

Focus Groups for a Needs Assessment of
Student Health Services
at UW-Stout


by

Wendy S. Knutson

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Kristina Gorbatenko-Roth, PhD

The Graduate School
University of Wisconsin-Stout

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**The Graduate School
University of Wisconsin-Stout
Menomonie, WI**

Author: Knutson, Wendy S.

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ABSTRACT

Student Health Services (SHS) at UW-Stout was concerned that a low utilization rate by students meant that barriers existed to care, or students were not satisfied with the care provided by SHS. In spring 2005, seven focus groups were conducted (N=31) to determine if barriers to care existed at SHS, and if so, what they were. Groups were separated by sex and by user or non-user of SHS. After analysis of the data, four overarching constructs were identified. In decreasing order of response frequency, the constructs were: awareness, access, process critiques and wellness/preventive/self-diagnosis. Differences between males and females were examined. No serious concerns with the quality of services provided by SHS were identified by participants. Barriers to care were identified in the constructs of awareness and access and are discussed within this paper.

The Graduate School
University of Wisconsin Stout
Menomonie, WI

Acknowledgments

This year is truly a landmark year for me in many ways. My son will graduate from high school, turn 18, and begin college at UW-Madison. I will have a significant birthday and complete my Masters' Degree. In April, 1998, I could have never foreseen this year unfolding in this way.

At this point, I wish to acknowledge some of the amazing women in my life: My sister, Rebecca, the one and only. Kristina Gorbatenko-Roth, Ph.D., and Lynn Murel, M.D., who believed in me, encouraged me, and challenged me to always do more than I imagined I could. Meridith Wentz, Ph.D., who accomplishes the impossible every day before breakfast – thanks for giving me my start in institutional research, for giving me opportunities every day to learn, and for setting an example of excellence to follow. Therese, Shari, and Heather for being my friends. Gretchen, you know why. Merrilee, rest in peace. I wish you could see this day.

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TABLE OF CONTENTS

ABSTRACT	ii
List of Tables	vi
Chapter I: Introduction.....	1
Chapter II: Literature Review	5
<i>Current Global Health Needs of College Students</i>	13
<i>Funding of Services</i>	15
<i>Healthcare needs of students in the UW System</i>	16
<i>Funding of Services in the UW System</i>	18
<i>Student healthcare at UW-Stout</i>	20
<i>Funding of services at UW-Stout</i>	21
<i>Current Issues at UW-Stout SHS</i>	21
Utilization of services at UW-Stout SHS.....	21
Current research needs of SHS	23
<i>What is a Needs Assessment?</i>	23
Chapter III: Methodology	27
<i>Subject Selection and Description</i>	27
<i>Method</i>	28
<i>Procedures</i>	28
<i>Measures</i>	31
<i>Procedures</i>	32
<i>Limitations</i>	34
<i>Data Analysis Plan</i>	34

<i>Documentation</i>	34
<i>Long-table Approach</i>	35
Chapter IV: Results.....	37
<i>Student Awareness of SHS</i>	66
<i>Implications of Findings for Increasing Students' Awareness of SHS</i>	68
<i>Access to Services</i>	69
<i>Solutions suggested by students</i>	71
<i>Limitations of study</i>	72
<i>Conclusions/Recommendations</i>	73
References.....	74
Appendix A: E-mail invitation.....	77
Appendix B: Poster	78
Appendix C: Scheduling e-mail.....	79
Appendix D: Reminder e-mail.....	80

List of Tables

Table 1: Ranking of UW System Schools by Segregated Fee Rates.....	20
Table 2: SHS Encounters in AY 2004-05 by Standing, Gender and Class Status.....	23
Table 3: Responses by Construct and by Gender.....	39
Table 4: Awareness by sub-construct: Frequency and Percentage of Male Responses.....	41
Table 5: Awareness by sub-construct: Frequency and Percentage of Female Responses.....	42
Table 6: Access by Sub-construct: Males.....	48
Table 7: Access by Sub-construct: Females.....	49
Table 8: Process Critiques by sub-construct: Males.....	55
Table 9: Process Critiques by sub-construct: Females.....	56
Table 10: Wellness/Preventive/Self-diagnosis by sub-construct: Males.....	62
Table 11: Wellness/Preventive/Self-diagnosis by sub-construct: Females.....	62

List of Figures

Figure 1: Percentage of Total Responses by Construct and by Gender.....	40
Figure 2: Comparison of Male and Female responses by Percentage in Construct of Awareness.....	43
Figure 3: Comparison of Male and Female Responses by Percentage in Construct of Access	50
Figure 4: Comparison of Male and Female Responses by Percentage in Construct of Process Critiques	57
Figure 5: Comparison of Male and Female Responses by Percentage in Construct of Wellness/Preventive/Self-diagnosis	63

Chapter I: Introduction

The University of Wisconsin-Stout Student Health Service (SHS) is located on North Campus in a freestanding building. It exists to provide health care services to UW-Stout students at no or minimal additional cost to them, as student health is one of the items covered by segregated student fees. In addition to tuition, all students in the UW-System pay what is known as a segregated fee. These fees provide additional operating revenue for a host of student services, including health care. Segregated fees and additional fees paid by users (for drugs, additional lab tests, etc) provide operating expenses for SHS, such as salaries. General Program Revenue (GPR), obtained from tuition, pays for physical facilities, maintenance, and utilities (SHS audit, 1997).

Student Health Services at UW-Stout provides primary care for most illnesses, including diagnosis and treatment. They provide referrals to other physicians or services when necessary. They provide continuation of treatment programs already underway, as when students enter UW-Stout with a pre-existing physical condition such as asthma or diabetes, or a mental illness such as depression. They provide physical examinations for a variety of needs, including: athletic participation, student teaching, routine pre-employment and limited pre-operative. The mission of SHS is to be "*committed to promoting and maintaining a healthy campus community*" with health being more than just the absence of disease. Most medications are available for a nominal fee and are dispensed at the clinic. Confidential treatment of STD's is also available.

Preventive care is available to students, including immunizations against disease and screening for a variety of conditions, including tuberculosis. Contraceptives are available, both

free (condoms) and at a reduced cost (oral contraceptives). Additionally, health education is provided to students both through the clinic personnel (usually 1:1) and through peer educators, who are UW-Stout students trained to relay information about a variety of healthcare issues to other students, often in informal group settings.

Students receive care from a Medical Doctor (MD), Registered Nurses and Nurse Practitioners, the latter two supervised by the M.D. Additional paraprofessional staff provide support in the laboratory and the business office. All professional staff maintains current licensures in their select disciplines, and CPR certification is maintained by RN's.

This study looks at a concern raised by the Clinic Manager and the Medical Director in the fall of 2004. Specifically, they were questioning why only approximately 35% of UW-Stout students utilize SHS in any given year and wondered if unidentified barriers existed to prevent students from seeking care.

To attempt to answer this question, the SHS was relying on an existing customer satisfaction data collection procedure. On a given day each month, all SHS encounters were to be given a comment card when they were leaving that would give them the opportunity to provide feedback concerning their visit. One concern with this procedure was an inconsistency with the distribution of the cards. If the receptionist, who was responsible for distributing the cards, perceived that she was already too busy, she would choose not to distribute the cards. The receptionist was quite frank about this when it came up in an early meeting with clinic employees. Additionally, students often did not wish to take time following their clinic appointment to complete a card. It was to be completed in a waiting area in the clinic, which may have also been a contributing factor. There was no analysis of the comment cards, other than a compilation of the comments. Nothing was done to group comments together thematically, note

the frequency of concerns expressed, or identify trends. This feedback procedure was not indicating problems (or much of anything else), so it was necessary to look elsewhere if concerns were to be identified. Additionally, the comment cards were only reaching those students who actually visited SHS, so if barriers existed to care, those students were not being reached by this method.

Consultants determined that in order to provide information that would answer the Medical Director's and Clinical Manager's concern, a Needs Assessment was needed. The needs assessment occurred in two phases, the first of which is the subject of this study: phase one; focus groups utilizing a small sample to identify the barriers to service; and phase two; a survey to be administered to a large sample of the campus population using the information gathered in the focus groups. Phase one, focus groups, commenced in the spring of 2005, and will be addressed for the remainder of this paper.

There were a total of 31 participants (n=31) in seven focus groups. Four groups were made up of female students, three groups of male students. Five groups were made up of students who had previously utilized SHS, two groups had not. Groups were facilitated by UW-Stout graduate students, and conducted on-campus. All groups were asked the same set of four questions and an initial icebreaker question. Groups were tape recorded and the recordings were transcribed. Notes were also taken by an assistant facilitator.

The transcriptions were analyzed by five graduate students. Two male graduate students analyzed the transcripts from the male focus groups, and two female graduate students analyzed the transcripts from the female focus groups. The principal investigator and author of this report analyzed all data from all groups. The approach used to analyze the data resulting from this study is called an inductive method. (Patton, 1997) The inductive method uses "criteria that are less

formal as one searches openly for whatever areas of strengths or weaknesses may emerge from looking at what's happening in the program". This method also focuses on improvement vs. passing summative judgment on the program. Inductive reasoning takes a more open-ended approach to data analysis, allowing whatever data comes forward to do so. For the actual physical process of analyzing the 100+ pages of transcripts, the data was analyzed using a method described by Krueger and Casey (2000) as the "long table approach". This method actually takes the documents apart into the phrases from which they are comprised by cutting them apart and rearranging them into new documents by themes. Individual statements are moved around as new themes are identified and definitions further defined.

Using this approach, four major constructs were identified: 1) Awareness of SHS, 2) Access to services, 3) Process critiques, and 4) Wellness/Preventive/Self-diagnosis. Each construct was in turn broken down into sub-categories. Results were compared by sex. Responses by category and subcategory were ranked by frequency of occurrence in the documents.

The results indicate that the largest barrier to service is lack of awareness of Student Health Services and the services provided. Recommendations to SHS included focusing efforts towards raising awareness prior to investing resources in clinic access/ process modifications, and suggestions for doing so.

Other recommendations included considering a large-scale Needs Assessment for more generalizable results, asking questions related to access, process, and wellness issues raised in the Focus Groups. This could best be done by creating and administering an online survey to either a large random sample or the entire population of UW-Stout students.

Chapter II: Literature Review

An early quotation regarding college health in America comes from Thomas Jefferson, speaking as the Rector of the University of Virginia in 1826:

...There shall be established in the University a Dispensary which shall be attached to the Medical School, and shall be under the sole direction and government of the Professor of Medecine who shall attend personally at the Anatomical theatre, or such other place as he shall notify, from half after one to two oclock, on every Tuesday, Thursday and Saturday, for the purpose of dispensing medical advise, vaccination, and aid in Surgical cases of ordinary occurrence, to applicants needing them.

All Poor, free, persons, disordered in body, topically or generally, and applying for advise, shall receive it gratis; all others, bond or free, shall receive it on the payment of half a Dollar at each attendance, for the use of the institution, and all persons shall be vaccinated gratis, and the Students particularly shall be encouraged to do so, as a protection to the institution against the malady of the small pox.” (Turner and Hurley, 2002)

In the late eighteenth and early nineteenth centuries, a young America realized the value of education, and colleges were established. The concept of student health services, like that of colleges, came to America from Europe. As early as the fifteenth century, the issue was addressed by the regents of Manchester College, London, when students with “horrible and contagious infirmities” were not allowed to enroll. (Turner and Hurley, 2002)

The formal development of college-based health services is generally recognized to have occurred at Amherst College, in 1856. Then President William A. Sterns noted that:

Students of our colleges have bodies which need care and culture as well as the intellectual and moral powers and which need this care at the same time with higher education. The breaking down of the health of students, especially in the spring of the year, which is exceedingly common, involving the necessity of leaving college in many instances and crippling the energies and destroying the prospects of not a few who remain, is, in my opinion, wholly unnecessary if proper measures could be taken to prevent it. (Turner and Hurley, 2002)

Further, in 1859, Nathan Allen, MD, set guidelines for the student health program at Amherst, including:

- a medical examination of every student on arrival at the college
- a course of instruction in hygiene
- treatment for the sick
- a regularly conducted program in physical exercise for all students

Dr. Allen also urged for data collection and analysis in the form of “an annual report including particularly the kind and number of sicknesses from which the college students were suffering”. (Turner and Hurley, 2002)

On other college campuses, programs were also being created, including Mount Holyoke in 1860, Vassar, under the direction of Dr. Alida C. Avery in 1865, and Yale in 1855.

In 1866, Dr. E.M. Hartwell of Johns Hopkins, reported that Physicians were in charge of student health at the following colleges: Amherst, Harvard, Yale, Johns Hopkins, Haverford, Vassar, and Wellesley. (Turner and Hurley, 2002)

A survey conducted in 1909 by G.L. Mylan, then chairman of a committee of the American Physical Education Association on the State of Hygiene in Colleges and Universities surveyed 138 colleges and universities. He received responses from 124.

Findings included:

- 75% of students received physical exams prior to participating in athletics.
 - 14% administered by a Physician
 - 30% by the Medical Director
 - 56% by the Physical Education Director.
- 50% of respondents provided medical/surgical treatment
- 15% provided urgent care only
- 12% provided infirmary care
- 4% provided care to athletes only. (Turner and Hurley, 2002)

It is hard to imagine that health and physical activity have not always been linked. However, once the connection was established, it followed that classes in personal hygiene, the forerunner to health education, would be added to college curricula, where it has remained part of student health.

Vassar and Wellesley established infirmaries, followed by Princeton (1893) and the College of William and Mary (1894).

The University of California - Berkeley provided the first comprehensive student health program (by today's standards) in 1901, providing both medical and infirmary care. It was developed when the discovery was made that increased absenteeism on campus was due to illness, not idleness.

The University of Wisconsin owes the establishment of its Student Health Services to a typhoid outbreak in 1907, which led to the establishment in 1910, of their SHS. Cornell University also established their SHS in 1903 due to typhus.

The progress of student health services was aided by WWI. The first World War had far-reaching effects. Recruits were found to be in poor physical condition, and it fell to colleges and universities to remedy the problem. Boynton (1971) wrote:

Historically, wars have always created concern on the part of nations for the health of their young people. In England, for example, the Boer War resulted in the first national legislation to protect the health of children. Likewise, in this country, the first World War caused national concern for the health of your young people because of the large numbers of young men found to be physically unfit for military service... we find that WWI had a very direct effect on focusing attention on the need for college health programs. Inspired by pre-induction physicals which identified physical defects in young men, colleges and universities began to set up (or expand) programs to prevent and correct physical defects which might interfere with academic programs.

Additionally, in 1918, there was funding provided by Congress to “develop effective measures in the prevention of venereal diseases”. Congress also recommended the creation of departments to teach informational hygiene, provide individual health exams and physical training, provide emergency care to students in both a clinic and infirmary, supervise the campus for sanitary practices, and create a higher awareness campus-wide of hygiene. Congress also provided funds to establish student health centers at forty universities following WWI.

(Christmas, 1995)

California had previously identified the problem of poor physical fitness, making physical education mandatory in their schools in 1866. This was seen by them as crucial in keeping young men fit for military service. Ohio followed with mandatory physical education in 1892, Louisiana in 1894, Wisconsin in 1897, North Dakota in 1899, Michigan in 1911, and following WWI in 1921, twenty-eight states had mandated physical education in the schools. The universities led the way by developing programs to train teachers, including a four-year major course in physical education in 1911 at the University of Wisconsin. (Turner and Hurley, 2002)

In 1920, the American Student Health Association (ASHA) was created by twenty college medical officers, with a stated purpose to “promote health of college students through health education, preventive and therapeutic medical care, and attention to a healthful environment in the campus community”. Fifty-three delegates signed the Constitution, including representatives from the areas of student health, university health, health department, hygiene, and Physical Education. Doctor Sundwall of the University of Minnesota was elected the first President of the organization. Dr. Thomas Andrew Storey was elected to the executive board of ASHA in 1920, becoming its President in 1925. Dr. Storey held a PhD in physiology from Stanford and an MD from Harvard. He created the Department of Hygiene in New York City, and spearheaded the fight to continue education on venereal diseases on college campuses. He became Stanford’s Director of the Department of Hygiene in 1926, and continued his work to prevent and treat venereal diseases throughout his life. (Turner and Hurley, 2002)

College health was discussed at an international conference held in Greece in 1936. Unfortunately, this was the only gathering of this group, due to WWII, but the issues raised

continue to be relevant, including maintaining statistics related to student health. (Turner and Hurley, 2002)

A 1937 survey of student health service was conducted by the Office of Education. Three hundred fifty-two institutions responded. Their finding included:

- Of colleges with less than 500 students, only 10% had full-time and 53% had part-time physicians
- Of coed institutions of 500-1000, 40% had full-time physicians and 35% had part-time physicians and 20 institutions had mental health providers.
- In institutions of 1000-2000 students, 90% had one or more physicians.

Most information sources regarding student health comes to an abrupt stop at this point. The 1930's were the years of the Great Depression and the escalation of hostilities in Europe.

(Boynton, 1971)

To summarize the years prior to WWII, an era before antibiotic therapy, the emphasis in college health was on maintaining good health in students, using nutrition, exercise, and mental health therapies, physical activity, and hygiene – what is, today, essentially known as Health Education, health promotion, and primary prevention.. Quarantines were used to isolate students to prevent epidemics, necessitating the presence on campus of infirmaries (Vassar, Wellesley, Princeton, William and Mary among them). This translates to today's public health programs.

Post WWII, college health took a new direction. With the advances in medicine made during WWII, including antibiotic therapy, the need for quarantines decreased, and with that, the need for infirmaries also decreased. They were phased out across the years, and the resources to operate them were redirected to new areas of care, including: primary care, ambulatory care, and

health education. Primary (clinical) care remains the emphasis in many student health services today.

At the Third National Conference on College Health in 1947, postponed since 1932, there was a new openness of discussion relating to health issues, in particular “social hygiene”, a euphemism for issues relating to sexuality (Turner/Hurley, 2002). A survey that year of 300+ institutions indicated:

- 90% offered ambulatory health care
- 51% offered mental health care
- 91% had Physical Education courses
- 94% had a dispensary
- 54% had an infirmary

Nearly 100 years after Amherst opened its student health service, in 1953, Drs. Moore and Summerhill of Cornell undertook an ambitious survey of 1157 colleges. They had a response rate of 61%, using a combination of personal interviews and questionnaires. Of the original 1157, 200 claimed “no responsibility for health of students in any way” so results are based on 957 respondents. Survey results included:

- 90% of institutions surveyed required entrance physicals
- 60% required a chest X-Ray on admission
- 60% required a medical history
- <50% required vaccinations
- $\frac{3}{4}$ kept health records
- 80% reported providing clinical care
- 80% offered courses in Health Education

- 90% had Physical Education classes
- $\frac{3}{4}$ of institutions with SHS had athletic care (supervised $\frac{2}{3}$ of time by SHS).
- 50% had responsibility for dormitory sanitation
- <20% did research
- 85% of four-year colleges and 90% of four-year with graduate programs had clinical care.
- An average of 3170 visits per 1000 students.

(Dorman and Christmas, 2002)

The beginning of the second century of student health care saw the children of the WWII veterans coming to college campuses in large numbers. The “Baby Boomers” were entering higher education, and growth occurred, unlike any experienced previously. Their parents, who were the first generation to benefit from comprehensive health benefits provided by the GI Bill, expected no less for their children. In 1962, it was reported that, “the idea that colleges have a responsibility for the health needs of their students is apparently gaining acceptance, in part because of internal developments and part because students and their parents are taking it for granted”. (Randol, et al, 2002) This would appear to have remained the popular opinion of parents through today.

Dr. Willard Dalrymple, a past president of ACHA and director of SHS at Princeton, remembered the 1960’s as bringing “an increased acceptance of and encouragement of human emotion” Additionally, new services (particularly for women) were offered, and students became active in their own care. (Dalrymple, 1995)

It was in the 1970’s that the responsibility of education to provide health services was called into question, as a conflict existed between those who saw higher ed as responsible for

only the cognitive development of students conflicting with those who saw it linked to a holistic view of the student. A warning bell for the future was sounded by ACHA executive director James Dilley in 1976 when he said, “We must become more adroit in our justification of a health delivery service system that serves a unique segment of that society.” (ACHA, 2005)

In the 1980s, the role of student healthcare changed again, reflecting the emergence of HIV and AIDS. Prevention in the form of health education was the only way to stem the growth of an incurable illness. Zimmer (1995) said, “Most clinics hired a single individual to carry health education into the community and their clinical practice, but some centers created multi-disciplinary departments with prevention specialists who concentrated on specific content areas, including sexuality, stress management, nutrition, alcohol and other drugs, and patient education.”

Current Global Health Needs of College Students

Keeling (2005) identifies four components of college health: 1) medical and nursing services (mostly primary care, including women’s health; 2) counseling and psychological services (mental health care); prevention programs and services (including health education and health promotion); and 4) health protection services (public and environmental health).

Although it may certainly be argued that all are important, college campuses differ greatly on how important each component is, and what model should be followed in providing care.

The model generally followed in most college health services, according to Keeling, is the medical model, which emphasizes treatment and secondary prevention. This is a model which often meets resistance from counselors, who disagree with the assumptions and implications of the medical model, and often results in counseling centers being separated from

the health center. The same dissociation often occurs with professionals providing prevention, advocacy, and disability services.

Clinicians (including MD's, NP's, PA's and counselors) view their work as a series of clients who are provided services. Their care is documented in a patient record, and the provider is held accountable for the quality and efficacy of the treatment provided. Outreach is rarely a part of these providers.

Professionals in health education, by contrast, see their work occurring with groups – communities vs. individuals. They use data collected through surveys, focus groups and research studies. They are accountable to the campus community, and perform little, if any, 1:1 work. Instead, they work at achieving broad goals. Often, this group is aligned with resident life staff. UW-Stout utilizes this kind of a model. A holistic model, with an integrative view of needs and programs, where the relationships between the four components listed above are closely coordinated, strive to deliver and create a pattern of services, and are united with senior administration. This model is rarely seen, but has been successfully implemented at Columbia University. Their SHS combines primary care, health promotion, counseling, psychological services and Disability services. (Amgott, Seward, and Kenzig, 2005).

Neither of these models guarantee successful service outcomes. The goal, however, of any student health program is to “plan and deliver excellent, needs-driven services that advance the health of all students.” (Keeling, 2005)

The American College Health Association (ACHA) conducts a survey twice yearly, called the National College Health Assessment (NCHA). In Spring 2005, 54,111 college students took the survey. 61.2% described their health as “very good” or “excellent”.

When asked what conditions the respondents reported experiencing in the last school year, the three most frequently mentioned conditions were:

1. Allergy problems (46.9%)
2. Back pain (47.6%)
3. Sinus infection (30.2%)

81.6% of respondents (78.1% male, 85.8% female) experienced one or more of all of the listed conditions within the last school year. Twenty-nine conditions were listed, including depression, STD's and eating disorders. Note: These conditions are reported only, not necessarily treated.

(ACHA , 2005)

Funding of Services

Ericson, Mills & Ludlow (2002) list several options used in financing college health programs. Each have advantages and disadvantages to use, which depend on; 1) the philosophy and commitment of the administration; 2) the ability of the college/university to provide the funds needed from the existing budget to maintain a quality program; 3) the competition from other services who depend upon the same fund source to operate their program; 4) the fee recommended by a fee committee composed of students and perhaps faculty and staff; and 5) the willingness of the institution to look at non-tuition revenue sources.

- Prepaid Health Fee – Payment in advance for a predetermined set of services, usually by means of a segregated fee paid by students. Fees are collected by the institution, and remain on-campus for use by the health services. (This method is used by UW-Stout)
- Tuition or General Revenue – Funds come from the General Fund. They are prepaid, but not segregated.

- Fee-for-Service – Student pays a fee each time a service is received. Usually not used as a stand-alone method, but in conjunction with another method.
- Insurance – This is to supplement care by providing access to services not available at student health services. It is not a substitute for services provided at student health services, generally those with high unit costs; emergency room or hospital care.
- Supplemental Sources – providing fee-for-service coverage to faculty, staff or students' families. Another source is contracting to provide services to other organizations. Research grants are another supplemental source.
- Combination of Funding Sources – most often used. Based on the vision of the health care program by students and administration.

Healthcare needs of students in the UW System

The University of Wisconsin began providing health services in Madison in 1910 in response to concerns about typhoid and diphtheria. According to Van Hise, “a study of the question of student health led to the conclusion that it was necessary to have individual students looked after by the university authorities”. (History of the University of Wisconsin, 2003) The Board of Regents approved the levying of a \$1 fee per semester to employ a physician. Dr. Joseph S. Evans established a student clinic and medical service, only the second college to do so. Dr. Evans treated almost a thousand students during his first semester at Madison. A second physician was soon appointed to assist, and 120 students a day were seen by January, 1911. Health services were available at an infirmary and Bradley Memorial Hospital from 1919 to 1968, when they were moved into a converted children's inpatient psychiatric facility. (UW Student Health Services, 2002)

Currently, all schools in the UW System, including UW-Stout are governed by the Board of Regents. On December 8, 1978, the Board of Regents adopted Regent Policy Document (RPD) 78-9. In doing so, the Board adopted Part IV of the Basic Health Module, a report written by a UW-System workgroup after studying issues related to student health. In adopting the policy, the Board said, *“The University of Wisconsin system recognizes that the present and future health of its students is among the most precious of its students is among the most precious of its public resources. To this end the Regents have expressed an interest in the development of a **minimum module of student health care.**”* In 1984 changes were made for purposes of gender equity. (UW Student Health Services, 2002) In 2002, this policy received a program review by the Office of Internal Audit. As a result of this audit, the Basic Health Module was amended by Resolution 9012, May 2005. The introduction to this module now reads, *“The University of Wisconsin System recognizes that the present and future health of its students is among the most precious of its public resources. Students’ most pressing health concerns influence academic achievement and affect civility, citizenship, and connectedness. Attention to important health issues permits the university to educate and prepare learners as whole human beings”*.

To this end, in this document the Board of Regents delineates a basic module of the minimum level of health care services that must be available to students at each of the UW-System four-year institutions. Essential to the acceptance of the basic module is the continuation of the principle that institutional self-determination with respect to levels of health care will continue. Determination of the level of services to be provided above this basic module will be the responsibility of the Chancellor of each institution. Recommendations for increases above the level established by the Chancellor will be made by appropriate institution governance groups for consideration by the Chancellor and the Regents.

The following services are to be provided/available:

- Clinical (medical and nursing) Services
- Mental Health and Counseling Services
- Public Health
- Health Education, Health Promotion, and Prevention Services
- Access to affordable and sufficiently comprehensive health insurance

Funding of Services in the UW System

According to the Basic Health Module:

Existing University of Wisconsin System and Board of Regents policies delineate the acceptability of several options for funding the provision of health services to students. Student segregated fees are the preferred primary funding source for student health services and health education/wellness programs. General program revenue funding (GPR) and fee-for-services funding are deemed acceptable. General program revenue is the preferred primary funding source for counseling services including personal individual, group, crisis intervention, and AODA counseling; outreach and prevention; and consultation with faculty and staff regarding student problems. Most campuses will use a combination of these three funding sources.

Students should play an important role in determining the balance between segregated fee and fee for service funding. There should be a goal of keeping student out of pocket expenses so that cost will not be a barrier to students receiving necessary health care services.

Financial and Administrative Policy, Segregated Fee Expenditures – F20, specifically describes appropriate categories of segregated fee expenditures for the operations and activities of institution health services. These include salaries for staff including student staff, professional services, facilities/equipment/supplies/services, organizational membership fees, and debt service

reduction. Regent Policy Document 90-3, Funding of University Facilities Capital Costs, specifically prohibits the use of segregated fees as a source of funding for the construction of student health service facilities. GPR funding is the prescribed funding source for construction of student health service facilities. Gift funds are an allowable/acceptable source.

The table below shows the breakdown of how much students at each university in the UW-System pays for health care as a part of their segregated fees. . A portion of the non-allocable fees paid goes to fund SHS. In fall 2005, UW-Stout students paid \$91.92/semester for SHS. The range among UW schools is \$71.29/semester at UW-Parkside to \$252.08/semester at UW-Madison. As pictured in the table below, UW-Stout ranks 7th lowest among UW system schools.

Table 1

Ranking of UW System Schools by Segregated Fee Rates (as of 06/30/04)

Student Health	2003-04 Rate	2004-05 Rate	Increase (Decrease)	% Change
Parkside	73.08	71.29	(1.79)	-2.4
River Falls	72.25	72.25	0.00	0.0
Superior	67.30	76.50	9.20	13.7
Green Bay	81.87	79.00	(1.97)	-2.4
Platteville	75.00	86.00	11.00	14.7
Oshkosh	82.86	87.49	4.81	5.8
Stout	89.76	91.92	2.16	2.4
Eau Claire	90.79	97.16	6.37	7.0
Milwaukee	116.00	124.10	8.10	7.0

Student Health	2003-04 Rate	2004-05 Rate	Increase (Decrease)	% Change
Whitewater	129.84	135.36	5.52	4.3
Stevens Point	173.50	175.50	2.00	1.2
La Crosse	182.32	185.21	2.89	1.6
Madison	242.36	252.08	9.72	4.0

Student healthcare at UW-Stout

Student health care at UW-Stout is provided on-campus by Student Health Services (SHS).

Services provided at SHS include:

- Standard office procedures for diagnosis and treatment of illness and injuries, health education and information, and referral.
- Providing cooperation of continuation of other treatment programs already under way.
- Physical examination: athletic participation, student teaching, routine pre-employment, limited pre-operative.
- Preventive health screening:
 - Men's health care-TSE and others.
 - Women's health care-BSE, pap smears, pregnancy testing and others.
- Diagnosis and treatment of sexually transmitted infections.
- Confidential HIV testing.
- Minor surgical procedures, such as dressing changes.
- Immunizations: Measles, Mumps, Rubella (MMR), Tetanus, Hepatitis B, Tuberculosis skin testing, Flu shots, Meningitis Vaccine - Menumone.
- Laboratory tests.

- Medications and contraceptives available for a nominal fee.
- Crutch loan service and orthopedic supplies are available for a nominal fee.

Services not covered include:

- X-rays and dental care
- Refractions for eyeglasses
- Pharmacy
- Referral physician care
- Emergency room visits
- Ambulance service
- Severe trauma care
- Hospitalization

A total of 4405 encounters were listed by diagnosis within categories. The three most commonly diagnosed categories in 2004-05 were: 1) Respiratory (25%), 2) Gynecological/Urinary (17.3%), and Muscoskeletal (17.1%) (UW-Stout, 2004)

Funding of services at UW-Stout

Students pay for their access through segregated fees. For the Academic Year 2005-06, students paid \$96.24 per semester for health fees, or 13.8% of their total segregated fees. (UW-Stout, 2006)

Current Issues at UW-Stout SHS

Utilization of services at UW-Stout SHS

For the Academic Year (AY) 2004-05, there were a total of 7504 encounters, 6936 undergraduate and 568 graduate, 3683 males and 3821 females. By status, there were 87 UG

special students, 1859 Freshmen, 1314 Sophomores, 1404 Juniors, 2272 Seniors, and 568 graduates. See table 2 below for a complete breakdown of encounters by demographics.

Table 2

SHS Encounters in AY 2004-05 by Standing, Gender and Class Status

	Encounters (7504 total)	(%)
By standing:		
UG	6936	92.4
Grad	568	7.6
By gender:		
Male	3683	49
Female	3821	51
By class status:		
Freshman	1859	24.7
Sophomore	1314	17.5
Junior	1404	18.7
Senior	2272	30.2
UG special	87	1.1

Of the 7504 encounters, 2448 were considered “new” visits. Encounters begin at the start of each academic year, so 2448 students of over 7000 utilized SHS that year. How does this compare to other schools? Keeling (2005) reported that 70-80% of students use a health center while they are in college, and 60-70% use SHS in any given year. UW-Stout’s utilization rate of SHS, at approximately 35% of eligible students in 2004-05, falls far below Keeling’s figure.

Current research needs of SHS

The medical director and clinic administrator of SHS were concerned with their low utilization rate by students, which for the 2004-05 Academic Year was reported to be 35% (Student Health Services 2003-04 Annual Report) They were interested in identifying possible barriers to care.

Additionally, they were interested in determining what services students both wanted and needed and whether those services were being provided by SHS. It was determined by means of a needs-based program evaluation that it would be necessary to conduct a needs assessment to answer the questions. Yet, there were concerns from SHS staff that conducting a needs assessment might provide more information about “wants” than needs. If students were asked what they wanted in an ideal facility, would they say that they wanted everything, but would not really use it? Davidson (2005) defines need as “something without which unsatisfactory functioning occurs” and want as “a conscious desire without which dissatisfaction (but not necessarily unsatisfactory functioning) occurs”. It would be necessary in the final determination to distinguish between needs and wants as they related to the mission of the SHS.

The needs assessment, which will be further discussed in this study, was to be implemented through a series of focus groups. The informational goal of the focus groups was to identify barriers to seeking care at SHS by both students who utilized the services and those who did not.

What is a Needs Assessment?

Simply put, a needs assessment is used to identify the differences between what is and what should (ideally) be. Needs assessments are used to conduct a systematic investigation into 1) what the needs of the program recipients are, 2) what the program provides (or will provide)

and 3) how the users of the program perceive the utility of the services provided in meeting their identified needs. The findings are then compared to determine if the program is actually meeting the needs of the people it serves. Needs assessments can be conducted on programs that have been operating for some time to see if the program is continuing to meet the needs of its users, in addition to being used for the rationale of implementing programs in the first place.

Authors writing about needs assessments have defined them as follows. Davidson (2005) defines a needs assessment as “A systematic process for identifying the dimensions on which impactees (i.e. program recipients) need to achieve or maintain satisfactory functioning.”

Jane Roth states (1990), “...the term ‘needs’ was usually being defined (implicitly if not explicitly) as the discrepancy between a target state and an actual or present state regardless of whether the topic under discussion was an entity, institution, or other system” The discrepancy formula defining “need” therefore becomes, according to Roth:

$$X - A = N$$

(target state – actual state = need)

Roth further states that, “Needs assessment is often loosely linked to program planning and therefore is concerned with efficiency and effectiveness of components and may involve expansion, contraction, or at least a refocusing of activities and services.” Continuing, she states a need assessment “is concerned with identifying what the present state of an entity or system is, what it ought to be, and what alternatives are available for proceeding from the ‘is’ to the ‘ought to be’”. McKillip (1987) identifies the above type of needs assessment (discrepancy based) as being the most widely used, and it is the model of needs assessment that was used for this study.

According to McKillip (1987), Needs Assessment is a tool for decision-making in the human services and education. Decisions that can be helped by a needs assessment start with two judgments: (a) services available to a population are (or are not) adequate; and (b) if inadequate, specific actions will correct the inadequacy. If services are inadequate and corrective programming is available, there is a need. If services are adequate, there is no need. Because there are usually many needs, once needs are identified, they must be evaluated so choices can be made among them.

McKillip identifies five steps of needs assessment:

1. Identify Users and Uses of The Needs Analysis

This is the first step in needs analysis. If the users are not consulted in the process, the information gathered will not be useful.

2. Describe the target population and the service environment as it currently exists.

In this step, the following questions need to be answered: Who are the clients of SHS?

Where is SHS located and what services do they offer?

3. Identify needs

Describe problems: Why is the needs assessment being conducted?

Describe solutions: What are the recommendations for solutions to the problems identified by the needs assessment?

4. Assess the importance of the needs:

How should the findings be addressed?

Which are easier to address vs. difficult/costly to address?

What are the implications of each?

5. Communicate results:

Who is the audience, and how will results be communicated to the stakeholders?

The above steps were used in conducting the Student Health Services needs assessment described in this study. The remaining chapters will discuss the focus group study methodology and results.

Chapter III: Methodology

This study was conducted to determine if there were barriers to UW-Stout students seeking services at Student Health Services (SHS). If barriers were identified, the clinic Administrator and the Medical Director were willing to consider changes in programming. The research protocol developed and implemented for this study is discussed below. The study was fully approved by the IRB prior to the beginning of data collection.

Subject Selection and Description

Focus groups were to be comprised of UW-Stout students enrolled both full and part-time at the time of the study. Groups were split between users and non-users of SHS. This split was made because, up to this point, the only feedback SHS was receiving was from users of their services, by way of comment cards handed out one day each month to all students who used the clinic that day. It was felt by the researchers that barriers to seeking care may be seen differently by non-users of SHS than by users.

Groups were initially intended to be stratified by class, as SHS had previously identified seniors as the most frequent users of SHS, and freshmen as the least frequent. As such, it was thought to be advantageous to separate focus groups by college year/class to possibly identify differences in responses between groups. Using this method, there would have been twelve potential groups: Freshmen, sophomores, juniors, seniors, graduate students, and non-traditional students, separated into users and non-users of SHS.

Upon further reflection, due to the possibly sensitive nature of the subject under discussion, it was decided to separate groups by gender. Health-related issues are by nature sensitive, and data collected on users of SHS indicated many visits were related to sexual health,

including screening for sexually transmitted diseases (STD's), treatment of STD's, and prescribing/distribution of contraception. Other sensitive topics such as eating disorders and mental health were also apt to arise, and researchers felt that participants would be more willing to openly discuss these issues in a group that was segregated by sex. To accomplish this without adding additional groups, the planned groups by class were collapsed into freshmen/sophomores, juniors/seniors, graduate students and non-traditional students, and then split by user/non-user, for a total of sixteen potential groups.

Method

Procedures

The focus groups were planned to have five to eight participants in each group. This number has been recommended in the more recent literature on focus groups (Kruger and Casey, 2005) when dealing with complex topics (such as health). Larger groups, they feel, are harder to control, and if participants don't have the opportunity to speak, they will instead whisper to another person in the group. Kruger and Casey (2005) also discuss the use of small or "mini" focus groups with 4-6 participants. This size group is seen as easier to recruit and lead, and lend a higher level of comfort to participants. It may, however, limit the breadth of information that can be gathered simply because a fewer number of participants will have fewer total experiences to share.

To increase awareness of the study, an e-mail was sent to all instructors in the UW-Stout Psychology department, informing them of the study and asking them to encourage their students to: 1) watch for their e-mail inviting them to participate, and 2) volunteer for the study.

Psychology instructors were selected because the study was based in the Psychology department, and students, professors, or both from the department will likely be looking for participants in studies of their own.

In February 2005, all UW-Stout students, graduate and undergraduate, enrolled for the Spring 2005 semester received an e-mail to their UW-Stout e-mail account from the investigators offering a complimentary lunch and inviting them to participate in a discussion group about student healthcare. (Appendix 1) To minimize the need for potential participants to answer multiple demographic questions on this e-mail, e-mail addresses were pre-sorted by sex (male/female), by class status (freshman/ sophomore, junior/senior, graduate) and age (undergraduate students 25 and over) for a total of eight groups. To maintain confidentiality and protect e-mail addresses from spammers, all e-mails were sent as a bcc. (Blind carbon copy – no other addresses appeared in the “To” field).

Potential participants were asked to first hit reply, indicate times of availability in an embedded Excel table, self report as a previous user or non-user of SHS in a second Excel table, and send the e-mail back to the investigator. Each demographic group was given a unique identifier in the subject line of their e-mail, so when e-mails were returned, the responses automatically sorted into previously created Outlook mail folders. For example, all freshman/sophomore female responses would sort into their own e-mail folder when they were returned. An additional sort was performed by the investigator when the e-mails were opened, separating identified users and non-users of SHS. The embedded excel tables from each reply were copied/pasted by the investigator into a master scheduling spreadsheet so potential participants and meeting times could be paired.

The design called for eight groups, with up to eight participants in each group, for a possible 12 groups and up to 96 participants. Instead, there were 31 participants in 5 groups, 3 groups of females and two of males. Given the low response rate, it was determined that groups would be collapsed across categories of class. Groups continued to be split by sex and by user or

non-user of SHS, but distinctions were not made between freshman/sophomore and junior/senior participants. A distinction was made between undergraduate students under 25 years of age and graduate students, but non-traditional undergraduate students were combined with the graduate students in a female user group. All male groups were combined, regardless of age or class, due to a lower response rate than females. Seven focus groups were conducted, with a total of 31 participants, of which 12 were male (39%) and 19 were female (61%). Four groups consisted of female participants (three user and one non-user groups) and three groups of male participants (one non-user and two user groups).

To try and recruit additional male participants, all female groups were scheduled the first week of the study, with hopes of receiving more male responses for the second week of the study. Additional recruitment was attempted by placing posters (Appendix 2) in buildings around campus, and by putting table tents in dining areas on campus. Males were recruited across a five-day period at SHS by giving all male students that had an encounter at SHS a flyer about the focus groups and inviting them to attend by calling or e-mailing. There was minimal response to any of the additional recruitment methods.

Groups were created and potential participants were sent an e-mail giving them the date, time and location of their focus group and inviting them to attend. (Appendix 3) Additional e-mail reminders were sent to participants the day before and early in the morning the day of their scheduled focus group to remind them of the event. (Appendix 4) All groups were scheduled around the lunch hour (11:15, 12:20, or 1:25) during scheduled class periods to increase participation. All groups were held in a central location, meeting rooms on the first floor of the Memorial Student Union.

Measures

Four questions were developed by the investigators to be asked of each focus group. The questions were designed to begin on a broad, general scale and become more focused as the groups became more comfortable with the process. Questions were asked in the same order in each group. Each question was also reworded so if participants did not understand the question the first time for whatever reason, the facilitator had an immediate contingency question that could be consistently asked across groups. Additionally, prompts for greater clarification were also developed for each question. The same process for rewording and prompts was followed for each question. The questions, rewording, and prompts follow:

Question 1: If you could design campus-based healthcare from scratch, what would it include?

- Rewording: If there were no healthcare center on campus and you were hired to start one, what would you make sure to include in it?
 1. Prompt: For example, where would it be located?
 2. Prompt: What would the hours be?
 3. Prompt: What services would it provide?

Question 2: Think back to the last time you considered using healthcare anywhere on or off-campus. What went into your decision-making process to use or not use services?

- Rewording: Last time you were about to, or did use healthcare services, what pushed you “over the edge” to go or not go?
 1. Prompt: Did you decide to wait and see?

Question 3: What have you heard/what do you know about SHS at UW-Stout?

- Rewording: What are the rumors about SHS, or what do you know first-hand about SHS?
 1. Prompt: What is the reputation of SHS overall?
 2. Prompt: What is the reputation of the staff?

Question 4: What keeps you from using SHS at UW-Stout?

- Rewording: Can you think of anything that if SHS changed, would make you more likely to use the services?
 1. Prompt: Are the hours an inconvenience?
 2. Prompt: Does the location play a factor?
 3. Prompt: Do you prefer to go to your home MD? Why/why not?

Procedures

A facilitator and a note-taker were present for each focus group. The facilitator and the note-taker were the same gender as the participants in the scheduled focus group, as the literature recommends that the facilitator and note-taker be as similar to the group participating as possible. This helps eliminate perceived barriers of class or status between the facilitator and the group. It would also help facilitate sensitive topic discussions as discussed above. Sessions were tape-recorded, so facilitators checked the microphones and recording devices prior to the arrival of the study participants, and recorded the date, time, and makeup of the group they were to facilitate. Two tape recorders were used for each group in case one recorder would fail. When participants arrived for their scheduled focus group, they were greeted by the facilitator, had their name checked against a list of students that had been invited to attend, were given a name tag, two copies of the consent form, and were invited to help themselves to lunch. General conversation took place between the facilitator, note-taker, and the participants prior to the

beginning of each focus group, but the facilitator was not to discuss the purpose of the meeting. Participants were asked to read through the consent forms, sign one and return it to the facilitator, and retain the other.

At the designated starting time of the focus group, the facilitator closed the door to the meeting room. The participants were greeted and thanked for their participation that day. Participants were asked if they had any questions concerning the consent forms they were being asked to sign. After questions were answered, the signed consent forms were collected by the facilitator. The tape recording and note-taking were mentioned, and participants were assured they would not be identified by name in any information disseminated about the focus groups, and the tape recorders were turned on. Each facilitator introduced him/herself and the note-taker, presented a brief introductory statement about the purpose of the focus groups, and introduced the ground rules for the group. In brief:

- Anyone was free to speak at any time, it would not be necessary to raise one's hand to speak or take turns going around the table.
- Participants were free to leave at any time, and were not required to speak to any topic that they were uncomfortable discussing.
- Participants were asked to keep what was discussed in the focus groups confidential.

The focus group then began with the facilitator asking a general ice-breaker question for all participants to answer. He/she then proceeded to ask the first question. Rewording and prompts were used as necessary to encourage discussion between participants.

In a later group of males, participants were given paper and pencils and asked to write down their responses to the first question. This proved to be helpful in getting the participants to

organize their ideas. Whether this was because as students, it was a familiar device, or for another reason, it nonetheless was a helpful strategy.

Limitations

The primary limitation of the survey is the small sample size ($N = 31$). Other limitations would be the non-random, self-selective nature of the participants. Because of these limitations, data from this study is largely non-generalizable. However, it was part of the plan of the Needs Assessment to use the inductive focus groups findings as a guide for the ensuing deductive needs assessment survey development process, with the needs survey to be administered to a larger sample (mentioned earlier in chapter 1 as phase II). A survey was developed based on the issues raised in this study, and administered in the spring of 2006 to the entire UW-Stout body. Results from that survey are not part of this study.

Data Analysis Plan

Krueger (1988) says that focus group analysis is to be “systematic and verifiable”, following a prescribed, sequential process. He recommends that the moderator or assistant moderators also conduct the data analysis because they have had exposure to the discussions, and observed the interactions.

Documentation

Each focus group had a facilitator and a note-taker, both graduate students with training in facilitation of focus groups. In addition, all groups were tape-recorded using two different cassette recorders. Each recording was begun with the date, time, and demographic of the participating group. In addition, a label was placed on each cassette tape, listing the group number (1-7), the date, time, and demographic of the group. Field notes that were taken by the note-taker contained the same information. The tape recordings were transcribed by a Chippewa

Valley Technical College student in the Medical Transcription program. Each tape was transcribed with double-spacing between speakers, and with the facilitator's comments in bold type. The field notes from each focus group were typed up by the investigator and added to the transcription from that group. Additionally, the primary investigator debriefed the facilitators and note-takers for each group after completion of the group to gather additional information.

Field notes also contained any notes from the debriefing that occurred following each focus group. All five investigators, who also acted as facilitators and note-takers for at least one focus group, read the transcripts and field notes. Female investigators read and analyzed the transcriptions from the female groups and male investigators read and analyzed the transcriptions from the male groups. The primary investigator read and analyzed all five sets of transcriptions and field notes.

Long-table Approach

The next step in the process of analysis was the qualitative "long table" approach. (Krueger and Casey, 2005). Each investigator was given copies of the transcripts they were analyzing as described above. Each transcript was printed on a different color paper to assist with coding. Each investigator read the transcripts multiple times to determine categories for coding. The first reading through the transcripts was to read for content, and to become familiar with the information, identifying possible themes. Subsequent readings of the material included marking texts to identify codes.

Then each investigator cut up their transcripts by comment, and taped each individual comment to large sheets of paper, one sheet for each identified category.

When all five investigators completed their initial coding, they met to identify and discuss the categories each had developed. Each investigator identified their categories and their criteria for

inclusion of data in each category, and posted their category sheets on the wall so all investigators could see all the identified categories. The investigators then clarified the categories and their criteria, and created a list of categories they would all use. All investigators then recoded their data into the newly established categories. The results of this analysis approach are presented in the following chapter.

Chapter IV: Results

Using the data analysis plan as indicated in chapter 3, the investigators identified four major overarching constructs of the focus group proceedings. They were:

1. Awareness of Student Health Services, defined as “The who, what, when, where and why of SHS”. This construct addressed the awareness of the SHS and its services by UW-Stout students. Forty percent of all male and 34% of all female responses were identified as belonging to this construct. Included in this construct are statements made by respondents regarding the need by UW-Stout students to increase their knowledge about what was available to them at SHS.
2. Access to services, defined as “Real or perceived barriers to receiving services at SHS”. Access comprised 35% of all female responses and 24% of all male responses. The construct addressed those things that would prevent students from utilizing services at SHS.
3. Process critiques, defined as, “Comments regarding the implementation of SHS’ procedures and processes”. Process critiques comprised 23% of all male responses and 15% of all female responses. The construct addressed procedural issues that occur on a day to day basis identified by respondents as opportunities for improvement. These were made both by users and non-users who had heard from other people who had used services.
4. Wellness/preventive/self-diagnosis was defined as “Requests for wellness and illness-related services and information”. Thirteen percent of all male and 16% of all female responses were in this construct. This construct addressed how students could best feel empowered to manage their own healthcare, both proactively and reactively.

A total of 996 total responses were made during the 7 focus groups, 511 (53%) female and 455 (47%) male. Of these, the frequency of response within each construct was tabulated for males and females. The frequency of each response by construct and by gender is indicated below, along with the percentage of total responses by construct and by gender, illustrated below.

Table 3

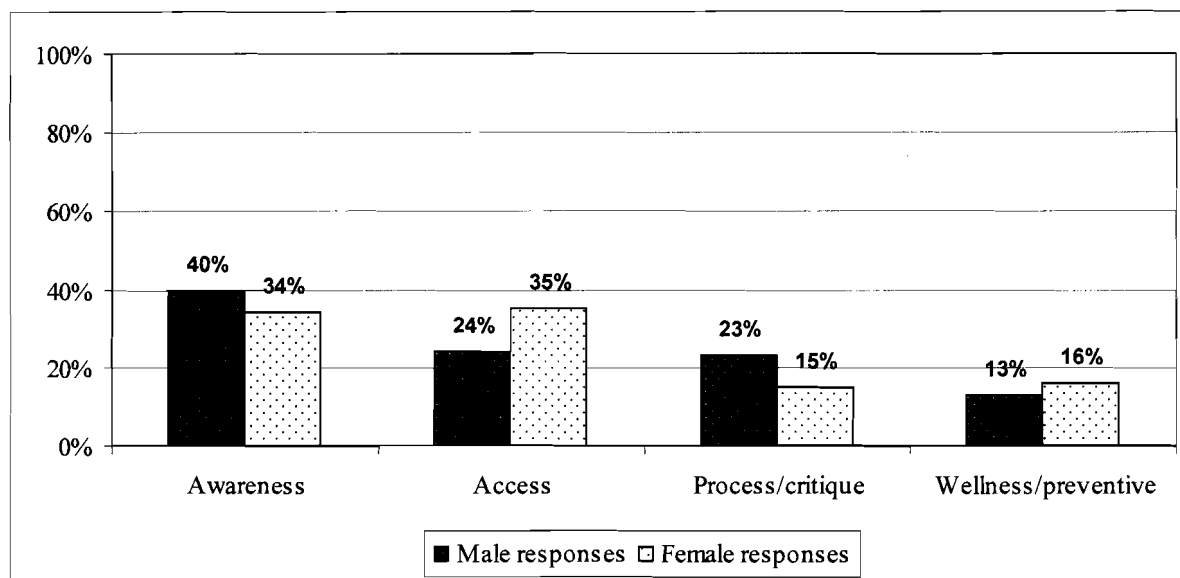
Responses by Construct and by Gender

	Male responses	% of all male responses	Female responses	% of all female responses
Awareness	180	40	173	34
Access	110	24	179	35
Process Critiques	105	23	78	15
Wellness/Preventive	60	13	81	16
Totals	455	100	511	100

Figure 1 (below) represents the percentage of total responses by males and females in each of the four major constructs.

Figure 1

Percentage of Total Responses by Construct and by Gender



Additionally, for each construct, sub-constructs, defined by the investigators as belonging to the construct and meeting the criteria of the construct itself, were identified and tabulated within each construct, by frequency of response for males and females.

Construct #1: Awareness of Student Health Services

Awareness of Student Health Services was defined as “The who, what, when, where, and why of SHS”. This construct addressed the need by UW-Stout students to increase their knowledge about what was available to them at SHS. Forty percent of all male and 34% of all female responses were identified as belonging to this construct. In addition, the following sub-constructs were identified:

- Orientation: a process identified as an opportunity to raise awareness of SHS to entering freshmen students.
- Dorms: the dormitories as a place to raise awareness of SHS.

- Web: Use of the SHS website as another way SHS could increase the students' awareness of services provided.
- Payment: students were not aware of the low cost of services that were available to them.
- Services: students were also not aware of the breadth of the services available.
- Quality: awareness of the quality of the services being offered should be marketed to students. Overall, the quality of services was perceived as high by those participants who had received services from SHS.
- Referrals: It was not widely known that SHS would provide referrals to patients needing that service.
- Staff profiles: awareness of the qualifications and professionalism of the staff should be more widely available.

There were 180 male responses in the construct of awareness, which was 40% of all male responses. The table below gives the frequency of responses by males in each subconstruct and the percentage of all male responses in the construct.

Table 4

Awareness by sub-construct: Frequency and Percentage of Male Responses

Subconstruct	Frequency	% of all male awareness responses
Quality	43	24
Services	36	20
Payment	28	16
Dorms	23	13

Subconstruct	Frequency	% of all male awareness responses
Staff Profiles	17	9
Web	15	8
Referrals	11	6
Orientation	7	4
Totals	180	100

There were 173 female responses in the construct of awareness (34% of all female responses).

The table below shows the frequency of female responses in the construct of awareness, listed by sub-construct, followed by the percentage of responses of the total number of female awareness responses.

Table 5

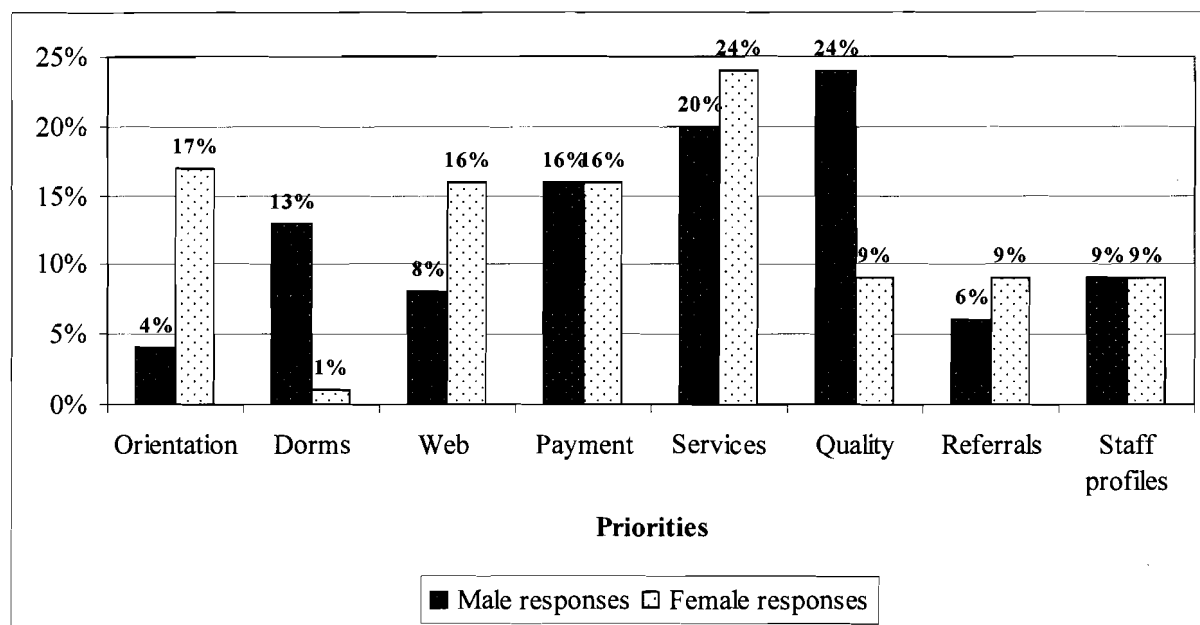
Awareness by sub-construct: Frequency and Percentage of Female Responses

Subconstruct	Frequency	% of all male awareness responses
Services	41	24
Orientation	29	17
Web	28	16
Payment	28	16
Quality	16	9
Referrals	15	9
Staff Profiles	15	9
Dorms	1	1
Totals	173	100

Figure 2 (below) illustrates the comparison below of male and female responses by percentage of response by subconstruct in the construct of awareness. This view demonstrates where males and females differ in their distribution of responses.

Figure 2

Comparison of Male and Female responses by Percentage in Construct of Awareness



Overall, within the construct of awareness, the largest difference in percentage of responses between males and females were in the sub-constructs of how information should be disseminated about SHS. Males suggested using the dorms and females suggested using orientation and the UW-Stout website. In the sub-constructs where a higher frequency of responses were made, females made more comments about the services that SHS provides, and comments were overall more positive. Their comments also indicated more knowledge of the services provided by SHS. Males made more comments about the quality of the services that

SHS provided, and their comments were more skeptical, although females also had concerns in this area. Specific highlights of the Awareness subcontracts are discussed below.

Quality

The responses indicated that both male and female participants had concerns about the quality of care they would receive at SHS, including whether or not there were “real” doctors and nurses working there. Examples of responses made in this sub-construct include:

- “One thing I get an impression about...my impression is that it’s like, second-rate health care.” (male)
- “It just seems second-hand in a way.” (male)
- “Yeah, kind of like the Goodwill of health care, you know.” (male)
- “So, I think for some students they just don’t really trust SHS since they do only have one real doctor.” (female)

Services

The comments made by males demonstrated more frequently a lack of knowledge; not only about what services were offered, but that the services were offered at all. A sample of responses regarding the lack of awareness of services follows:

- “I think it would be awesome to have your own clinic that just students could go to.” (male)
- “So we have our own clinic? I didn’t even know that.” (male)
- “What do they currently offer? I don’t even know, like, I’ve only been there once...” (male)
- “I think a lot of my friends don’t really know much about SHS.” (female)
- “None of my friends really use it. I don’t know if they probably know about it.” (female)

Payment

Male and female participants responded equally in frequency of response regarding payment. Largely, participants did not realize that SHS was available to them at little or no additional cost, so they did not seek services. A typical comment in this regard was:

- “The reason I didn’t go there on my own in the first place until I needed to was because I thought like the services were going to cost money. I didn’t realize that just getting a regular checkup was free, and so I was like afraid... I didn’t know how much it was going to cost.” (female)
- “Hey, I’m a freshman and I never even heard of it until I started hocking up a lung and someone said, “You should go and check that out,” and I’m like, “Well, I don’t have health care,” and they’re like, “It’s free,” and I’m like, “What the hell?” (male)

Presence

Male and female participants did not respond similarly to the idea of ‘presence’, that is, where they have been made aware of SHS, or where they think they should be. Male participants thought SHS should increase their presence in the dorms in greater frequency than female participants. An example of their comments:

- “Yeah, it’s going to start in the dorms and it would probably have to be the RA’s that would have to know as much as they can about it to feed to the students, because they are the ones who are going to see people on the floor to get sick first.” (male)

Female students agreed that SHS should raise their profile, but they differed in where they felt that should occur. The most frequent response by females was that using a website would be a way of raising awareness. A comment on using the website to accomplish this:

- “OK, that would be a really good idea, to put it on either an e-Scholar or just the regular UW-Stout homepage, because, I know like it’s kind of hard to search it because you get so many things and you have to like go through it, I think it would be so much better if it were on the homepage...” (female)

Orientation presence

Orientation presence was also mentioned, more frequently by females than by males, but by both. Comments included:

- “I think it’s a good idea with incoming freshmen too; make that a big part of orientation. Because I remember when I came here, I think, I don’t know, I think they may have pointed out where it was, but they didn’t say anything about it... so maybe make it a big part of their orientation.” (female)
- “You could make it part of your, what’s it called, registration process (orientation).” (male)

Referrals

‘Referrals for other service’ was identified equally by male and female participant responses.

Comments in this area included:

- “... if they can’t do it themselves, they can’t provide the care that you need... at least they could give you recommendations.” (male)
- “...I had a problem, the doctor, she didn’t specialize in. So, she set me up like I said with you know, someone else to do it. And she said, you know, “once you get/find out a medication or something you should take, I can just prescribe it for you instead of you going back (to the specialist) all the time.” (female)

Staff Profiles:

A final issue addressed in the first construct was staff profiles which addressed equally the credentials of the SHS staff. These kinds of comments were also found within the sub-construct of quality of services.

- “Well, I worry if they have like real doctors there, I guess that’s the first thing I worry about. I never went there for health problems so I don’t know if their doctors are real MD’s or not.” (male)
- “Some people might want to know what kind of nurses and doctors they have there. Are they real doctors or stuff like that, which they are...” (female)

Construct #2: Access to Student Health Services

Access to Student Health Services was defined as, “Real or perceived barriers to receiving services at SHS”. Access comprised 35% of all female responses and 24% of all male responses. Within the construct of access, the following sub-constructs were identified:

- Location: Where SHS is located (north campus) and how that impacts accessibility to services.
- Hours of operation: When SHS is open and how that impacts its accessibility to services.
- Seasonal hours: When SHS is open during the academic year and how that impacts its accessibility to services.
- Web presence: Accessibility to SHS via the web for appointments and how that impacts its accessibility to services.
- Transportation: How students get to and from SHS and how that impacts its accessibility to services.

- Emergency/urgent care/after hours care: The availability of emergency, urgent, and after hours care and how they impact its accessibility to services.

There were 110 male responses in the construct of access, which was 24% of all male responses. The table below gives the frequency of responses by males in each sub-construct and the percentage of all male responses in the construct.

Table 6

Access by Sub-construct: Males

Sub-construct	Frequency	% of all male access responses
Time	42	38
Location	39	35
Web	8	7
Time of year	7	6
Transportation	6	5
MD Access	5	5
ER/Urgent Care	3	3
Totals	110	100

There were 179 female responses in the construct of access, which were 34% of all female responses. The table below shows the frequency of female responses in the construct of access, listed by subconstruct, followed by the percentage of responses of the total number of female access responses.

Table 7

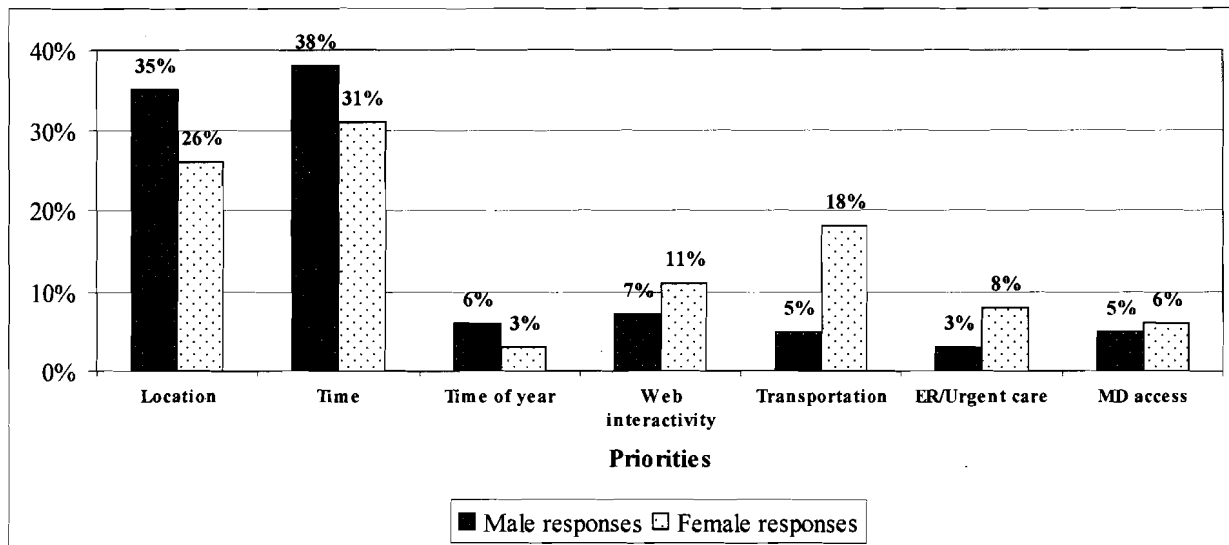
Access by Sub-construct: Females

Access by sub-construct: Females		
Subconstruct	Frequency	% of all female access responses
Time	55	31
Location	44	25
Transportation	32	18
Web	19	11
ER/urgent care	14	8
MD Access	10	6
Time of year	5	3
Totals	179	100

Responses for each sub-construct within the construct of access are shown below as a percentage of all responses in the construct, split by sex. Figure 3 (below) illustrates the comparison below of male and female responses by percentage of response by subconstruct in the construct of access. This view demonstrates where males and females differ in their distribution of responses.

Figure 3

Comparison of Male and Female responses by Percentage in Construct of Access



What emerged at a high frequency in this construct for both males and females were the hours of clinic operation and the location of the clinic. Responses were largely negative for both sub-constructs. Both male and female participants frequently mentioned hours of operation as a barrier to receiving care. A concern was that the clinic was open largely during class times, so it would be necessary to miss class to go to SHS. In the sub-construct of transportation, the percentage of comments by males and females were largely different, with females expressing more concerns about the availability of transportation to SHS.

Specific highlights of the Access sub-constructs are discussed below.

Time

- “I have rehearsal every night until like 9:30, so if I was sick it would be really hard to go to like all my classes and still find time to drag my candy-ass all the way up to north campus...” (female)

- “Office hours, sometimes are... it’s hard to make your class. If you could have one night or evening, like even ‘til 6:00 even run into, or maybe like the clinic stay open one night a week until 8:00, I mean it wouldn’t have to be every night ‘til 8:00.” (female)
- “It might be nice to have some hours – a little more extended hours even if it was only partial availability, because right now sometimes it’s a little crazy trying to get there before 4:30 or whatever...” (male)

Location

As is true for real estate, location of SHS was a primary concern, expressed by both male and female participants. SHS is located on north campus, where the only other UW-Stout facilities are dormitories. UW-Stout students live on both north and south campuses. It should be noted here that the focus groups were held in late February/early March, when winter weather would be more of an issue. Another concern was limited parking available at the clinic. The lot next to the clinic is a permit lot, which limits who can park there. Comments on location follow:

- “If you’re sick and its winter, you’re not going to walk, and if you don’t have a car, then you’re just kind of screwed, because you wouldn’t have any other way to get there.” (male)
- “It depends on what your issue is. And if it’s 20 below, it’s not really a good walk, just, I get dropped off in the morning and I have to walk, and there have been a couple of days where I would have probably gone up there for some things, but there is no way if it’s that cold I’m walking up there hauling my backpack.” (female)

Transportation

Transportation relates closely to location, but the comments were more specific. This sub-construct was mentioned by both males and females. Comments regarding transportation follow:

- “Well, ideally, if we had an underground tunnel system...” (male)
- “It’s like we can transport the drunks but not the sick people.” (female)

Web

Access to SHS was also seen as having web applications. This was mentioned by male and female participants in this sub-construct. The issue was primarily having access to scheduling information online so appointments could be made from wherever there was wireless access (presumably where there was no/limited phone access). Another issue was providing pre-registration information at one’s leisure as opposed to when one was sick and needing care.

Comments follow:

- “Do they have a website? But I suppose if you know you’re going to have an appointment tonight or the next day they could just, there could be this stuff on line, if you wanted to do it in your dorm room.” (female)
- “One thing that I would like would be if there was a way you could set up appointments on line like e-mail or something, because like right now I don’t even have a phone.”
(male)

Time of year

In addition to hours of operation, seasonal hours were also mentioned. SHS operates full-time during fall and spring semesters, afternoons during WinTerM, and not at all during summer.

Mentioned infrequently by males and females in the construct of access, comments included:

- “Maybe, I think, a small summer staff, too, because I remember going down there and they were telling me that they wouldn’t be open at all during the summer, so that if there was – if they needed to, if the hospital needed to get files from the clinic, they

wouldn't be able to do it, or something like that...I thought it was kind of interesting that they didn't have anyone around in the summer." (male)

- "Another thing for the ideal health services would be one that is open all the times that classes are which include summer and winter. I think they are closed summer, and winter they are only open mornings or something." (female)

ER/Urgent Care

Emergency/Urgent care/After hours was a sub-construct that included male and female responses in the construct of access. This sub-construct was about obtaining care during clinic hours without an appointment, and obtaining care outside of scheduled clinic hours. Comments included:

- "You know where as you're sick now, you need to be seen now." (female)
- "And if it is that bad have a way that they can either see a doctor or get to the hospital without calling 911, there's no way to get to the hospital quickly and 911 is a bit more expensive than a \$6 cab fare." (male)

MD Access

MD Access was the final sub-construct in the construct of access, with males and females responding equally. This sub-construct was about how the clinic is operated, with one MD supervising the RN's and NP's. Comments included:

- "They only have, like, one doctor and a lot of nurses, and so like if you have any questions and the nurses don't know them, they have to go to the doctor, and that could take awhile, too, so maybe if they had more than one doctor." (female)

- “I think when I went in I had to call ahead of time, because they said they didn’t take walk-ins or something like that, maybe unless it was more of an emergency or sickness, since I was just doing it...” (male)

Construct #3: Process Critiques

Process critiques were defined as, “Comments regarding the implementation of SHS’ procedures and processes”. Process critiques comprised 23% of all male responses and 15% of all female responses. Within the construct of process critiques, the following sub-constructs were identified:

- Positive Feedback: These were positive comments from participants about the services they received at SHS.
- Payment: This is about how students pay for services that they receive at SHS.
- Confidentiality: This is about how participants perceive how their confidential information is handled at SHS.
- STD/OC happy: This is about the assumptions that participants perceive SHS staff make about sexually transmitted disease and oral contraceptives when students seek services.
- Test results: This is about how participants feel SHS communicate test results to them.
- Inconsistency: This is about participants receiving contradictory information from different staff at SHS when receiving services.
- Misdiagnosis: This is about participants experiencing misdiagnosis when seeking treatment at SHS.

There were 105 male responses in the construct of process critiques, which was 23% of all male responses. The table below gives the frequency of responses by males in each subconstruct and the percentage of all male responses in the construct.

Table 8

Process Critiques by sub-construct: Males

Process Critiques by sub-construct: Males		
Subconstruct	Frequency	% of all male process critique responses
Payment	28	27
Confidentiality	25	24
Positive Feedback	19	18
Inconsistency	19	18
STD/OC happy	14	13
Test results	0	0
Misdiagnosis	0	0
Totals	105	100

There were 78 female responses in the construct of process critiques, which was 15% of all female responses. The table below gives the frequency of responses by females in each subconstruct and the percentage of all female responses in the construct.

Table 9

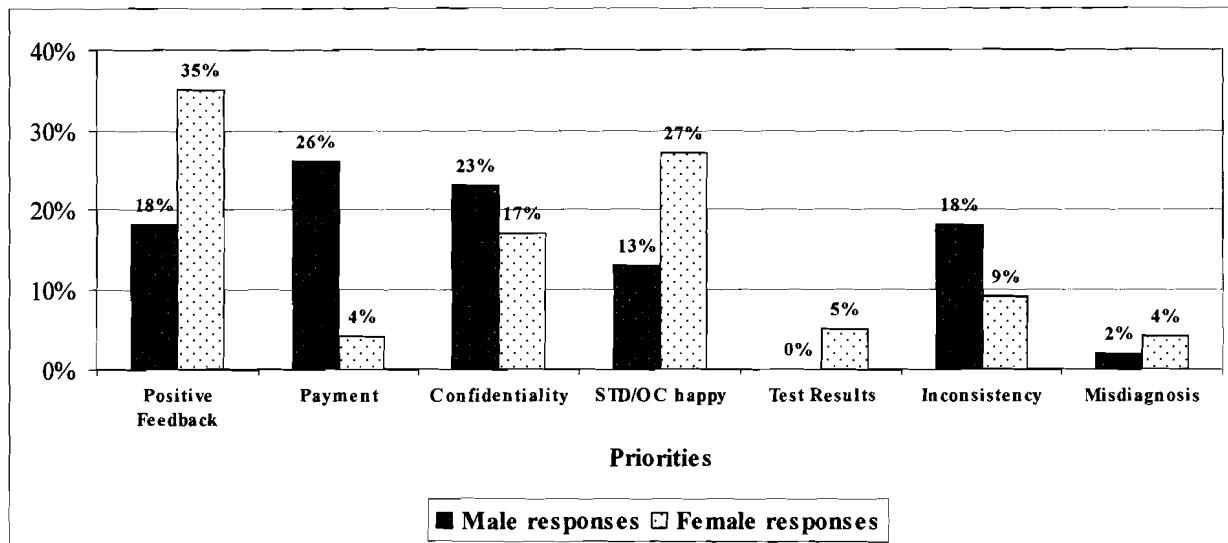
Process Critiques by sub-construct: Females

Sub-construct	Frequency	% of all female process critiques responses
Positive Feedback	27	35
STD/OC happy	21	27
Confidentiality	13	17
Inconsistency	7	9
Test Results	4	5
Payment	3	4
Misdiagnosis	3	4
Totals	78	100

Figure 4 (below) illustrates the comparison of male and female responses by percentage of response by subconstruct in the construct of process critiques. This view demonstrates where males and females differ in their distribution of responses.

Figure 4

Comparison of Male and Female Responses by Percentage in Construct of Process Critiques



Positive Feedback

Positive feedback was provided more frequently by female participants than male participants. Examples of comments include: Specific highlights of the Awareness sub-constructs are discussed below.

- “They are very, very friendly...very kind, very caring...” (female)
- “I was going to say, every time I have gone, everybody seemed really knowledgeable with what they were talking about and very helpful.” (male)
- “They gave me a lot of information and they weren’t talking down to me, either...I felt really comfortable going back.” (female)

Confidentiality

The next process sub-construct frequency-wise was confidentiality, with more males than females responding. This sub-construct covers how clinic users perceived their rights to confidentiality while visiting SHS. Comments include:

- “I think one thing that I ran into one time is I think it would be nice to be able to see a doctor without telling somebody else why. I went into SHS one time... and everyone was in the waiting room and the receptionist was just like, so what is our problem, why are you coming in? ...and that bothered me.” (female)
- “...even when making appointments I feel uncomfortable because they will repeat things and I know how small the office is.” (female)
- “They’re real careful about being confidential and everything...I’m not really worried about confidentiality.” (male)

STD/Birth Control Happy

Another process that participants remarked on, not surprisingly in higher frequency by females than males was a sub-construct called “STD/Birth Control happy”. This sub-construct contains comments made by participants regarding encounters with SHS where participants felt that SHS staff placed too much emphasis on contraception and STD’s regardless of the problem the participant presented. Examples of these comments include:

- “I did have one friend that went in and every time she went in, they were like, “Well, how often are you having sex?” and just like this big thing about sex...you know, a professional attitude towards all their clients, whether we are 18 or 45, we all deserve the same amount of professionalism...we were good enough to come in to see if there was a problem.” (female)
- “I walked in and said that I needed to pick up a prescription and they were like, “oh, for birth control?” And I was like, no, but if it had been, that would have been a little; you can’t say that in a waiting room, hello.” (female)

- “Yeah, well, she didn’t necessarily force, she didn’t end up doing it so it wasn’t like forced treatment but she was really pushing, she was like, “we should test you for an STD”, and I was like, “no”.” (male)
- “Maybe they should be a little bit more open-minded of who their patients are. We’re not all partying seven days a week and getting STD’s.” (female)

Payment

Payment emerged as more of an issue for males than females. These comments were about the cost of health care and availability/lack of insurance. Examples of these statements include:

- “When people don’t... well, people don’t have insurance or...and so it’s hard if you have to go to the hospital you have to pay for that bill out of your pocket. So, that’s harder for students, too. I mean, some people are covered under their parents, but if they are not, it can be expensive.” (male)
- “You don’t think less of it because it’s cheap.” (male)
- (I’m not even sure of all the services that are included at SHS) “Like what you have to pay for and what you don’t have to pay for. It’s a little shady.” (female)

Inconsistency

Inconsistency was mentioned by more often by males than females as a process critique. Comments were related to being told different things by different people regarding processes. An example of this follows:

- “I had asthma as a kid and the doctor essentially forced on me another medication for asthma medication that I don’t need. But, I took it anyway, and when I left, well she said it would be ten bucks, and I was like, “Well, ten bucks isn’t bad for a prescription,

whatever”, and then, when I left, they were like, the people at the desk were like, “Oh, yeah, there’s no charge.” And I was like, “She told me ten bucks,” and they were like, “Oh, no, there’s no charge”, and then I got a bill later for ten bucks, and I was like, whatever.” (male)

Misdiagnosis

Misdiagnosis occurred very seldom, according to both male and female participants. An example of misdiagnosis follows:

- “I had a plantar’s wart on my foot, and that was the only time that I’ve had problems with them because they said it wasn’t a wart, they said there was glass inside, so misdiagnosing I guess would be the thing that happened there, but aside from that one time, and they cleared it up the second time I went – they were like, “Oh, crap, it is a wart, sorry about that”, so what can you do?” (male)
 - “I have had friends that were diagnosed with something and had something completely different because they had never got health and followed the instructions that they gave and so they went back to the doctor and had something completely different.” (female)

Test Results

The sub-construct of test results was comprised of comments made by participants about inconsistency in reporting test results. This sub-construct was not mentioned in high numbers by either sex. An example follows:

- “...somebody was supposed to call me back with results of a test or whatever and I never got that call and I ended up calling them and they were like, “Oh, we were just going to

call you” and I was like, “Oh, yeah, whatever” but they were supposed to call me like after two days and I ended up calling them on the fourth day...” (female)

Construct #4: Wellness/Preventive/Self-Diagnosis

Wellness/preventive/self-diagnosis was defined as, “Requests for wellness and illness-related services and information”. Within the construct of wellness/preventive/self-diagnosis, the following sub-constructs were identified:

- Peer Health: This was about receiving information from peer health educators employed by SHS.
- Consolidation of services: This was about what services should be available at SHS, such as mental health services, nutrition services, etc.
- Self-care, diagnosis: This was about assisting students with deciding when they needed to seek services from SHS, and how they could treat illnesses themselves.
- Wellness/preventive: This was about getting information through SHS to stay well and prevent illness.
- Website: This was about using the World Wide Web to make information about health available to students through the SHS website.

There were 60 male responses in the construct of wellness/preventive/self-diagnosis, which was 13% of all male responses. Table 10 (below) shows the frequency of male responses in the construct of wellness/preventive/self-diagnosis, listed by subconstruct, followed by the percentage of responses of the total number of male wellness/preventive/self-diagnosis responses.

Table 10

Wellness/Preventive/Self-diagnosis by sub-construct: Males

Sub-construct	Frequency	% of all male responses
Tough guy/gal	26	43
Self-care, self-diagnosis, triage	11	18
Peer health	10	17
Consolidation of services	7	12
Web	6	10
Wellness/Preventive	0	0
Totals	60	100

There were 81 female responses in the construct of wellness/preventive/self-diagnosis, which was 16% of all female responses. The table below shows the frequency of female responses in the construct of wellness/preventive/self-diagnosis, listed by subconstruct, followed by the percentage of responses of the total number of female wellness/preventive/self-diagnosis responses.

Table 11

Wellness/Preventive/Self-diagnosis by sub-construct: Females

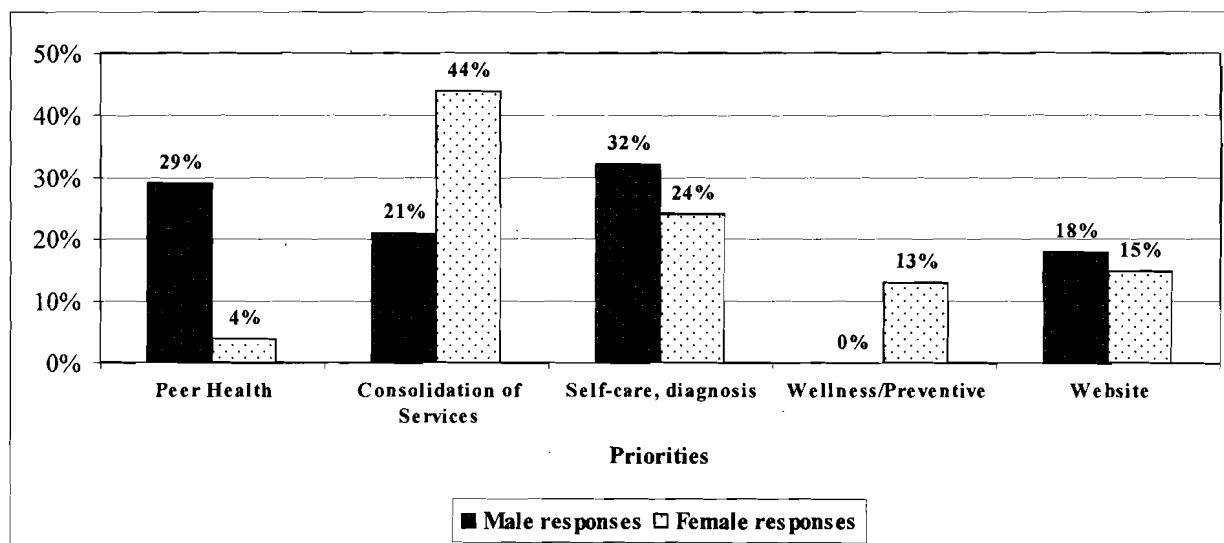
Sub-construct	Frequency	% of all female responses
Consolidation of Services	34	42
Self-care, self-diagnosis, triage	19	23
Web	12	15
Wellness, Preventive	10	12

Sub-construct	Frequency	% of all female responses
Peer Health	3	4
Tough guy/gal	3	4
Totals	81	100

Figure 4 (below) illustrates the comparison below of male and female responses by percentage of response by subconstruct in the construct of Wellness/Preventive/Self-diagnosis. This view demonstrates where males and females differ in their distribution of responses.

Figure 5

Percentage of responses in Construct of Wellness/Preventive/Self-diagnosis by Gender



This fourth and final construct identified was a hybrid, comprised of wellness, preventive, and self-diagnosis. There was considerable overlap in the statements, so it was determined to combine them in the construct. The definition of the construct is, "Requests for wellness and illness-related services and information." Specific highlights of the Wellness/Preventive/self-diagnosis sub-constructs are discussed below.

Tough guy/gal

Self-care and diagnosis was mentioned more frequently by males than females. In earlier stages of coding, this sub-construct was called “tough guy/gal” and identified as a possible construct. It was called “tough guy/gal” because the comments dealt with not being “sick enough” to need medical care. In subsequent coding, it was determined that the responses did not occur frequently enough to be a construct, and were instead coded as a sub-construct within the larger construct of self-diagnosis. Examples of these comments, defined as

“Reluctance/resistance/refusal to seek medical services” include:

- “...the only times I do go is like, I need to have a form filled (out) ‘cause I got to go for a job or something, or, I’m really dying.” (male)
- “When I’m not sick I’m not going to go down there, because I don’t want to waste their time.” (female)

Consolidation of Services

Consolidation of services for both males and females addressed the idea of the “one-stop shop” with all health/wellness/preventive/health education services all located in the same building. Examples of comments include:

- “...if I had my own health system to set up, there would be a lot more resources available...maybe counseling or clinics or just even programs like dangers of smoking programs to get off smoking, the whole STD testing and awareness. Just more awareness...on good health, exercise, fitness.” (male)
- “...I went through a wellness program and they told me that I could go down to SHS to get that done over there.” (male)

- “If they (SHS) can’t do it, I think they should have someone specifically just to or have appointments with people and help them set up like appointments with other places. You know, if they could do that instead of just saying, you know, “go here” and so the students themselves have to call it, and you know, maybe someone to help them make a step to do something.” (female)

Web

As it has in other constructs, using the web is seen as a way to convey information. Using the web was mentioned by males and females almost equally. Examples of comments include:

- “Even if they had like an online symptoms thing where you could type in a symptom and it would follow a link to maybe what you have ...” (male)
- “I think we actually have a number of things online that are just like, if you have the flu, you have the symptoms, do this. I think we have that.” (female)

Peer Health

Peer health was a sub-construct mentioned far more frequently by males than females. This may suggest more willingness by males than females to accept information from those they perceive as peers rather than authority figures. This was demonstrated by the following comment:

- “Yeah, I think the peer health educators’ thing is a good idea because they’re all regular students also, they’re not some doctor. That seems pretty informal...It felt a little better knowing that he was also in the same position I was in, so he was real easy to talk to.” (male)

However, not all students have an awareness of the peer health educators. The following comment (also from a male participant) demonstrates that:

- “I have no idea what they do and I’ve never seen them, they’re like little mystical creatures that must do something out there...”

Wellness/Preventive

Wellness/Preventive was raised only by female participants. One comment follows that was specific to preventive care and demonstrates just how much preventive services and health education is needed by this population.

- “College students aren’t really concerned with preventive measures as far as health...you know, like the cholesterol thing. People just don’t get their cholesterol tested because heart attacks don’t happen until your 40’s or 50’s.” (female)

Overall/ Summative Results

The results, based on the frequency of responses, indicate the primary barrier to UW-Stout students seeking care at SHS was a lack of awareness of what SHS could provide. Perhaps the most telling comment in this area came from a male student in the non-user group who, near the end of his group said, “So, we have our own clinic? I didn’t even know that. That’s kind of cool.” However, it did not appear that participants had any reluctance about seeking care at SHS once their concerns (e.g. payment, qualifications of staff) were addressed. They mentioned concerns, but not at a level where they said they would not seek care there. The implications of these results will be discussed in the next chapter.

Chapter V

Discussion

This study was undertaken at the request of the medical director and clinic administrator of SHS. They wanted to know if low utilization rates of SHS were related to barriers, real or perceived, and what those barriers were. In particular, they wondered if students had concerns about the quality of care provided by SHS. From this initial study, they hoped to form the basis for a larger study that could identify future programming needs.

Consistent with what SHS had been discovering with their in-house feedback cards, the quality of care provided by SHS was not identified by participants as a barrier to seeking care at SHS. Rather, the primary barrier to seeking care appeared to be a lack of knowledge about the clinic and its services, indicated by the high frequency of responses in the constructs of both awareness and access. In this chapter, findings regarding the general and gender effect responses to these two constructs will be presented. In addition, their implications for SHS will be discussed.

The remaining two constructs, process critiques and wellness/self care/preventive, contain comments that, while insightful for SHS, do not address the original concern of barriers to care to the same degree. Rather, they are suggestive for future SHS programming changes. All constructs, however, should be considered in the next phase of this study, the comprehensive needs assessment with a larger N.

Student Awareness of SHS

As the analysis in chapter four indicated, the highest frequency of responses overall was in the construct of awareness. Specifically, it had the highest frequency of male responses and

the second most frequent female responses. These two constructs, taken together, account for 2/3 of all responses, and when viewed together, raise similar issues for SHS.

Generally, the responses in the constructs of awareness and access indicated a lack of knowledge. In the construct of awareness, these were some of the concerns:

- Are there Doctors?
- Can they write prescriptions?
- How much are co-pays for services?
- How do you get an appointment?
- What can they do for you?
- More knowledge about billing
- I wonder if they fill prescriptions.
- Blood sugar testing
- Cholesterol testing
- Referrals to specialists
- Where is it?
- Tests for respiratory infections
- Online information of services offered
- Do they accept insurance?
- What kind of doctors and nurses do they have there?
- Can they take X-Rays there?
- Do they have a website?
- Who's on the staff? An MD or an NP?
- All I know is that they're on North Campus somewhere
- What is SHS actually set up for?

- What are the hours now?
- Can they do blood work on site?
- I think a lot of my friends don't know about SHS
- I don't think people are aware of how in-depth the things they have for us are
- I didn't know they had student insurance
- I didn't go because I thought the services cost money.

Within this construct, there were differences in how male and female participants responded. Males made more responses related to concerns about the quality of care they would receive, and showed less knowledge overall about what might be thought of as 'common knowledge'. For example, they demonstrated this by their comments about whether or not "real doctors" would provide care, the cost of the services provided at SHS, and not realizing that care was available at no/low cost.

Implications of Findings for Increasing Students' Awareness of SHS

The above exhaustive list underscores the need to educate students on a range of issues. Thankfully however, the information that needs to be portrayed to the students should be easily disseminated with little to no need for programmatic change. Possible means for doing so are discussed below.

Most of the information could be disseminated via website, and in fact was already available on the SHS website at the time of the focus groups. Perhaps what needs to be communicated to students is how to access the information already out there, such as through using the RA's in the dorms or during freshman orientation.

A few of the subjects are perhaps better dealt with in a different manner, particularly the ones dealing with clinic staff. Comments indicated that respondents did not feel comfortable not knowing who would be treating them. Although clinics commonly use websites with photos and

information about physicians and staff, and this would also be an option for SHS, an alternative could be to have SHS present at an orientation event where they could meet both students and parents. This should serve to reassure parents about the quality of care, leading them to recommend that students seek services from SHS if ill. Students would also have the opportunity to meet the clinic staff, which in turn should help raise their awareness.

Student respondents offered their own solutions for raising awareness within this construct, but again differed by sex when they discussed delivery method. Males suggested using the Resident Assistants (RA's) in the dorms to make students aware of services at a higher rate than did females, who felt that orientation was a better venue for that information. Both males and females suggested disseminating information via the UW-Stout website.

Implications of Findings for SHS Utilization

What primarily emerged from the focus groups in this construct was an apparent willingness to receive care from SHS, once respondents understood what was available to them and by whom. If this could be seen to generalize across the UW-Stout population, once more students became aware of SHS services offered and cost, student medical clinic utilization rates would be expected to increase, potentially dramatically. To increase awareness, SHS should probably use multiple methods to convey the information to reach both males and females instead of relying on one method.

Increasing awareness however is only the first step in increasing utilization. To fully realize the increased utilization potential, the services need to be provided in a manner and time desired by the students. This topic will now be addressed in the following section.

Access to Services

In the construct of access, comments indicated a desire for change in the existing services. Comments included:

- They don't take walk-ins
- Later hours
- A service that could get you to the hospital
- More information telling you where it's located
- There's very little parking
- More central location on campus
- Understaffed – can't get in
- Can't get the prescriptions I need
- Urgent care hours
- Nurse's office on south campus
- Satellite office/triage on south campus
- Shuttle service to clinic
- Help with insurance billing
- Weekend hours
- Online pre-registration
- Open year-round

These concerns were raised by participants who were aware that SHS existed, wanted to use or have used services, and expressed issues with accessing services. Addressing these concerns is more complicated than addressing the concerns which arose in the previous construct, because to change any of these requires either reallocation of existing resources or additional resources.

The most frequently mentioned barrier to seeking care at SHS was the hours of operation. Clinic hours and class hours run concurrently for the most part, and students were unwilling to skip class to attend appointments. To further complicate matters, clinic appointments are scheduled on the hour and ½ hour, and class times stagger after the first class at 8:00. The second period begins at 9:05, 10:10, 11:15, etc. This meant that even if a student had one free class period during the day, the likelihood was that they would miss part of two class periods to attend an appointment, allowing for travel time to and from the clinic.

This also addresses additional barriers to SHS care seeking: the location of the clinic and transportation to/from the clinic. There are no classes on the north end of campus where SHS is located. A student living on north campus would walk to classes, walk back to SHS for an appointment, walk back to south campus for classes and back again to north campus after class. They expressed concerns with this scenario, particularly in the winter, and especially when they weren't feeling well in the first place. These scenarios preclude students who are not attending classes due to their illness, which then raises the issue of being too sick to go to class, but still having to walk to SHS to receive care.

Although hours of operation and clinic location were primary barriers for all students, there were some differences by sex in other areas of the construct. Females voiced more concerns about transportation to and from the clinic, while males were more concerned with access to clinic services year-round vs. current operations based on the academic calendar (e.g. limited access during WinTerM and no access in the summer).

Solutions suggested by students

Students had many suggestions for addressing their concerns. Regarding hours of clinic operations, they suggested opening earlier, staying open later, being open one or two evenings a

week , and occasionally being open on Saturdays. Regarding the location of the clinic, they suggested locating it more centrally (e.g. moving the clinic to South Campus), operating a satellite clinic in Memorial Student Center (MSC) where a nurse could provide triage services to students, and, finally, connecting the north and south campuses with a tunnel. Regarding transportation, they suggested having shuttle service available from SHS to take students back and forth, and “house calls” by SHS to the ill student’s location.

Implications for SHS Barrier Removal

What emerges from the construct of access is that students want services to be easily accessed. They would like to be able to fit in clinic appointments between classes in the same way they would fit in lunch: in-between classes and at a physically close location. However, change in the construct of access is more difficult than change in the construct of awareness because of the nature of what is being changed. Where information can be disseminated easily and quickly, with relatively little cost, changing clinic hours of operation, the location of the clinic or providing additional services to students like transportation are all more labor/cost intensive. Further, their implementation may create resistance in clinic staff and would require reallocated or additional budget dollars.

Limitations of study

Two areas in particular raise concerns regarding the limitations of the study. The first is the small sample size of the study. Although extensive effort was taken throughout the study to recruit a higher number of participants, it was not obtained. The second area is the absence of random selection for the study. Rather, all UW-Stout students were invited to attend, and they self-selected to participate. These limitations could suggest a lack of confidence in the ability of the results to represent the entire campus population. However, despite the small sample size, the

participants returned similar responses across focus groups, particularly in the constructs discussed in this chapter, awareness and access. Given the small sample size, the only programming suggestions based on this study were those involving little or no change in resource allocation. Further programming changes should wait for the results of the larger study, so they could be based on more generalizable results.

Conclusions/Recommendations

It would appear that the utilization of SHS by UW-Stout students would increase if more students were made aware of the services provided. This could be accomplished through a variety of means, some of which would possibly be more successful in increasing male participation, and others which may be more successful in increasing female participation. The methods suggested by students were not cost or labor intensive, and would be relatively easy to implement.

Utilization of SHS may also increase if students were able to easier schedule appointments around a wider range of clinic hours of operation, and if they had transportation to and from SHS. This would be more difficult to implement, and would require either reallocation of existing resources, or additional resources, with no guarantee of success.

It would be the recommendation of the investigators to proceed first with raising awareness of SHS among students to see if utilization increases to the desired level. If it does not, increasing utilization by changing access should be considered, but given the small sample size, it would be prudent to undertake further data collection to see if the issues of access are generalizable to a larger population. The use of the information gathered in this study should form the basis for such a larger survey.

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Appendix A: E-mail invitation

- Would you like UW-Stout to buy you lunch?
- Do you have suggestions on what health services Stout should provide students?

If you answered **YES** to either of these questions, *please keep reading...*

You are invited to join a small discussion group with other UW-Stout students to talk about healthcare on campus. What you and other students tell us will then be considered by UW-Stout when it makes future decisions about campus-based health services.

- Discussions will last only 55 minutes over the lunch hour.
- Lunch will be provided!
- Groups will be made up of 6-8 people, all male or all female.

If you are interested in participating, please answer two brief questions.

NOTE: Before you can answer these questions, please hit “reply” - this e-mail will re-open in a new window so you can type in the boxes.

Please indicate whether or not you have used Student Health Services at UW-Stout in the past – this is just to decide in which discussion group you belong.

Please indicate Yes or No below with an X

	Yes	No
Have you ever used Student Health Services at UW-Stout?		

Please indicate when you are free to do the discussion.

Type an **X** below in all of your available times:

	Tuesday	Wednesday	Thursday
11:15 - 12:10			
12:20 - 1:15			
1:25 - 2:20			

That's it! If you are selected to participate, (based on your availability and our needs), you will be contacted soon! *Thank you for your time.*

Please hit “send” to complete this process.

Appendix B: Poster

- Would you like UW-Stout to buy you lunch?
- Would you like to possibly change student healthcare at UW-Stout?

IF YES...

- Discussions will last only **55 minutes** over the lunch hour
- **LUNCH WILL BE PROVIDED**
- Groups will be made up of 6-8 people, all male or all female

YOU ARE INVITED to join a **small discussion group** with other UW-Stout students to talk about healthcare on campus. What you & other students tell us will then be considered by UW-Stout when it makes future decisions about campus-based health services.

Appendix C: Scheduling e-mail

Thank you for volunteering to be in a healthcare discussion group.
Your discussion group is scheduled for:

Date: Tuesday, March 8th
Time: 11:15 - 12:10
Pioneer/Prairie room of Memorial Student Center;
First floor, across from the bookstore.

Your lunch will be available about 15 minutes before your group is scheduled to begin. Please arrive around 11:00 if you can, so your discussion group can begin on time.

Thank you! We appreciate your participation in this project. The groups are small, so please make every effort to attend – we value your input.

Please feel free to contact me with any questions at the e-mail address below.

Sincerely,
Wendy

Appendix D: Reminder e-mail

Your discussion group for Student Health Services is meeting today

at **12:20** in the Pioneer/Prairie Room of MSC – first floor across from the Bookstore.

Yesterday's participants told us the lunch was awesome, and they had a great time – See you there!