

## Findings from the Interviews and Focus Groups

The primary objectives of the qualitative study were pursued through three questions:

1. What is the experience of Somerset/Middlesex County residents in accessing medical care?
2. What are the health services and resources most needed now to improve community members' health?
3. What are the barriers to accessing health care?

Some of the findings:

## Perceptions of Health Care and Community Health

### Meaning of health care

- A dominant perspective expressed in all of the focus groups was that “health care” meant having access to professional medical care when one needed it and being able to pay for that care.

### Health status

- Some described the health status of their community as “pretty good” or “better than other communities,” citing proximity to numerous health care facilities as a contributing factor.
- Others believe that the health status in their communities is “not the best” because residents are “not taking as good care of themselves as they ought to.”
- Obesity and lack of physical activity are seen by some as a primary causes for their communities' subpar health status, and social determinants of health (i.e., poverty, poor access to fresh produce, safe neighborhoods to play/exercise, etc.) are identified as major contributors to this problem.

**Primary Health Conditions** – The three major perceived primary health conditions identified:

- obesity (adult / childhood)
- mental health
- diabetes
  - Other conditions discussed with considerable frequency and emphasis included: dental issues, hypertension, cancer, substance abuse/addictions, and communicable and infectious diseases such as HIV/AIDS, pertussis, and sexually transmitted diseases.

## Health Care Resources

**Existing Resources** – These resources fell into three broad categories:

- Physical well-being – these resources include hospitals, clinical care sites, programs leveraging assistance for special populations, and those aimed at specific diseases.
- Mental well-being – these resources include those addressing general mental health, domestic violence, addiction and substance abuse. Many of these programs are difficult to access because of their concentration in the New Brunswick area.
- Social determinants of health – the resources that aim to address the social determinants of health include food pantries, soup kitchens, community gardens, farmers' markets, transportation services, exercise classes and spaces, baby equipment loan programs, and arts programming. These resources are found throughout the hospitals' catchment area.

**Needed Resources** – These fell into three categories:

- Resources for one primary health condition – obesity.
- Educational programs and awareness campaigns on a variety of topics for both patients and providers.
  - Recommended training for physicians (culturally competent and bilingual) to better diagnose / refer for mental health problems, domestic violence, addiction, and understanding developmental disabilities.
- Comprehensive medical and mental health services.

Other Recommendations:

- Resources developed locally and not concentrated in the New Brunswick area.
- Better coordination of resources

## Funding

- Community stakeholders said they reduced services when they lost funding
- Community stakeholders are challenged to address complex needs with inadequate resources
- Service providers noted increased pressure on services by people living outside the area they serve.
- Some unique funding sources were available in certain limited geographical areas.

## **Barriers to Health Care**

### **Health System Navigation**

- New Brunswick (in particular) is very health resource-rich in terms of the number and kinds of health services and health information available.
- There are various barriers that inhibit many people from being aware of these resources or understanding the system well enough to navigate it effectively.
- Several structural and cultural barriers were noted that shape how people use (or fail to use) the health care system, including:
  - language barriers with providers
  - signage difficult to understand
  - lack of coordination between the hospitals and other health care facilities
  - insurance and ability to pay for services
  - financial disincentives or penalties that work against effective/efficient use of the health care system.

### **Health Care Information**

- There were mixed perspectives regarding how participants trusted certain sources of information.
- Information sources included:
  - information from health care facilities
  - agencies and / or community organizations
  - the Internet
  - pamphlets
  - others such as newspaper ads, health fairs, magazines, library, TV promotions, and word of mouth.

### **Health Care Access**

- The most pronounced barrier to care – discussed commonly by both community stakeholders and focus group participants – was access for the uninsured.
- Patients believed that they get inferior services because they are on Medicaid or do not have insurance.

### **Unmet Health Needs**

- Patients postpone or forgo needed care as a consequence of inadequate insurance coverage.
- Specifically mentioned were eye exams, glasses, hearing aids, cancer screening tests (even when there is a family history of specific cancers), physicals, and dental care.

## **Cultural Issues**

- The hospitals' catchment area is very diverse with people of multiple races and ethnicities, originating from many countries, and speaking a broad range of languages.
- This creates challenges for providers and consumers, including:
  - A paucity of bilingual therapists, clinicians, and even medical and support staff in health care facilities.
  - Patients are often unable to find providers who speak their language or find specialized health information in their first language and therefore find it difficult to request and advocate for services if they do not speak English well.
    - Hindi focus group participants requested that the hospitals consider putting information on their websites in multiple languages.
    - Some focus group participants described choosing to get their health care needs met in their home countries (Dominican Republic, India).
  - Cultural beliefs often affect health behaviors and health care choices, which can challenge community stakeholders and health care providers.
    - Community stakeholders recommended interventions that are based on cultural norms and designed after consulting with the affected communities.

## **Doctor-Patient Communication**

- Most of the focus groups raised the role of communication with their doctors as an important factor in their feelings about the quality of their health care.
  - Those who felt they could reach their doctors by phone easily expressed satisfaction.
  - Patients who felt their doctors were inaccessible by phone had a negative assessment of their doctors and often of their health care in general.
- Recommended:
  - Having a "greeter" who meets patients at the door, says hello and welcomes them into the facility.
  - Designate a nurse who could "do the assessment, who could do some teaching, and who would be available for the patient."

## **Community Perceptions of Hospitals**

- A negative experience at either hospital can color the patient's perception of hospital (even decades after the experience) and impact the patient's behavior.
- Community stakeholders perceived "antagonism" between the two hospitals because they "compete for the same health care dollar" and an inherent imbalance, due to the fact that only one of the hospitals owns an ambulance service.
- Improved communication between the two hospitals is recommended.