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Low-Income Uninsured Perceptions, Beliefs, and Level of Knowledge Concerning Primary Care Services

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Abstract

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MA, Winston-Salem State University, 2010

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

In the United States, there is an issue with low-income uninsured patients using emergency services for nonurgent conditions instead of using primary care services. Primary care services are more beneficial than emergency services for such patients, in that they can receive continual or follow-up care through primary care and thus achieve better health outcomes over the long term. Though information is available concerning factors in (or the rationale for) low-income uninsured patients choosing the emergency department (ED) instead of primary services for nonurgent conditions, research focusing on low-income uninsured patients' perspectives, beliefs, and level of knowledge about this matter is missing from the literature. The purpose of this qualitative phenomenological study was to gain an understanding of the perspectives, beliefs, and level of knowledge of low-income uninsured patients about primary care services and to explore whether patient education can improve access to primary care. The health belief model was used to explore 6 concepts: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy. Criterion sampling was used to recruit 10 participants, an interview tool was used to collect data, and the data was analyzed deductively. Results revealed that members of the low-income uninsured population believed primary care to be better than the ED because it offers cost-effectiveness, preventative care, efficiency, and familiarity. Results indicated that lack of money or insurance prevented participants from using primary services. This study may bring awareness that leads to the improvement of patient education and navigation, the reduction of ED usage, and an increase in primary care utilization.

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Dedication

I dedicate this project to my wonderful husband, Danny Brown, who have loved and supported me though the struggles of graduate school and life. This work is also dedicated to my exemplary children, Brittany Jeffries and LeDaniel Brown, who motivated and encouraged me relentlessly during the dissertation process. A big thanks to my mom, Carolyn Graves, who always believed in me and my dad, John Graves, who taught me that if I work hard, I could accomplish anything. Most of all, I thank my Father in Heaven and my Lord and Savior, Jesus Christ, for this opportunity.

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Chapter 1: Introduction to the Study

Background

The overutilization of emergency departments (EDs) across America is a growing concern in health care (Carlson, Menegazzi, & Callaway, 2013). Many uninsured low-income patients frequent the ED (Flores-Mateo, Violan-Fors, Carrillo-Santisteve, Peiro, & Argimon, 2012) for nonurgent situations (Basu & Phillips, 2016; Shaw et al., 2013) instead of using primary care services (Flores-Mateo et al., 2012). Primary care is more beneficial than visiting an ED because patients receive ongoing or continuous and follow-up care, which results in better health outcomes (Flores-Mateo et al., 2012). Researchers identified a range of factors explaining why patients choose EDs for nonurgent conditions (Flores-Mateo et al., 2012); however, there is a clear gap in the literature pertaining to patients' levels of knowledge, beliefs, and perspectives. This research may assist health care providers in understanding the role that patients' knowledge, perceptions, and beliefs play in their decision making when choosing ED over primary care when faced with nonurgent health care needs. Ultimately, improved patient navigation and education may result in the reduction of ED usage and the improved utilization of primary care services.

Problem Statement

ED overutilization is a national problem (Carlson, Menegazzi, & Callaway, 2013) that is more prominent among the uninsured low-income population (Flores-Mateo et al., 2012; McWilliams, Tapp, Barker, & Dulin, 2011). This population tends to use ED services for nonurgent conditions that are more effectively addressed in a primary care facility. There are documented reasons as to why low-income uninsured patients choose

ED over primary care services, including chronic illnesses, the aging of the population, unawareness of cost, lack of organization in primary care, greater ED accessibility and availability, perception of patients as to the seriousness of ailments, and higher confidence in ED than primary care (Flores-Mateo et al., 2012). Additional factors have been described as quality perceptions, race, gender, poor mental health, seriousness of condition, prior hospital admittance, social networks, employment, persistence of condition, and prescription drug abuse (Behr & Diaz, 2016). However, no research exists pertaining to the level of knowledge, beliefs, and perspectives of low-income uninsured patients regarding their decision-making process in choosing the ED over primary care.

In 2010, the government implemented the Patient Protection and Affordable Care Act (ACA) in an effort to improve primary care access and utilization and diverting patients away from expensive ED services (Cheung, Wiler, & Ginde, 2011). However, even with the implementation, studies have shown that there is an increase in ED visits (Medford-Davis, Eswaran, Shah, & Dark, 2015) and the uninsured are more likely to visit the ED than the insured are (Lee, 2015). Frequent users of the ED, also called *frequent flyers*, typically use ED services four or more times per year (Grover & Close, 2009).

Primary-care-related ED visits (PCR-ED) are visits to the ED for conditions that are categorized as preventable or treatable through appropriate primary care (Enard & Ganelin, 2013). These visits result in decreased efficiency, higher cost, and lack of appropriate continuous medical care for patients (Enard & Ganelin, 2013). In some instances, lack of continual care can lead to poor health outcomes (Enard & Ganelin, 2013). Additionally, primary care access plays a leading role in health outcomes for patients (Belue, Figaro, Peterson, Wilds, & Caniam, 2014) due to the benefits received when using primary care services (Enard & Ganelin, 2013). This study provides understanding about the role that patient knowledge, perceptions, and beliefs play in decision making when low-income uninsured patients choose ED over primary care services when faced with nonurgent health care issues.

Purpose of the Study

The purpose of this qualitative phenomenological study was to understand beliefs, perspectives, and level of knowledge of primary care among low-income uninsured Americans. Additional purposes included understanding whether patient education about primary care availability, affortability, and benefits can lead to improved access to primary care.

Research Questions

The research questions that guided this study are shown below:

- What are the beliefs, perceptions, and level of knowledge of low-income uninsured patients concerning primary care services?
- How can patient education about primary care availability, affordability, and benefits lead to improved access to primary care for low-income uninsured patients?

Theoretical Framework

The theoretical framework for this qualitative study was based on the ideals found in the health belief model (HBM). The HBM was developed to explain why U.S. Public Health Services' medical screening programs, especially those for tuberculosis, were unsuccessful (Steckler, McLeroy, & Holtzman, 2010). The HBM is a tool used to provide an in-depth look into an individual's beliefs, perceptions, and behaviors concerning health care (Glanz, Rimer, & Lewis, 2002). More specifically, it identifies the concepts of perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and cues to action (Glanz, Rimer, & Viswanath, 2008). The HBM model was used in understanding the participants' perceptions, beliefs, and level of knowledge concerning primary care and understanding whether behavior change toward primary care is possible.

Nature of Study

A phenomenological approach was used for this study. This approach best aligned with the research questions and most appropriately addressed the problem being studied. Low-income uninsured individuals' lived experiences concerning primary care were captured through this approach, providing detailed insight into the lives of the participants.

A qualitative method was used for this research, with the interview design serving as the data collection tool. The interview tool allowed the low-income uninsured participants to share their experiences related to primary care. Churches, convenience stores, barber shops, beauty salons, and recreational parks were the locales used to find participants for this study. Open ended questions were asked during the interview process, which led to in-depth responses that transcended yes-or-no answers. This style of questioning allowed greater insight pertaining to the participants' perceptions, beliefs, and knowledge levels about primary care. Data were analyzed using NVivo 11 Pro software.

Definitions

Emergency department (ED): Functions as a safety net in providing care to all patients regardless of ability to pay (Carlson, Menegazzi, & Callaway, 2013).

Primary care service: The level of care that provides patients entry into the health services system to assist with all current problems. Additionally, primary care provides individuals care over time and care for all conditions, and it coordinates care among other providers and health facilities (The Johns Hopkins Primary Care Policy Center, n.d.).

Primary-care-related emergency department (PCR-ED) visits: Visits to the ED that are categorized as preventable or treatable through appropriate primary care (Enard & Ganelin, 2013).

Low-income uninsured: Individuals who do not have enough income to qualify for government subsidies through the ACA and do not qualify for Medicaid (Geyman, 2015).

Health care utilization: The use of health care services for reasons such as to cure sickness, to repair breaks and tears, to prevent or delay future health situations, to reduce pain and provide improved quality of life, and gain information concerning the patient's health status and prognosis (Centers for Disease Control and Prevention, 2004).

Emergency department (ED) frequent users: Also known as *frequent flyers*, frequent ED users are a diverse group of patients who visit the ED four or more times a year (Grover & Close, 2009).

Nonurgent conditions: Medical issues that are non-life-threatening or non-limb-threatening, or medical problems that do not require immediate attention (Durand et al., 2012).

Health outcomes: The measurement of a population's state of physical, mental, and social well-being. Positive health outcomes consist of being alive, functioning holistically, and having a sense of well-being. Negative outcomes consist of death, loss of the ability to function, and lack of well-being (Parrish, 2012).

Assumptions

I assumed that the participants in this study would respond to the interview questions thoughtfully, accurately, and honestly. Likewise, I assumed that a sample of low-income uninsured participants would generate data that would answer the research questions of this study. Additionally, I assumed that themes would emerge out of the given responses that would provide evidence to guide future research.

Scope and Delimitations

The scope of this study included low-income uninsured participants who frequented the ED for nonurgent conditions. The focus of the study was narrowed to members of the low-income uninsured population because such patients tend to frequent the ED more than the insured population (Lee, 2015). The focus was specific to the low-income uninsured who visit EDs in North Carolina hospitals because North Carolina nationally ranks number four in uninsured patients (Garfield, 2016).

Limitations

Although a strong emphasis was placed on quality throughout this study, limitations must be addressed to provide accuracy for this research project. One limitation worth mentioning was within the data collection process concerning the interview tool. In face-to face interviews, participants may be less honest or thoughtful, hesitant to speak and share ideas, or less articulate and shy. This may present challenges and less adequate data (Creswell, 2013). I overcame this limitation by using a private room at the local library that provided a comfortable and quiet setting for interviewing. Additionally, I was cordial and demonstrated forbearance toward the participants while using a calm verbal tone when interviewing. This placed the participants at ease and was used to combat any issues of reservation. Although I tried to eliminate any interviewer-interviewee intimidation or power, there was always a chance that the participant would respond to the interview questions in a biased manner.

Another limitation was that, in a study of this sort, it is impossible to be totally confidential when collecting data. The initial interview log contained participant demographics such as name, telephone number, email address, and so forth. After the initial demographics were collected, the participants were known throughout the remainder of the study as Participant 1, Participant 2, Participant 3, and so on.

A final limitation was associated with the small sample. It is almost impossible to generalize the findings of this research project because they were based on a small number of individuals (Shenton, 2004). The results of this study cannot be generalized to any other low-income uninsured persons because the participants were limited to the experiences described; nevertheless, transferability is possible for similar studies with the same methodology that are conducted in different environments (Shenton, 2004). Although total transferability in this study was not possible, I used thick descriptive language in explaining the phenomenon and describing the participants to accommodate future studies.

Significance

The focus of this study was the overuse of emergency services by low-income uninsured patients. This population frequently uses emergency services for nonurgent conditions that would be treated more efficiently, cheaply, and beneficially at a primary care facility (FloresMateo et al., 2012). In answering the research questions, I sought to gather information as to whether there are factors such as beliefs, perceptions, or lack of knowledge that contribute to the decisions of low-income uninsured patients to visit the ED for nonurgent conditions instead of primary care. These findings may assist health educators and promoters in better educating patients about alternative ED options. Additionally, these results may be used to improve patient navigation efforts by assisting health care administrators in effectively steering frequent ED users toward primary care facilities for all nonurgent health issues. This may result in overall reduction in ED visits and an increase in visits to primary care facilities.

Summary

Overutilization of the ED for nonurgent conditions is a problem that has been described as an “international symptom of health system failure” (Durand et al., 2012, p. 2). Frequent users of the ED tend to be people of low income status who lack health insurance (Flores-Mateo et al., 2012). Patients that seek primary care for nonurgent issues have better health outcomes than those that use the ED (Flores-Mateo et al., 2012). Research efforts have been directed toward identifying effective ways to decrease ED usage; however, there is an information gap that pertains to the patient’s knowledge level, beliefs, and perceptions of primary care services and whether education may play a role in the decision-making process.

Chapter 2 is a review of literature consisting of peer-reviewed journals published within the past 5 years. The review is a compilation of studies that provides an overview of healthcare for uninsured low-income patients, ED utilization, health outcomes, primary care utilization, primary care accessibility, advantages of primary care, and perceptions of primary care services. I examined research in closely related areas while pointing out the lack of research focusing on low-income uninsured patients’ knowledge levels, beliefs, and perceptions concerning primary care. Chapter 3 of this study consists of a research design and rationale, methodology, instrumentation, participants, data analysis, and validity/reliability measures. Chapter 4 provides details concerning the results of the study. Lastly, Chapter 5 of this dissertation offers an overview of results along with conclusions and recommendations.

Chapter 2: Literature Review

Introduction

Despite the growing body of literature about reasons that patients choose the ED over primary care services, there is a gap in research regarding the perspective of low-income uninsured Americans and their perceptions, beliefs, and level of knowledge about primary care. This lack of knowledge could promote health disparities for low-income uninsured communities whose members use the ED in nonurgent situations instead of primary care services (Flores-Mateo et al., 2012). The purpose of this study was to gain an understanding of low-income uninsured patients' perceptions, beliefs, and knowledge about primary care and their effect on decision making when seeking nonurgent care. The literature review provided an overview of studies on healthcare topics relevant to the low-income uninsured, ED overutilization, primary care accessibility, and the role of the health care system in navigating frequent ED users toward primary care services.

This chapter consists of a description of the literature search strategies, themes found in the research, and the reason for the selection of the research methodology. There were a few studies reviewed that showed multiple factors that resulted in decreased utilization of ED services and increased usage of primary services.

Literature Search Strategy

Peer-reviewed full text articles published between 2013 and 2016 were located using Walden's online library. Specific databases searched were ProQuest, MEDLINE, CINAHL Plus, and PubMed. Multiple search terms along with combinations were used to locate relevant materials. The search terms included, but were not limited to, *healthcare for the low-income uninsured, emergency department utilization, health outcomes, safety-net services, primary care utilization, primary care accessibility, advantages of primary care,* and *perceptions of primary care services.*

Theoretical Foundation

The theoretical framework for this qualitative study was based on the ideals found in the health belief model (HBM). The theory of HBM was developed to explain why U.S. Public Health Services' medical screening programs, especially those for tuberculosis, were unsuccessful (Steckler et al., 2010). This model identifies the concepts of perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Glanz et al., 2008). In this study, the HBM tool was used to provide an in-depth look at individuals' beliefs, perceptions, and behaviors toward health care (Glanz et al., 2002). Additionally, it can assist in understanding participants' perceptions, beliefs, and levels of knowledge concerning primary care and whether behavioral change toward primary care is possible.

Health Care for the Low Income Uninsured

The purpose of the Affordable Care Act (ACA), established in 2010, was to improve health care by reducing cost, improving affordability, increasing access, and improving quality of care in the overall healthcare system (Geyman, 2015). A study conducted in 2015 showed that healthcare cost continued to rise and many Americans (approximately 37 million) were still uninsured due to lack of affordability of health care and inadequate access to health care (Barlett & Steele, 2004; Geyman, 2015). Geyman (2015) suggested that the title *Affordable Care Act* was misleading, in that it made one think that health care was affordable and available to everyone, yet there were many factors that determined whether health care was affordable. These factors included the price and cost of health care, the value amount of insurance coverage, household income, and cost of living (Geyman, 2015). One study conducted by the Associated Press in 2014 found that one-fourth of insured Americans felt that they were unable to pay for adequate health care, whether they were insured through their employer or ACA's marketplace exchanges (Geyman, 2015). In 2013, for a typical family of four, health care used up 20.7% of cost of living, and in the same year, the average income for Americans was $51,404, where the total health care cost for a family of four with insurance (provided by employer) was $23,215 (Geyman, 2015).

The goal of ACA was to change the number of uninsured from 50 million to 32 million people by the year 2019 (Geyman, 2015). This was to be accomplished through online health insurance marketplace exchanges and Medicaid expansion (Geyman, 2015). The exchanges allowed the uninsured the opportunity to comparison shop for insurance plans and receive federal subsidies to assist in the affordability of insurance, if they qualified (Geyman, 2015). Only those with yearly incomes that fell between 138% and 400% of the federal poverty level (FPL) were eligible (Geyman, 2015). Medicaid expansion was designed so that every state would expand Medicaid (insuring more people through Medicaid) and the federal government would pay 100% in the first 3 years and then scale back to 90% by the year 2020 (Geyman, 2015). Surprisingly, it was offered to all 50 states, but some governors (24 out of 50) opted out and chose not to expand the Medicaid program, leaving 4.8 million Americans uninsured, which led to the coinage of the phrase *Medicaid coverage gap* (Geyman, 2015, p. 211). This group, also known as *low-income uninsured*, failed to have enough income to obtain federal subsidies and did not qualify for Medicaid, which left them without insurance coverage (Geyman, 2015).

Despite all efforts to insure as many Americans as possible, evidence showed that there were still many people who fell into the low-income uninsured category with little to no hope of gaining coverage in the future. Geyman (2015) predicted that 37 million Americans could still be uninsured even after ACA is fully implemented in 2019. Likewise, Hellander (2015) reported that in the year 2024, an estimated 27 million Americans could still be uninsured.

In contrast, studies showed that there were 9.5 million fewer uninsured, with a drop in the uninsured rate for both adult and young adult age groups, after the ACA implementation (Geyman, 2015). Unknown to many, insured Americans can face many challenges, including possible debt, bankruptcy due to low-value policies, plans with limits and exclusions, high cost-sharing, and limited out-of-network protection (Geyman, 2015). The uninsured, meanwhile, may deal with psychological and medical concerns pertaining to lack of insurance (Barlett & Steele, 2004). Barlett and Steele (2004) suggested that uninsured Americans experienced embarrassment which stemmed from not having the means to pay for health care, which sometimes resulted in a delay in treatment where medical attention was only sought after in critically ill situations (Barlett & Steele, 2004). Lack of medical insurance can have dire or fatal consequences for uninsured patients (Barlett & Steele, 2004; Geyman, 2015). Geyman (2015) reported that people with Medicaid had better health outcomes than the uninsured and an estimated 7,115 to 17,104 needless deaths will occur due to states' rejection of the Medicaid expansion under ACA (Geyman, 2015).

Emergency Department Overutilization

The low-income uninsured population has typically overutilized ED services (Flores-Mateo et al., 2012). Some of the visits to the ED made by members of this population are nonurgent (Basu & Phillips, 2016; Shaw et al., 2013); however, there are also situations in which the uninsured legitimately use ED services because seeking or going to a primary care facility could result in further injury, illness, or death. Nevertheless, for the remainder of this study, the use of the ED by uninsured low-income patients is referred to as nonurgent, referring to situations that could be properly handled by a primary care physician.

The ED serves as a safeguard for approximately 51 million Americans who lack health insurance because it is a place where no individual is denied care based on lack of ability to pay (Carlson, Menegazzi, & Callaway, 2013). Carlson et al. (2013) found that uninsured Americans were responsible for an estimated 20 million ED visits (approximately 1 in 6) annually and showed differences in ED utilization patterns compared to insured Americans. Researchers have demonstrated multiple reasons for patterns of ED usage among the uninsured. Flores-Mateo et al. (2012) suggested factors contributing to patients using the ED for primary care services such as more chronic illnesses, an aging population, no cost awareness, lack of organization in primary care, greater accessibility and availability of the ED, perceptions of patients as to the seriousness of ailments, and higher confidence in ED than primary care. Behr and Diaz (2016) identified driving factors for frequent ED users as quality perceptions, age, race, gender, poor mental health, seriousness of condition, prior hospital admittance, social networks, employment, persistence of condition, and prescription drug abuse. Studies have shown that patients receiving interventions targeting those factors can decrease the frequency of ED utilization significantly (Behr & Diaz, 2016).

Researchers have suggested multiple types of interventions to correct the problem of ED overutilization by the uninsured. Flores-Mateo et al. (2012) suggested developing health education, implementing interventions to limit ED access, requiring copayments, and making primary care or alternative services (urgent care) more accessible as means of decreasing ED usage. Flores-Mateo et al. noted that athough copayments should not discourage those who need ED services, they may effectively deter some patients who should not use the ED. Likewise, educational interventions alone cannot effectively reduce ED usage, but must be grouped with other measures (multifaceted intervention) to be effective (Flores-Mateo et al., 2012). Although educating patients about health-service use was not enough to decrease ED visits, one study showed that education was successful in decreasing hospital admissions (Flores-Mateo et al., 2012). Other researchers found that even providing subsidized insurance to some low-income individuals did not change ED utilization among low-income adults in Massachusetts (Lee et al., 2015).

In contrast, some researchers have demonstrated that providing communication interventions to low-income uninsured patients and primary treatment teams can decrease excessive ED usage (Baskin, Kwan, Connor, Maliski, & Litwin, 2016). Flores-Mateo et al. (2012) proposed that intervention was key in reducing ED usage and that there was a direct link between primary care accessibility and reduction of ED visits. More specifically, Flores-Mateo et al. performed a study using an intervention with a focus on increased out-of-hours primary care services to reduce ED visits. Interestingly, some of the research was performed in countries with a national health system and a strong primary health care platform (Flores-Mateo et al., 2012). The research revealed that ED visits decreased after extended hours were implemented (Flores-Mateo et al., 2012). In short, Flores-Mateo et al. proposed that primary care accessibility decreased ED visits and that patients with a continued patient-physician relationship may be likely to pursue the primary care physician's opinion before seeking assistance from the ED, especially for nonurgent conditions.

Primary Care Accessibility

For years, the health care community has indicated concern about overutilization of the ED (Flores-Mateo et al., 2012), especially when patients have replaced primary care with ED visits for nonurgent situations (Flores-Mateo et al., 2012). Aside from the fact that ED visits cost more than primary care, frequent ED users may fail to receive continual and follow-up care (Flores-Mateo et al., 2012). In the ED, the provider has limited knowledge of the patient's previous and current health issues and treatments (Flores-Mateo et al., 2012). In the absence of relevant heath care information, patient care may be compromised because patient-provider decision making is challenged. Moreover, ED resources may be used for nonurgent health-related issues as opposed to life-threatening conditions, and ED overuse may lead to staff burnout, which results in employee and patient dissatisfaction (Flores-Mateo et al., 2012).

Primary care access plays a significant role in health outcomes for patients (Belue, Figaro, Peterson, Wilds, & Caniam, 2014). This was seen in a study of uninsured diabetes patients whom were considered to have an elevated risk for poor outcomes because of the lack of primary and specialty care access (Belue et al., 2014). These limitations resulted in poor management of diabetes, which in turn led to poor health outcomes (Belue et al., 2014). The study was performed by Hamilton Health Center, a federally qualified health center, and its purpose was to evaluate the effectiveness of the Diabetes Healthy Outcomes Program (DHOP) for uninsured patients (Belue et al., 2014). Over a 2 year period, 189 participants were studied to assess the effectiveness of the program (Belue et al., 2014). Belue et al. (2014) reported that diabetic participants who accessed primary and specialty care experienced greater glycemic control.

Another advantage of the uninsured using primary care for nonurgent conditions is an overall reduction in cost (Bradley, Gandi, Neumark, Garland, & Retchin, 2012). In a study performed at Virginia Commonwealth University Medical Center on uninsured low-income adults (Bradley et al., 2012), the participants were enrolled in a continuous 3 year community-based primary care program at the university. The results showed decreases in inpatient cost, ED visits, and inpatient admissions, as well as an increase in primary care visits (Bradley et al., 2012). Additionally, Bradley et al. (2012) concluded that although the uninsured had fewer ED visits and lower costs after receiving health insurance, the full extent of health care savings could not be seen until several years later.

Bicki et al. (2013) also reported that nonurgent health conditions accounted for over 9 million ED visits in U.S. hospitals yearly because patients lacked access to primary care physicians. This resulted in unnecessary ED usage for nonurgent conditions and more costly services (Bicki et al., 2013). Bicki et al. demonstrated that adding walk-in hours at a free clinic increased health care access for the uninsured and was found to be cost-effective for the clinic and patients. In other words, community clinics that serve the uninsured can treat nonurgent medical conditions at lower cost and thereby reduce the ED burden related to treating these conditions (Bicki et al., 2013).

Health Care System's Role in Navigation

The United States has failed to fix its greatest problem concerning the role of government in access to health care and health care quality for all citizens (Kronenfeld & Kronenfeld, 2015). In most other developed countries, the government plays a significant role in making sure that most citizens have access to health care services (Kronenfeld & Kronenfeld, 2015). Of course, countries have diverse means of providing access to citizens (Kronenfeld & Kronenfeld, 2015). For instance, some have created national health care systems, whereas others use health-insurance-based systems (Kronenfeld & Kronenfeld, 2015). Some have argued that the U.S. health system is confusing as a result of the presence of multiple health care insurers, both private and public, and the divergent functions of providers (Kronenfeld & Kronenfeld, 2015). Regardless of the diverse ways in which other countries have tackled the issues of health care access and quality for all citizens, there are mechanisms to ensure that all citizens receive basic access to quality health care while simultaneously keeping health care costs reasonable (Kronenfeld & Kronenfeld, 2015). Kronenfeld and Kronenfeld (2015) suggested that the same cannot be said about the United States.

The U.S. health system has established programs called “safety-nets” (Nguyen, Makam, & Halm, 2016, p. 2). The *safety net* is an accumulated network of clinics, public hospitals, community health centers, and other healthcare organizations whose primary purpose is to provide primary care to individuals regardless of ability to pay (Nguyen, Makam, & Halm, 2016). Studies have shown that access to primary care reduces the use of more costly health care (i.e., the ED) for uninsured individuals through prevention and timely treatment (Mackinney, Visotcky, Tarima, & Whittle, 2013).

Safety nets have been created for uninsured Americans who cannot afford healthcare elsewhere (Nguyen et al., 2016), resulting in patients paying little or no money at all for office visits. Researchers have found that free clinics are vital, especially in light of the number of uninsured still not covered by ACA (Kamimura, Christensen, Tabler, Ashby, & Olson, 2013). Walker (2013) reported that the uninsured failed to receive preventative care, which led to unfavorable outcomes and hospitalizations for acute conditions. Additionally, Walker demonstrated the cost-effectiveness of providing primary and preventative health care to the uninsured through free clinics compared to ED and inpatient care. A study showed that clinics can meet the primary health care needs of the uninsured for a sensible cost, which can result in decreased ED visits, hospital admissions, and health care costs (Walker, 2013).

Although it is evident that primary care services are beneficial to low-income patients, access has been reported as a challenge for some communities (Block et al., 2015). The Johns Hopkins Hospital, a provider of free primary care to many uninsured and underinsured individuals since 2009, ran a program called The Access Partnership (TAP; Block et al., 2015). The goal of the program was to link uninsured and underinsured patients to primary care (Block et al., 2015). Reportedly, the program was successful because the expansion of primary care resulted in an inflow of chronic illness patients, which led to the primary care practices reaching capacity within 7 months (Block et al., 2015).

While there was overwhelming evidence that navigated uninsured patients from ED to primary care facilities reduced ED usage (Belue et al., 2014; Flores-Mateo et al., 2012) there were studies that offered different results. For example, one study suggested that referring low income uninsured from hospitals to primary care clinics failed to reduce overall ED visits, but showed a reduction in ED visits from those patients with chronic physical or behavioral issues (Kim, Mortensen, & Eldridge, 2015). Kim et al. (2015) concluded that ED usage was reduced with the expansion of safety-net clinics and a focused plan to link primary care providers with high-need ED patients.

Patients' Perceptions, Beliefs, and Knowledge

There is little known about the decision-making process of the patients who choose ED services over primary care services (Shaw et al., 2013). However, Kangovi et al. (2013) stressed that when patients chose the ED over primary care the results were harmful for the patient and costly for the health care system. Kangovi et al. performed a study in the hope of understanding how a patient's socioeconomic status (SES) was directly linked to decision-making. The study revealed that people of low SES utilized acute hospital care more frequently and primary care less often than patients with high SES (Kangovi et al., 2013). Furthermore, the low SES group perceived acute hospital care to be less expensive, to have greater accessibility, and to have better quality of care than ambulatory care settings (Kangovi et al., 2013).

Another study was performed on both uninsured and insured seeking perceptions of the use of the ED for vs. primary care services for nonurgent conditions. The participants were placed in two subgroups depending on whether there was prior knowledge about primary care options (Shaw et al., 2013). The results showed that there was a significant difference in patients who knew about primary care options but chose ED services over patients who had no prior knowledge of other primary care services and used the ED as a default source of care (Shaw et al., 2013). The study showed that one-fourth of the patients indicated that the ED was used because there was no knowledge of optional primary care services (Shaw et al., 2013). The other patients with prior knowledge of optional primary care services indicated that the choice to use the ED was attributed to the following:

- Medical professional instructions
- Access barriers to regular care provider
- Perception of racial issues stemming from primary care options
- Emergency health care need which required ED services
- Barriers obtaining transportation to get to primary care services
- Associated cost for using primary care as opposed to the ED (Shaw et al., 2013)

Rationale for Phenomenological Research

The review of literature demonstrated a lack of qualitative research specifically investigating the perspectives, beliefs, and level of knowledge of patients in relation to the availability of primary care services and the health benefits of primary care. The lack of understanding regarding the patients view point indicates a qualitative phenomenological research approach is necessary.

Phenomenology is a qualitative research approach that is used widely in the health care field when the research study aims to focus on understanding the lived experiences of several individuals (Creswell, 2013). Edmund Husserl, a German philosopher, developed this theory as a means of studying people's experiences and their descriptions of a phenomenon (Patton, 2015). This study was geared toward gaining a phenomenological understanding of low income uninsured Americans experiences regarding primary care. This approach can render themes which can answer the research questions: What are the perceptions, beliefs, and level of knowledge of low income uninsured patients concerning primary care and ED services? How can knowledge about primary care availability, affordability, and benefits improve health outcomes for low income uninsured patients?

For years, researchers within the health care discipline have used the phenomenological approach as a means of understanding the experiences of individuals. Lee et al. (2014) completed a study aimed at understanding Chinese women's experiences obtaining maternity care, utilizing maternity health services, and their perceived obstacles pertaining to immigration. The researchers gathered data using the interview process where themes developed identifying the immigrant women's preference for linguistically and culturally competent clinicians, the development of alternative support systems, and the utilization of private services (Lee et al., 2014). Similarly, Moreira, Lopes, and Diniz (2013) used a phenomenological approach to understand the perception of pregnant women concerning cervical cancer. The interview techniques were used as a data collection tool which revealed themes associated with the pregnant women's perceptions of cervical cancer and the importance of Pap smear testing during pregnancy (Moreira, Lopes, & Diniz, 2013). The study revealed that pregnant women who received Pap smear tests purposely ignore the word 'cancer' when speaking with health professionals and they failed to link Pap smear exams as a preventative measure against cervical cancer (Moreira, Lopes, & Diniz, 2013, p. 511).

Conclusion

The review of literature clearly revealed that despite the implementation of the ACA in 2010, there are still millions of Americans who lack medical insurance coverage (Flores-Mateo et al., 2012; Geyman, 2015) and these patients tend to frequent EDs (Flores-Mateo et al., 2012) unnecessarily with nonurgent conditions (Basu & Phillips, 2016; Bicki et al., 2013; Shaw et al., 2013). Researchers have suggested that overutilization of ED services led to higher health care cost and poor health outcomes for the uninsured population (Flores-Mateo et al., 2012). Increased access to primary care services have also been noted to decrease ED usage (Walker, 2013), lower health care cost (Bradley et al., 2012; Flores-Mateo et al., 2012), and improve health outcomes (Belue et al., 2014). There are government programs called safety-nets the purpose of which is to provide primary care services to the uninsured regardless of their ability to pay (Nguyen et al., 2016). Although the navigation of the uninsured from ED to safety-net facilities is beneficial (Belue et al., 2014; Flores-Mateo et al., 2012), there is little evidence that the government plays a role in the navigation process. Despite the scholarly advances in the benefits of primary care as opposed to ED services for nonurgent conditions, a gap exists regarding perceptions, beliefs, and level of knowledge of the patients. There is still a need to gather information which can assist health care experts in understanding the perceptions, beliefs, and knowledge level of the uninsured low-income population pertaining to primary care.

A case was made for the use of a qualitative phenomenological research approach where data were collected from participants using the interview technique for this study. The methods for this research study are explained further in Chapter 3.

Chapter 3: Research Method

Introduction

The purpose of this study was to understand low-income uninsured Americans' beliefs, perceptions, and level of knowledge related to primary care services. This chapter consists of an introduction followed by sections addressing the research design and rationale, role of the researcher, methodology, instruments, data collection, data analysis, issues of trustworthiness, reliability, and ethical procedures. The chapter concludes with a summary.

Research Design and Rationale

The primary purpose of this qualitative study was to gain a clear understanding of levels of knowledge, beliefs, and perspectives concerning primary care services among low-income uninsured Americans. Additionally, its purpose was to understand whether patient education about primary care availability, affortability, and benefits can lead to improved utilization of primary care services. I used a phenomenological approach to explore the phenomena (Patton, 2015) and answer the research questions. This approach was warranted as a means of capturing and describing the experiences of people associated with a common phenomenon (Patton, 2015). The research questions that guided this study are shown below:

- What are the perceptions, beliefs, and level of knowledge of low-income uninsured patients concerning primary care services?

- How can patient education about primary care availability, affordability, and benefits lead to improved access to primary care for low-income uninsured patients?

The phenomenological design used for this qualitative research was the best approach to answer the research questions.

Role of the Researcher

As the researcher in this study, my goal was to conduct a qualitative research study using a phenomenological approach to collect data. The research was conducted using convenience-based sampling to gather in-depth interviews from 10 volunteer participants. The interviews performed were conducted face to face. Face-to-face interviews were conducted in a private conference room at a local library. This venue offered a comfortable, quiet, and nonhostile environment for the participants. My role during this phase of research was to collect data without exerting any type of influence over the participants. In keeping with this concept, there was no personal or professional relationship between myself and the participants, including supervisory or instructor relationships that might present issues related to conflict of interest or power over the participants.

I protected the research participants by implementing research controls, managing biases, and following the study's guidelines as ethically as possible. Research controls were put into place by ensuring that all guidelines for participant recruitment, data collection, and data analysis were followed throughout the study. Biases were managed during the analytical phase of the study by interpreting data with honesty, integrity, and trustworthiness. This was accomplished by using epoche and bracketing, also known as *phenomenological reduction* (Patton, 2015). In the epoche process, I refrained from expressing ordinary perceptions, preconceived notions, or personal involvement with the phenomenon (Patton, 2015). I used bracketing to follow, uncover, define, and analyze the data without any outside influences (Patton, 2015). Additionally, reflective journaling was used make sure that observations corresponded to or correlated with findings.

I ensured that I conducted the study ethically by following informed consent and privacy guidelines and allowing Walden's Institutional Review Board (IRB) to review the research plan. Walden University's IRB process was used to protect the participants' human rights and to ensure that the study would not cause any physical, psychological, social, economic, or legal harm (Creswell, 2009). Informed consent information was given to all participants prior to engaging in the research to acknowledge that participants' rights would be protected during data collection (Patton, 2015). Participants' privacy was honored during the data collection process by using pseudonyms to identify them and not using the actual identities of participants (Patton, 2015).

Methodology

The primary purpose of this study was to gain a clear understanding of the perceptions, beliefs, and levels of knowledge of low-income uninsured patients concerning primary care services. A qualitative study was the appropriate methodology because it answered the research questions. Qualitative research is used for exploring and understanding the meaning of an individual or group's connection to a social or human problem (Creswell, 2009). This study used deductive analysis whereby patterns, themes, and categories emerged from the data (Patton, 2015), and a process of working back and forth between the themes and database was used until a complete set of themes was established from the data (Creswell, 2013). Inductive analysis was not warranted because it would have required data to be analyzed from an existing framework or theme (Patton, 2015).

Participant Selection Logic

The participants in this study were people of low income status that lacked medical insurance. To be considered low-income uninsured, participants needed to under qualify for federal subsidies through the ACA because their annual income fell below the federal poverty level standard and over qualify for Medicaid because their annual income was too high (Geyman, 2015). Specific screening criteria were used to identify whether participants qualified to participate in the study based on their current insurance and income status (Appendix A).

The strategy for selection was a purposeful approach in which all participants experienced the same phenomenon (Creswell, 2009). This strategy provided a better understanding of the research problem and questions. There were 10 participants in this study because each participant was interviewed in depth, which led to the collection of a large amount of data (Patton, 2015). In qualitative research, generally, there are no rules for sample size (Patton, 2015); however, for phenomenological studies, researchers have suggested sample sizes spanning from one to 325 (Creswell, 2009). Originally, I started with a sample size of 10 because I felt that this was sufficient to answer the research questions. After interviewing the participants, I found no need to add more participants because saturation had been reached. Saturation, or redundant sampling, occurs when information is maximized with no additional information forthcoming from interviewing new participants (Patton, 2015).

Semistructured, in-depth interviews were used as the primary means of data collection. Interview questions (Appendix B) were developed from the literature review and the assumption of the uninsured low-income participants' experiences pertaining to primary care services. The interview questions were focused toward answering the research questions. Participants were interviewed until data saturation was met.

The sampling strategy used was criterion sampling. Criterion sampling is a form of purposeful sampling where all participants meet the same criteria and the participants studied are a representation of others who experienced the same phenomenon (Creswell, 2013). In the search for participants, I visited recreational parks, churches, convenience stores, beauty salons, and barber shops and placed flyers (Appendix C) in these locations to find volunteers for this research.

Instrumentation

Data collection is one of the most important aspects of qualitative research. Interviewing is a common data collection technique used in qualitative research (Jamshed, 2014). The interview method used in this study was semistructured, in-depth one-on-one interviews. Handwritten notes were taken during the interviews to avoid missing vital interview material, adding reliability to the study. Additionally, an audiorecorder was used to capture all interview content, which allowed the information to be transcribed verbatim (Jamshed, 2014). A semistructured interview guide was used to achieve optimal use of the interview time (Jamshed, 2014). Additionally, prior to testing, interview questions were reviewed and approved by experts in the healthcare field.

The experts were chosen for their years of experience in healthcare settings. The expert panel consisted of a physician, a social worker, and a medical laboratory scientist. The physician and medical laboratory scientist were former colleagues, but I met the social worker through a mutual acquaintance. The physician had worked in hospital and primary care environments and had experience working with patients with different health concerns, backgrounds, and economic statuses. The social worker had years of experience with medical insurance, specifically Medicaid. She was a benefits program supervisor for the department of social service within her state. She was responsible for 11 Medicaid case workers who processed applications on a day-to-day basis. The medical scientist had worked in the laboratory for an extensive number of years and had a graduate degree in health services. She had experience in health care management as well as data collection and analysis.

The experts were contacted via email with a description of the study and a request for their participation in the review of the interview questions. All experts agreed and were emailed the list of interview questions. I received responses within a week from the social worker and medical scientist, which stated that they saw no need for changes; however, the physician responded after 2 weeks with notable changes. He suggested changing the order and wording of some of the questions in order to make them less leading and easier to interpret during the data analysis phase. I made these corrections to the questions, resubmitted the changes to the IRB, and received approval (Approval Number: 06-23-17-0527240) to move on to the data collection phase of the study.

Procedures for Recruitment, Participation, and Data Collection

The participants in this study were low-income uninsured Americans. As noted above, flyers were placed in a variety of locations in the community to recruit participants. The flyer contained my contact information. Once a potential participant contacted me, I reviewed the screening questions with the individual to determine eligibility. If the individual met the criteria to participate in the study, a detailed explanation of the study, a description of participants' contribution to the study, and a written consent document were emailed to the participants. After receiving a signed consent form from a participant via email, I scheduled a time for the interview.

Generally, one-on-one, semistructured interviews last for a duration of 30 minutes to more than 1 hour (Jamshed, 2014). I scheduled all interviews for a maximum time of 1 hour. Potential participants were selected from the Burlington, North Carolina area. If more participants were needed, I planned to extend the recruitment to surrounding cities such as Greensboro, Graham, or Mebane. To ensure accuracy, I audiotaped and transcribed all interviews verbatim. Additionally, demographic data (age, gender, and race) were recorded and transcribed; however, participant names were not recorded to ensure the privacy of the participants. Participants were identified as Participant 1, Participant 2, Participant 3, and so on. At the end of all interviews, participants were thanked and reminded of their important contribution to the study. This design of interview questioning did not require any follow-up interviews with participants; however, in giving the participants the ability to end the interview, I gave them my contact information in case they wanted to add anything, forgot to mention anything, or wished to clarify a point (Patton, 2015). A $25 Walmart gift card was given to each participant as thanks for participation.

Data Analysis Plan

In qualitative research, data analysis is performed after data have been collected and reduced into themes, codes have been generated, and findings have been presented using figures, tables, or discussion (Creswell, 2013). The data collected for this study may contribute to existing knowledge on perceptions and belief patterns of low-income uninsured patients pertaining to primary care services and the role of patient education in improving access to primary care services for this population. After the data were collected, data analysis was performed using open coding and then axial coding. More specifically, open coding was used to generate one category for the key focus of the theory and then additional categories, and axial coding was used to form the theoretical model (Creswell, 2013). I used NVivo 11 software to organize and analyze the data collected during the interview process. This software was user friendly and allowed easy manipulation, storage, and searches within the data. Additionally, NVivo 11 Pro assisted me in analyzing, managing, shaping, and making sense of the data.

Issues of Trustworthiness

This qualitative research plan focused on the issue of underutilization of primary care services for nonurgent conditions among low-income uninsured patients. It is important to establish the trustworthiness of a study in order to evaluate its worth (Lincoln & Guba, 1985). Lincoln and Guba (1985) suggested that trustworthiness is established when credibility, transferability, dependability, and confirmability are met within a study. Credibility applies when confidence in the truth is established from the research findings (Lincoln & Guba, 1985). Credibility was demonstrated by allowing the themes or codes found in the data to be documented as evidence and thus bringing validity to the findings (Creswell, 2013). Additionally, I used systematic analysis to enhance credibility in this study. This was accomplished by performing deep analysis of the findings, reexamining initial findings, and continuously working back and forth between themes and the data (Patton, 2015). Transferability or external validity applies when a researcher shows that the research findings are applicable in other contexts (Lincoln & Guba, 1985). I used a thick description strategy in explaining the phenomenon and describing the participants (demographic data) to enhance transferability of the study. Dependability refers to when research findings can be duplicated (Lincoln & Guba, 1985). Dependability was demonstrated through the clearly stated research questions and the alignment of the study design (Miles, Huberman, & Saldana, 2014). Likewise, dependability was established in the data analysis phase through constant comparison and refinement of the themes generated by NVivo 11 Pro software (Lincoln & Guba, 1985) and within my justifiable and reasonable interpretation of the data. Finally, confirmability refers to the situation in which study findings are shaped without any type of researcher bias, motivation, or interest (Lincoln & Guba, 1985). In this research, confirmability was established by using explicit and detailed description of methods and procedures, the sequence of the data collection and analysis process, and the approval and reanalysis of the study through Walden University's IRB (Miles, Huberman, & Saldana, 2014). To further confirm the research, I used reflective journaling to capture my observations (Ortlipp, 2008) along with epoche and bracketing to eliminate any personal preconceptions, notions, or influences (Patton, 2015).

Ethical Considerations

Although researchers follow clear codes of ethics and guidelines to protect participants' rights, the IRB or overseeing agency also mandates legal matters such as securing permission and maintaining privacy for participants (Miles, Huberman, & Saldana, 2014). Approval was obtained from Walden's IRB to protect the best interests of the participants. In this study, participants' names were kept private by means of deidentification, and participants were asked to sign a consent form. Deidentifying the participants was accomplished by assigning all participants chronological numbers according to the order in which they were interviewed. I did not have any power over the participants and did not pressure them in any way to participate in this study. All information was totally confidential, and the participants were never exposed to any risk pertaining to the study.

Summary

This chapter has reviewed the study's purpose and my role as the researcher. The qualitative phenomenological rationale was described in detail. I discussed procedures for participant recruitment, data collection, and data analysis. I stressed strategies that were used to prove trustworthiness and ensure ethical processes within this study. The results and findings of the study are revealed in Chapter 4.

Chapter 4: Results

Introduction

The purpose of this qualitative phenomenological study was to examine and understand the beliefs, perspectives, and level of knowledge of the low-income uninsured population about primary care services through the completion of individual interviews. The research questions for the study were as follows:

1. What are the beliefs, perceptions, and level of knowledge for low-income uninsured patients concerning primary care services?
2. How can patient education about primary care availability, affordability, and benefits lead to improved access to primary care for low-income uninsured patients?

This chapter provides a description of the research setting, demographics, data collection, data analysis, evidence of trustworthiness, and results.

Setting

Flyers placed in beauty salons, recreational parks, churches, convenience stores, and barber shops resulted in 16 responses from prospective participants. Although I received initial contact from 16 individuals who were interested in participating in the study, two did not meet the criteria because they had medical insurance, and four did not agree to schedule dates and times for interviews. The 10 interviews that formed the data set for the study were held in a private conference room at a local library. The local library provided a safe and convenient location for the interview sessions. The interview sessions lasted between 15 and 30 minutes each. The participants were from the

Piedmont region of North Carolina; more specifically, the participants resided in Alamance and Guilford Counties. Figure 1 illustrates the region in the State of North Carolina from which the 16 volunteer participants were recruited with the use of criteria-based sampling. In criteria sampling, participants are required to meet specific requirements prior to participating in a study.

One of the requirements for participation in this study was that individuals must live in the Piedmont area of North Carolina. The 10 participants who were interviewed for this study lived in Greensboro, Mebane, Graham, and Burlington, North Carolina. Mebane, Graham, and Burlington are located in Alamance County, and Greensboro is in Guilford County.

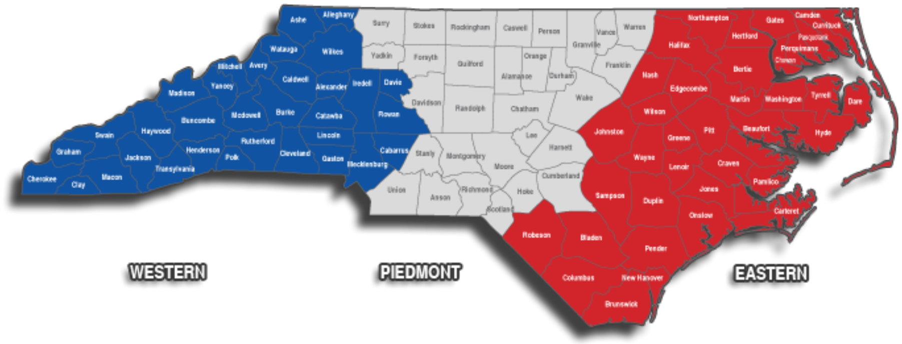

Figure 1. Map illustrating region and counties where participants resided.

Demographics

The three areas of demographic information relevant to this study were gender, age, and race. The purpose of including demographic information was to provide population characteristics (Salkind, 2010) within the study. Demographic information is important because these variables may influence perceptions and indirectly influence health-related behavior (Glanz et al., 2008). The research participants' demographic information is represented in Table 1.

Table 1

Demographics of the Participants

Participant #	Gender	Age	Race
1	Male	41	White
2	Male	31	White
3	Female	29	Black
4	Female	22	White
5	Female	47	Black
6	Male	48	Black
7	Female	35	White
8	Female	27	Black
9	Female	27	Black
10	Male	27	Black

Data Collection

The data were collected from 10 individuals who were considered to have low income and who were uninsured, through person-to-person interviews over a time span of 14 days. Each participant answered eight interview questions, which were administered by me in a library in a private-room setting. All interviews were standardized to ensure that the exact same wording and sequence of eight open-ended questions were used. Although all interviews were scheduled for 1 hour, the actual interview lengths varied from 15–30 minutes. All interviews were audiotaped, with participant consent, and transcribed by me. Additionally, a confidential field log of all scheduling details such as date, time, and location of interviews was kept along with my observations.

Data Analysis

After the data were collected from the interviews, an Excel spreadsheet was created with the interview questions and responses to provide a clearer view of the data. After manually coding from the Excel spreadsheet, subcategories and common themes were then generated from the data set. NVivo 11 Pro software was used for the comparison of manual themes and subcategories and to confirm data saturation through word search analysis.

The data were analyzed deductively by generating general codes and then moving to broader representations of categories and themes. Themes were synthesized within the constructs of the HBM illustrated in Table 2, which aligned the research questions to the theoretical framework of the HBM, illustrated in Figure 2. The framework of this study was designed to investigate and explore the uninsured low-income participants' beliefs, perceptions, and levels of knowledge concerning primary care. The results were organized according to the constructs aligned with the HBM and coded by the eight categories within the interview questions. Common themes and patterns that emerged during the interview process were formulated and reported in this study.

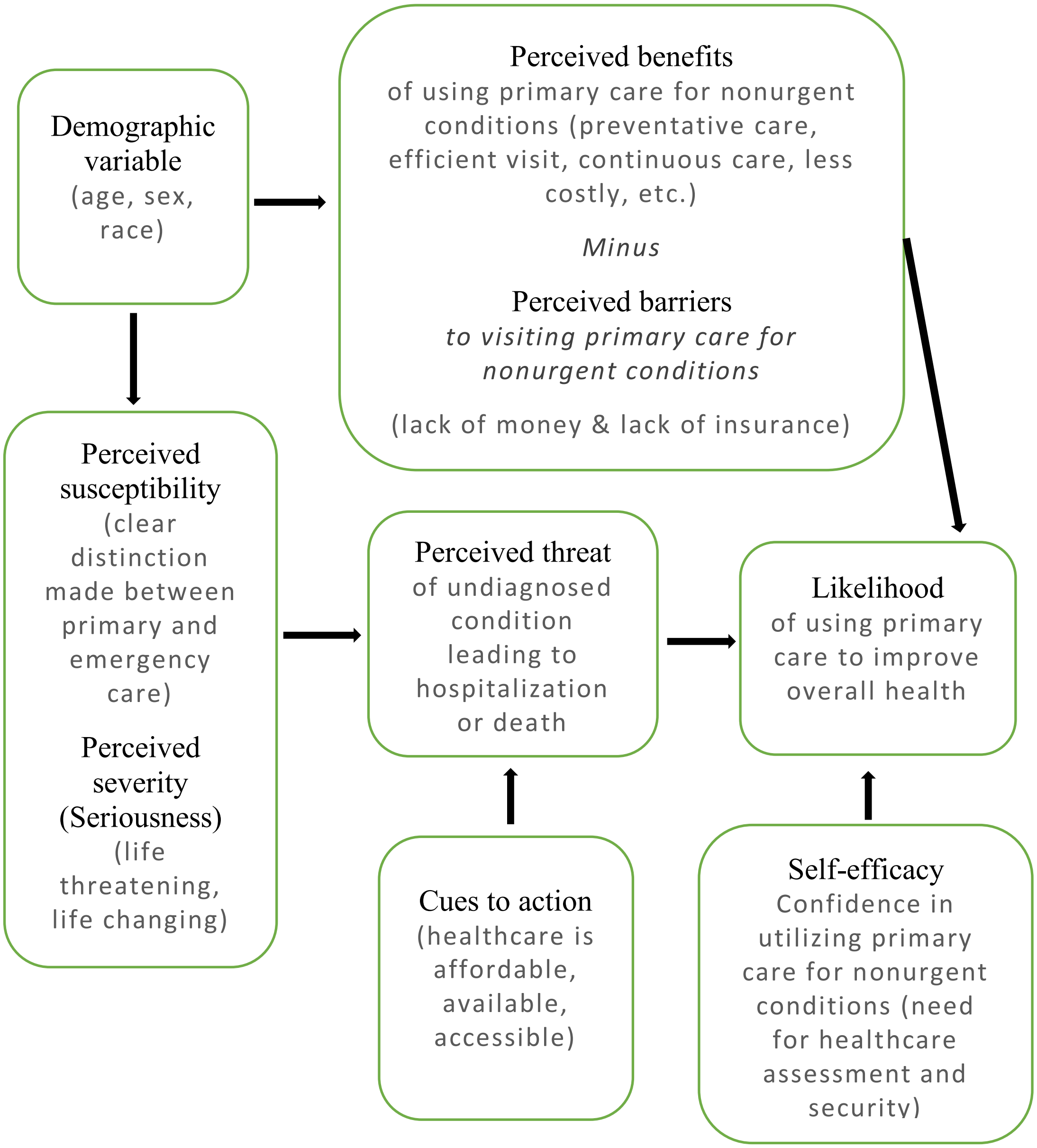

Figure 2. Health belief model theoretical framework applied to low-income uninsured population's beliefs, perceptions, and level of knowledge about primary care services.

Table 2

Themes From Interviews About Primary Care Beliefs and Perceptions

HBM construct	Major data themes	Select quotes
Perceived susceptibility	Clear distinction made between primary and emergency care	(P8) “Primary care is better than the emergency room because you don’t have to wait long.” (P9)"I think they are capable because they went to school for it and it's not overnight learning. It takes years and practice.”
Perceived severity (seriousness)	Life-threatening Life-changing	(P9) “You could die from not having primary care.” (P1) “There is a possibility of bad things happening if you don’t get annual visits.”
Perceived benefits	Provide continuous care Provide preventative care Less costly Provide efficiency Provide familiarity Build positive rapport Build trust	(P1) "Primary care is more beneficial for people with health issues. I am referring to diabetes and asthma patients.” (P8)“You are suppose to get seen once a year by a primary care doctor” (P6) “Well primary care is going to cost you for a visit but not as much as emergency room.” (P9) “With primary care, you get seen faster and you have a regular doctor or physician. (P6) “Well, with the primary doctor, he knows you, know you by name and stuff and he got your history compared to the emergency room doctor.” (P8) "They (primary care physicians) will talk to you and they’ll tell you about themselves" (P2) "You build a trust or friendship with that person (primary care physician) by seeing them all the time. "
Perceived barriers	No insurance/no money	(P7) “I think not having insurance and money, that’s the biggest issue.” (P10) “Afraid of what the doctor will say.” (P9) “Now, if I really have to go, I’m probably going to be there all day and I’m going to need somebody to cover my shift.”
Cues to action	Affordability Accessibility Availability	(P10) “Very likely use if it is affordable, why not! I need to go to the doctor myself now but it is too costly.” (P3) “I’m the type of person that if it is easy for me to have access to primary care, I would benefit from it more because I will use it more.” (P7) “If I had it, I would use it. I would definitely use it.”

Note. Adapted from "Using the Health Belief Model to Develop Culturally Appropriate Weight-Management Materials for African-American Women," by D. James, J. Pobee, L. Brown, and G. Joshi, 2012, *Journal of the Academy of Nutrition and Dietetics*, *112*, p. 667. Copyright 2010 by the American Psychological Association.

Results

Health Belief Model Constructs

Typically, people make life decisions based on the impact that they expect these decisions to have on them and their families. The HBM is used to determine the relationship between health beliefs and health behaviors (Glanz et al., 2008); for this reason, the HBM constructs of perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and cues to action were measured in this study. Perceived susceptibility refers to individuals' beliefs about the chance of experiencing a risk or developing a condition (Hayden, 2014). Perceived severity relates to individuals' beliefs about the seriousness of a condition (Hayden, 2014). Perceived benefits involve individuals' beliefs concerning the effectiveness of an action to solve a problem (Hayden, 2014). Perceived barriers refer to individuals' perceptions of the difficulties they will encounter in taking a proposed action (Hayden, 2014). Cues to action are prompts or strategies that are needed to move individuals into the state in which they are ready to take action (Hayden, 2014). Self-efficacy is the confidence that individuals have in their ability to take the given action (Hayden, 2014).

The five HBM constructs were evaluated using the eight interview questions. This section consists of the results of the interviews using the structures of the HBM model and the themes that emerged through the guided interview questions. The themes identified are closely blended within the findings, which provide greater detail and accuracy.

Perceived susceptibility. Perceived susceptibility refers to the perception of an individual regarding the likelihood of visiting a primary care facility for nonurgent conditions (Hayden, 2014).

Interview Question 1: What do you know about primary care? This question was asked with the intention of gaining information about the participants' general knowledge concerning primary care services because the participants' knowledge about primary care was directly linked to their susceptible behavior in using the service. The participants' responses to the question showed a clear distinction between primary and emergency care. Understanding how members of the low-income uninsured population differentiate primary care from emergency care is important because it affects their perception of primary care services and their perceived likelihood of utilizing primary care services for nonurgent conditions.

The participants were clear in expressing the differences between primary and emergency care services. Participant 1 (P1) stated, "Usually, you know if you are going to a primary care physician, or whatever, instead of an emergency room, it is usually for the sniffles or a cough or something like that. In emergency situations, definitely go to the emergency room." Participant 6 (P6) shared, "I know when you go to the emergency room they just check you out and then they tell you to go to a certain doctor or primary care. It is better to go to the doctor, primary care doctor, and you can just do everything there, it's not an emergency." Participant 10 (P10) stated, "They pretty much know your symptoms and they may know more than you going to the emergency room and just seeing any doctor." Participant 7 (P7) expressed, "You can go to them (primary care physician) for pretty much everything unless you have to go to the emergency room and most of the time that is in an accident or something like that." Participant 8 (P8) declared, "Primary care is better than the emergency room because you don't have to wait long." Participant 9 (P9) disclosed, "Basically primary care is better than emergency (care) but some people cannot afford it because of the job they work. They (primary care physicians) are your main doctor so I think it's better to choose primary care than the emergency room." The participants perceived that the purpose of the emergency room is emergency care and that primary care facilities are used for routine or regular and preventative care.

Interview Question 2: Do you think it is important to receive primary care for treatment of nonurgent conditions? Why or why not? The aim of this question was to show the participants' perceptions concerning the importance of receiving treatment for nonurgent conditions at a primary care facility. The question addressed whether their view of the importance of treatment of nonurgent conditions would make them more or less susceptible to visiting primary care facilities. Participants 1 and 4 were subjective in their responses and expressed the belief that nonurgent conditions were better treated with home remedies than by visiting a primary care facility. Participant 1 (P1) stated, "So, I really don't see a whole lot of importance," and Participant 4 (P4) said, "I mean it depends … like, it's like a sprained ankle or something then yes but if it's like a cut or something well no. If you can handle it at home then no but if you can't then, yes. All other participants were adamant in stating the importance of primary care for nonurgent conditions. Participants 2, 3, 5, 9, and 10 stated the belief that primary care treatment of nonurgent conditions is important because the patient and the physician can become familiar and comfortable with each other. Participant 2 (P2) claimed, “Yeah … I think it would be because it would be somebody that you know, somebody that you are familiar with, somebody that you are familiar with instead of seeing somebody different all the time.” Participant 3 (P3) proclaimed, “I think it is (important). I’ve always been told that you should have a regular doctor on a regular basis. Someone that you and your body is familiar with.” Participant 5 (P5) asserted, “Well, emergency people, they’re not as familiar with you. I mean because you’re going to your primary care doctor more on a regular basis.” Participant 9 (P9) stated, “I think it’s important because some people don’t like everybody else knowing their business through the emergency room. They can feel safe with that one primary care doctor.” Particular 10 (P10) shared, “Yea, I mean, if it is like a follow-up appointment of course. You will want to go to a doctor that you already know because they know your background … they know a little more about you.” The participants perceived that it is important to be treated for nonurgent conditions at a primary care facility, with the exception of two, who believed that home remedies should be tried first. They believed that nonurgent conditions would be better treated at home through home remedies and that one should only use primary care if absolutely necessary. Most participants expressed that primary care is important because the patient and physician can gain a sense of familiarity and comfort with one another.

Interview Question 6: Tell me your beliefs about primary care physicians regarding their ability to treat nonurgent conditions. My intention in asking this question was to show whether the participants’ perceptions concerning the capability of primary care physicians would make them more or less susceptible to visiting primary care physicians for nonurgent conditions. All the participants found primary care physicians capable of treating nonurgent conditions. I have included comments of six participants. Participant 3 (P3) specified, "I think their ability is there because I feel that they have more time to research if something is going on with you before it gets worse. So, I do believe they have the ability to handle nonurgent nonemergency conditions." Participant 4 (P4) shared, "They went to school and learned about how to handle every condition of sickness." Participant 7 (P7) stated, "Oh yeah, a sinus infection, you know, or you've got salmonella … they are better to identify it [illness]". Participant 8 (P8) proclaimed, "Yeah, they (physicians) all basically have the same schooling but in a different way." Participant 9 (P9) divulged, "I think they are capable because they went to school for it and it's not overnight learning. It takes years and practice." Participant (P10) asserted, "Yeah, they are probably more capable than emergency doctors because they don't have as many patients coming and they are not really rushing or trying to get to this patient and that patient. Their main focus was you. They all went to school." The participants acknowledged that primary care physicians were fully capable of treating nonurgent conditions because they attended school in order to become a physician.

Perceived severity. Perceived severity is the individual's beliefs regarding the seriousness of the impact of contracting the condition (Hayden, 2014).

Interview Question 5: What do you believe are the consequences for not seeking primary care treatment for nonurgent conditions? The questions intended to obtain the participants' individual perceptions and beliefs of the seriousness of their personal risk if they choose not to visit primary care for nonurgent conditions. Most participants perceived that it was risky for them not to utilize primary care for nonurgent conditions resulting in possible undiagnosed illnesses. They also believed that these undiagnosed illnesses could result in negative outcomes that could put them at risk for life changing or life-threatening health issues. It is important to understand how the low-income uninsured population view the consequences for not utilizing primary care services for nonurgent conditions. This is pertinent because participants who perceive the threat of an undiagnosed illness to be serious might be more inclined to seek primary care treatment for nonurgent conditions.

I included comments from eight participants concerning how an undiagnosed illness can lead to poor health which is life-changing. Participant 1 (P1) communicated, “There is a possibility of bad things happening if they don’t get annual visits.” Participant 3 (P3) expressed, “I think you’re beneficial if you have a primary care doctor, so you know what is going on a head of time and you catch it before something bad happens. Something as simple as a common cold could turn into something worse.” Participant 4 (P4) shared, “If it’s like something serious and the person don’t go to the doctor, then it could turn out to be worse.” Participant 5 (P5) stated, “If you never just go see about yourself then anything was going on inside your body and you just don’t know about it. It’s better to get an early detection of it instead of just letting it go.” Participant 6 (P6), declared, “Even if it’s not an emergency, it can get real bad…depends on what it is, it could get real bad. Participant 8 (P8) affirmed, “Although some people got nonurgent conditions, something could be really wrong with them, but they don’t know it. Something could be seriously wrong, and they don't know what's going on until they go to the doctor and a doctor tell them, explain to them what's wrong so they'll know what's going on with them." Participant 9 (P9) agreed, "I think something really could be going on in the body and then one day, you wake up and it's too far gone and it's too late." Participant 10 (P10) confirmed, "It could get worse, whatever is wrong with you could get worse."

Two participants perceived undiagnosed illness as life-threatening leading to hospitalization or death. Participant 8 (P8) expressed, "People could die, be put in the hospital, or anything could happen if a person don't have primary care." Likewise, Participant 9 (P9) stated, "You could die from not having primary care." Most participants shared their belief that failing to visit primary care for nonurgent conditions could lead to undiagnosed illnesses which could be life-changing such as hospitalization or life-threatening such as death.

Perceived benefits. Perceived benefits are the individual's belief in the effectiveness of the advised action in resolving the problem or the condition (Hayden, 2014).

Interview Question 3: Do you think it is beneficial for you to receive primary care for treatment of nonurgent conditions? Why or why not? Interview Question 4: What do you perceive are the benefits for patients to visit primary care for nonurgent conditions? The questions intended to obtain the motivations of the participants based on their perceptions of the positive outcome of visiting primary care when they have a health issue or condition that is nonurgent. All participants perceived that there are benefits to receiving primary care services for nonurgent conditions. These benefits were strong motivators to change from frequenting an ED to using primary care services for nonurgent condition.

The participants expressed multiple benefits to visiting primary care for nonurgent conditions. Some participants noted that continuous care is a benefit to receiving primary care services. Participant 1 (P1) shared, "It is beneficial for blood test to make sure that everything is ok…like annual visits. Primary care is more beneficial for people with health issues. I am referring to diabetes and asthma patients." Participant 3 (P3) relays, "I think that it's good to keep up with it (illness) on a regular basis for like just going for check-ups and stuff like that instead of just going when there is an emergency. People with blood pressure problems and stuff like that, I think that it's good to keep up with it on a regular basis." Participant 9 (P9) shares, "If you have certain conditions, it is best to go to a main person and not switch to the next one because that primary care physician may not know much about your background than the other one that you go to regularly."

Another benefit to receiving primary care services for nonurgent conditions is that it is cheaper than visiting the ED. Participant 6 (P6) expressed, "Well primary care is going to cost you for a visit but not as much as emergency room." Participant 7 (P7) asserts, "If I get sick, if I need to go for a physical, I just went there (primary care) which was very convenient and a lot less expensive." Participant 9 (P9) declares, "You really set yourself for failure if you don't have one (primary care physician) but sometimes people can't afford it. So, they have to do what they have to do."

Efficiency is a benefit to receiving primary care services for nonurgent conditions. Participant 1 (P1) shared, "I think the process is quicker and easier knowing that let's say if you already been there (primary care) before they already know what's going on with you." Participant 3 (P3) proclaimed, "I think the process is quicker and easier because you already been there before, and they already know what's going on with you." Participant 6 (P6) declared, "It's (primary care) quicker and then you got that one rate that you have to pay." Participant 9 (P9) communicated, "With primary care, you get seen faster and you have a regular doctor or physician. You can get in and out. With emergency room you go in and it's going to take you about an hour or two or three. It is convenience if you can go ahead and get in and get out. If you went to another person, that is a doctor, you never seen there is no telling how long you were in there. I mean different doctor's offices work differently ways. So, I think it's best to stick to the one person (doctor). You can get in and out because you are a regular patient."

The development of trust is another benefit established by Participant's 2 and 9. Participant 2 (P2) proclaimed, "The primary care physician is someone that you can develop a relationship overtime to know well enough to trust that person. You build a trust or friendship with that person by seeing them all the time. They are the only one that takes care of you and stuff like that." Likewise, Participant 9 (P9) shared, "You can feel safe with one primary care doctor instead of going to the emergency room and not know what they (emergency staff) are about and how they work. Some people are particular, you know, and they like to go to that one particular primary care person. You can trust that doctor's office."

Preventative care is a benefit for receiving primary care for nonurgent conditions. Preventative care is described as annual visits, physicals, and check-ups. Participant 8 (P8) stated, “You are supposed to get seen once a year by a primary care doctor” and Participant 4 (P4) revealed, “If you need a check-up or whatever, you could go and they (primary care physicians) could take care of you.”

Some participants felt that a benefit to having primary care means having a physician with shared familiarity. I chose five participants to illustrate the importance of knowing their physician and their physician knowing them. Participant 2 (P2) shared, “Primary care physician would be somebody that you know, somebody that you are familiar with, you know, somebody that you are familiar instead of seeing somebody different all the time.” Participant 3 (P3) revealed, “Having a regular doctor, primary care, is basically having someone who knows your chart. They pretty much know everything about you. Someone that you and your body is familiar with, so they can understand what’s going on with you at all times.” Participant 5 (P5) expressed, “Emergency people are not as familiar with you because you are going to your primary care doctor on a more regular basis.” Participant 6 (P6) asserted, “Well, with the primary doctor, he knows you, know you by name and stuff and he got your history compared to the emergency room doctor.” Participant 10 (P10) declared, “That doctor (primary care) knows you more than any other doctor would. Someone you are already use to.”

Participants noted that when they visit a primary care facility they build a rapport or personal relationship with the physician. This is seen as a benefit because the physician is seen as someone that cares about them and their health.” Participant 2 (P2) proclaimed, “Over time, the primary care physician will get to know that patient. At the same time, that primary care physician will care for you better than dealing with a stranger that see a lot of people every day. They (emergency physicians) just going to do what they absolutely have to do. Not really caring for the patient.” Participant 10 (P10) shared, “It is a good relationship because you are use to that person (primary care physician) versus a stranger at the emergency room.” Participant 4 (P4) explained, “Like if you get sick or hurt, you can go to them and they take care of you.” Participant 8 (P8) communicated, “They (primary care physicians) will talk to you and they’ll tell you about themselves, about how long they been a primary care and stuff like that. You have to keep going constantly, constantly, constantly, to the emergency room before they start knowing you.”

The participants unanimously believe that there are benefits when they visit primary care for conditions that are nonurgent. The benefits are continuous care, preventative care, cheaper care, efficiency, trustworthiness, familiarity, and obtaining a good rapport with the physician. Notably, half of the participants perceived that the main benefit of visiting a primary care for nonurgent conditions is the physician knowing the patient, their medical history, and the patient feeling comfortable with a physician who know them.

Perceived barriers. Perceived barriers are the individuals’ perceptions of the difficulties that they will endure in taking the recommended health behavior (Hayden, 2014).

Interview Question 7: What do you perceive are barriers for you concerning visiting primary care for nonurgent conditions? The question was intended to evoke the participants' perceived obstacles in them not visiting primary care for nonurgent conditions. The description of the participants' perceived tangible or intangible barriers in visiting primary care for nonurgent conditions assists in understanding the participants' likelihood in performing the behavior.

Participants shared their perceived barriers to not receiving primary care services for nonurgent conditions. They shared where external circumstances, internal fears, and negative beliefs often prevent low-income uninsured from seeking primary care for nonurgent conditions. The external circumstance is lack of insurance and/or money. The internal fear barrier stems from the patients fear of diagnosis which prevents them from seeking primary care for a nonurgent condition. The negative beliefs expressed by the participants are scheduling conflicts where both the participant and the physician's office have issues with scheduling a time.

The external circumstances voiced by participants were a lack of means which include lack of insurance and/or lack of money was a main theme that was shared among most participants. Participant 2 (P2) indicated, "Maybe people can't afford that kind of attention (care)." Participant 3 (P3) professed, "Insurance for one and then you know…insurance and knowledge." Participant 4 (P4) proposed, "No insurance or some people are stubborn, they don't take time to go." Participant 5 (P5) shared, "Maybe because of the insurance, you know, money…more than likely." Participant 6 (P6) communicated, "Money and insurance…well, that's all I can think of." Participant 7 (P7) conveyed, “I think not having insurance and money, that’s the biggest issue.” Participant 8 (P8) declared, “May not have money to ride the bus. When you go to the doctor, they are going to ask you if you have any type of insurance. If you say no, they still might see you but they’re going to send the bill. You have to pay that before you was seen again. Sometimes they will tell you that you can’t be seen until you pay some kind of money.” Participant 9 (P9) pronounced, “You really set yourself up for failure if you don’t have one (primary care physician) but sometimes people can’t afford it. So, they have to do what they have to do.” Participant 10 (P10) confirmed, “Some people don’t have Medicaid and they have to pay money out of pocket and they don’t have the money to do so.”

Another barrier expressed was the internal fear of diagnosis that participants stated as a reason why the uninsured low-income chose not to seek primary care for a nonurgent condition. Participant 8 (P8) shared, “People could be scared…” and Participant 9 (P9) proposed, “Sometimes people are afraid to see a physician about their health, some people don’t know if something is wrong until it is too late.” Participant 10 (P10) simply stated that the reason some people don’t go to a primary care for a nonurgent illness is because they are, “Afraid of what the doctor will say.”

Participants articulated negative beliefs concerning scheduling conflicts relating to the participant’s work schedule as well as the primary care office availability. Participant 5 (P5) believes, “Sometimes doctors don’t always have spaces for people to be seen.” Whereas Participant 4 (P4) shared, “…some people are stubborn, they don’t take time to go or they can’t get off work to go” and Participant 7 (P7) likewise stated, "Now, if I really have to go, I'm probably going to be there all day and I'm going to need somebody to cover my shift."

All the participants described barriers to visiting primary care services when faced with nonurgent sicknesses. They shared that external circumstances, internal fears, and negative beliefs often plague patients which cause them to resist visiting a primary doctor in times of illnesses that are not emergencies. Surprisingly, all but one participant mentioned that the lack of money or the lack of insurance is the primary reason that they or others do not visit primary care for nonurgent conditions.

Cues to action and self-efficacy. Cues to action are factors that could trigger a prescribed health behavior and self-efficacy is the confidence or belief of an in their own ability to execute the behavior successfully (Hayden, 2014).

Interview Question 8: If primary care is beneficial, affordable, and available, what is the likelihood that you would use primary care for nonurgent conditions? Why or why not? The question was asked to evaluate whether the participant would visit primary care for nonurgent conditions if primary care was beneficial, affordable, and available. Likewise, this question was asked to obtain a description of the participants' belief of their own ability to utilize primary care for nonurgent conditions.

Cues to action are determined by the prompts that are needed to move the participants to utilize primary care services for nonurgent illnesses. The low-income uninsured are motivated to utilize primary care services for nonurgent illnesses when it is affordable, available, and accessible. Participants maintained that affordability is key to prompting them to use primary care for nonurgent conditions. Participant 1 (P1) conveyed, “I think affordability is the biggest part. If I could afford it, I probably would use it.” Participant 3 (P3) proclaimed, “Now affordability, that’s definitely a key to that because, I mean, if it’s not affordable, somebody’s not going to make that a priority” and Participant 10 (P10) divulged, “Very likely use if it is affordable, why not! I need to go to the doctor myself now, but it is too costly.” Accessibility and availability were also identified as prompts to move participants to action. Some participants found accessibility as an important aspect of whether they would use primary care services. Participant 3 (P3) declared, “I’m the type of person that if it is easy for me to have access to primary care, I would benefit from it more because I will use it more.” As for availability, Participant 7 expressed, (P7) “If I had it, I would use it. I would definitely use it.”

Participants displayed high levels of self-efficacy concerning their ability to utilize primary care services for nonurgent conditions. The need for healthcare assessments such as annual visits, physicals and check-ups appear to increase participants level of self-efficacy. Participant 1 (P1) detailed, “I would use mostly for annual visits and annual check-ups.” Participant 3 (P3) expressed, “I do need to have a primary care doctor.” Participant 5 (P5) professed, “It’s always beneficial to get a check-up just to see how everything is.” Participant 6 (P6) affirmed, “When I get sick or when I get a cough…I am going to them (primary care) because I need it. I need it as much as I get sick, you know.” Participant 7 (P7) declared, “I was able to go get a physical every year like I am suppose to because I can afford it. If I got sick, I could go because I could afford it.” Participant 8 (P8) simply stated, “I am a female. I need to be seen by a doctor." Participant 10 (P10) shared, "You need to know what is going on with your body at all times. At least once a year, go get a check-up or something like that so you will know."

Also, an increase level of self-efficacy appears to be established when the participants felt security in the ability to receive health care. This is confirmed by the participants following accounts. Participant 2 (P2) stated, "If I can have all that (affordability, accessibility, and availability), and nothing to stop me, then I will go." Participant 3 (P3) indicated, "I have this, so why not use it." Participant 4 (P4) disclosed, "If you need the help, then you know you can get it with the doctor." Participant 6 (P6) showed, "I would use it every day." Participant 7 (P7) declared, "Oh, I would definitely use it anytime I needed it. The way things are right now, money is tight, and I don't have insurance. My kids have Medicaid, but I don't qualify which I don't understand but when I get sick, I have to wait until I am really, really, really sick. Whereas, if I had it, I would use it. I would definitely use it." Participant 9 (P9) conveyed, "Whatever is due when I go, I could pay it. So, with a regular doctor, I won't have to worry about nothing. I know I have a good doctor and a good doctor's office."

All the participants stated that if primary care services were beneficial, affordable, and accessible, they would utilize this service for nonurgent illnesses. As for the participants belief of their own ability to utilize primary care for nonurgent illnesses, the participants believed that they would utilize the services because of their need for office visits such as annual visits, physicals, and check-ups. The participants also showed confidence in their ability based off their sense of security with having health care accessible to them.

Evidence of Trustworthiness

Trustworthiness was established within this study by maintaining credibility, transferability, dependability, and confirmability, as defined in Chapter 3. To assure the study's credibility I used systematic analysis to work back and forth between the themes and the data to add validity to the study. Additionally, I allowed the themes, found in the data, to be documented as evidence which brought validity to the findings. I used thick descriptions to explain the phenomenon and I described the participant's demographic data to allow transferability of the study. Dependability was accomplished by the clearly stated research questions, alignment of the study design, constant comparison and refining of the themes in data analysis phase, and accurately interpreting the results. Finally, I demonstrated the confirmability of the study by providing a detailed description of the methods and procedures, sequencing of the data collection and analysis process, reflective journaling, bracketing, and obtaining approval and reanalysis of the study through Walden University's Institutional Review Board.

Summary of Responses

Responses to interview questions revealed that the lack of treatment for nonurgent conditions could lead to undiagnosed illnesses. These illnesses could subsequently lead to hospitalization or death. There were many factors that prevented participants from utilizing primary care facilities for nonurgent illnesses. There was an awareness of the importance of seeking a primary care services for nonurgent illnesses. It was agreed among participants that primary care physicians are educated and highly skilled in the profession. Participants unanimously agreed that if primary care is available, affordable, and beneficial, they would utilize primary care services for nonurgent conditions; however, some participants noted that they would only use the services if absolutely warranted. The primary reasons for usage of primary care services were the need for health care evaluations (assessment) and the peace of mind (security).

For the first research question regarding the low-income uninsured beliefs, perceptions, and level of knowledge pertaining to primary care services, the results indicated that the participants believed that it is important and beneficial to receive primary care for nonurgent conditions. They also believe that primary care physicians are more than capable of treating nonurgent conditions because of the skills and knowledge they obtained while pursuing their degree in medical school. Additionally, the participants perceived that there could be dire consequences, such as hospitalization or death, when treatment of nonurgent illnesses are delayed when they choose not to see a primary care physician for this illness. Likewise, the participants noted the lack of money and insurance as perceived barriers that would prevent them from visiting a primary care for treatment in non-emergent situations. Lastly, the participants knew that primary care services provide regular, routine physician care that is utilized for nonurgent illnesses which is the opposite of an emergency physician who specializes in emergency situations.

For the second research question regarding how patient education about primary care's availability, affordability, and benefits can lead to improved access to primary care for the low income uninsured patients, participants showed that enhanced education would improve access to primary care. All the participants stated that they would utilize primary care if it was available, affordable, and beneficial. The participants expressed a state of tranquility regarding the ability to have a primary care physician to use whenever needed for various health care maintenance and concerns.

Chapter 5 consists of the interpretation of the findings, limitations of the study, recommendations, future implications, and the conclusion.

Chapter 5: Discussion, Recommendations, and Conclusion

Introduction

Purpose of the Study

The purpose of the study was to examine the perceptions, beliefs, and level of knowledge about primary care services of low-income uninsured Americans. Low-income uninsured Americans are frequent users of emergency services for nonurgent illnesses as opposed to using primary care services for these conditions (Flores-Mateo et al., 2012). Literature provides multiple reasons as to why low-income uninsured patients choose emergency over primary care for nonurgent illnesses; however, research focusing on low-income uninsured patients' perspectives, beliefs, and level of knowledge about this matter appears to be missing from literature. Examining low-income uninsured Americans' perspectives, beliefs, and levels of knowledge concerning primary care services could lead to understanding the decision-making process of these individuals. A better understanding of this decision-making process could facilitate the development of improved patient education and navigation efforts, reduce overall ED visits, and increase primary care visits.

This study was based on the following research questions:

1. What are the perceptions, beliefs, and level of knowledge for low-income uninsured patients concerning primary care services?
2. How can patient education about primary care availability, affordability, and benefits lead to improved access to primary care for low-income uninsured patients?

A qualitative, phenomenological approach was used to address the research questions because it allowed for the capturing of low-income uninsured patients' lived experiences concerning primary care, thereby providing detailed and descriptive insight into the lives of the participants. This research revealed that the participants had a good understanding of the differences between primary and emergency care services. Participants also recognized that it is beneficial to have a primary care doctor treat their nonurgent conditions. The participants perceived that their overall health could be at risk if they did not have access to a primary care facility. In addition, the participants acknowledged that they would use primary care if there were no barriers because of its accessibility and their need for health care security.

In this chapter, I discuss my interpretations of the findings based on the research questions, which were guided by the theoretical framework, HBM. This discussion is followed by a description of the limitations of the study, recommendations for further research, social change implications, and conclusions.

Interpretation of the Findings

There is limited research on the decision-making process of low-income uninsured patients when choosing ED services over primary care for nonurgent conditions. The findings of this study extend the current body of knowledge concerning factors in low-income uninsured patients' decision-making processes by reporting on the perceptions, beliefs, and knowledge about primary care services expressed by 10 people from North Carolina. The findings could be used to explore better ways to navigate and educate low-income uninsured individuals about health services that are available at little to no cost, which could result in reduction in ED usage.

All of the low-income uninsured individuals interviewed in this study were knowledgeable concerning the differences between primary and ED care. They believed that it was important to have a primary care physician to attend to their nonurgent health care needs and that primary care physicians were more or just as capable as ED physicians of treating illnesses. As a matter of fact, most participants referred to bad experiences they had when visiting the emergency room and noted that primary care is better than the ED. Some expressed that ED doctor was too busy, ED wait times were too long, and ED was too expensive.

Participants contended that there are many benefits to using primary care for nonurgent needs such as annual visits, noting that primary care is less costly and involves shorter wait times. Nearly all participants stated that the best benefit of primary care is that it offers a better physician-patient relationship. The participants believed that in contrast to ED doctors, primary care physicians are familiar with patients and their medical histories. Participants believed that this physician-patient familiarity would lead to them establishing trust in the primary care physician.

Participants perceived that their health is at risk when they fail to have routine and annual primary care visits. They believed that failure to receive preventative care can result in the misdiagnosis of underlying illnesses. Furthermore, the participants believed that these illnesses, if not diagnosed and treated early, could lead to hospitalization or death.

Most participants believed that lack of money and insurance were the primary reasons that they did not use primary care. All of the participants believed that they would use primary care if it were available and affordable because it would provide security and convenience. Nearly all of the participants believed that if primary care were affordable for them, they would use it for preventative care such as routine and annual visits. Some participants also believed that accessible, affordable primary care would give them a sense of tranquility because if circumstances arose in which they needed treatment, they would have a primary care doctor treat them (health care security). *Health care security* refers to a situation in which individuals feel secure in knowing that if they get sick, they have insurance or money to pay for treatment.

Confirmed Findings

Findings in this study were consistent with other studies. For example, all of the participants stated that they would use primary care services if they were accessible to them. This view was supported by other researchers. Flores-Mateo et al. (2012) found that there was a direct link between primary care accessibility and reduction of ED visits. Likewise, Mackinney et al. (2013) showed that access to primary care reduced ED visits for uninsured individuals. Furthermore, Block et al. (2015) reported that the establishment of TAP program, which linked patients to primary care by expanding primary care access, was very successful in showing that through primary care expansion the uninsured would use primary care practices.

Most participants supported the findings of Bradley et al. (2012), who showed when the cost of primary care is no longer a factor for patients, patients experience decreased inpatient costs, ED visits, and inpatient admissions, along with increased primary care visits. This was confirmed by most of the participants in this study, who expressed that lack of insurance and money represented the key reasons that they did not use primary care services. All of the participants adamantly contended that they would use primary care services if they were affordable.

Further, most participants confirmed Flores-Mateo et al. (2012) proposal that patients with ongoing patient-physician relationships may pursue primary care physicians' opinions before seeking assistance from the ED, especially for nonurgent conditions. In this study, the participants placed a great deal of emphasis on the importance of having a primary care physician to gain social benefits, as well as physical ones. Although they believed that preventative care is an important benefit of primary care, they noted that establishing physician-patient rapport and familiarity is of equal importance. The participants perceived that they could build physician-patient relationships with primary care physicians who they could not form with ED physicians. The participants believed that through this physician-patient relationship, their physicians would come to know them and their medical history and, subsequently, they would become familiar with their physicians and began to trust them.

Unconfirmed Findings

Some researchers have found that even providing subsidized insurance to some low-income individuals did not change ED utilization for low-income adults (Lee et al., 2015). In contrast, the findings of this study suggest that lack of insurance is a barrier for the low-income uninsured pursuing primary care. Most participants believed that if primary care were affordable, they would use primary care services for nonurgent conditions.

Kangovi et al. (2013) noted that patients of low socioeconomic status (SES) perceived acute hospital care to be less expensive, to have greater accessibility, and to have better quality of care than ambulatory care (Kangovi et al., 2013). On the contrary, in this study, most participants perceived ED care to be more expensive and have poorer quality of care than primary care. My findings showed that participants perceived primary care services to be of higher quality than the ED because primary care has shorter wait times and is less expensive. Even more, some participants perceived that primary care physicians are better than ED physicians because they have access to their medical history and can treat their ailments more effectively.

Theoretical Framework

This study was conducted within the framework of the HBM as described by Glanz et al. (2008). The HBM is the most widely used theory in the areas of health education and health promotion (Glanz et al., 2002). In its design, it provides an in-depth look into an individual's beliefs, perceptions, and behaviors concerning health care (Glanz et al., 2002).

The model has four main constructs wherein perceptions, individually or in combination, can explain health behavior (Glanz et al., 2002). These perceptions are susceptibility, severity, benefits, and barriers (Glanz et al., 2002). The perceptions of an individual regarding susceptibility to an illness, the severity or seriousness of the illness, the benefits of adopting healthier behaviors, and the barriers that prevent change in behavior are the basic constructs determining whether behavioral change is possible or not (Glanz et al., 2008**;** Hak-Seon et al., 2012). An individual's perceptions concerning susceptibility to and seriousness of an illness are combined to form the perceived threat of that illness to the individual's way of life (Glanz et al., 2008**;** Hak-Seon et al., 2012). As a result, there are three scenarios for possible behavior change. First, behavior change is possible if the perceived benefits of an individual using preventative actions to avoid an illness are regarded as greater than the perceived threat of the illness (Glanz et al., 2008; Hak-Seon et al., 2012). Second, behavior change is impossible if the perceived barriers to taking preventative actions to combat the illness are regarded as of greater negativity than the harm resulting from developing the illness (Glanz et al., 2008; Hak-Seon et al., 2012). Last, for an individual, the perceived benefits of adopting healthier behaviors minus the perceived barriers keeping the individuals from adopting these behaviors contribute to determining the likelihood of the individual taking preventative action (Glanz et al., 2008; Hak-Seon et al., 2012).

In addition to the four main constructs noted above, the HBM includes two more constructs: cues to action and self-efficacy (Hayden, 2014)). Cues to action are viewed as action triggers that influence behavior (Hayden, 2014)). This construct operates when an individual's readiness to change behavior (perceived susceptibility and perceived benefits) is enhanced when cues instigate action (Glanz et al., 2008). Self-efficacy, the final construct, is based on the individual's belief in his or her own ability to perform the required behavior to yield certain outcomes (Glanz et al., 2008). To clarify, if an individual believes that a new behavior is beneficial (perceived benefit) but fails to believe in his or her capability to perform that behavior (perceived barrier), the likelihood of that person trying the new behavior is very low (Hayden, 2014)).

All six HBM constructs (perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy) were used in this study to assist in the investigation of low-income uninsured individuals' perceptions, beliefs, and levels of knowledge about primary care services and to provide insight into whether behavioral change concerning primary care services is possible. The results were as follows.

The majority of participants in this study believed that they were susceptible to receiving less than optimal care in the ED. They perceived that primary care is more beneficial, efficient, and cost effective than the ED. The majority of the participants believed that failing to visit primary care for nonurgent conditions could lead to undiagnosed illnesses that could be life-changing, with consequences potentially including hospitalization or even death. An overwhelming majority of the participants believed that choosing primary care for nonurgent conditions has benefits that include continuous and preventative care, cost effectiveness, efficiency, trustworthiness, familiarity, and developing and maintaining good rapport with a physician. Of all these benefits, half of the participants perceived that the greatest benefit for them was visiting the same office and seeing the same physician for their health care concerns. The participants believed that it is important for a physician to know them and their medical history, and for them to be comfortable with the physician. All of the particpants interviewed believed that they experienced barriers to visiting a primary care facility for nonurgent conditions, and almost all believed that lack of money or health insurance was the primary reason that they did not visit primary care for these conditions. All of the participants believed that if primary care were beneficial, affordable, and accessible, which are the cues to action, they would use this service as much as possible and whenever there was a need for health care services. As for self-efficacy, all of the participants believed that if primary care were beneficial, affordable, and accessible, they would use this service for nonurgent conditions. The participants based this confidence on their need for continuous and preventative care and their longing to be health care secure.

Limitations of the Study

The participants in this study were 10 low-income uninsured people living in two counties within the Piedmont area of North Carolina. The results of this study contain the lived experiences of this group and may not be generalized to all low-income uninsured individuals. However, the findings of this study can be used for future research on health care decision making within the low-income uninsured population.

Evidence of Trustworthiness

Credibility

Throughout the study, I ensured credibility and established validity by performing systemic analysis of the data (Patton, 2015). I cross checked the consistency of the interview responses in the data analysis phase when creating codes and themes (Patton, 2015).

Transferability

I ensured transferability by providing a detailed description of the phenomenon and the participants, which should allow the research to be transferred to other contexts or settings (Lincoln & Guba, 1985).

Dependability

I ensured dependability by clearly stating the research questions, aligning the study design, and constantly comparing and refining the themes in the data analysis phase (Lincoln & Guba, 1985).

Confirmability

Confirmability was established because I used bracketing to ensure that no personal bias, motivations, or interests would be injected into the study findings (Lincoln & Guba, 1985), so that the findings would reflect the participants' own narratives, words, and experiences. Additionally, I used reflective journaling to make sure that my observations aligned with the actual findings.

Recommendations for Future Research

Additional investigation is recommended to gain further understanding of low-income uninsured individuals' knowledge, beliefs, and perceptions about primary care services using other variables such as ethnic group, age, gender, and/or educational background. Measuring different demographic information would be valuable in future research because these variables may influence perceptions and possibly indirectly influence health-related behavior (Glanz et al., 2008).

Another recommendation is the need for research regarding the low-income uninsured’ s awareness of safety net programs. This study was not designed to assess the participant’s knowledge about alternative ED services; however, that information is now relevant since the findings reveal that lack of insurance and money are the two barriers that prevent the participants from visiting primary care for nonurgent conditions. The low-income uninsured have the option to be seen at a safety net facility at little to no cost. Safety net facilities could be an alternative to ED utilization and navigate them toward primary care services.

Implications for Positive Social Change

This study was centered around the uninsured low-income patients who over utilize ED for non-emergency conditions and underutilize primary care services. I have attempted to add reasoning regarding the decision making of this population to choose the ED for nonurgent conditions instead of primary care. The findings could potentially lead to social change for the individual, their family, and health care professionals.

Since the key barriers for visiting primary care for nonurgent conditions are the lack of insurance and money, the uninsured low-income individuals and their families could use this information to learn about safety net programs within their community. These programs are government sponsored and serve this population by offering health care services at little or no cost. There was overwhelming evidence that navigated uninsured patients from ED to primary care facilities reduced ED usage (Belue et al., 2014; Flores-Mateo et al., 2012). The individual and their families can feel confident and secure in knowing that they can afford health care.

Health care professionals such as ED nurses and doctors can use these findings to better educate and navigate patients from frequently using the ED for nonurgent conditions toward primary care through safety net programs. Researchers urged that ED usage was reduced with the expansion of safety-net clinics and a focused plan to link primary care providers with high-need ED patients (Kim et al., 2015). Likewise, this research can assist community health workers in improving patient navigation by educating the patient about alternative ED options which can result in the reduction of ED utilization and an increase in primary care usage, which can improve the overall health of the low income uninsured population.

Conclusion

Exploring the lived experiences of low-income uninsured individuals regarding primary care services allowed me to gain insight into the decision making of this population in choosing the ED over primary care for nonurgent conditions. Currently in the United States, the low-income uninsured utilize ED services for nonurgent conditions more than any other group (Grover & Close, 2009; Lee, 2015). Understanding the uninsured low-income populations perceptions, beliefs, and level of knowledge concerning primary care is important in finding ways to educate and navigate them away from the ED and toward primary care services for those conditions that are not of an emergent nature.

The results of this study revealed that there were no preconceived negative misperceptions or beliefs about primary care that caused the uninsured to visit the ED for nonurgent conditions. On the contrary, the results indicated that the participants found primary care to be more favorable than the ED. They believed primary care to be better because it offers cost-effectiveness, preventative care, efficiency, and familiarity.

The findings showed that the participants overwhelmingly agreed that if they had insurance or the money to pay for services they would use primary care for nonurgent health care concerns. The results reveal that the low-income uninsured utilize the ED for non-emergent conditions because they do not have the money or the insurance to go to primary care. Despite the benefits provided through having a primary care physician, this population failed to have the financial means to pay and is forced to use the ED for their nonurgent health needs.

There are alternative ED options available to this population that may assist in providing primary care at little to no cost. The results of this study may provide awareness to the health care promoters and educators concerning ED usage by the low-income uninsured. Additionally, health care administrators may benefit from this study because the results could improve patient education and navigation, reduce ED usage, and increase primary care usage.

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Appendix A: Invitation to Participate in Study

This study will help answer the questions:
What are the perceptions, beliefs, and level of knowledge of low income uninsured patients concerning primary care services?

How can patient education about primary care availability, affordability, and benefits lead to improved access to primary care for low income uninsured patients?

You are invited to participate in this study if:

1. You are equal to or greater than 18 years old
2. You do not currently have medical insurance
3. Your income status is low income or income within \$11, 490 - \$22, 865.10 per single family home
4. You have visited the emergency room at least 3 times within the past year for nonurgent condition
5. You live in Burlington, North Carolina or sounding cities (Graham, Mebane, or Greensboro)
6. You are willing to participate in a 1 hour, face-to-face interview about your life experience
7. You are willing to provide follow-up information if needed by the researcher after the initial interview if needed. This could be via email, phone or in-person.
8. You have a willingness to participate in the study as it is designed.

The researcher for this study is Pamela Brown; Pamela is conducting this research as her doctoral dissertation through Walden University's health care services program. If you are interested in learning more about this study or becoming a study participant, please contact Pamela Brown by phone or email.

It is important that you feel no pressure to participate in this study and know that I appreciate your consideration.

Pamela Brown

Appendix B: Interview Questions

What do you know about primary care? (RQ.1)

Do you think it is important to receive primary care for treatment of nonurgent conditions? Why or why not? (RQ.1)

Do you think it is beneficial for you to receive primary care for treatment of nonurgent conditions? Why or why not? (RQ.1)

What do you perceive are the benefits for patients to visit primary care for nonurgent health conditions? (RQ.1)

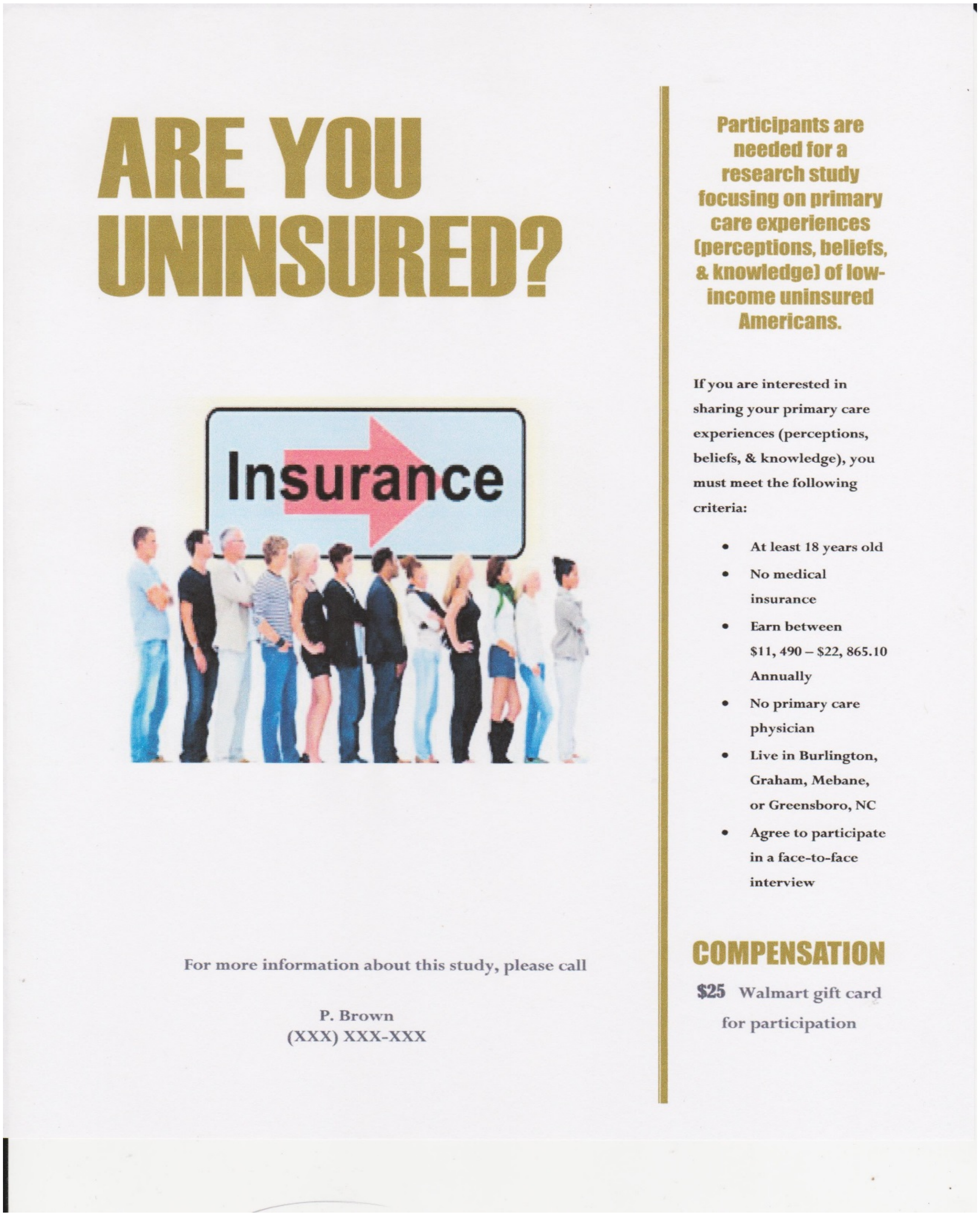
What do you believe are the consequences for not seeking primary care treatment for nonurgent conditions? (RQ.1)

Tell me your beliefs about primary care physicians regarding their ability to treat nonurgent conditions? (RQ.1)

What do you perceive are barriers for you concerning visiting primary care for nonurgent conditions? (RQ.1)

If primary care is beneficial, affordable, and available, what is the likelihood that you would use primary care for nonurgent conditions? Why or Why not? (RQ.2)

Appendix C: Flyer



ARE YOU UNINSURED?

Participants are needed for a research study focusing on primary care experiences (perceptions, beliefs, & knowledge) of low-income uninsured Americans.

If you are interested in sharing your primary care experiences (perceptions, beliefs, & knowledge), you must meet the following criteria:

- At least 18 years old
- No medical insurance
- Earn between $11, 490 – $22, 865.10 Annually
- No primary care physician
- Live in Burlington, Graham, Mebane, or Greensboro, NC
- Agree to participate in a face-to-face interview

COMPENSATION

$25 Walmart gift card for participation

For more information about this study, please call

P. Brown
(XXX) XXX-XXX