Access to Health Care:
Experiences and Views of Communities in Lewis & Clark County

Key findings

- There is a shortage of readily accessible health care providers.
- Cost barriers impede full access to health care, particularly for lower income people and the uninsured.
- The health care system is not easily navigable, and there is insufficient awareness of available services.
- Providers are not sufficiently incentivized to prioritize people's health needs.
- The hospital is not providing an adequate service to all community members.
- Reliance on personal transportation is an issue for everybody, and is of particular concern to rural communities.
- Participants see a collective responsibility for keeping people healthy, be it through the community or the government. For many this was grounded in the belief that health care is a human right.

Executive Summary

- **Availability of health care:** Residents generally felt there was a shortage of service providers in the county. Rural residents felt this particularly acutely. Low income residents also had difficulty finding health care providers, but higher income residents had less difficulty, with the partial exception of in-county mental health services.

- **Access (Cost):** Most participants – particularly low-income and middle-income residents – have experienced difficulty finding health insurance, using the insurance they have, or paying out-of-pocket.

- **Quality:** There were many positive statements regarding quality of care, particularly regarding the Lincoln Clinic. However, across the board there were serious quality concerns about some aspects of care, particularly related to St Peter's Hospital.

- **Acceptability/Dignity:** Concerns about dignity in accessing and receiving health services were raised by low-income residents – particularly the uninsured and those on Medicaid – as well as residents seeking long-term mental health care.

- **The Human Right to Health Care:** The majority of participants considered health care to be a human right. Several others emphasized ethical obligations to meet health care needs, but did not feel comfortable expressing that in human rights terms. Many participants stressed that to have a healthy community, the government or the local community should help everybody to be as healthy as possible.

- **Suggestions for reform:** Participants offered a range of suggestions for Lewis & Clark County, including expanding health care services, particularly primary care, improving care coordination, improving the navigability of the health system, improving transportation, and expanding financing options.

I. Introduction

The Universal Access to Health Care Task Force conducted nine focus groups with community members across the county to assess the health needs of community members and collect their suggestions for improving access to care. The objectives of this research were as follows:

- To identify how sample populations (esp. rural, low-income, uninsured and underinsured) use health services
- To identify barriers to accessing health care
- To identify unmet health needs
- To solicit recommendations on what measures the county should take to ensure universal access
- To obtain feedback on the Board of Health's resolution

Methodology

Nine focus groups with a total of 56 participants were held in different locations across the county. Participants were recruited through Task Force members with the help of local community groups. Participants for each group were identified on the basis of a sampling framework, which prioritized the participation of uninsured, lower-income and rural communities. Each focus group was facilitated using a detailed Discussion Guide based on the research objectives. Focus groups were approximately one to two hours in duration, with on average about five to eight community members per group. They took place in Helena, Canyon Creek, Lincoln, and Augusta in August, October, and November of 2009. Discussions were audio recorded, transcribed and analyzed. The data analysis consisted of:

1. De-identification of focus group participants in recording transcripts.
2. Analysis of data into common themes and categories for each individual focus group.
3. Consolidation of themes and categories from separate focus groups into an overarching framework.
4. Analysis of group demographics using data from participant monitoring forms.

The focus groups discussed the current state of the health care system in Lewis and Clark County, including people's health needs, availability of needed services, experiences with accessing health care, quality and accountability of health services, and issues of dignity. Additionally, researchers solicited suggestions for improvements, views about the human right to health care and the county's role in protecting this right. Participants were also given information on staying informed about the Task Force's activities, providing feedback on research findings, and participating in upcoming community events.

This all-volunteer effort had some limitations, particularly with regard to identifying and recruiting participants based on the sampling framework. Not all sampling quotas were fully met, for example poor people were relatively under-represented in rural locations. Nevertheless, the profile of participants shows that a diverse cross-section of community members took part in this research, with good representation from lower-income and uninsured people.

Participant Monitoring Data

Of the 54 participants, across nine focus groups, approximately 60% were women and 40% men (based on an intentional overrepresentation of women in the sampling). Just under half of all

participants (49%) were between 45-64 years of age. The proportions of young (up to 34 years old) and old people (from 65 years old) were roughly equal (with 28% and 22%, respectively).

Participants' stated education level was higher than the county average (according to census data from 2000), which may reflect the inclusion of a student focus group and the under-representation of poor people in rural locations, but also the number of participants preferring not to state their education. Three quarters of participants who gave information about their education level had a high school diploma, an associate's degree, or a bachelor's degree. An additional 17% of responding participants had obtained a graduate degree, while 4% had not finished high school. Over two-thirds (68%) of participants had incomes of $49,999 (the median income in Lewis & Clark Co.) or less. Among those, 18 participants (42% of all participants) made less than $20,000 per year. The sampling intentionally focused on lower-income and poor people.

Of those who had health insurance, about 34% had employer-sponsored insurance, while 26% were insured through a public program (i.e. Medicare and Medicaid, excluding coverage through the Department of Veterans Affairs). Over one fifth of participants (21%) were uninsured.

The vast majority of participants identified as US-born Caucasians, and two participants identified as Native American.

Focus groups held:
- Task Force members (TF)
- YWCA, Helena
- Canyon Creek (CC)
- Lincoln 1 (L1)
- Lincoln 2 (L2)
- Augusta (Aug)
- Foodshare, Helena (FS)
- Helena (with a Mental Health focus) (H4)
- Students, Helena

Acknowledgements

II. Availability of Health Care

66 *Some of the doctors that are listed in the yellow pages, they're full. I've been having trouble finding a family doctor because I was going to one, but I can't see him anymore. I'm trying to find a new one, but the people that people have been referring me to, they're full so they won't take any more. And I stopped looking, but I've had that happen a few times."*

YWCA Focus Group

SUMMARY

Availability of health services in Lewis and Clark County can be poor. A shortage of primary care providers impedes the adequate provision of primary care to local residents, as does a lack of evening and weekend office hours during which patients can make appointments without conflicting with their work schedules or their need to travel to see a provider. Residents also noted a shortage of specialists, particularly quality dental care for low-income residents as well as mental health providers. Referrals to specialists often require patients to go out-of-county or out-of-network, the latter resulting in the patient having to make high out-of-pocket payments.

The discussions revealed that many community members are aware that providers working within the current health care model are required to operate as businesses, whose financial viability often depends on making decisions based on business needs, not necessarily population health needs. Rural residents have come to expect that providers may only practice in areas that promise large populations to care for and the potential to recruit and retain staff. Similarly, providers working within a market model may only take self-paying patients or those with private insurance, or restrict the number of publically-insured patients they accept.

 Physical distance and transportation to providers were highlighted as significant problems, particularly for residents in the more rural communities and for older people. Visits to providers require private transportation or dependence on family and friends. The ambulance service in Helena is too expensive for many; in contrast, Lincoln and Augusta residents praised the service provided by local volunteer ambulances. Issues of transportation go hand in hand with geographic isolation from health care facilities, especially for the elderly and northern county residents.

Poor navigability of the health system was identified as another key barrier. The structure of the current system and its many different layers of administration mean that each person, depending on their insurance (or lack of insurance), requires a different set of information in order for them to successfully navigate the system. Patients often do not know where to go to get the information they need in order to access the services they can afford, and prices for services may not be uniform in different locations. Some people were not aware of the free or inexpensive services offered by the Cooperative Health Center.

Family doctors/primary care providers

- Lower income residents generally reported difficulties finding primary care providers, specialists, and quality dentists available to them.
- The poor availability of primary care doctors for low income residents manifests itself most clearly for participants when those primary care doctors who accept low income patients advise them that they have a full patient load. (YWCA, Lincoln 1)
- Physicians that are available may not accept Medicare or Medicaid, or may restrict the number of publicly-insured patients they take. (Task Force, Foodshare)
- Participants perceive a general shortage and high turnover of primary care doctors. They noticed a trend of doctors leaving Helena (e.g. to work for the VA or in other areas). Some also felt that the remaining doctors might not give care of comparably high quality (Foodshare). In some cases, patients would prefer to travel to towns farther away than see doctors that give poorer quality care. (Augusta)
- Primary care doctors' role in managing patients' complex medical problems was appreciated, and it was feared that doctors may stop practicing because they may not find it cost effective as long as they are paid only for performing procedures. (Helena 4)
- Family doctors and mental health providers were often difficult to access because of their opening hours, which generally clashed with working hours. Many respondents were unable to take time off work to go to the doctor and did not receive paid sick days (YWCA, Lincoln 1). Rural participants were aware that there is a physician available after hours, but the doctor is based in Helena. (Lincoln 2)
- There may be a stigma attached to using the Cooperative Health Center (Task Force) as well as low awareness (Foodshare, Students).
- Satellite clinic is available in Lincoln:
  - Residents greatly appreciate the presence of the clinic and the quality of care received there. The clinic was closed for some time, however, and many residents have moved their care elsewhere. Respondents feel they would move care back to the clinic if they were assured services would stay and they would not have to switch providers again. (Lincoln 2)
  - The clinic is of particular use to the elderly. (Lincoln 1)
  - More specialized care requires travel to Helena or other main centers (Canyon Creek, Lincoln 1, Lincoln 2), but residents appreciate the clinic saving them from traveling for primary care appointments. (Lincoln 2)
  - At least one participant did not know that the clinic also provides pharmacy services. (Lincoln 2)
  - There was some concern that the workload may be too heavy for the two doctors at the Lincoln clinic. (Lincoln 2)
  - Some Lincoln residents access health care out-of-county (Missoula), but do plan on utilizing the Lincoln Clinic services in the future. (Lincoln 2)
- There is no clinic or health service in Augusta. Most Augusta residents, and northern county residents generally, receive medical services out-of-county (mostly in Choteau or Great Falls) because of geographic convenience, with the exception of VA services (in Helena). Augusta respondents were generally satisfied with the quality of care found in Choteau and Great Falls. (Augusta)

Specialists

- Specialists are generally difficult to access – particularly for low income patients – because they are expensive, insurance may not cover the referral, especially referrals made to out-of-network providers. (esp. YWCA)
- People often need to travel either out-of-town, county or even state to access specialist care that they feel fulfils their needs. (TF, Foodshare, Lincoln 1&2, Augusta, Students)
- There is a shortage of in-network specialists. (YWCA, Students)
- Participants in need of psychiatric services thought that there is a lack of psychiatrists, and reported that patients often work with therapists in lieu of, or while they search for, a psychiatrist. (H4)
- There is a lack of in-county/in-network inpatient mental health services. (TF)
- Appointments with specialists require travel to urban centers for rural residents. Costs associated with transport over long distances are an issue (CC, Lincoln 1&2, Aug)
- Lincoln has a chiropractic service available once or twice a week. (Lincoln 2)

Other Health Services

- The elderly often depend on caregivers. In Lincoln, there are so few caregivers that one or two leaving town can have a great impact. (Lincoln 1)
- Some services that are covered by insurance (such as post-operative physical therapy) may not be accessible if patients cannot take time off work to go to therapy appointments. (Lincoln 1)
- St Peter's ambulance service is so expensive that some residents will not consider calling it. Other ambulance services are available (e.g. Lincoln Ambulance, Augusta volunteers ambulance) but may take a long time to arrive, meaning that it is often faster to simply drive to the ED. (CC)
- There was much concern among residents of Augusta that the Choteau branch of the Great Falls Clinic would be closing and that patients would be referred instead to Kalispell, which is much farther away. This not only creates concern about transportation, but also about choice of health care provider. (Aug)
- There was concern about a high turnover of mental health case-workers due to high levels of burn-out. This was seen to disrupt quality of care for patients. (H4)
- There is a need for more dentists. Dental appointments at the Cooperative Health Center are difficult to schedule, as patients must arrive very early in the morning and have no guarantee of seeing a dentist. Other area dentists seem to have a full patient load or will only take patients with insurance. (FS)
- One participant with dental health problems had rotting teeth that needed surgical removal, but was unable to afford to go to a dental surgeon. While some dentists may offer affordable services, dental surgeons do not. (H4)

Transportation

- Rural residents and the elderly voiced particular concerns about getting to and from health care providers and raised transportation as an issue of access to care.
- Residents of rural towns reported their reliance on personal transport to get to and from medical appointments (CC, Aug). Lack of personal transport creates problems for residents beyond the reach of public transportation and creates reliance on family members to drive long distances for medical care (CC, Lincoln1&2). Many elderly

residents lack personal transportation (CC). Some residents in Lincoln resort to using to Lincoln ambulance, even for non-emergency transportation. (Lincoln 2)
- o The distances between rural areas and main health care centers are substantial (a two hour drive from Lincoln to Helena). (Lincoln 1)
- o Several years ago, grants funded a bus from Augusta to Choteau, but patients would have to devote an entire day to taking the bus because of its schedule, so service was discontinued after one or two years due to underutilization. (Aug)
- o Many Augusta locals go back and forth between towns (Choteau, Great Falls, Helena), for work, making access to services easier. (Aug)
- o Lack of adequate public transport (and of bicycle and pedestrian-friendly streets) in Helena was noted by many Helena participants. For low income people this added to the difficulty of accessing healthy food. (YWCA, Students)

Geographic Isolation
- o Northern county residents felt too isolated to benefit from Lewis and Clark County health services in Helena and Lincoln. For example, although Lincoln is closer to Augusta than Helena, it is difficult to access because it is on the "other side of the pass." Therefore, residents of Augusta are more likely to access health services in neighboring counties. (Aug)
- o Out-of-county service providers in Choteau target Augusta residents more for outreach (e.g. providing a bus service) than Lewis and Clark County providers.(Aug)
- o The distance between Lincoln and the next available provider is a problem, because referrals to other towns often require the commitment of a full day (Lincoln 2).

Navigability of the Health System
- o Most groups reported a general lack of information about health services and local resources available to residents.
- o Lack of accessible information about health services means that patients have difficulty finding the service they need. This can be so discouraging that it has, on occasion, resulted in the patient forgoing care altogether. (YWCA)
- o Some participants were not aware of the Cooperative Health Center and its sliding scale fees. However, one respondent, a teacher at the local high school, felt conflicted about giving information about the Center because it is busy and current patients have difficulty obtaining appointments. (Foodshare, Lincoln 2, Students)
- o Participants expressed difficulty understanding which health insurance plans were available and affordable for them. Some of those with insurance were concerned about the complexity of their policies. Paperwork in general can be a barrier to accessing coverage. (Aug., Students)
- o Some participants felt that drug pricing was not transparent, and were looking for ways to obtain more affordable drugs. They noted that some people were able to access drugs much more cheaply than others. (Lincoln 2)
- o Patients lack of information on the quality of available primary care providers. (YWCA)
- o Medical bills are difficult to interpret. One hospital visit can produce several different bills for various services. This lack of centralized billing increases confusion. (CC)

Children/Teenagers/Students

- o Teenagers and students tend to be unaware that they can get free or sliding scale care from the Cooperative Health Center. (Foodshare, Students)
- o Participants thought that teenagers may feel unable to access health care because they may not be comfortable telling their parents about their health needs. (Foodshare)
- o The school nurse divides her time between the elementary school and the high school, meaning that students do not always have access to a nurse at school. (Foodshare)
- o Respondents with experiences with mental health issues felt that it was important to have a designated mental health service for children in order to prevent and treat problems early in life, rather than waiting to treat problems when patients reach adulthood. (H4)
- o One respondent reported that she knew parents (mostly low-income) who refrain from filling out forms that would enable children to get free services (e.g. school lunches) because they are unwilling to give their information to a government-run program. (FS)
- o Students reported that accessing basic health care at the Carroll College Wellness Center was easy (they can receive certain medications, consultations and care by a nurse practitioner, and referrals to doctors if needed), and an on-site gym was also appreciated. (Students)

III. Access (Costs)

> 66 *You know, I grew up pretty darn poor. And I remember 15 years of early marriage paying 5 or 10 dollars to a whole bunch of separate medical providers. And not being able to, I mean, it takes 15 years to pay off something. Well that's going on all over the country right now. And there's a whole bunch of people that aren't getting service at all. I mean, that makes me sad."*
>
> 2nd Lincoln Focus Group

SUMMARY

Almost all respondents felt that health care and health insurance were too expensive, and many residents had (at some point) forgone health insurance or health care, or both, due to financial considerations. In some cases, uninsured individuals were without coverage because of a calculated decision that purchasing insurance was not worth the substantial expense (and low coverage benefits) when compared with their perceived low risk of falling ill or their option of paying out-of-pocket. Overall, participants noted that access to health care is based on a person's ability to pay for it, and they reported experiences illustrating that this has led to inadequate and unequal access to health care.

Although many respondents had insurance, many had skimpy plans with high deductibles that often precluded them from using their insurance to pay for needed care. Because of the expense, participants reported forgoing care or waiting to get care until they could no longer avoid it. When care was sought, information about bills was often confusing or incomprehensible without

assistance. Many respondents felt threatened by medical bills, did not feel supported by their insurer, and in some cases, feared legal repercussions on their financial status.

Public insurance programs were generally seen as a positive option; however, there were problems with eligibility and application processes. There was a concern that some people could benefit from public insurance but were not eligible (particularly low-income people just above the Medicaid income threshold and retired individuals not yet old enough to qualify for Medicare).

Affordability of insurance coverage

- o Most people had concerns about the cost of insurance coverage, deductibles and co-pays. (YWCA, Lincoln 1&2, Foodshare, Augusta, CC,TF, Students)
- o Some participants perceive a lack of alternative financing options – other than private insurance – for low-income patients, such as sliding scale fees or payment plans. (YWCA)

> **❝ [I]f you don't have money, then you don't have the right to care."**
>
> Helena 4 Focus Group

- o Employer-sponsored insurance plans can have such high deductibles or co-pays that it can be impossible for patients to take advantage of services under the plan. In such cases, patients have forgone routine, preventive check-ups and use health care services only in case of emergency. (Lincoln 1&2, Foodshare)
- o Even among cheaper private insurance options, premiums seemed too expensive and deductibles too high to be worth paying. (Aug)
- o Access to needed services for high-risk patients with pre-existing conditions may not be affordable because of the increase in cost of insurance. (TF)
- o In some cases, residents remained uninsured and paid out-of-pocket for care, only seeking care for what they could afford. This included paying for a diagnosis but treating with over-the-counter medications or self-care at home (Augusta).
- o A few respondents reported that acquaintances had negotiated with their insurance companies to bring down the amount they have to pay out-of-pocket for expenses. Many participants did not know it was possible to do this (Augusta).

> **❝ The cost of medical care is probably the number one thing preventing anyone from going to the doctor"**
>
> Augusta Focus Group

- o One participant's husband had major health problems and the couple was waiting to have them addressed in the next calendar year so that the deductible ($5000) would be satisfied early and costs kept lower for the remainder of the next year. (Lincoln 2)
- o Multiple participants mentioned difficulty in obtaining coverage for mental health services. (TF, YWCA, H4)
- o Lower-income participants, both in Helena and more rural areas, felt that being uninsured was the only practical option when compared with purchasing even the lowest-cost, high-deductible insurance plans.
- o Students stated that in their job search they would prioritize employers that offered health insurance. Students may also be incentivized to stay at college longer because

their student status enabled them to continue coverage under their parents insurance. They expressed concern about losing their coverage upon graduating. (Students)

Information about insurance and billing

- o Medical bills can be confusing, and participants expressed frustration with interpreting bills and reported that mistakes were often made. A lack of clear billing procedures makes it difficult for patients to know whether they are being charged correctly. (CC)
- o Concerns were raised about coverage or financing of services that are not available locally or in-service. (TF)
- o For out-of-state students insured through their parents, billing, payments and reimbursements can be problematic. One student received bills up to year after undergoing a basic procedure, because it was unclear whether the out-of-state insurance company would cover care received in Lewis & Clark County. (Students)
- o Students found the wait for reimbursement by the insurance companies to be daunting. (Students)

Government-provided insurance

Medicaid/CHIP

- o Several respondents reported problems with the application process for Medicaid. It is considered difficult, lengthy and confusing. (YWCA)
- o Participants reported that Medicaid patients had been dropped from the program without explanation and had to re-enroll. (Foodshare)
- o Medicaid patients may rely on their caseworkers and it can be difficult to obtain information about coverage if their caseworker is unavailable. (Foodshare)
- o Providers may have to wait for confirmation that Medicaid will cover a procedure before performing it, delaying patients' treatment. (H4)
- o There was concern about the number of young people that cannot afford insurance but make too much to qualify for Medicaid. (Lincoln 2)
- o CHIP was seen as valuable for poor families. (Students)

Medicare

- o Few options exist for adults between the ages of 19 and 65 who do not work full-time (e.g. no longer work, work part-time, or are unable to work). This is a particular concern for seniors who have retired but are not yet old enough for Medicare. This group is more likely to have pre-existing conditions, making it difficult for them to find coverage. (Lincoln 1&2)

> 66 *We're on Medicare, and it's wonderful. It's wonderful. I mean I wish everybody in the country had it."*
>
> 2nd Lincoln Focus Group

- o While Medicare ensures that people get preventive screenings, some participants stressed that care would be improved if people had preventive screenings throughout life, rather than from 65 years onwards, at which age people often already have medical problems. (H4)
- o Participants thought it was a problem that vision and dental services are not covered by Medicare. (H4)

Supplemental Security Income

- o A psychiatrist's support may be needed to obtain supplemental security income (SSI), yet psychiatrists are not always readily available or affordable. (H4)

Cost of treatment

- o Almost all participants in the Students group remarked that out-of-pocket payments for services and prescriptions were a barrier that prevented them from obtaining needed care, even with insurance. Coverage does not equal access to care: ***"even if you have access, you can't always afford to have the procedure."*** (Students)
- o Specialist services were considered too expensive for low income people. (YWCA)
- o Services in Helena may be more expensive than elsewhere in Montana. (TF)
- o Reimbursement for Emergency Room rates can be very unfavorable to patients. Under some plans, patients pay 80% of emergency costs unless they are admitted to the hospital within 24 hours. In contrast, critical care or urgent care clinics are considered by insurers to be primary care, and patients pay only 20% of costs. (Aug)
- o Some participants related stories about people they knew who would not take medications because they could not afford to pay for them, or felt that it would be financially better for their spouses if they died rather than seek treatment that could lead to financial burden. (Aug, Foodshare)
- o Some children go to school sick, as their parents are reluctant to take them to a doctor, despite having insurance, because of a high deductible. (Foodshare)
- o Some participants felt that sliding scale options are less fair to those that have insurance with high deductibles. They felt their coverage was not worth much if an uninsured person could access services more cheaply by paying a sliding scale fee based on their income. (Lincoln 2)
- o Several respondents had gone out-of-county or to Canada or Mexico to save money on prescriptions. (Augusta)
- o Participants have heard many stories of residents seeking less expensive surgical care abroad rather than staying in the U.S. (Foodshare, Augusta)
- o Participants expressed concern that some people may have large debts, despite being insured, because they have suffered serious illnesses that required a lot of medical care. The payments for treatments that are not covered by insurance, or for deductibles and co-pays, can put people into debt. (TF)
- o Dental care was seen as especially difficult to access without financial help. This was of particular concern to patients that needed more complex dental treatment, such as dental surgery. (H4)
- o Payment for services provided in a mental health center gets allocated according to a formula, not according to a person's health needs. It would make more sense if the money followed the person, not the procedures (H4).

Insurers controlling care

- o Respondents had concerns about insurers controlling access to care and choice of primary care providers. Examples included long time primary care providers leaving or being taken off a patient's insurance network. Providers themselves had also denied patients access because of small, outstanding co-pay bills. (TF, Foodshare)
- o Insurance companies do not always cover tests or treatment that could protect health and prevent disease, as opposed to emergency treatment. One participant had gone

through an appeals process to get coverage for a preventive service, but to no avail. At the same time, doctors often insist on unnecessary and expensive tests when insurance does cover them. (TF)

Legal concerns
- o Some respondents feared medical bankruptcy and having a lien put against their house. (Aug)
- o Residents have received letters threatening legal action against them for unpaid medical bills, despite payments being rendered in installments. (Aug)
- o One respondent's health care provider threatened to have his wages garnished by 85% because his insurance company refused to pay his bill. (Aug)
- o One respondent had to take legal action against an insurer to get bills paid. (Aug)
- o However, one participant felt that litigation control was necessary to help control the cost of health care. (Lincoln 2)

Impact on small business
- o One respondent, a small business owner, felt she was unable to lay off employees because they would lose their insurance with their job. Therefore she has made an effort to retain staff, even if it meant economic hardship for the business. (Lincoln 2)
- o Another small business owner reported that the inability offer health insurance for employees negatively impacted hiring. (Students)

IV. Quality

> 66 *I was really in pain, and nobody came out in all this time to say 'ok, is there anything we can do?' … And I was getting madder and madder, but there wasn't anything I could do about it because I couldn't move. [He] gave me a couple of pills, and said I could take one or two of them, and said, 'Alright, I'll have the nurse get you a walker so that you can get home alright.' I have steps going up to my house, and my bathroom was upstairs, I live alone, and I told him this. And he said, you know, 'I'd really like to admit you but I can't.'"*

Task Force Focus Group

SUMMARY

There were many health services in Lewis and Clark County that garnered praise. However, such comments were overshadowed by even more negative comments about quality of care received. The quality of care at the Lincoln Clinic, the Women, Infants, & Children (WIC) services at the Cooperative Health Center, and volunteer ambulance services were highly praised. Yet participants raised repeated and serious concerns over the quality of care at St. Peter's Hospital in Helena, particularly regarding emergency care. Beyond specific types of providers, participants' concerns related to the current system's rewards for the use of technology and pharmaceuticals rather than quality, appropriate care. There was also an impression that the quality of care

received was dependent on a patient's ability to pay. Participants also raised multiple concerns over the lack of quality, patient-centered mental health care tailored to the individual patient.

Additionally, participants reported a lack of communication between providers in cases where they were seeing multiple providers, both regarding patient care as well as sharing knowledge and information. This created frustration for patients and created doubts about the efficiency of care they received. In some cases, participants stated or implied that providers, particularly St Peter's, prioritized profitability at the expense of quality care.

Positive feedback

- Higher-income residents generally voiced fewer concerns about quality and dignity in health care than middle and lower-income residents.
- Augusta residents expressed satisfaction with care received in Choteau and Great Falls in neighboring counties. (Aug)
- Quality of care from local volunteer EMT services was well regarded. (CC, Aug)
- Residents of Lincoln appreciated the quality of service given by the volunteer ambulance. (Lincoln 2)
- The school nurse was regarded as excellent. (FS)
- Foodshare participants felt that the Foodshare program was excellent. (FS)
- VA services in Helena were well regarded. (Lincoln 2)
- WIC services were applauded as excellent. (YWCA)
- One participant reported experiencing good cardiology care at St Peter's, and a participant's grandson received good quality care for a liver transplant. (Lincoln 2)
- Appreciation was expressed to the Centers for Mental Health for trying to shift the paradigm to a more client-centered approach.(H4)

Negative feedback

Hospital

> ❝ *One reason you go to St. Pete's, and that's to die."*
>
> Canyon Creek Focus Group

- Long waiting times in the emergency department (ED) led to frustration, particularly because the service was perceived as expensive and of poor quality. Complaints included not having tests run for serious symptoms, poor diagnosis, poor treatment, and having to ask repeatedly for medications. (CC, FS, TF, Students)
  One participant shared his experience as follows: *"I had my gallbladder taken out, and that was at night, so my wife - I was hurting. I'm not going to call the ambulance, so my wife takes me into the hospital, right? I sat in the hospital for 4 hours, and it was an hour and a half in the waiting room. There wasn't more than two people in the waiting room."*(CC)

- Generally, participants preferred to use the urgent care service rather than the ED, and there was also specific concern about the urgent care site being taken over by the hospital. (CC)
- Many participants expressed overall dissatisfaction with the level of care provided by St. Peter's Hospital. In the Students group, one participant had to receive urgent care from a different source after St. Peter's provided inadequate care. Another student, who had experienced poor care and knew of friends who experienced poor care, noted that she would only use that hospital's services if she could not afford a different source of care. In another group, a participant mentioned that a case was "grossly misdiagnosed" at the hospital, so care was sought out-of-county instead. (TF)

> 66 *Having been to St. Pete's quite a bit … I don't know that that's exactly where I would want to be to get surgery or have a baby, but I'm limited, you know, if I had no other options, that's where I would have to get my care."*
>
> Students Focus Group

- Concerns about how billing was handled also undermined trust in the hospital. Some respondents felt that providers were more concerned about how bills would be paid than the patient's medical problem. (FS)
- One participant complained that St Peter's no longer felt like part of the community because it was reducing needed services in favor of services that generate more money for the hospital. (FS)

Other providers
- It was the consensus in the Student group that the quality of care received in general was greatly determined by a patient's ability to pay. (Students)
- The necessity of referrals in order to receive specialist services is seen as a barrier to actually getting specialist treatment. (FS)
- In Helena, home care services are available in all communities, but may not be of good quality. For example, some recipients of Meals-on-Wheels may dislike the meals given (FS). However, in Lincoln, the availability of home care services itself is a problem. (Lincoln 1)
- One participant's daughter was unable to obtain a sterilization procedure due to scheduling difficulties at Planned Parenthood. There is only one doctor that performs sterilizations on a limited basis. When the woman became pregnant, she was also unable to obtain an abortion, again due to scheduling difficulties. (FS)
- Mental health care for very ill patients was perceived as relying heavily on drugs and institutionalization. This was not seen as the best option for all patients. (H4) Respondents in another group raised concerns about doctors preferring surgery or drugs over more conservative measures such as physical therapy. (TF)
- Some respondents felt that alternative and natural therapies were valuable and should be made available.(H4, TF)
- One participant gave an example of how side-effects of a drug were not flagged up by a doctor and no proper instructions for taking a drug were given (H4).
- Mental health case workers burn out and quit frequently, which has been disruptive to treatment. (H4)

Patient-centered Care

- o Participants with mental health care needs reported that these needs are often not met, because of the structure of the mental health system. Instead of modifying a care plan to meet the needs of a patient, the patient is treated according to a "one-size-fits-all" plan that may not be appropriate for them. *"If the bureaucracy is getting in the way, then get rid of the bureaucracy, don't penalize the person"*(H4)
- o Some participants perceived a lack of knowledge and expertise among both providers and the general public about complex or rare conditions. (H4)
- o Hospitals were seen as not to be sharing useful knowledge and information because of bureaucracy and competition between businesses. This was perceived as creating expertise silos, resulting in valuable information not being available to all health care providers in the community. This was seen as inefficient and leading to overlap of testing and treatment for patients and researchers. (H4)
- o Information sharing between the VA, local hospitals and primary care doctors was seen as too limited, so that good practice by bigger institutions, such as the VA, could not be replicated (H4).
- o A participant pointed out that because there was no medical school in Montana, doctors and other health care professionals may receive the majority of their ongoing education through drug or device company representatives. Drug company representatives seek to encourage as many health care professionals as possible to use their products, even though these products may not always be the best treatment option. (H4)
- o Multiple providers working with one patient did not always communicate well with one another about the patient's care, creating a frustrating experience for patients. (YWCA)
- o Doctors referred patients to specialists outside their network, making it impossible for their patient to see a specialist due to cost issues. (YWCA)

V. Acceptability/Dignity

> 66 *I went in Wednesday, pulled a tooth that was abscessed. I told them I needed antibiotics, and they said no. I went back Friday as my face was even more swollen than it is now. He kind of laughed and said, "Well, I guess we should have started those antibiotics anyhow." Then reminded me that I was getting the care for free. … I'm going to get into a different dentist that will take payments because this broke one tooth, pulling one out, and I was reminded twice that I was getting the service for free."*
>
> YWCA Focus Group

SUMMARY

Some participants, particularly those without financial means and those with specific health conditions, felt judged, stigmatized, and treated badly in the local health system. They attributed this to their inability to pay for their care, the public's and providers' lack of proper understanding of their health problems, or a lack of respect by health providers. Multiple participants felt that

doctors had been dismissive of concerns related to their care, and in one case, were made to feel that they had no right to demand quality care simply because they were not paying for the full cost of their care.

Most poor participants felt that in a system that sells health care as a market good, those unable to pay for their care were either left out or perceived as using scarce public resources or receiving "charity". That such fear of stigmatization may be well-founded was confirmed when participants in other focus groups expressed resentment of alleged "welfare" recipients or undocumented immigrants accessing care.

There was also concern about mental health care, and particularly a lack of understanding among providers about different mental health disorders. Participants complained about not receiving adequate care, such that when their condition worsened, they were reported to the police rather than mental health providers.

Respect and Stigmatization

- o Pride was an issue for respondents with lower incomes. Some respondents felt it was beneath them to accept "charity" or government programs to pay for their care, and were not willing to ask for support.
- o Some participants, particularly those with low or no incomes, expressed concern about not being treated with respect by health providers. (YWCA)
- o Respondents would prefer ED care with simply friendlier staff. (CC)
- o One respondent reported difficulty in finding a doctor that would write prescriptions for narcotic pain medication, in part because of doctors' fears that these drugs would be sold on the black market. Patients may feel unable to complain for fear of being flagged as a drug abuser on their medical charts. (Foodshare)
- o The "treatment teams" (consisting of a case-worker, psychiatrist/psychologist, the patient, a family member and an advocate) run by day treatment facilities for mental health patients are often held without the patient's attendance, and decisions are made about them that they had no involvement in. This is frustrating for patients, and as a result, many stop treatment through this program. (H4)
- o The group focusing on mental health issues thought it was important for information to be disseminated into the community so that people were educated about rare or complex disorders that could cause unusual behavior. It was felt that if the public were aware of the issues related to these disorders, stigma about mental illness could be reduced, and appropriate help could be obtained when problems arose. (H4)
- o Poor or inadequate information about mental health disorders can be taken for deviant behavior and criminalized. This can lead to further stigmatization, and even criminalization, of a patient. (H4)

VI. Is Health Care a Human Right? What Is the Role of Government?

> 66 *I believe [health care] is a right, but it does come with responsibility, and that's the challenge for society, to impress upon people what their basic responsibility is to each other, as a society what we're all responsible to each other here to do our best to be contributors to society, to be honest, to be good parents, good friends, you know it's the community. Somehow we have to rise up better, I think, than we do."*
>
> 2nd Lincoln Focus Group

SUMMARY

All but one of the focus groups were asked whether they considered health care to be a human right, and the majority responded that health care was indeed a human right. Poor participants in particular, as well as Medicare and Medicaid beneficiaries, overwhelmingly viewed health care as a human right.

Some participants qualified their position with a caveat that the right to health care went hand-in-hand with a certain degree of responsibility to keep oneself healthy. Of those who stated that they did not believe health care to be a human right, most participants still placed high importance on health care as a fundamental human need, and often associated the availability of health care with an ethical responsibility. When asked to elaborate their positions, responses suggested that it was the unfamiliar language of "human rights" that participants hesitated to use, rather than reservations about the substance of the concept itself.

Participants expressed a range of views on the government's obligation to protect and fulfill the human right to health care. While some participants (especially Medicare beneficiaries) were expressly in favor of public financing of health care, others – especially rural participants – were more resistant to the idea of government involvement and saw government in a "moderate guidance" role at best, or as a provider of insurance for children. However, there was a general agreement that some collective obligation exists to ensure access to health care for all, especially in order to have a healthy community. Most participants saw some role for either government or the local community to help everyone to be as healthy as possible.

Is Health Care a Human Right?
- o All but one focus group discussed the Board of Health's recognition of the human right to health care, along with the government's obligation to protect this right.
- o Over sixty percent of those participants who were asked whether they considered health care a human right responded in the affirmative: *"It's everyone's right as a human being."* (H4)
- o Medicaid and Medicare participants generally agreed that health care was a human right, as did students. People who considered themselves middle class but whose

incomes put them in the lower-income brackets tended to display resentment of those receiving "free" health care, and did not consider health care a human right.

> 66 *We're human beings; it doesn't matter whether we make $7 an hour or six digits a year. We're humans and we all have something to offer. … Why can't we get good health care? Anyone of us in this room deserves excellent doctors and caring, patient people. Why is our income a factor in that? I don't understand that. So it should be a right, and it is very much about respect."*
>
> YWCA Focus Group

- ▪ Several participants said that everyone was entitled to quality health care, but many struggled with giving meaning to the concept of a human right. *"I consider it to be our ethical responsibility to supply it to everybody, but I don't see it as a human right."* (H4)
- o Some participants felt that certain people 'deserved' health care less - especially people on welfare, or those that had chosen 'unhealthy' lifestyles. This is a view explored further in the "Responsibility" section.
- o Several participants considered health care a "basic human need" that does not necessarily translate into a human right. When pressed further and asked to describe a "basic human need," these participants often went on to describe a general concept substantively similar to a human right. This may suggest that it is not the idea, but the terminology of "human rights" that made those participants uncomfortable.
- o Some participants linked their view of health care as a human right to moral considerations involving personal and collective *responsibility* for health.
- o Others linked the human right to health care more closely to the principles of *equity*, fairness, universality, and inclusion.

Equity

- o Most participants thought that some people in Lewis & Clark County, particularly those with higher incomes, had better access to health care than others. (YWCA, Lincoln 1, Lincoln 2, Students)
- o Students felt that they had been privileged to have insurance, but that health insurance in fact should not be a privilege. There was a sense that it was unfair that some people were denied access to health care and to healthy foods simply because they had less money: *"Just from my observation of equal access, it doesn't seem fair that I have access and other people don't."*(Students)
- o Several participants, generally from the lowest income bracket, when asked if they thought whether it would be a violation of people's human rights if some people get better access to care than others, responded that it would be. (FS, YWCA, TF)
  - ▪ Multiple participants considered such circumstances as violations of a human right or ethical principles. For example, one participant stated, *"It used to be that if you were a dentist or a doctor you took an oath to take care of people."* (FS).
  - ▪ *"[F]rom what I understood of doctors, they have what's called a Hippocratic Oath – that neither by action nor inaction can they allow a person to befall harm, or be harmed…[I]f that's the case, then how come so many doctors turn*

people away and so many hospitals and so forth? And all these services are not available to people when they should be? If their Hippocratic Oath says that they're not allowed by even <u>inaction</u> to harm people, then that makes no sense." (H4)

o People's income was seen to determine the level of health care they can get; those with higher incomes were understood to be more likely to have better access to health care. (Lincoln 2, TF, YWCA, Students)

o Some inequities were seen as related to employment status, yet it was also pointed out that employment itself did not guarantee health insurance.
  ▪ Some employers do not, or cannot afford to, offer health insurance for employees.
  ▪ Some employees may earn income from multiple part time jobs, without working enough hours to qualify for insurance at any one job, and may not make enough to buy insurance privately. (TF, YWCA)

o Some participants felt it would be fairer if everybody had the same kind of health care, both in terms of access and equal quality.
  ▪ *"[T]his health care that we have is not very good; you can't even get a doctor. I said we need the same kind of health care as [the government has]. You know, if we all have the same – you want everybody … to have health care – why not just give everybody the same kind you guys have. Then everybody'll be better off."* (FS)
  ▪ *"What if I found a lump in my breast and I couldn't go to the doctor to even find out what it was, because I didn't have insurance. It's ridiculous. Unfair."* (Students)

o A respondent with a low income background explicitly stated that all humans are equal and everyone deserves excellent health care, no matter what income or social status. Others emphasized that everyone should be entitled to basic health care. "Basic" may vary among individuals, and individual care should be respondent to individual needs. (YWCA)

o A participant who questioned the right to health care thought it would be fair if everybody paid tax for health care on a sliding scale, but only if everybody, including very poor people and welfare recipients, paid some portion of their income into the health care pool. Nobody should be able to get completely free care, and individuals should be held accountable to some degree for what they receive. This view was based on the participant's perception that welfare recipients get better and quicker health care than people who work. (Lincoln 1)

o One respondent stated that health care was a human need; however the respondent did not feel that this translated to health care being a human right.
  ▪ *I think would be more accurate if this state "basic human <u>need</u>." Health care in my mind is a basic human need. Some of us need more of it than others, it's just like food on the table, it's a basic human need. Do we have the right to T-bones and the next guy over here eat oatmeal every night? He doesn't have a right to eat T-bones every night, just because somebody else does. … Food consumption, health care, housing – it's all different. It's not a basic human <u>right</u>, it's a need.* (CC)

Responsibility

- o Rural residents were more likely than Helena residents to say that health care required some personal responsibility: ***"I think it should be a right but it comes with responsibilities."*** (Lincoln 2)
- o The second Lincoln group discussed the idea of responsibility in detail. One respondent felt that health care was a privilege that must be restricted to those that are responsible for their own health and that contribute to society.
  - ▪ Upon probing, however, the respondent felt that nobody should be denied health care, and that everybody is entitled to the 'privilege' of health care.
  - ▪ Another respondent felt that nobody should be denied health care, but struggled with the concept of giving health care away for free to people that were not perceived as sufficiently responsible.
  - ▪ It was also mentioned that some people's "unhealthy habits" provided a challenge.
- o Another respondent extended the individual responsibility concept to a more collective responsibility:
  - ▪ ***"I believe it is a right, but it does come with responsibility, and that's the challenge for society, to impress upon people what their basic responsibility is to each other, as a society, what we're all responsible to each other here to do our best to be contributors to society, to be honest, to be good parents, good friends, you know it's the community."*** (Lincoln 2)
- o Several rural respondents thought that welfare recipients and immigrants got care more frequently than those that were insured, because the sliding scale available to low income people was more affordable.
  - ▪ Several middle aged, lower and middle-income respondents with some form of insurance felt that welfare recipients were undeserving of care because they did not contribute as much to society as middle-class workers. (Lincoln 1, CC, Lincoln 2).
  - ▪ They felt resentful that their income disqualified them from the supposed benefits received by the poor.
  - ▪ These participants self-identified as middle class, but their reported income put them in the very low-income bracket.
- o At the same time, poor participants reported that it was difficult for them to obtain affordable and appropriate health care. (YWCA, FS)
  - ▪ Applying for government-sponsored health insurance was difficult, undignified and disempowering.
  - ▪ Respondents felt that "free" health care was not of good quality.

The Role of Government and Community

Participants were asked to discuss the health care responsibilities of local, state and national government, which are affirmed in the Board of Health's resolution. Opinions about government's role in guaranteeing or providing health care were divided, but there was some agreement on a certain community responsibility for facilitating access to health care, with 'community' taking on varying meanings.

- o Many participants felt that there was some obligation on society as a whole to provide options for people that cannot afford coverage. ***"I'd be willing to pay my share, according to my income, to have something that took care of everybody."*** (Lincoln 2)

- *"[M]y sense of us as a society is that if there is anybody within my society who somehow is treated as less than me, then not only is that a reflection on me, but it means it's damaging to me as well. … it's the basic personal philosophy about being responsible for the people around us, and 'being my brother's keeper,' or however you want to phrase it. So I do feel strongly about that. I know that is not necessarily a common view. I know that's very specific to some people."* (TF)
- Facilitating access to health care for all was also seen as a beneficial in financial and public health terms: *"The healthier you are, the healthier I am. And the less money I spend on your medical care. So it's very self-serving for me to keep you healthy."* (H4)
- Many participants felt that health care in the U.S. was "about the money;" that health care businesses valued profit at the expense of people's health. (FS, Aug, CC,TF, H4)

Government's Responsibility
- Rural residents were more resistant than Helena residents to the idea of government responsibility for ensuring access to health care.
- Government should provide an "equal playing field" and equal access to health care. (Students)
- Government should provide "moderate guidance" (Lincoln 2) or price regulation (Students).
- Some participants expressly acknowledged in positive terms that the government already provides health care in the form of the VA and Medicare. *"[W]e don't have to reinvent the wheel, we've already done it in the United States."* (FS) *"We're on Medicare, and it's wonderful. It's wonderful. I mean, I wish everybody in the country had it."* (Lincoln 2)
- Others pointed to problems with the administration of current government sponsored programs. (Lincoln 2)
- Participants in one group reported that acquaintances have had good experiences with the VA and took that as a positive example of government-run health care. However, one respondent argued that veterans have been known to receive extremely poor care (YWCA). In another group, a participant reported that a few doctors in Helena have left their positions to go work for the VA, so it may make sense to expand the VA to serve the community in general. (FS)
- While there was some agreement on universal coverage for children, one participant felt that this also implied that adults should provide for themselves without government interference, at least if they can afford it. (Lincoln 2)
- Most participants in a group made up of poor and low-income young women agreed that the government should have some role in health care; however, at least one participant expressed concern about how the quality of health care would be affected if health care was government-run. This group had previously voiced concerns about poor access to, and quality of, care in free clinics and the Medicaid program. (YWCA)
- Participants in one group discussed their experiences with the Canadian health care system. One respondent gave an example of excellent, timely and inexpensive care received in Canada, but this was countered with another respondent's case of a death in the family due to a delayed cancer diagnosis. The respondent felt that in the U.S. system, care would have been timelier. However, other respondents within the same group pointed out that insurance coverage is required to get such timely care, and that

in some cases people would go without care because they don't have coverage. (Lincoln 2)
- o Some participants pointed to universal health care systems in other countries and wanted to see some consideration of how those principles could be applied in the U.S. (Lincoln 2)
- o At least two students compared the United States on an international level and highlighted the fact that many countries provide universal health care rather than a competitive private health care system. They concluded that it would be possible for the U.S. to provide universal health care, and that this should be done. ***"I feel like Germany, and Switzerland, and Japan, and all those, they have systems that work really well. That everybody's happy with, that everybody's covered. There's no, like, nobody goes bankrupt for medical bills and stuff, and I feel like the US could combine all those and make something that, like, everybody can be covered. It's possible. People are doing it today, you know. They have been doing it for years and it is possible to do it and we don't need this, competitive [system] where people don't even have healthcare. It is possible to do it and I think it should be done."*** (Students)

Accountability
- o Some participants felt that money spent in the health system was not used for needed health services and could not be accounted for from a health perspective. One participant gave the example of a fountain outside St Peter's Hospital. (FS)
- o Private insurance companies' decision-making was raised as a concern by some participants. For example, when mistakes are made with billing, errors take a long time to be fixed, but patients continue to receive bills with incorrect charges in the meantime. There is no information about whom to talk to so that charges may be explained. (CC, Lincoln 1)
- o A lack of choice of doctors was raised as a concern for patients (CC), and one participant felt that if they made a complaint about a doctor, they would not get good treatment the next time they used the service. (FS)

Health Care as a Common Good
- o Many participants referred to society's need to keep people healthy. If people were unhealthy, they would become a burden on society because they would not be able to work or take care of themselves. Therefore, as one participant said, the government has a responsibility to ensure that people are kept healthy to maintain a functional, productive society. (TF) To have a quality community, you must have quality health care. **"*[l]t's an essential component to the lifeblood of the community, and to have a quality community you have to have health care…"*** (Lincoln 2)
- o One participant explicitly said that it was the government's responsibility to ensure that public goods such as shelter, food and health care are accessible to all. (TF)
- o Many participants referred to the negative consequences of no one being responsible to ensure access to care. They pointed out that health care was simply not affordable for many people (YWCA), and that uninsured people were afraid to go to the doctor because they were unable to pay. (TF)

- Some lower-income participants felt there should be some level of government help for "middle class" workers with bare-bones insurance plans or no insurance who are not eligible for Medicaid but may face financial hardship due to high medical costs.
    - A participant who felt that no one should get free care (in particular welfare recipients and people with poor lifestyle choices) also considered that government or society should step in for people in a catastrophic situation that is beyond their control. While this participant thought that government does not have an obligation to keep people healthy, and that instead individuals should personally maintain their health, there was an interest in some form of government relief for working people who face high costs. (Lincoln 1)
- One participant thought that if people were unable to access health care because they were unable to afford it, it should be the person's family's responsibility to provide them with money for health care. If the person did not have family or if the family could not provide for them, the person's church should step in to help cover their health care needs. ***"That's what we're supposed to do as a society. It's not up to the government to take care of us, it's up to us to take care of us."*** (CC) In this case, society was viewed as distinct from government; government was seen as a distant entity rather than of the people and by the people.

The Role of Local Government – Lewis & Clark County Board of Health
- Some participants voiced skepticism about whether there was anything the county would really be able to do to address their concerns. (Aug)
- There was hope that the county could engage in discussions with neighboring counties to better address the needs of residents on the borders. (Aug)
- It would be helpful if transportation needs for medical visits were addressed at the county level, especially for seniors and those who cannot get to Helena on their own. (Lincoln 1, Lincoln 2)
- The county could also have a role in ensuring better funding for the Cooperative Health Center, so the Center can provide increased and better service. (Foodshare)
- The county could maintain a user-friendly website or employ other strategies to keep residents informed about health services (YWCA, Lincoln 2)
- The county could work with the state to improve pay for doctors, perhaps cover part of the funding to keep good providers in the county. (H4)

VII. Suggestions for Local Reform

SUMMARY

The focus groups yielded a host of suggestions from participants about what should be done in order to improve health care for county residents, most of which centered on expanding existing services, improving care-coordination, improving navigability of health services, and expanding or improving financing options to address the high costs of coverage and care. While some suggestions referred to issues outside the county's authority, many others would require only minor changes. In many instances, participants did not readily think of systemic changes and instead focused on specific improvements to make their usage of the system easier. Some participants,

mainly from Augusta (whose residents tend to use services outside the county), were skeptical that anything could be done at the county level to address their concerns.

Participants particularly pointed to a need for expanding primary care services, especially for low-income and rural patients. Suggestions included improving funding for satellite and traveling clinics, and expanding office hours. There were multiple suggestions to improve the availability of children-centered services, both primary care and mental health services. Improved coordination of health-related information sharing was a major issue raised in several contexts: disseminating health services information to residents, improving communication between providers, and coordinating with neighboring counties to ensure adequate services for northern county residents. Multiple suggestions to improve transportation, particularly for the elderly, were also made.

Among the recommendations that may need to be addressed at the state level were extending eligibility for Medicaid and requiring employers to allow paid sick days. Yet most suggestions could be implemented at the county level, such as improving the availability of comprehensive, user-friendly information and advice about health services via a health information center or an 800-number, and improving public transportation, particularly within Helena and between Lincoln and Helena. Expanding primary and dental care at the Cooperative Health Center and satellites would fill crucial gaps, particularly for rural and lower-income communities. Finally, based on participants' comments, the role of the hospital in the community would have to be improved with some urgency.

Expand health services, particularly primary care

- o Improve funding to satellite or travelling clinics in rural areas or poorer towns. (CC)
- o Resources should be put into first line care, rather than into specialists, because these services are utilized by more people. (CC)
- o Participants expressed interest in a clinic or partial services opening in Augusta. This could include scheduling doctors or nurse practitioners to come out from other centers on a regular basis to run basic clinics and make referrals where necessary. (Aug)
- o Expand the use of well-trained nurse practitioners in more rural settings to help ease the burden on need for physicians. (Aug)
- o Extend opening hours of primary care providers and specialists to allow working people to attend appointments without having to find cover at work. (YWCA, Lincoln 1)
- o Reintroduce a children's mental health facility. (H4)
- o Improve pay and create more manageable caseloads for mental health practitioners to prevent burnout, reduce turnover rates and improve outcomes for patients. (H4)
  - *"[T]here's one shining example of what science has been able to tell us, and that is that of all the possible modalities for treating any mental illness, the one modality that is a predictor of a good outcome over time is a single, positive, supportive relationship for the person with a mental illness"* (H4)
  - *"….And that person doesn't need to be a professional. That's where the peer support specialists could come in."* (H4)
- o Hire peer support specialists to ease the burden on mental health professionals. (H4)
- o Open an assisted living facility for elderly residents of Lincoln, as some elderly residents move to Helena to be closer to services despite wanting to stay in Lincoln. (Lincoln 2)
- o Improve payment system for primary care services.
  - *"[M]y greatest, uh, concern and fear is that my PCP will no longer practice because he doesn't get paid for … monitoring my four chronic illnesses, he*

> ***only gets paid by procedure… so he gets $20 to spend an hour and 45 minutes with me. […] So I'm real concerned that I will outlive the primary physician care. And that it will fall to me to try to orchestrate that stuff.*** (H4)

- o Focus on early intervention and preventive care. Ensure that people get early preventive care to ease the burden of later, acute-on-chronic care. Also, health education is important to help people make better decisions. (Lincoln 2)

Improve care-coordination

- o Create a better communications link using an exchange or in-service trainings about best practices between all the health facilities in Lewis and Clark County. This could foster more efficient use of resources and avoid unnecessary overlap in remote areas.
- o Provide greater input in mental health planning through a representative from the county health department at Local Advisory Council (LAC) meetings. (H4)
- o Better coordination between multiple providers working with one patient would help mitigate patient frustration about disjointed treatment of the patient's situation, which may result from poor communication between providers. (YWCA)
- o Mental health programs sometimes require patients to partake in a certain amount of "basic skills" work at the day treatment clubhouses (cleaning floors, tables, and toilets, etc.) (H4) Yet if a mental health patient had completed that portion in one place, they would have to repeat that part of the program if they moved to another area with a separate program. This shows poor coordination for patients who have moved from a program in one area to a new program in a similar, neighboring area (H4)
- o Review the current state of the mental health care system, particularly the roles of LACs, SAAs, and peer-based care models.
- o Considering that many Augusta residents go out-of-county for care, participants suggested that the three neighboring counties (Lewis & Clark, Teton, and Cascade) should work together to coordinate care needs. (Aug)

Improve navigability of health services

- o Distribute comprehensive, user-friendly information about health services in places that low-income residents and recent arrivals to the area frequent: the job service, library, doctors' offices, grocery stores, bulletin boards, laundry mats, or gas stations. (YWCA)
- o Consider creating a visitors' center or local information 800-number that would include information on local health services that may also address suicide intervention, rape, domestic abuse, addiction, and general health care information. Such a number must be well advertised in local media. (YWCA)
- o Empower high school students by providing them with the information they need to access care for themselves or for their siblings. (FS)
- o Consider using mass media (TV, radio, websites) to help educate the public about health and health services. (H4)
- o Consider creating a county health-coordinator position that would be responsible for all avenues of information dissemination (Meals-on-Wheels, assisted living, CHC, etc). (Lincoln 2)
- o Create a position of mental health-coordinator to oversee mental health services, fostering consistency and efficient coordination between services.(H4)
- o Create a county website or interactive page that makes information about health services and financing options available. Make it easily printable for dissemination to

those without internet access, and have the option of asking questions to be answered by a moderator. (Lincoln 2)

Improve transportation
- o Improve public transportation to grocery stores, particularly more affordable grocery stores and ones that offer healthy options. Expand or eliminate limits to the amount of groceries that public transportation users can carry with them on buses. (YWCA)
- o Create transportation options such as a bus service between towns. (Lincoln 1 & 2)
  - ▪ Option could include allowing seniors recreation time or ability to accomplish errands while traveling to and from Helena for appointments (e.g. bingo, grooming etc., where proceeds could go toward the cost of the shuttle). (Lincoln 1)
- o Improve public transportation in Helena and create bike lanes. (Students)

Expand and improve financing options
- o Ensure that a distinction is made between the availability of health care services and the availability of health insurance, as the availability of insurance does not automatically make health services accessible. (TF, Students)
  - ▪ This could be achieved by requiring people to pay for routine maintenance costs (such as check-ups), while letting insurance cover illness or injury as needed. (TF)
  - ▪ The availability of care to those who cannot afford routine care could be addressed by increasing support for the Cooperative Health Center. (TF)
- o Create uniform pricing for services throughout the county. (TF)
- o Create flexible financing for insured patients whose plans do not cover certain needed benefits. (TF)
- o Flexible financing options could include offering a sliding scale or payment plan options for all services. (YWCA)
- o Simplify Medicaid application procedures to ensure that qualifying people receive coverage, and ensure that help and information is available to Medicaid users when needed. (YWCA)
- o Enlist local community groups or churches to help raise funds or to provide care for residents. (CC)

Treat all patients with respect and respond to their needs
- o Patients should be treated with respect regardless of their form of payment. Respect should not depend on ability to pay or the patient's health condition. (YWCA, FS)
- o Treat patients according to their specific problems, rather than trying to fit a patient into a rigid treatment framework. (H4)
- o Consider requiring paid sick days, so employees can use such days for accessing health care without losing income. (YWCA)
- o Allow one day a week during which people can take time off work (similar to the 4-day school week already in place) so that people who work can schedule medical appointments. (Lincoln 1)