's medical resources included the following: six family practice clinics, a critical access hospital, dialysis center, three ophthalmology clinics, three dental clinics, one orthodontic clinic, three chiropractic providers, diabetic education programs, six nursing homes, two assisted living facilities, two home health agencies, one mental health out-patient clinic,

three counseling clinics, eight pharmacies (five that provide delivery of medications), and The Lighthouse Center of Hope (provides pregnancy and STD counseling). Other pertinent community features included: transportation buses for the elderly and disabled, the Dale Howard Community Center, four golf courses, Ellsworth Community College, six elementary schools, four middle schools, four high schools, two police stations, eight fire stations, an airport, six grocery stores, 12 gas stations, a movie theater, over 20 parks, several restaurants/fast food chains, and 15 churches. These community resources provided a place for physical activity, education, and entertainment. They also provided the community with a sense of safety and means to acquire essential resources such as food and gasoline.

Information gleaned from secondary data suggested some unmet needs. For instance, diabetes and obesity rates in Hardin County were a concern. According to the Henry J. Kaiser Family Foundation (2011), the adult diabetes rate in Iowa in 2010 was 7.5%. Some, 66.2% of Iowans were considered to be overweight or obese. The most recent data regarding the percentage of overweight Hardin County adults found it to be higher than the national average, at 70% (Iowa Department of Public Health, 2009). The number of obese Hardin county residents was greater than the state average. Obesity also affected Hardin County children, as 15.8% of low-income preschoolers were considered obese (City-Data.com, 2010). Obesity has been closely linked to other deadly health conditions and can be an extremely costly condition (Center for Disease Control and Prevention, 2012). These conditions could be even more costly to the 2,000 plus uninsured Hardin County residents. Besides the documented health care issues of diabetes, obesity, lack of insurance; patient to health care provider ratio in Hardin County was 1,754:1 (County Health Rankings & Roadmaps [CHRR], 2012). The combination of lack of health insurance with limited number of medical providers was a factor that could make it

difficult for Hardin County residents to access affordable care. The author hypothesized that a free/low-cost medical clinic would be a beneficial and worthwhile clinic program within the Hardin County area that would improve the health outcomes for many residents.

A needs assessment was conducted to determine the need for a free/low-cost medical clinic in Hardin County. The author hoped that this assessment would provide the documentation and the impetus to create a potentially sustainable free/low-cost medical clinic in the Hardin County area.

Population

Hardin County is primarily a rural community located in central Iowa, approximately 50 miles from the larger cities of Waterloo, Mason City, and Ames. It is comprised of 12 small towns with the largest being Iowa Falls. At the time of this project, the population in Hardin County, Iowa was on the smaller size compared to some other counties in Iowa. It was comprised of mostly Caucasians (97%) and adults aged 18-65 years old (50%) (United States Census Bureau [USCB], 2012). Greater than 70% of Hardin County residents were affiliated with a religious congregation, 100% of which were Christian (City-Data.com, 2010). In 2011, the estimated population in Hardin County, Iowa was 17,426 persons (USCB, 2012).

Education plays a large role in obtaining employment. Lack of employment contributes to lack of health insurance, as many obtain health insurance through their work place. According to multiple sources, things such as poverty, unemployment, lack of insurance, etc. potentiate poor health outcomes and can further cause death in some individuals who fall into these groups (CNN, 2006; CNN, 2009; The New York Times, 2008). In 2011, 7.1% in Hardin County were unemployed (City-Data.com, 2010), 1% higher than Iowa's unemployment rate (Henry J. Kaiser

Family Foundation, 2011). While 91% of residents completed their high school education, only 20% had a Bachelor's degree (USCB, 2012).

Within Hardin County, the mean household income was 44,694 dollars per year (USCB, 2012), 5,000+ dollars less than the Iowa and U.S. average (Henry J. Kaiser Family Foundation, 2011). Over 40% of Hardin County residents were considered homeowners (Iowa State University Extension and Outreach, 2011), with an average person per household of 2 (USCB, 2012). The percentage of those Hardin County residents who were living in poverty, defined as 100% below the federal poverty line, was nearly 12% (City-Data.com, 2010). According to the USCB, 9.9% of Hardin County residents lived below the poverty line, meaning they fell below 100-138% of the federal poverty line. This was nearly 2% higher than both the national and Iowan average (Henry J. Kaiser Family Foundation). The number of Iowans on Medicaid (15%) was less than the national average (17%); however, slightly more Iowan adults were on Medicare (29%) than compared to the national average (26%) (Henry J. Kaiser Family Foundation). According to the Iowa State University Extension and Outreach (2011), 11.5% of Hardin County residents were uninsured, affecting over 2,000 residents in Hardin County.

Epidemiology

The average life expectancy in Hardin County was higher than that of the United States average by nearly two years (United States Department of Health and Human Services [USDHHS], 2009). Of the deaths that occurred in Hardin County, 50% were related to either heart disease or cancer. This is important because both cancer and heart disease can be considered preventable diseases, if systems are in place to help decrease risk factors, detect the disease early, and initiate treatment (Eyre et al., 2004). The USDHHS provided information regarding some of the risk factors for premature death in Hardin County (see Appendix A).

According to the USDHHS, 81.4% of Hardin County residents ate "few" fruits and vegetables, 26.4% did not exercise, and over a quarter of the population had high blood pressure and were considered obese. Nearly 23% smoked tobacco, all of which contribute to heart disease and cancer.

There was a high frequency of heart disease within Hardin County, thought to be correlated with the high percentage of people who were obese, hypertensive, smoked, used drugs, exercised little, and ate very few fruits and vegetables. However, according to the Henry J. Kaiser Family Foundation (2011), the number of deaths per 100,000 due to heart disease was 4.3 less in Iowa than the U.S. average. The number of overweight and obese adults in Iowa was 66.2%, which was 2.4% higher than the national average. The percentage of adults who participated in moderate or vigorous physical activity was 1.3% less than the national average.

The diabetic rates were less than the national average, as well as the number of tobacco smokers (Henry J. Kaiser Family Foundation, 2011). The number of overweight or obese children was 26.5% in Iowa, with the national average being 31.6%. The percentage of children with emotional, developmental, or behavioral problems who received mental health care was 74.5%, compared to the U.S. average of 60%. Although these statistics were better than the national average, it contributed to the question whether services were needed to continue to assist Hardin County residents with tobacco cessation, diabetes, childhood obesity, mental health, and other modifiable medical conditions.

The USDHHS (2009) provided information specific to those within a vulnerable population. According to the USDHHS, "Vulnerable populations may face unique health risks and barriers to care, requiring enhanced services and targeted strategies for outreach and case management" (USDHHS, 2009, p. 1). The data collected by the USDHHS documented nearly

10% of Hardin County residents had no high school diploma, just under 6% were suffering from major depression, and over 4% were considered to be recent drug users.

The County Health Rankings & Roadmaps (CHRR) (2012) provided valuable information with regards to health outcomes in Hardin County. In Table 1 (see Appendix B), morbidity, mortality, health behaviors, clinical care, socio and economic factors, and physical environmental factors in Hardin County in the timeframe of this project were identified and were easily compared with both the State and National level in order to identify weakness or barriers to healthcare within the community. The premature death rate was higher than the national average (CHRR, 2012), suggesting a need for more preventive services. Hardin County also had an increased number of "poor mental health days," and the number of those in "poor to fair health" was 3% higher than the national benchmark.

There are a variety of health detriments known to contribute to poor health and early or preventable deaths. These fall into two major categories: individual and community risk factors. Individual risk factors are those personal behaviors that a person might change given adequate time, support, and resources. In Hardin County, the number of adults who smoked is 25%, a number well above the national benchmark. The adult obesity rate in Hardin County in 2012 increased from the previous year by 5%, again ranking Hardin County well above both the national benchmark and the state average. Additionally, nearly 1/3 of Hardin county residents were physically inactive. This could be due to lack of access to recreational facilities, as Hardin County residents had 50% less access than the state and nation. Excessive drinking and the number of sexually transmitted infections was double that of the national average (CHRR, 2012).

Health detriments within the community included factors such as allocation of resources or inability to access care due to the physical environment, policies, and infrastructure. In this

particular community the number of uninsured was 11%, which is comparable to the national benchmark and the state average. However, Hardin County had a primary care physician to patient ratio of 1,754:1. This number was nearly double that of the national benchmark. Unemployment as well as the number of children living in poverty was greater than the state average and well above the national benchmark. Furthermore, the number of preventable hospital stays was higher than the national benchmark (CHRR, 2012).

The Institute of Medicine reported that there were 18,000 deaths in the United States each year due to lack of insurance (Davis, 2003) and those without insurance have a 25% greater chance of dying than those with private insurance (Institute of Medicine, 2002). There is an increasing need to bridge the gap of health care inequity all over America, and Iowa is no different (The Dahlen Company, 2012; Davis, 2003; Institute of Medicine, 2002; Iowa Fiscal Partnership, 2010). The health related outcomes of Hardin County reflected a population at risk and led to the author's two questions: (a) Is a free/low-cost medical center one way to increase equity in healthcare and (b) is such a clinic viewed as a priority by Hardin County residents?

Purpose of the Project

The purpose of this project was twofold: (a) to better understand the need for a free/low-cost medical clinic within the community and (b) if there is a need, to identify if this need is a priority to the community. The researcher planned to conduct two focus groups in order discuss if the establishment of a free/low-cost medical clinic is a priority to the community, and what barriers and limitations they foresaw to the establishment of such a clinic.

Literature Review

An exhaustive review of the literature was conducted using Ovid and Google. Key search term included: health assessment, needs assessment, rural, and community. The terms

were utilized in various combinations producing 21 articles, published between 2002 and 2012. After further review of the articles for pertinence, seven articles remained. Additionally, one website and four books were found to be pertinent to the literature review. The literature review focused on four main questions relevant to a needs assessment for a free/low-cost medical center: (a) what is a community needs assessment, (b) what value is a community needs assessment, (c) what are the types of community needs assessments, and (d) what barriers exist to creating and sustaining a free/low-cost medical center.

Community Needs Assessment Defined

According to Royse, Staton-Tindall, Badger, and Webster (2009), a "needs assessment is a process that attempts to estimate deficiencies" (p. 3). Many authors described a needs assessment as a systematic gathering of data and information to assist in identifying health related problems, creating priorities, and examining program needs, ideas, and ways for improvement (Curtis, 2002; Friedman & Parrish, 2009; Hodges & Videto, 2011; Witkin & Altschuld, 1995). A needs assessment is useful for identifying priorities and to help with program evaluation (Beverly, Mcatee, Costello, Chernoff, & Casteel, 2005; Byrne et al., 2002; Kazda et al., 2009). Community health assessments are a "core public health function… that describes both a process and its tangible products…" (Irani, Bohn, Halasan, Landen, & McCusker, 2006).

The term "community" is a vague term. It is used to connect people of similar interests and/or those with similar geographical locations (Nardi & Petr, 2003; Royse et al., 2009). Often researchers will utilize a geographical location as their setting for a community needs assessment. For this project the needs assessment will be confined to Hardin County, a geographical location.

Value

A needs assessment can be of immense value to the community. It provides a way to gain useful information in order to detect and describe particular needs, discover what is creating or perpetuating these needs, and then create a plan to meet or amend the need (Witkin & Altschuld, 1995). It can be used to diagnose the health of the community, help to identify priorities, insure that resources are being adequately used and are actually needed within the community, and assist in identifying barriers to program implementation (Hodges & Videto, 2011; Irani et al., 2006; Nardi & Petr, 2003; Royse et al., 2009). Needs assessments help the community develop a sense of ownership and collectiveness, which in turn is more likely to create a useful and sustainable program (Hodges & Videto, 2011).

Type of Needs Assessment

There are numerous ways of tackling a community needs assessment. These can be done in the form of written or phone surveys, windshield surveys, observation, individual interviews, community forums, focus groups, or gathering secondary data. In order to choose how the needs assessment will be conducted, the researcher must first identify what is the question that drives the needs assessment, what is the timeline for the assessment, and what resources are available to conduct the assessment. With this information the researcher can then decide what type of data collection strategies to utilize in order to successfully complete a needs assessment (Hodges & Videto, 2011; Royse et al., 2009; Witkin & Altschuld, 1995).

Byrne et al. (2002) provide characteristics of high-quality community health assessments: use of current data, use of appropriate secondary data, comparison of data with other state and national benchmarks, and well organized and easily readable charts, chapters, and priories. Additional characteristics include a well explained action plan including roles of key

stakeholders, explanation of the community partners' roles within the identified issue, well integrated content throughout the assessment, and examination of accessibility and availability of services with regards to the issue. Many researches use one or two methods when conducting a needs assessment. Beverly et al. (2005) utilized both a survey and focus groups for their needs assessment, while others chose to use face-to-face interviews (Kazda et al., 2009), phone interviews (Curtis, 2002), secondary data (Finifter, Jensen, Wilson, & Koenig, 2005).

Survey. A survey is a way to generate information via self-reporting. This can be done in numerous ways: written, mail, telephone, e-mail, or web-based. There are many advantages to conducting a survey. A survey can be economical, require a low amount of resources, easy to administer, can create rapid responses, and offers much less irrelevant data than other methods. Some of the disadvantages include: possible language, literacy bias, missing data due to unanswered questions, and may need the assistance of a trained administer. Additionally, it can be difficult to create a questionnaire that is not too broad or not too narrow. The survey questionnaire's reliability and validity can also be difficult to evaluate (Hodges & Videto, 2011; Royse et al., 2009; Witkin & Altschuld, 1995).

Observation. Windshield tours are a form of observation that can be useful to identify issues and assets of the target population. The advantages of observation include having generally accessible data available with a small investment of resources. It also is a unique way to collect data and can be valuable alongside other collected data. However, this method may take a lot of advanced planning in order to decrease bias. This type of data collection technique can be helpful but it can also be fairly unreliable if not done correctly (Hodges & Videto, 2011; Witkin & Altschuld, 1995).

Interview. Interviewing is another method often used to conduct a needs assessment. This method can be completed in a variety of ways: face-to-face, telephone, or web-based. It can be carried out individually or within a group setting. Interviews can be semi-structured or structured depending on what the researcher is intending to elicit. Either way it is important for the interviewer to know how to conduct the interview in order to collect reliable data. Interviews allow for clarification regarding the questions asked and the answers provided, which can certainly be helpful. This method can reveal feelings, attitudes, and expressions that surveys cannot. The disadvantages of this method include: increased cost to perform, time-consuming, smaller sample size, and bias inadvertently interjected during the interaction between the interviewer and the interviewee (Hodges & Videto, 2011; Witkin & Altschuld, 1995).

Community forum and focus group. Community forum and focus groups are often considered group interviews, and are frequently used in the conduction of a needs assessment. People with a similar or vested interest in the topic are recruited to participate and the discussion can then be recorded for later analysis. Some researchers will include a non-biased facilitator and observer to be present during the forum or focus group. Rich data can be extracted due to the ability of interviewees to feed off of each other's ideas while engaging in the interview. Multiple views can be heard and emerging themes can be explored. Additionally, it can be less expensive than other methods. The disadvantages of this type of a data collection include: possible domination of the session by one or two people, the requirement of an expert and skilled facilitator during the group process, difficult and time-consuming analysis, lack of complete representation from all community views, and irrelevant data generated if interviewees are permitted to go off task (Hodges & Videto, 2011; Royse et al., 2009; Witkin & Altschuld, 1995).

Secondary data. Data collected from other sources, such as local, state, and national agencies and organizations, are considered secondary data. There are many benefits to the collection of secondary data. Due to the Internet, data is often readily available, saving time, resources, and duplication. There is no risk to participants, and the data can be viewed over time, which can help identify trends. Disadvantages may include: limited access in some circumstances, most recent data not yet available resulting in a time-lag, an incomplete or non-match with the target population, and unreliable, non-credible, and misleading data (Hodges & Videto, 2011; Royse et al., 2009).

Needs Assessments

Montgomery County in Indiana utilized printed surveys to perform a community health assessment. Not only were these surveys available for pick-up at certain locations, but an additional 3,000 surveys were mailed to homes in the area (Montgomery County Free Clinic, 2011). Pinto (2007) completed a needs assessment in order to identify if there was a need for a faith-based medical clinic in Hartford, Connecticut. The author built upon pre-existing census data and data that was collected by the local hospital. Pinto then sought to gain in-depth information about this need through key informants (church leaders) and focus groups. This study had ten key informants who participated in the interview. The focus groups were recruited through the use of a fliers and announcements at church, which resulted in ten participants.

Barriers to Free Medical Clinics

The major barriers to the establishment of a free/low-cost medical clinic revolve around the lack of resources. According to Allen (2011), many free health clinics identified funding as a major issue to the sustainability of their clinic. Other barriers included lack of staff (nursing and primary care providers) and lack of specialty care services. Many clinics identified medication,

facility space, electronic medical records, diagnostic tests, and medical equipment as their priority resource needs (Allen, 2011). It is important to recognize potential barriers in order to discuss the probability of the community being able to overcome these barriers to establish and sustain a free/low-cost medical clinic.

One successful clinic operating in Waterloo, Iowa now serves over 19,000 patients. The clinic grew in 1978, when it received an urban health initiative grant. Since then the clinic has continued to grow and prosper with the help of federal funding from the United States Department of Health and Human Services' Health Resources and Services Administration (Peoples Community Health Clinic, 2009).

Setting

Project Setting

The setting where the needs assessment took place is Hardin County, Iowa. The needs assessment was conducted over a three-month period. Starting with recruitment of participants via flyers, and ending with a review of all collected data to determine if there was a need for a free/low-cost medical clinic within the community.

Readiness for Change

At the time of the clinical inquiry project the Ellsworth Municipal Hospital was going through a lot of change, as they were building a new hospital across town. Many of the financial issues associated with this change were in the closing stages. By October 2012, they had the financial aspect of the project behind them and were ready to look at other community projects. The hospital, continually looking for ways to improve the community, was looking for ways to care for people in special ways (Ellsworth Municipal Hospital, 2012). The board of directors was very open to hearing the concerns of the community and supporting the efforts related to

conducting a needs assessment, and if need be, support the efforts to establish a free/lost cost medical clinic.

Anticipated Driving Forces, Timing, and Barriers

There were a multitude of factors that supported the timing of this CIP. There were also potential barriers to a successful completion of the CIP. This next section will discuss both.

One driving force to the completion of the needs assessment included the fact that a needs assessment could provide the organization with a great deal of information, while also being fairly inexpensive. The completed CIP would provide additional information about the need for a free/low-cost medical clinic at a time when there was movement and financial support to improve community resources leading to improved health outcomes for Hardin County.

The timing of the needs assessment was driven by four factors: (a) social justice, (b) ethical consideration, (c) the building of a new hospital, leaving behind an older but still functional building that could be used for a free/low-cost clinic, and (d) possible volunteer staffing for such a clinic. The first two driving forces came from social justice and ethical considerations. Creating a free medical clinic for those in need was ethically the right thing to do. The nursing code of ethics discussed the need to serve the public and promote the health of all people (American Nurses Association, 2001). The third driving force was the hospital's target date for moving to its new location. It was less than two years in the future, making it timely to consider planning for a new free/low-cost clinic. There were already discussions in the community about what the hospital was going to do with the old building once they moved. The hospital responded by telling the public that they would like to utilize the space to serve the community and they were open to any ideas. This included the development of a free/low-cost medical center. Another driving force was the fact that nearly 50% of the providers who worked

in the Iowa Falls clinic were retiring within the next one to five years. Many of them expressed a willingness to volunteer a few hours per week providing this type of service.

There were two major barriers identified that could potentially influence the successful completion of a needs assessment. First, there was concern that it would be difficult to get others on board with a project that they might not be passionate about. The second factor was a limited timeline as the needs assessment had to be completed by April 2013.

Participants/Population

Inclusion and Exclusion Criteria

Inclusion criteria for the focus group included the following: Hardin County residents who lived in Hardin County for greater than one year and had an interest in the health of Hardin County residents. Exclusion criteria included the following: those who were non-Hardin County residents, residents who had lived in the area for less than one year, residents less than 18 years of age or older than 80 years of age, and residents without a deep interest in the health of the community.

Size and Rationale

The researcher conducted the needs assessment utilizing the focus group method of data collection. Two separate focus groups were originally planned with interested and concerned volunteer citizens participating. In actuality only one focus group was convened. This group consisted of ten volunteers from Hardin County who had a vested interest in the health of the community. Also included in the focus group was the researcher, as facilitator, and a note taker, who did not participate but only took notes during the discussion. The discussion revolved around three basic questions. The focus group was encouraged to discuss these questions fully and in depth. They discussed if there was a need for a free/low-cost medical clinic, what barriers

or limitations existed and how they would suggest overcoming those barriers, and if they saw a free/low-cost medical clinic as a priority for Hardin County. The time with the focus group was observed, digitally audio recorded, and transcribed for further analysis.

Recruitment Plan

The focus group was recruited via flyers placed in various locations throughout Hardin County (Appendix C). The flyers were placed in local convenient stores in Hardin County, the Iowa Falls and Eldora laundry mat, the Iowa Falls coffee attic, various other businesses, pharmacies, and clinics. Those who wished to participate were able to volunteer for the focus group, assuming they met the inclusion criteria. The researcher recruited a local healthcare provider to attend the focus group, function as a note taker, and assist in validating that the focus group was accurately transcribed.

Measures/Outcomes

Sources

Data came from three sources: the verbatim transcripts from the focus group, the notes from the observer, and the summarized key points written during the focus group and confirmed by the participants at the time of the focus group. The researcher analyzed the data for recurring themes combining all three sources into one essential framework.

Processes and Procedures

The Oregon Health & Science University Institutional Review Board approved this study. When a potential focus group participant responded to the flyer, they were asked the eligibility set of questions (Appendix D). Once deemed eligible, the researcher briefly explained the purpose, date and time of the group discussion. If the caller agreed to participate then the researcher asked for an e-mail or home address to send the participant confirmation of the date,

time, and place for the focus group, along with a copy of the informed consent to read prior to the focus group. To maintain confidentiality, the researcher in her introduction asked participant to avoid using names or other identifiying information. Several times during the foucs group discussion the researcher summarized key points, writing them on a white board in the room and then validated them with the particpants. At the end of the focus group after particpants left, the researcher and the note taker cross compared what they had understood in order to verify accuracy. Digital voice recordings were transcribed verbatim by the researcher and then read through while the digital voice recording played to verify accuracy. Written key points and observer notes were transcribed for further analysis by the researcher. The note taker received training in the planned procedures, and at the conclusion of the focus group and the comparison session verified that the approved protocol was followed. Once all the data was transcribed and identifing information removed, all recordings, original notes, and written key points were destroyed. All transcipts and subsequent analysis were stored on a password protected flash drive and kept in a locked file cabinet in the researcher's locked office at the Ackley Medical Center, where only the researcher has access to the key.

Analysis of Data

Data from the participants were recorded and analyzed by the research team. The qualitative data obtained from the focus group was compiled and analyzed by the researcher. The researcher reviewed the transcription for recurring themes. These themes were further reviewed until three to five major themes emerged and were compared to the written key points taken during the session. With this information the researcher was able to answer whether the community (a) saw the need for a free/low-cost medical clinic within the community, (b) thought

potential barrier could be overcome, and (c) if they identified this need is a priority to the community.

Proposed Implementation and Outcome Evaluation

Analysis of Implementation Process

In discussing the implementation and process of the focus group there are areas that may have impacted the data gathered: recruitment, placement of the recruitment flyers, the flyers themselves, and difficulty in facilitating the group. As soon as IRB approval was obtained the researcher began posting flyers around Hardin County. Flyers were posted in various locations and shortly thereafter twelve potential participants contacted the researcher. Two participants were excluded as they were not Hardin County residents. The remaining participants met the criteria and agreed to participate. The researcher notified them by e-mail of the date, time, and location of the focus group. The consent for research was also sent via e-mail to allow the participants to review it prior to the focus group. No further calls were made to the researcher.

The response to the flyers, while initially successful, only generated enough participants for one focus group. There were four hypothesized reasons for this. First, the flyers were posted for only one month, possibly not providing enough exposure to recruit participants. Second, several of the flyers were moved throughout those weeks to areas that were not as visible. Third, the local librarian suggested that an issue might have been the flyers themselves. She thought that people might have been worried about the confidentially of the study and more information regarding this should had been included in the flyer. Fourth, it is possible that people were simply not interested in participating in a discussion about a free/low-cost medical clinic. This could be due to lack of interest, lack of time, lack of transportation, or other unknown reasons. Whatever the cause, because of the researcher's own timeline, the researcher recruited enough

participants for one focus group. In retrospect, it might have been more beneficial for the researcher to list a specific date, time, and location on the flyer, and have a community forum rather than a focus group. Another potential solution could have been newspaper or radio advertisements to recruit participants.

The focus group was comprised of a dynamic group of individuals. They were able to answer each of the questions asked by the researcher, and various perspectives were brought forward regarding the need for a free/low-cost medical clinic in Hardin County. The participants came from various backgrounds such as public health, mental health, community centers, and working class residents, which provided the researcher with a rich amount of information regarding the topic. The researcher found it difficult to balance keeping the participants on topic and allowing them to expand on their ideas. The participants were very passionate about the topic and had a great deal to say about the current state of healthcare in Hardin County.

Outcome Results

Once the transcription was complete, the researcher read though its entirety and then returned to the beginning to identify recurring themes within the text. After the content was analyzed several themes and subthemes emerged regarding each of the three basic questions (a) Do you believe there is a need for a free/low-cost medical clinic in Hardin County, why or why not? (b) What barriers will need to be overcome in order to successfully establish a free/low-cost medical clinic and how would you recommend overcoming these barriers? (c) Should the creation of a free/low-cost medical clinic be a priority to Hardin County? These themes were then compared to the notes taken from the white board and from the note taker. All themes from the white board and from the note taker were mentioned within the transcript. Additionally, the notes taken from the white board and those taken by the note taker were very comparable. No

differences were found, although the note taker's writings regarding the main themes were much more detailed, compared to the summarized key points listed on the white board. Major themes identified included: a need for a fee/low-cost clinic, funding, mental health, travel, and medical professionals. The researcher also used word counting as a way to analyze the data and identify recurring themes. Results can be found in Appendix E.

One major theme, the need for a free/low-cost clinic, was mentioned 12 times during the discussion. Response to the first question regarding if the participants believed there was a need for a free/low-cost clinic was undisputed. "I will say that there is [a need for a free/low-cost clinic] and a lot of it is with government choices for Medicaid" stated one participant. Another participant said, "I would agree with that…" while yet another agreed saying "I see the greater need for all kinds of services technically low-cost or free."

The most recurring theme noted from both types of analysis issues surrounding funding. Funding was mentioned 29 times during the nearly one hour-long discussion. This included participants discussing the need for funding, the need to fight for funding, and lack of funding. It was mentioned several times that funding was available but there was an issue with getting the money allocated to Hardin County. Lack of funding was a reason why needs were not being met, therefore creating a need for a free/low-cost clinic. This was consistent with the researcher's content analysis.

Many participants had vast knowledge regarding the funding available in Hardin County. Several of them discussed how there would be funding available for the establishment of a free/low-cost clinic, but it was a matter of obtaining those funds. According to one participant, "They are taking money on behalf of Hardin County but not coming to Hardin County to provide the services… and that's not just primary health, that's the pregnancy services, that's all kinds of

services, and they are all in Marshall County but they take money in a coalition form utilizing Hardin County's information and taking Hardin County's money. So if you can get them to part that away, you'd be shocked as to what you might have." Another participant agreed with this saying, "well funding is available that we do not utilize."

Participants recognized that the lack of funding created a need in the community. They spoke to funding being a barrier to having a free/low-cost clinic, but saw ways to overcome the funding barrier. Getting supervisors involved to help allocate funds was mentioned seven times as a way to overcome the funding barrier. A participant asked, "Should our supervisors be involved in this? Would they have any pull in getting it here?" "Absolutely" stated one participant. Another said, "That's how you could overcome it [barrier to getting funding to Hardin County], is to get the supervisors to say hey you took this money in our name you give it to us. Instead of take it in our name and then disseminate it as you see fit." One participant shared a personal comment that really summed up the issue of funding and the need for a free/low-cost clinic, stating "How dare you take it [funding] from them when every single day we are staring in the face of people who, you know, I have one [story] that I'll share with her, that his domicile is a garbage dumpster behind a business over by HyVee. He needs what you are proposing [a free/low-cost medical clinic]. Here. Here."

Mental health was mentioned several times and emerged as a major theme. Several of the participants discussed the issue of Hardin County residents with mental health issues, lack of mental health providers, and issues related to the stigma associated with mental health issues. "Mental health is completely lacking. As a therapist here in this town… I have never worked in a town where I had no services to help me provide my services" stated a participant. According to another participant, "And we need to look at the mental health component…" and yet another,

"Yeah and they are not getting mental health [in regard to the elderly population]." A few of the participants discussed how some of Hardin County residents simply don't know that they need help, where others are concerned about the stigmatism of having a mental illness.

Transportation, identify by the group as travel, is another barrier that was identified by the focus group, not only with the large homeless population but with those who are unable to afford to travel. Several participants referred to travel, stating, "Travel is going to be the biggest one [barrier]." Another participant agreed saying "Well travel is going to be a big one…" One participant suggested that the clinic travel in order to reach more patients, "I think that most of the stuff we get going is in Iowa Falls, so it would be nice if the clinic would be traveling. It might be a little easier for people from Eldora that don't have transportation or people from Ackley." The same opinion was echoed by another participant, "I think there are places you can hold a traveling clinic that are appropriate within those communities that would be able to meet what the needs of the clinic would be." This topic did cause some disagreement between some of the participants. "Hardin County has a pretty darn good transportation system really compared to some other communities… there is some access to some travel… you got to get on a bus and you have to call but it's pretty reasonable. It was five dollars." However, most agreed that travel was an issue, since some Hardin County residents did not have even five dollars for transportation.

Even if residents were able to access the clinic, there was also an issue with lack of medical professionals. "I think one barrier is to get medical personal to sign on because of the lack of funding or whatever." Several others agreed with this participant stating, "Oh yeah" and "I would agree with that too." The participants discussed the need to obtain funding to pay for these medical professionals. When asked about having volunteers staff the clinic, the

participants discussed how the current providers in the community are overworked and would likely not be willing to help staff the clinic. There was a general need for more providers to help serve the area. The researcher asked how they would suggest overcoming this barrier if they were unable to hire someone to work at the free clinic, there were no concrete solutions. "I don't know how you would get someone to volunteer" stated one participant. The researcher further probed the focus group to see if targeting retiring physicians would be one solution to this problem. However, there was not much response to this question. "Well not all of them" and "but a few" was the only response to this question.

The researcher brought the group back on topic and summarized the final question by asking whether a free/low-cost medical clinic should be a priority for Hardin County. There were various perspectives related to Hardin County within this group; however, all participants agreed unanimously that there was a need for a free/low-cost medical clinic, and that time and resources should be allocated to the development of such a clinic.

Discussion

Context

Although there was a wide array of views, the three basic questions were answered unanimously. The participants all seemed to have some experience working with low-income people and each had a vested interest in this topic. The focus group took place in a confidential meeting room at the Iowa State Extension Office in Iowa Falls, Iowa, which provided the participants with an area where they could talk openly without worrying about others eavesdropping. This focus group took place during a period in Hardin County history when unemployed or self-employed residents were unable to afford health insurance and resources such as time and funding were scarce.

Implementation in Relation to Literature

The ten participants of this focus group felt that there was a need for a free/low-cost clinic, that the barriers could be overcome, and that time and resources should be allocated to create a free/low-cost medical clinic. Hardin County statistics, as discussed in the Population and Epidemiology sections of this paper, support the participants' consensus of need for this type of service. As intended, the participants had a similar or vested interest in the topic (Hodges & Videto, 2011; Royse et al., 2009; Witkin & Altschuld, 1995). While the results from this focus group cannot be generalized to any other population, the results of this focused community needs assessment provided useful information in identifying themes around the need, including identifying barriers, and eliciting suggestions to create a plan to meet or amend the need (Witkin & Altschuld, 1995). Finally, the focus group validated that this is a priority to which the resources of time, energy, and funding should be allocated (Hodges & Videto, 2011; Irani et al., 2006; Nardi & Petr, 2003; Royse et al., 2009). The information gathered from this focus group provides a foundation for discussion that can assist in the ongoing community discussion regarding a free/low-cost clinic.

Outcomes in Relation to Literature

The data outcomes from this focus group had very similar findings as those mentioned in the literature. One major barrier to the establishment and sustainment of many free health clinics was funding (Allen, 2011). This was a recurring and persistent theme discussed within the focus group. Another barrier mentioned in the literature was lack of staff. This was also discussed within the focus group, and identified as a major theme particularly with regards to the lack of medical professionals and volunteers.

According to Allen (2011) many clinics also identified medications as a barrier, something else that was discussed within the focus group. Allen (2011) mentioned potential barriers such as facility space, electronic medical records, diagnostic tests, and obtaining medical equipment. These were not discussed during this focus group. However, the focus group did identify other barriers such as travel and patients not knowing they needed help or fearing the stigma attached to having a mental health condition.

Clinical Implications/Recommendations

There were a few limitations to this Clinical Inquiry Project: small sample size, lack of complete representation from all community views, irrelevant data, and possible domination from one or two people during the actual group process. These limitations are comparable with the disadvantages discussed by Hodges and Videto (2011), Royse et al. (2009) and Witkin and Altschuld (1995) regarding the utilization of a focus group for a needs assessment. Recruitment only produced enough participants for one focus group, limiting the researcher's ability to look for and compare themes across focus groups. A second focus group including those who would utilize the clinic might produce dramatically different themes and thus would be recommended in order to gain more insight.

A process issue that was unexpected involved the ten participants who were intentionally not identified on the audio tape; it made it difficult for the researcher to distinguish each of the ten voices. Therefore, when it was transcribed verbatim no participant identifiers could be utilized. Although this protected the anonymity of the participants some of the emerging themes may have come from the same person, which was the instance with regards to mental health. Mental health was mentioned 17 times, one of the top three themes. The researcher, who functioned as the facilitator, was able to identify this participant in the text, and over half of the

references made regarding mental health were from this one participant. The frequency of the mental health theme made it one of the top recurring themes, thereby possibly introducing a bias into the data. However, it was a theme that was discussed by other participants, confirming that the theme would still be present within the study. As mental health was brought up repeatedly, the researcher did ask for clarification during the discussion, whether the topic under discussion was a free mental health clinic or services, or a general medical clinic. The unanimous answer from the participants was the latter, a general medical clinic. According to Hodges and Videto (2011) and Witkin and Altschuld (1995), asking for clarification is a way to validate the findings.

Validity in this study was improved by having a non-biased note taker present at the focus group, and having the same person review the transcribed audio tape prior to it being destroyed. This study had ten passionate participants fulfilling Royse et al.'s recommendation that focus groups should have eight to twelve participants with a vested interest in the topic (2009). Although these ten participants were in agreement during most of the discussion, this also introduces some bias into the study. In the future, having a more heterogeneous group of participants with varied perspectives would be beneficial to identifying if there was a need for a free/low-cost medical clinic and what barriers existed.

According to Goldin and Hanson (2002), it is important to identify a specific problem, understand the scope of the problem, understand the population needed to be served, know the existing health care system, understand how to reach the population, and be able to identify areas of support. The focus group participants had extensive knowledge about the needs of Hardin County and its population. They also had a high degree of understanding regarding what support and services currently existed, including funding that Hardin County could be using to its

advantage. These things are imperative for the successful development of a free medical clinic (Goldin & Hanson, 2002).

The participants did discuss the barrier of lack of medical professionals and volunteers. This could be a huge barrier as the number and the quality of volunteers are critical to sustaining a clinic (Goldin & Hanson, 2002). However, the participants had no concrete suggestions on how to overcome this barrier. Obtaining funding in order to hire a medical provider to work at the clinic was the only proposed solution to the problem.

The focus group also discussed that a traveling clinic would be the best option for the population, as lack of healthcare and inability to travel was an issue with the entire Hardin County. The focus group discussed that transportation was a problem for many, and a traveling clinic would best suit this population's needs. According to Goldin and Hanson (2002) it is important to determine the best location for the population being served. It is also important to secure funding. This was validated within the focus group as a major recurring theme.

Conclusion

The information gleaned from this focus group identified both a need for a free/low-cost medical clinic in Hardin County and that it should be a priority. The participants had extensive knowledge regarding the health care needs of the population of Hardin County. They were enthusiastic about the topic and eager and hopeful to see something materialize from this study. For that to happen, the author has the following recommendations:

- Hold at least one more focus group focusing on residents who would use the services of a free/low-cost clinic to identify any other needs, barriers, and issues that may not have emerged during this project.

- Present the information from focus groups to a group of champions who would be willing to begin implementation of this type of service within Hardin County.
- Under the auspices of the group of champions, hold a community forum including those people who would utilize the clinic, support the clinic, and oppose the clinic. The community forum could assist in the collection of further data that would support or refute the need for such a service, as well as bring fourth other barriers that previously were not identified.

At the same time, ongoing information gathered from this CIP and future data collection should be presented to the public, not only for transparency, but to raise public awareness, encourage collaboration, to begin to build support for both public and private funding or in-kind donations, and to assist in placing a free/low-cost clinic on the public agenda. This could be accomplished in several ways, including utilization of the media via radio interview and newspaper articles The information should be presented to various boards who have the capacity to provide resources, such as time, money, or other supplies, to assist in this type of service. The local hospital board, various church boards, public health board, the Hardin County Circle of Life committee, among others, should be included in these presentations. It is important that many residents and groups are aware of the issue and are allowed to become involved in lending their assistance, developing or actually providing resources. This will increase the chance of success, not only for the establishment and sustainment of a free/low-cost medical clinic, but also for the success of creating a healthier Hardin County. As one participant stated, "It takes a village for these families."

Summary

There is an increasing need to bridge the gap of health care inequity all over America, and Hardin County Iowa is no different (The Dahlen Company, 2012; Davis, 2003; Institute of Medicine, 2002; Iowa Fiscal Partnership, 2010). This CIP assessed the needs of Hardin County in regards to the need for a free/low-cost medical clinic in Hardin County, Iowa. There are a large number of people in Hardin County who are unemployed, live in poverty, and lack health insurance or the funding for health care. The focus group clearly identified that there was a need for a free/low-cost medical clinic in Hardin County. The focus group participants believed that not only would such a clinic be valuable, but should be a priority, with time and resources allocated to the project in order to successfully establish this service for its residents. The focus group identified several barriers, but participants offered constructive suggestions and the belief that the barriers were surmountable, with the benefits of establishing a free/low-cost clinic greatly outweighing the risks. This was a project designed to assess need for a free/low-cost medical clinic. Further steps must be taken in order to move forward in developing a free/low-cost medical clinic in Hardin County, including further research, community presentations, and work to secure funding.

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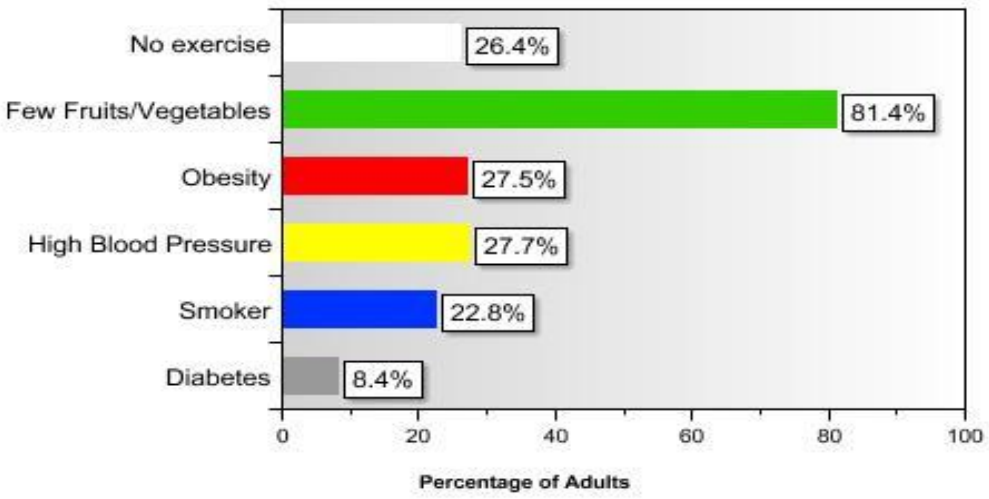
Appendix A

Figure 1: Risk Factors for Premature Death:[1] Hardin County, IA



Appendix B

Table 1: Hardin County, Iowa, & the Nation: County Health Rankings

	Hardin County	Error Margin	National Benchmark*	Iowa	Trend	Rank (of 99)
Health Outcomes						**52**
Mortality						46
Premature death	6,122	4,837-7,408	5,466	6,012		
Morbidity						57
Poor or fair health	13%	8-20%	10%	12%		
Poor physical health days	2.4	1.4-3.3	2.6	2.8		
Poor mental health days	3.5	2.0-5.1	2.3	2.7		
Low birthweight	6.3%	5.0-7.6%	6.0%	6.8%		
Health Factors						**58**
Health Behaviors						96
Adult smoking	25%	18-33%	14%	19%		
Adult obesity	33%	27-40%	25%	29%		
Physical inactivity	32%	26-38%	21%	25%		
Excessive drinking	16%	10-25%	8%	20%		
Motor vehicle crash death rate	21	13-29	12	15		
Sexually transmitted infections	190		84	313		

	Hardin County	Error Margin	National Benchmark*	Iowa	Trend	Rank (of 99)
Teen birth rate	31	26-36	22	33		
Clinical Care						38
Uninsured	11%	9-12%	11%	10%		
Primary care physicians	1,086:1		631:1	984:1		
Preventable hospital stays	68	60-76	49	63		
Diabetic screening	90%	79-100%	89%	88%		
Mammography screening	71%	60-80%	74%	71%		
Social & Economic Factors						44
High school graduation	91%			89%		
Some college	70%	63-78%	68%	67%		
Unemployment	6.7%		5.4%	6.1%		
Children in poverty	17%	12-23%	13%	16%		
Inadequate social support	14%	8-22%	14%	16%		
Children in single-parent households	19%	13-25%	20%	27%		
Violent crime rate	94		73	291		
Physical Environment						10
Air pollution-particulate matter days	0		0	1		
Air pollution-ozone days	0		0	0		
Access to recreational facilities	6		16	11		

	Hardin County	Error Margin	National Benchmark*	Iowa	Trend	Rank (of 99)
Limited access to healthy foods	4%		0%	6%		
Fast food restaurants	12%		25%	44%		

* 90th percentile, i.e., only 10% are better

Note: Blank values reflect unreliable or missing data

Appendix C

For more information call 641-373-6738	For more information call 641-373-6738	For more information call 641-373-6738	For more information call 641-373-6738	For more information call 641-373-6738	For more information call 641-373-6738	For more information call 641-373-6738	For more information call 641-373-6738

Appendix D

Hi. My name is Jennifer Gahring and I am a doctoral student at Oregon Health and Science University. I am involved in a research project to find out if there is a need for a free or low cost medical clinic in Hardin County. If you are interested in this topic, would you be willing to participate in a focus group with 5-8 other people about this topic? The focus group will last for no more than 2 hours and will be held at (*insert name of community meeting room)*.

NO	YES		
Thank you very much for your time. Good bye.	First, I have three questions to establish whether you are eligible to participate in this study. Is this a good time to ask them?		
	NO	YES	
	When would be a good time to call you back: Date/Time	Are you between 18 and 80 years of age? Yes No	
	What number should I call you at?	Do you currently live in Hardin County? Yes No	
		How long have you lived in Hardin County? < 1 year > 1 year	
		I'm sorry but you do not meet the criteria for participation in this study because (*reason)*. Thanks so much for considering it. Good-bye	You do qualify to participate in this study. Which of the following dates would work best for you? (*List of four dates and times given*). Which would work best for you? Date: Would you like a reminder the day before the group meets? Yes No I will be sending you a consent form and additional information about the meeting location and time. May I please have an address or e-mail to send these things to you?

Thank you so much for your time and consideration. The information I am sending you will have my name and contact information on it. Please feel free to call with any questions you may have or if for some reason you need to change the date of your focus group or need to cancel.

Appendix E

Themes	Number of Times Mentioned
Funding	29
Government	17
Mental Health	17
Need for a free/low-cost clinic	12
Travel as a Barrier	10
Need for Medical Professionals	8
Need for Supervisor involvement	7
Kids	4
Elderly	4
County Need (not just Iowa Falls)	4
Homelessness	3
Urgent Care	2
Need for Pharmaceuticals	2
Stigmatism	2
Education and Teamwork	1