University of Tennessee, Knoxville

TRACE: Tennessee Research and Creative Exchange

Doctoral Dissertations   Graduate School

8-2020

A Phenomenological Study of Uninsured Individuals' Healthcare Experiences at Nurse-Managed Clinics in Mississippi

The title on the page actually reads "A Phenomenological Study of Uninsured Individuals' Primary Healthcare Experiences at Nurse-Managed Clinics in Mississippi"

A Phenomenological Study of Uninsured Individuals' Primary Healthcare Experiences at Nurse-Managed Clinics in Mississippi

Linda Hale Banks
University of Tennessee, lbanks5@vols.utk.edu

Follow this and additional works at: https://trace.tennessee.edu/utk_graddiss

Recommended Citation

To the Graduate Council:

I am submitting herewith a dissertation written by Linda Hale Banks entitled "A Phenomenological Study of Uninsured Individuals' Primary Healthcare Experiences at Nurse-Managed Clinics in Mississippi." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

<div align="right">Sandra P. Thomas, Major Professor</div>

We have read this dissertation and recommend its acceptance:

Mary Gunther, Nan Gaylord, John Smith

<div align="right">Accepted for the Council:</div>

<div align="right">Dixie L. Thompson</div>

<div align="right">Vice Provost and Dean of the Graduate School</div>

(Original signatures are on file with official student records.)

A Phenomenological Study of Uninsured Individuals' Primary Healthcare Experiences at

Nurse-Managed Clinics in Mississippi

A Dissertation Presented for the

Doctor of Philosophy

Degree

The University of Tennessee, Knoxville

Linda Hale Banks

August 2020

DEDICATION

This dissertation is dedicated to my sister, Theresa, a registered nurse who spent her professional life healing and helping the veterans of Mississippi through her caring actions toward service to others. To my husband and two daughters, Lamar, Sarah, and Brooke, thank you for your endless love and patience during this long journey, which provided much strength for me to continue to the end. Lamar, once again, your steady support was unwavering throughout this educational endeavor. Sarah and Brooke, thank you for insisting that I slow down and enjoy life along the way with you. I am so proud of the difference that each of you are making in the lives of others, as nurses. Also, a special acknowledgement to my parents, Milton and Mary Hale, who first taught me the love of reading, and always encouraged me to work hard and never give up.

I love each of you more than you know.

ACKNOWLEDGEMENTS

Abstract

The purpose of this phenomenological research study is to describe the lived experience of uninsured individuals accessing and receiving healthcare at nurse-led primary care clinics. This study is grounded in the existential phenomenological philosophy of Merleau-Ponty and guided by research procedures developed by Thomas and Pollio (2002). The study answers the question: What is the meaning of the patient's perception of their lived healthcare experience as an uninsured individual? The research design methodology included a purposeful, convenience sample to recruit participants. Nine participants comprising five women and four men, ranging in age from 34 to 65, were interviewed to elicit perceptions of their primary care clinic experiences as uninsured patients, living in profound poverty in Mississippi. This study allowed patients to describe figural aspects of their experiences of accessing and receiving healthcare in nurse-managed clinics. Data analysis included reading and exploring each transcript for meaning units, patterns, and global themes in developing a thematic structure. Four figural themes emerged: (1) *A Safe Place,* (2) *"They Make You Feel Like You are a Loved Human Being," (3) "They Just Ain't in a Rush" versus "In and Out," and (4) My Whole Body is Being Considered.* Study rigor was maintained through bracketing, data saturation, peer debriefing, review of the thematic structure by the Transdisciplinary Phenomenology Research Group, and the use of direct quotes to support findings. This study contributes to a deeper understanding and awareness of patients' healthcare experiences, and may help to improve services for this economically disadvantaged population. Such research findings could help support and provide new information regarding best practices for population health outcomes among targeted populations. Findings also add to the evidence-base of nursing literature with implications for education, practice, and policy in nursing.

Table of Contents

Chapter 1: Introduction

Several key factors—the increasing demand for primary care, the growing shortage of primary care providers, and the difficulty uninsured or underinsured individuals, living in poverty, have accessing primary care— strongly impact patients' healthcare experiences and can result in unwanted social and economic consequences. Nurse-managed health centers (NMHCs) can help alleviate primary care shortages (Auerbach et al., 2013). In 2010, the Patient Protection Affordable Care Act (ACA) defined a NMHC as a managed practice agreement among a group of advanced practice nurses that "provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health or social services agency" (42 U.S.C., 330A-1) (ACA, 2010). With a history of longevity rooted in service to the community, NMHCs deliver primary care to improve health outcomes among targeted, vulnerable populations (Randall, Crawford, Currie, River, & Betihavas, 2017). Despite their obvious value, little is known and understood about the healthcare experiences of uninsured patients, living in poverty, and who are served at these centers. In this chapter, I will provide brief background information regarding the value and role of NMHCs in serving vulnerable populations, to undergird the rationale and significance for the proposed study. Relevant literature will be synthesized in Chapter 2, followed by explanation of the proposed study methodology in Chapter 3.

Background

Access to primary care is important due to the primary care system's ability to help improve population health outcomes, enhance the patient experience, and reduce healthcare costs

(Bodenheimer and Sinsky, 2014). Given the current growth in the aging population and the number of people living with chronic conditions, the demand for primary healthcare services likely will continue to increase (Martsolf et al., 2016). In addition, the ACA expanded the U. S. government's role as a healthcare payer in 2010 (ACA, 2010) and extended Medicare and Medicaid (CMS, 2016) coverage, estimating the number of Americans seeking primary healthcare by an additional 32 million (Ely, 2015).

Compounding the mounting demand for primary care is the growing shortage of primary care physicians, which is expected to reach an estimated shortfall of between 14,800 and 49,300 providers by 2030 (Association of American Medical Colleges [AAMC], 2018). This shortage jeopardizes healthcare access for millions of underserved individuals. Lack of health insurance also limits individuals' access to primary care. During 2010, as many as 50 million Americans had no health insurance, and an estimated 26,100 people between the ages of 26 and 64 died prematurely due to lack of healthcare coverage (CMS, 2016).

Expanding coverage to previously uninsured individuals, the ACA increased coverage for nearly 20 million people in 2015 through Medicaid expansion and health market exchanges via Health Insurance Marketplaces (Kaiser Family Foundation, 2018b). As a result, by 2016, the number of uninsured people (under 65 years of age) fell below 27 million, a decrease from 44 million in 2013 (Kaiser Family Foundation, 2018a). However, amidst ACA alterations under the current administration, in 2017 the uninsured, under-65 population began to rise again (Berchick, Hood, & Barnett, 2018). In 2017, 28.5 million Americans had no insurance (Berchick et al., 2018). Regionally, the South (site of the present study) and West report higher uninsured rates than the North and East (Commonwealth Fund, 2018).

When seeking medical care, the uninsured have limited options – each with a financial cost. These options include paying physicians' out of pocket rates, seeking care from safety-net providers, or obtaining treatment at hospital emergency departments (ED), for which no direct payment is required (a result of the Emergency Medical Treatment and Labor Act of 1986; Shi & Singh, 2017). Compared to those with insurance, uninsured individuals are less likely to access care and receive preventive care or treatment for chronic conditions (Kaiser Family Foundation, 2018a; 2018b).

Healthcare access refers to "the ability of a person to obtain healthcare services when needed" (Shi & Singh, 2017, p.11). Generally, healthcare access is restricted to individuals who can afford to buy insurance from their private funds, are able to pay for services privately, have employee-provided health insurance coverage, are covered under a government-sponsored program, or obtain services through a safety-net provider (Shi & Singh, 2017). Struggling with adversities, individuals who are uninsured, underinsured or living in poverty represent a vulnerable population that find it difficult to access primary healthcare, placing them at risk for poor health outcomes and disparities (IOM, 2009; 2015; Kaiser Family Foundation, 2018a).

Inability to access primary healthcare is a profound health disadvantage, and the cost of inaction has serious social and economic consequences. Low-income and poor individuals are more likely to delay care due to lack of access, and go without preventive care or services for major health conditions or chronic diseases. Individuals who do not receive essential care are more likely to experience delayed detection of certain diseases and health decline, resulting in adverse outcomes. Postponing care also can result in serious illnesses requiring expensive, advanced treatment that leads to financial consequences and unaffordable medical bills (Kaiser Family Foundation, 2018a).

Nurse-provided care is high quality care that could help address the primary care shortage, especially among underserved individuals. Delivering primary care independently and collaboratively within innovative care models, nurse practitioners (NPs) are often the first point of contact for patients accessing the primary healthcare system (NNCC, 2017). NPs coordinate healthcare needs, provide cost-effective, high quality, convenient, and accessible care (IOM, 2010). Bodenheimer and Bauer (2016) reported that, in the future, NPs are expected to provide primary care to 150 million adults with one or more chronic conditions. In addition, nurse-led clinics serve primarily low-income, uninsured, and underserved populations, focusing on primary care, health promotion, and disease prevention (Sutter-Barrett, Sutter-Dalrymple, & Dickman, 2015). Indeed, nurses play a critical role in bridging the primary care gap of entry into the healthcare system by providing optimal healthcare experiences.

The Value and Role of NMHCs in Serving Vulnerable Populations

As an ACA initiative, NMHCs were expected to help provide primary care to newly insured individuals, thereby increasing their access to quality healthcare (Hansen-Turton, Sherman, & King, 2015). Today, more than 250 NMHCs are providing primary care across the U.S. and the District of Columbia (Hansen-Turton, Bailey, Torres, & Ritter, 2010; Holt, Zabler, & Baisch, 2014). Of these, 67% are community-based and operated by nursing schools, and 33% are independent, community-based, not-for-profit organizations (National Nurse-Led Care Consortium [NNCC], 2017; Hansen-Turton et al., 2010).

In addition to playing an important role in community wellness promotion, disease prevention, and chronic condition management, NMHCs historical mission to care for underserved populations provides much needed health services at the community level (Pohl, Barkauskas, Benkert, Breer, & Bostrom, 2007). As safety-net providers, NMHCs play a major

role in providing relief to millions of Americans who lack adequate primary healthcare access by delivering comprehensive coverage-including health promotion and disease prevention services-and helping bridge the primary care gap (Ely, 2015; Mason, Jones, Roy, Sullivan, & Wood, 2015). By contributing to the healthcare delivery system in an innovative way, NMHCs open doors to the uninsured who often go without screenings or preventive care, thereby helping prevent health complications to billions of dollars annually for the health sector (Hansen-Turton et al., 2015).

Statement of the Problem and Phenomenology Rationale

Although the available literature has some valuable information about facilitators and barriers to primary healthcare access for vulnerable populations, and NMHCs' community impacts and contributions in improving healthcare access for this population, descriptions of the patients' lived experiences while seeking, accessing, and receiving care at NMHCs are lacking. As will be demonstrated in Chapter 2, researchers have primarily focused on NMHCs' community impacts, health promotion among targeted populations, and contribution in improving healthcare access (Ely, 2015; Mason et al., 2015, Richard et al., 2016). None of these studies used phenomenology as a philosophical and methodological base, and none invited poor, uninsured adults (living in poverty) to tell their stories about primary healthcare experiences. Clearly, these individuals need to be given a voice, as they have a valuable contribution to make in improving primary healthcare.

Mason and colleagues concluded that promoting health demanded a system that focused on "knowing patients' experiences" (p. 551), building relationships through engaged providers and partners, and embracing an agenda that prioritizes the health of families and communities (Mason et al., 2015). By eliciting stories about patients' healthcare experiences, nurse researchers

can gather valuable information about the patient perceptions of effective interventions for promoting health and preventing illness in the community. Gaining a deeper understanding of patients' experiences surrounding their healthcare at nurse-managed clinics is important and significant to the nursing discipline. Such research findings could help support and provide new information regarding best practices for population health outcomes among targeted populations.

Philosophical Basis

Given the scarcity of research regarding the patient's healthcare experience, a qualitative research approach will be used to understand and describe patients' lived healthcare experiences as poor, uninsured individuals seeking and receiving primary care at a nurse-managed health center. This research approach is based on Maurice Merleau-Ponty's existential phenomenological philosophy (Merleau-Ponty, 1945/1962). This philosophy blends existentialism with phenomenological methods to elicit descriptions of an individual's perceptual contact with the world, and how they experience a certain phenomenon. Existentialism, a philosophy about who we are and how we come to live and experience an authentic life, originated with Soren Kierkegaard (1813-1855) (Haas, 2008; Thomas & Pollio, 2002). Existentialists turned to the methods of phenomenology developed by Husserl to systematically investigate phenomena that might be taken for granted in everyday life, to deepen understanding of their meaning (Thomas & Pollio, 2002.)

The tenets of existential phenomenology that were later developed by Merleau-Ponty will guide this study. These key tenets include: perception, intentionality, embodiment, relationships, and time (Haas, 2008; Matthews, 2006; Merleau-Ponty, 1962; Thomas, 2005).

Key Tenets

Perception. Merleau-Ponty's phenomenology of perception is a description of pre-reflection of the world - the world which is revealed to us. The primacy of perception "provides a direct experience of the events, objects, and phenomena of the world" (Thomas & Pollio, 2002; p. 14). From Gestalt psychology, Merleau-Ponty applied the figure/ground concept - some aspects stand out as figural (form) against the background of the perceived phenomena which appear as meaningful wholes (Merleau-Ponty, 1962). The nature of human experience is structured as whole and the meaning of individual elements depend on their relation to the wholes. Therefore, all figural aspects of (perceptual) experience emerge against an existential ground, and no figure stands alone (Haas, 2008).

The figural (focal) aspects of an experience are understood against the existential (back) grounds of body, time, other people, and the world (Thomas & Pollio, 2002). Events are perceived in figure or form against a background, co-creating one another in human experiences (Haas, 2008: Thomas, 2005). The unique perspective of the individual's experience and their world is then revealed before objective knowing obscures reality. The perception is real to the individual because perception is created from a singular perspective (Merleau-Ponty, 1962). "What is perceived must always be understood in relation to the horizon (the ground) upon which it appears" (Sohn et al., p. 126).

Intentionality. Relatedness to the world, or intentionality, is the interconnectedness between humans and the lifeworld. Merleau-Ponty is concerned with the ongoing transaction between humans and specific events, objects, or phenomena in the world (Thomas, 2005; Thomas & Pollio, 2002). *Being-in-the-social-world* is "being aware of the world as shared with other human beings who are subjects like ourselves," with whom we share meanings given to

natural and cultural objects, and "whom we can therefore communicate" (Matthews, 2006, p. 118).

Merleau-Ponty (1962) describes the nature of our perceptual contact with the world. One learns about the world through perception (Haas, 2008; Merleau-Ponty, 1962). "Perception is primary to the task of describing the human experience of human life" (Thomas & Pollio, 2002, p. 14). The meaning and understanding of an experience requires describing and understanding the event from the perspective of the one experiencing the event. The environment in which the healthcare experience occurs, serves to co-create one's experience, as one cannot separate self from the world around them. Disturbances may occur between body and world – as person and world co-create - and impact a person's existence. Merleau-Ponty differentiates between body object (body of medicine), and the body subject (lived body) of personal experience (Haas, 2008; Merleau-Ponty, 1962).

Embodiment. Merleau-Ponty views the body as a "fundamental category of human existence" where the world "exists only in and through the body" (Thomas, 2000, p. 686). The focal point of living meanings, the body is active, vital, and an expression of self. The body of personal experience is the body subject (the lived body), the sensory body of personal experience in which one interacts with the world. This sensory embodiment enables perception, and the possibility of thinking, in contrast to the body object (body of medicine). Merleau-Ponty did not subscribe to the Cartesian separation of mind and body (Moran, 2000). Thus, the *being-in-the-world* body interacts with the world with intentionality (Merleau-Ponty, 1962). One cannot separate one's self from the world around them. The environment in which the healthcare experience occurs, serves to co-create one's experience (Merleau-Ponty, 1945/1962).

Relationships with others. Through a network of relationships, people intersect and engage in one another's lives. Merleau-Ponty (1962) found this connection helpful for engaging in dialogue to discover the underlying structure or essence of a phenomenon. This is in contrast to Jean-Paul Sartre, who viewed the social world and other people with regard to the potential for conflict, rather than embracing others to seek and discover the structure of human experience. Thus, for Merleau-Ponty, connections with other people are essential to obtaining knowledge of a deeper essential structure of the human experience in understanding the dimensions of a thing "without which it would not be what it is" (Van Manen, 1990, p. 10). "The phenomenological world is not pure being but the sense which is revealed where the paths of my various experiences intersect, and also where my own and other people's intersect and engage each other like gears" (Merleau-Ponty, 1962, p. xx). The world of the healthcare clinic can offer the patient an opportunity to heal in a secure and safe place. Both the healthcare provider and patient intersect, potentially benefitting from the healthcare relationship with one another.

Time. Time is a subjective experience. Historical time, through the life of a person, is revealed through experiences of human personal existence. For Merleau-Ponty, time is not kept by calendars, clocks, or watches but dependent on moments that burst forth upon the person, "revealing our intentional relatedness to what is yet to come and what has already been" (Pollio, Henley, & Thompson, 1997, p. 117). Time can be perceived as continuous, fast or slow, and always changing. This is in contrast to the objectivist view of Descartes and Locke of time in the sense of events occurring one after the other, a person's life consisting of different stages (Haas, 2008; Matthews, 2006). Time for a patient in the world of healthcare could be perceived as prolonged or fleeting.

This study seeks to understand the unique perspective of an individual's experience and their world through the philosophical ground of existential phenomenology as developed by Merleau-Ponty (1945/1962). Perception, intentionality, embodiment, relationships with others, and time are major tenets of Merleau-Ponty's philosophy and pertinent concepts to this study (Thomas, 2005; Thomas & Pollio, 2002). The perception of an individual's experience is shaped against the existential grounds (background contexts) of body, time, world, and other people; the four major grounds of human experience (Sohn, Thomas, Greenberg, & Pollio, 2017; Thomas & Pollio, 2002).

Applying Merleau-Ponty's philosophical stance to this study, I will seek to understand the unique perspective of an individual's healthcare experience and their world through the philosophical ground of existential phenomenology (Merleau-Ponty, 1962). I will use the applied phenomenological method and procedures developed at UTK, first described by Pollio, et al. (1997), and further elaborated and refined in Thomas and Pollio (2002) and Sohn et al. (2017). This methodology is grounded in the philosophy of Merleau-Ponty, outlines bracketing for pre-understanding of a phenomenon, employs one-on-one participant interviewing, and utilizes an interdisciplinary interpretive group for data thematization (Pollio et al., 1997; Sohn et al., 2017; Thomas & Pollio, 2002). Discovering the human experience through a one-on-one dialogue, this research process focuses on the perspective of the one who lives it (Thomas & Pollio, 2002). Additional details regarding the philosophical foundation and procedures of the study will be provided in Chapter 3.

Purpose and Question

The purpose of this phenomenological research study is to describe the lived experience of an uninsured individual seeking, accessing, and receiving primary healthcare at nurse-

managed clinics in a Southern state. Exploring the meaning and gaining a better understanding of the patient's healthcare experience can help support and improve community-based nurse-led clinical services in planning health programs tailored to meet the needs of the individual and the community. **The specific research question for this study includes:** *What is the meaning of the patient's perception of their lived healthcare experience as an uninsured individual?*

Definition of Terms

Access

Access refers to "the ability of a person to obtain healthcare services when needed" (Shi & Singh, 2017, p.11).

Primary Care

Primary care is defined as "first-contact, accessible, continued, comprehensive and coordinated care" (WHO, 2018, p. 1). This definition includes the four key primary care attributes that are the foundational pillars of primary care articulated by Starfield (1992), which include first contact care, continuity of care, comprehensive care, and coordination of care. Effective primary care includes patient-centric, holistic, relationship-based care (Starfield, 1992).

Nurse-Managed Health Center

A nurse-managed health center (NMHC) is defined by the American Nurses Association (ANA) as an "organization that gives clients and communities direct access to professional nursing services which are holistic, client-centered and affordable, diagnosing and treating health problems, and promoting health and optimal functioning among target populations and communities" (ANA, 1987, p. 1). Most NMHCs serve the healthcare needs of underserved populations such as minorities, immigrants, and low-incomes without access to care (Hansen-Turton et al., 2015).

Academic Nurse-Managed Health Center

In 2010, the ACA further defined a NMHC as a managed practice agreement of advanced practice nurses that "provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health or social services agency" (42 U,S, C, 330A-1) (ACA, 2010). Academic nurse-managed centers (ANMCs) are academic-affiliated centers with a rich and long history of service committed to vulnerable populations that address community care gaps. Of the 250 NMHCs across the U.S. and the District of Columbia, 67% are community-based and operate under the administrative aegis school of nursing (NNCC, 2017). These centers provide a small but substantial amount of primary care services in the community – increasing accessibility to culturally competent cost-effective primary care (Hansen-Turton et al., 2015). ANMCs main distinguishing feature is to connect education, research, and practice – the tripartite mission.

Population Health

The definition of population health includes "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig & Stoddart, 2003, p. 1). Reducing health disparities and improving population outcomes are the two major aims of population health.

Safety-Net Providers

The Institute of Medicine (IOM) defines the health care safety-net as: "Those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable populations" (IOM, 2000, p. 1). Core safety-net providers typically include public hospitals, community health centers, and local health departments, as

well as special service providers such as autoimmune deficiency syndrome (AIDS) and school-based clinics. In some communities, teaching and community hospitals, private physicians, and ambulatory care sites fill the role of core safety-net providers. These facilities are critical in providing care and services in low-income, medically underserved, immigrant, and communities of color, often with limited healthcare resources available (Chokshi, Chang, & Wilson, 2017). "The health care safety-net serves as the default system of care for many people who fall outside the medical and economic mainstream" (IOM, 2000, p. 1).

Vulnerable Populations

Vulnerable populations may also be referred to as underserved, medically underserved, or safety-net populations. Unequal social, economic, health and geographic conditions are multiple factors attributed to vulnerability, of which the individual has little or no control (Shi & Singh, 2017). The Centers for Disease Control (CDC) stated that vulnerable populations may include "anyone who has difficulty accessing medical care" (CDC, 2019, p. 1). The uninsured population is vulnerable.

<div align="center">

Personal Perspective

</div>

Although I did not realize it, my nursing journey began as a young child in the public health department in my home town. Growing up, I received care at this clinic for routine examinations and immunizations. I remember positive experiences at this clinic and looked forward to each visit. However, as a young adult, I become aware of the perspective of the public health department as a "free" clinic that only those with little to no income used.

I experienced shaming as a result of using this clinic for healthcare and remember that the perspective from others in the community was that we (family) were receiving "free" care. Even though I shared many academic interests and commonalities with friends in my school and

the surrounding community, structural vulnerabilities and background differences existed. I felt

vulnerable to our family's limited healthcare access, realizing that the ability to see the

community general practitioner required a cash payment. Experiencing stigmatization related to

my healthcare experiences when young has stayed with me. Yet, the positive healthcare

experiences I encountered at the public health department encouraged my interests in becoming a

nurse. My interest in helping improve healthcare access for vulnerable populations has spanned

my entire nursing career. Moreover, my earlier nursing education, which included clinical

training in caring for underserved populations, left a great impression on me regarding caring for

those that society has left behind.

Once I became a registered nurse, I viewed nurses as caring professionals, dressed in

white, delivering empathetic care while meeting the needs of *all* patients. I knew there were

stories which existed behind each patient, struggling in a healthcare system, to feel and be cared

for. To this day, I never understood why one's zip code mattered and was shocked to see how

these numbers impacted the care for some. I became aware of the stigmatization of some patients

and found myself participating in an inflexible healthcare system that did not work for the

marginalized. I was disturbed when co-workers did not want to communicate with family

members regarding their loved ones' health status. I saw it as my professional role and duty to

help educate both patients and families about their illnesses and discuss realistic expectations.

Admittedly, these conversations took time – time that some staff members were unwilling to take

because it was interruptive to their daily routine and interfered with the completion of other

nursing tasks. But I enjoyed the interaction and teaching, and found that providing the

knowledge and time spent was a source of comfort for family members. Looking back, I hope

that my nursing interventions contributed to positive experiences for both patients and family members. I hope I showed empathy and communicated how much I cared.

Assumptions

Based on my previous experiences related to impoverished, uninsured individuals and their healthcare experiences, and review of the literature, the following are my personal assumptions identified for this study:

- Any individual is at risk of becoming uninsured and experiencing challenges in accessing healthcare (homeless, HIV, mental health challenges, terminal and chronic illnesses).

- Impoverished, uninsured individuals may experience little ownership, and little choice, in their health and healthcare due to not being heard – disrespect, discrimination and disempowerment exists.

- The nursing discipline should be aware of challenges faced by impoverished, uninsured individuals and communicate this in nursing practice and education.

- Nurses must intervene on behalf of impoverished, uninsured, vulnerable populations. It is our responsibility to care for those marginalized, that society has left behind.

- Healthcare access reflects a moral obligation to society – nurses should commit to social justice and equity for all patients.

- Improving population health outcomes (both individually and among a group of individuals) reduces health disparities and positively impacts the entire public

Limitations

The use of interviews as a data collection method carries certain limitations. Researcher-induced bias can influence the study. Bracketing of researcher bias is essential because the researcher may have strong feelings about the subject of interest. Therefore, bias can be a

15

potential problem in drawing conclusions and exploring experiences. A reflective self-assessment through bracketing allowed me to identify and set aside any biases about the experience. It was important to bracket out my own experiences and set aside preconceptions so that entirely new conceptualizations can be inductively derived from the study.

For example, one assumption I needed to bracket throughout the study was that some healthcare providers are not empathetic toward uninsured patients and consequently, may overlook their healthcare needs. Also, I believe that anyone is at risk of becoming uninsured in their lifetime; therefore, nurses should be able to understand how it may feel to be uninsured and willing to help those in need of healthcare in a positive way. Lastly, since I have personally cared for uninsured individuals, it was essential that I "unplug" from my situations and really listen to the participants in the study in order to accurately represent this phenomenon.

Phenomenology typically involves small groups, but generates large amounts of data that must be carefully managed. Through use of a purposive, convenience sampling, the perceptions of those interviewed, may not reflect those of a larger, demographic sample. Also, participants may not be equally articulate or perceptive and researcher presence may bias participant responses.

Generalizing findings to individuals, sites, or places outside of those under the study is not an expectation of a phenomenological study. Transferability is determined by the specific readers who gain insight and a deeper understanding of the phenomenon from the results. If these readers choose to or can apply what they have learned from the study findings to their current nursing practices, generalization can be expanded (Creswell, 2015; Thomas & Pollio, 2002).

Significance of Study

The knowledge gained from documenting poor, uninsured individuals' first-hand perceptions of their healthcare experiences is of significant interest to the nursing discipline. Nurses who understand such perceptions are better equipped to define and address this population's needs in order to help improve their primary healthcare experiences. Additionally, nurses can use this knowledge to inform their nursing practice as they support and plan tailored healthcare programs to meet individual and community needs for targeted populations.

Unfortunately, there is a dearth of research findings about this topic. While some literature describes the community effects of NMHCs providing primary healthcare services to safety-net populations (Mason et al., 2015), no studies have detailed patients' experiences as they seek, access, and receive primary care in the community. Furthermore, extant research states that evidence of effective interventions is "limited and fragmented" (Richard et al., 2016, p. 1). This qualitative study was designed to help fill this literature gap by giving uninsured patients a voice in describing their healthcare experiences, and their perceptions of the effectiveness of interventions they received from nurses in the primary healthcare delivery system.

These findings are significant to the nursing discipline as they can be used to extend HCP-delivered primary healthcare services to meet the healthcare needs of underserved individuals. Additionally, the findings can shed light on the facilitators and barriers these patients encountered when seeking healthcare. Those in the nursing discipline then can work to replicate the facilitators and address the barriers to effective primary healthcare for targeted populations.

Providing a detailed understanding of a single noteworthy phenomenon - uninsured patients' primary healthcare experiences - these findings will add to the limited body of nursing research about this topic. This study's findings also could help give voice to the voiceless; validate, support and possibly improve primary healthcare programs; illuminate NMHCs

contributions to addressing the primary care shortage; and serve as a springboard for future research. Ultimately, the knowledge gained from this study could help strengthen the healthcare system and support the most vulnerable in our nation.

Chapter 2: Review of Literature

The purpose of this literature review was to gain a better understanding of the delivery of primary healthcare services by nurse-managed health centers (NMHCs) for underserved populations and assimilate evidence related to the impact on clients served and their experiences. The two questions asked were: What contributions do NMHCs make on primary healthcare delivery in communities across the United States (U.S) for vulnerable populations? What is the impact of primary healthcare services by NMHCs on the underserved (uninsured and underinsured) population? Next, to refine and expand the review, the search was broadened to include the question: What are facilitators and barriers to primary healthcare access and experiences of vulnerable, uninsured populations? The author evaluated the quality of each article by considering its authenticity, informational value, source representativeness, and methodology (Whittemore & Knafl, 2005).

Inclusion Criteria

Each article had to be a primary research article describing the delivery of primary healthcare by NMHCs and experiences of vulnerable, uninsured patients accessing and receiving primary care. The search was limited to peer-reviewed journal articles and literature review articles that were published between 2003 and 2019 (to the present) in an English language journal. This search was relevant to the understanding of the contribution of primary healthcare delivery services by NMHCs on the clients served and the healthcare experiences of vulnerable populations. Articles about NMHCs providing primary care to vulnerable populations in a variety of settings were included. In addition, the inclusion of articles that explored facilitators and barriers to healthcare access allowed for a more comprehensive review of this vulnerable

populations' experiences. Studies were excluded from analysis that were not the primary source of information or original research.

Search Strategy

The CINAHL, PubMed, and EBSCO databases were searched using several keywords both alone and in combinations (nurse-managed health centers, academic nurse-managed centers, safety-net providers, vulnerable populations, uninsured, nurse practitioner, community, primary care, and primary care shortage). The initial search yielded 222 articles. Narrowing the search by reading the abstracts and reviewing the article study designs to determine their contribution to the phenomenon of interest yielded 86 pieces of literature. After reviewing these results, 44 full-text articles were obtained which met the inclusion criteria. Initially articles also were reviewed on NMHCs as educational sites and their financial viability, but most articles provided little information pertinent to the present study. The literature review was then broadened to allow exploring and using keywords social advocacy, social justice, nursing AND vulnerable populations, and patients' healthcare experiences AND uninsured (using Sociological Abstracts). Expanding the review allowed for a more comprehensive study focused on the facilitators and barriers of vulnerable, uninsured patients' and their experiences seeking and receiving primary healthcare. Twenty-nine articles were then selected and synthesized for this literature review.

Findings

Twenty-nine articles of varying research designs (descriptive, qualitative, quantitative, mixed-methods, and case study) were included for this review. The articles selected were categorized based on their main area of focus. The available professional literature addresses NMHCs community impact on vulnerable populations as safety-net providers, on targeted populations, viability challenges, health promotion through effective teaching strategies, and

20

contributions in improving healthcare access for vulnerable populations. The number of articles in each category include NMHCs and/as (a) safety-net providers (5), (b) targeted populations (4), (c) viability (2), (d) effective teaching strategies (3), and (e) contributions in improving primary healthcare access (5). Next, expansion of the literature to review facilitators and barriers to healthcare access, specifically addressing patient experiences of impoverished, uninsured populations yielded 10 of the overall 29 articles to include: (f) undocumented immigrants (1), (g) homeless populations (6), (h) language barriers (1), (i) health insurance access (1), and (j) healthcare insecurity (1).

NMHCs Community Impact on Vulnerable Populations

     Safety-net providers. Common findings across five studies addressed the impact of NMHCs on the communities served. The purpose of a descriptive study by Pohl, Barkauskas, Benkert, Breer, & Bostrom (2007a) was to evaluate the community impact of ANMCs in a Midwestern state. A convenience sample was selected which consisted of six focus groups that represented six ANMCs and four partnering universities, each part of the Michigan Academic Consortium (MAC). The mission of the consortium was to provide community-responsive primary care. Community was defined as the population served by the center in a specific geographical location.

     The focus groups ranged from three to nine participants (a total of 37 participants), including patients and families who used the centers for care, advisory board members, and local community organizations. Experts in focus group methodology identified four themes: (1) valued patient-centered care, (2) quality of care, (3) increasing access to care in addressing the safety-net, and (4) evidence of outreach.

Caring, listening, and taking time were three elements that participants valued by their healthcare providers during their visits. In particular, coordination of care was reported as valued because NPs took time to listen and coordinate needed care, which included referrals to specialty healthcare providers in the community. Describing quality of care as thoroughness of care, participants stated that NPs attentively listened while well-documenting their concerns and needs. Notably, most participant responses surrounded the theme of increasing access to care. The participants were pleased with the convenient location of the centers which increased their access to primary care. The ease of clinic access reduced participant emergency department visits. In addition, the ease of obtaining same day appointments, the ability to communicate quickly via telephone, and quick access to pharmaceuticals increased access to quality care. The centers addressed the safety-net population in their communities as evidenced by available outreach services such as public housing, a teen center, and a domestic violence shelter, each highly valued by community participants (Pohl et al., 2007a).

A limitation of the study was the use of a small geographical area, impacting generalizability. The focus group methodology was a strength of the study in that it allowed for an increased number of participant responses in obtaining useful data; however, there was potential bias selection as some respondents were ANMC acquaintances. Despite the limitations, valuable data included that respondents understood the value of ANMC delivery of patient-centered primary care, and understood the value of integrated and continuous care for families and communities, evidenced by the centers reaching out to the community.

Mason et al. (2015) emphasized the significance of establishing community partnerships through innovative models of care that promote health and manage illness for underserved populations. This qualitative descriptive study highlighted 39 nurse-designed Edge Runner Care

Models recognized by the American Academy of Nursing (ANA, 2018) for their success and impact on primary healthcare across diverse settings. These models of care focused on improving population health among vulnerable populations by partnering with communities through a shared vision to build healthy environments, a key feature of sustaining their models.

The researchers used multiple strategies to collect data, which included focus groups, websites and publications (to retrieve Edge Runner documents retrospectively), and verbal communications between the study participants and the investigators. Through purposive sampling, an invitation to attend the annual Academy meeting was sent to each of the 36 Edge Runner model designees to learn the purpose of the upcoming study. The same group later received an e-mail to participate in one of two telephone focus groups. Sixteen individuals attended the first in-person group, nine participated in the first telephone call, and 18 in the second call. The final sample consisted of 32 participants representing 30 of the 36 (83%) recognized models of care, that participated in either the in-person focus group, one of the conference calls, or both. These three interactions represented the major strategy for data collection.

Five study investigators asked the participants to describe the most important elements associated with their model of care focusing on person, environment, and nursing perspective. The investigators then analyzed all transcripts individually to identify commonalities and emerging themes. Data analysis strategies were employed which initially led to three to eight broad categories. Next, a review and refinement by the researchers identified primary common elements among the models of care.

Four common elements emerged across clinics to include: (a) delivery of holistic care, (b) individual and family-centered care, (c) patient engagement through partnerships, and (d) the

shift from individual care to the community. Study findings recommended reconfiguring the funding stream to include public and private equity match – in gaining social return on community investment for mutual benefit. Mason et al. (2015) concluded that promoting health demanded a system that focused on "knowing patients' experiences" (p. 551), building relationships through engaged providers and partners, and embracing an agenda that prioritizes the health of families and communities.

A qualitative, descriptive study by Esperat, Hansen-Turton, Richardson, Debisette, and Rupinta (2012) highlighted the NMHC's rich history and dedication to identifying community needs, serving their target population, and addressing community care gaps. Data was derived from the Division of Nursing of the Health Resources and Services Administration (Health Resources and Services Administration [HRSA], 2019), which supports NMHCs as a vital component of the primary healthcare system for safety-net populations with limited medical resources. Esperat et al. (2012) stated that of the 250 NMHCs across the nation, 138 NMHCs are affiliated with university-based schools of nursing and 112 are independent nonprofits or in hospital outpatient clinics.

Findings included that ANMCs provide quality and cost-effective care to target populations and are a rich source of clinical experiences to train nurses and NPs, helping to increase the healthcare workforce. Despite indicating support of the ANMC and its tripartite mission of education, practice, and research, the authors recommended identifying strategies to reduce dependence on the academic entity, a contrasting finding. One suggestion included partnering with an accountable care organization (ACO) to reduce dependence on the academic entity in an effort to expand the model beyond the academic practice environment for growth and expansion (Esperat et al., 2012).

A strength of the study is the implication for practice of NMHCs in caring for the nation's vulnerable populations and encouraging advance practice nurses to participate in health policy for change. The authors concluded that policy changes were essential to assure that NMHCs continued to play a major role in the primary healthcare safety-net for vulnerable populations, recognizing NPs at the forefront of these changes. A weakness of this study is the lack of clear detail in how the data set was collected (Esperat et al., 2012).

Pohl, Vonderheid, Barkauskas, & Nagelkerk (2004) researched the role of four Midwestern schools of nursing (SONs) and the barriers in serving the safety-net population through primary healthcare centers. The purpose of this descriptive, retrospective study was to: (1) compare the patient mix of ANMCs with community health centers (CHCs), (2) compare funding sources of ANMCs to CHCs, and (3) describe the SON's contribution to the safety net while examining the funding for ANMCs. A convenience sample of six ANMCs represented populations from a Midwestern state. Data was collected about services, funding, revenue, and cost categories from university representatives at each center.

Three broad categories (private, public, and uninsured) were created to compare ANMCs and CHCs patient-mix data. From 347 to 2,959 patients were seen across varying ANMCs. The patient-mix consisted of patients enrolled in private and commercial plans, Medicare, Medicaid, and public plans, such as Veterans Administration and county health plans. Private and commercial patients averaged 38.6% served by the centers, patients enrolled in public plans averaged 35.7%, and an average of 25.6% patients were uninsured (Pohl et al., 2004).

ANMCs received twice as much funding from grants as CHCs (31.8% versus 16.6%). Funding sources included third-party reimbursement ($M = 48.4\%$), grants ($M = 31.8\%$), and SON/university cash and in-kind donations ($M = 18.4\%$) for ANMCs. The majority of funding

for CHCs was from patient reimbursement (54.7%) followed by Bureau for Primary Health Care (BPHC) funds (22.4%), grants (16.6%), and other indigent care programs (6.4%).

Most patient revenue at the four ANMCs was generated through fee-for-service (FFS) plans. SONs receiving high levels of support were associated with lower collection and reimbursement rates, while providing outreach services to the community (a typical profile of how services are rendered to the safety-net population). A higher resource use and reimbursement from private payers was associated with lower levels of SON and university support (Pohl et al., 2004).

Further study findings indicate that grant funding and university donations are significant revenue sources for ANMCs, with a combined mean of 50% for academic and 39% for federally qualified health centers (FQHCs) (which are large CHCs). Third-party reimbursement revenue at FQHCs was reimbursed at 55% as compared to academic NMHCs at 48%. Other donations were 6% for FQHCs compared to 2% for academic NMHCs. What was evident was that although FQHCs and NMHCs are similar in populations served, reimbursement rates are greater for FQHCs (Pohl et al., 2004).

Overall, study findings indicated similarities and differences regarding patient mix and funding between ANMCs and CHCs. The ANMCs relied significantly on direct and indirect contributions such as rent-free space, cash contributions, and faculty-practice models from the SON or university. A significant finding of the study was that the contribution of SONs and universities to ANMCs was comparative to BPHC contributions to CHCs (Pohl et al., 2004).

The authors recommended research on ANMCs to gather and report data on a national level for a better understanding of this center, particularly the role that academia plays in serving the safety net population. Evidence-based information is needed to inform policy makers on

ANMCs, which are somewhat invisible, but substantially contribute to serving the safety net population (Pohl et al., 2004).

Measuring the excellence of NMHCs in areas of quality of patient care, clinical outcomes, and patient satisfaction was the purpose of a descriptive research survey study by Dols, Beckmann-Mendez, DiLeo, Weis, and Medina-Calvo (2018). Participants from 40 (35.1%) of 114 identified NMHCs responded to the "Nurse-Led/Nurse-Managed Health Center Quality Metrics Survey" which sought to determine current operational efforts utilized to measure progress of goals in delivering primary healthcare in communities serving vulnerable populations. Specifically, the electronic survey tool (designed by the research team) gathered clinic operational information, metrics used, and measurement methodology. The sample was obtained through advertising the study at an annual NP conference. Once NMHC contacts were established, snowball sampling was used to obtain contact information for additional NMHCs.

The number one goal (of six major goals) for clinics was to increase the number of patients served. Disease management, disease screening, preventive health, population health, and care delivery reflected the current focus for clinical outcomes at NMHCs. Of the 40 participating NMHCs, diabetes management was the primary focus for 18 centers (45%) followed by hypertension as the focus for 14 centers (35%). The remaining centers did not identify a clinical outcome focus. Behavioral health, mental health/depression, hyperlipidemia, substance abuse, and arrythmias were additional management priorities behind diabetes and hypertension. Patients were most commonly screened for colorectal cancer and depression, followed by breast and cervical cancer, in addition to hepatitis C, human immunodeficiency virus (HIV), osteoporosis, cancers, and sexually transmitted diseases. Preventive health measures

focused on weight loss, vaccinations, health promotion (education), smoking cessation, and sexually transmitted diseases.

Five (12.5%) NMHCs contributed to a reduction of urgent care and emergency center use in working toward achieving clinical outcomes that promote population health. Increasing access to prescription medications and convenient, available clinic hours helped promote positive health outcomes. These clinics focused on wellness behavior, mental health services, dental service, homeless health care, insurance referrals, community health education, and housing needs for vulnerable populations. These health services helped to reduce hospital admissions, readmissions, and antibiotic use – each a focus of primary health clinical outcomes. NMHCs also focused on care delivery that accentuated lesbian, gay, bisexual, and transgender friendliness.

Dols et al. (2018) found that measurement of patient satisfaction was performed by tools developed by 24 (60%) and purchased by 4 (10%) NMHCs. Patient satisfaction was not measured by 11 (27.5%) NMHCs. The remaining centers used free tools, or surveys adapted from other settings. Metrics rather than surveys were used by several NMHCs to measure patient satisfaction relative to patient return, increase in patient volume, clinician ratings, and number of appointments cancelled. An increase in patient population was used by 12 NMHCs as a measure of patient satisfaction.

Study limitations included that only 40 of 114 identified NMHCs participated in the study. Also, outcomes are difficult to report without consistent surveys and measuring tools across NMHCs. Recommendations for future studies included to continue to report, recognize, and reward NMHC performance as a unique model of care in realizing the impact of primary healthcare delivery. Studies should focus on quality of care, clinical outcomes, and patient satisfaction.

Targeting the population. Four studies discussed health promotion among target populations with chronic illnesses (Bucher & Thompson, 2012; Dyal, Whyte, Blankenship, & Ford, 2016; Ely, 2015; Nardi, 2011). Implementing evidence-based hypertension (HTN) clinical guidelines and community-based outreach programs for children with asthma are two best practice exemplars of ANMCs promoting health in low-income communities.

A descriptive study by Bucher and Thompson (2012) reported on effective interventions to reduce environmental triggers and improve symptoms of asthma, the most common chronic illness among children in the U.S. Over 18 months, data was collected from families ($N = 33$) by nursing faculty associated with an NMHC as a clinical outreach effort. The authors focused on program planning and delivery using a community planning model for multicomponent interventions, including home visits and education, to improve community programming and participation in reducing asthma-related exacerbations among children. Families received asthma education at least once, with five of 23 families receiving a second visit, and 10 families receiving a follow-up phone call. The first knowledge pretest score average was 89% (standard deviation [SD] = 18.93%), and the posttest score average was 92% (SD = 15.40%). Using a paired t test, the increase of 3% from pretest to posttest was not statistically significant.

Although no sufficient evidence indicated that the asthma education program was statistically significant, the provision of wellness services and health promotion for new families was recognized. Further, additional unexpected outcomes of the study included assisting one family with immigration issues and another family with applying for children's health insurance. Importantly, the authors point out that lessons learned surrounded the process of program planning and implementation. This underscores the significance of determining patient and family needs in advance of developing and implementing community outreach programs.

The use of evidence-based practice (EBP) guidelines was the focus of a study at an NMHC which served as a site for faculty practice and educational experiences for graduate students, [while increasing access to care for an underserved population] (Dyal, Whyte, Blankenship, & Ford, 2016). In collaboration, nursing faculty, nursing students, and health center nurses collected data from a convenience sample of patients (N = 304) with stage one or two hypertension (HTN) in a large southern city. The EBP guidelines reflected current best practices through access to a national HTN link incorporated into the patient's electronic healthcare record for point-of-access care in the exam room.

The implementation of HTN evidence-based guidelines had a positive impact. A paired t test showed a statistically significant change of 14.990 between the most recent systolic blood pressure (SBP) (M = 134.21, SD = 17.522) and initial SBP (M = 149.20, SD = 15.80), and a statistically significant change of 7.895 between the most recent diastolic blood pressure (DBP) (M = 83.2, SD = 10.129) and initial DBP (M = 91.10, SD = 11.515).

Both Ely (2015) and Nardi (2011) described an integrative approach to care that blends primary and mental healthcare in addressing the needs of individuals with mental illness. The goal of Ely's (2015) study was to analyze funding sources for NMHCs that offered integrated primary and mental healthcare. The integrated care model incorporates the patient's biological, psychological, social, and spiritual needs, rather than just the disease itself. A systematic review of financial barriers and facilitators found that integrating care enhanced clinic sustainability by increasing patient volume and improving the revenue mix (Ely, 2015). Some clinics managed chronic mental illness while offering health education to manage other chronic conditions such as cardiovascular disease, diabetes, and obesity. This target population required frequent visits, which garnered additional reimbursement. Although the patient volume increased, mental health

coding generated less revenue per visit than visits that required procedures such as radiography. The researchers noted that lack of full reimbursement by all insurance companies and collaborative relationship restrictions continued to threaten sustainability.

One strength of this study is the identification of common themes among clinics that impacted sustainability. These themes included (a) methods of reimbursement, (b) integration of care, (c) mission of clinic and population served, (d) procedure for coding, and (e) ratio of public insurance, private insurance, private pay or no pay. The author recommended additional research to identify the best financial structure to increase revenue for long-term sustainability. Facilitators to financial sustainability included converting to an FQHC, affiliation with an academic entity, and a blended income from grants and service-based reimbursement. Federal funding streams received by FQHCs generated additional funds with added services such as dental, pharmacy, and electronic medical records, while less grant-funding was available for NMHCs, thereby reducing profitability (Ely, 2015).

An integrated university health and wellness center (HWC) located in Illinois was the focus of a descriptive, longitudinal study over a five-year period (Nardi, 2011). Serving 7,200 individuals, this center operated three sites: a main clinic, a domestic violence shelter, and a student outreach center from a university with the goal of integrating and improving care access for all patients, including uninsured and underserved populations. The center offered cost-effective treatment while stabilizing and improving mental healthcare within a primary and preventive care model. Payment ratio included 72% from state funds, 13% cash payment, 10% Medicare, and 5% private insurance.

Study finding recommendations aimed at increasing access to care and sustaining services included: (a) working out a payment plan for uninsured patients, (b) efficiently and

equitably rotating the referral of patients from the ED with no insurance to center sites that receive uninsured patients, (c) encouraging centers to provide mental health services as part of general practice, (d) partnering with community health center programs to build and strengthen existing services in meeting target population needs, (e) collaborating with primary care providers to develop referral and treatment systems for uninsured patients with complex mental health problems, and (f) eliminating collaborative practice and supervision agreements required for APRN licensing in some states (Nardi, 2011).

The author outlined four key points related to the overall study recommendations. These key points included that: (1) integrated healthcare (mental and physical) treatment and follow-up visits are best provided in one setting and best managed by one HCP, (2) the integrated care model provided comprehensive healthcare to underserved groups, meeting community population needs, (3) the HWC addressed a growing problem - healthcare disparities - through providing cost effective, affordable, and accessible healthcare, and (4) the collaborative practice and required supervision agreements of NP practice be lifted allowing NPs to engage in the healthcare marketplace without restrictions.

These care models coordinated physical and mental health services within a primary care setting to support and improve mental health in the community and improve patient volume, that providing healthcare aligned with community needs. In any case, sustaining these clinics is difficult without full NP reimbursement for clinic visits. Although these studies reported that patient volume increased, the researchers affirmed that lack of recognition and full reimbursement by all insurance companies, collaborative relationship restrictions, and inability to receive federal grant funding continue to impede long-term sustainability of NMHCs and impact access to care (Ely, 2015; Nardi, 2011). These four studies represent exemplar ANMCs

that can reduce health disparities and expand primary health care to vulnerable populations. NMHCs can improve healthcare access and help mitigate the primary care gap while promoting wellness, preventing disease, and reducing health disparity.

An Effective Teaching Strategy. Three studies reported on the role of NMHCs in educating nurse practitioners for the delivery of primary healthcare to underserved populations. The purpose of a mixed-methods study by Tanner, Pohl, Ward, and Dontje (2003) was to evaluate clinical experiences of nurse practitioner (NP) students. Data was gathered from a convenience sample of 97 NP students in eight ANMCs which were part of the Michigan Academic Consortium's (MAC) Nurse-Managed Primary Care Centers. Researcher methodology included interviewing focus groups and NP evaluation of both clinical sites and preceptor guidance. Findings were based on quantitative surveys and focus groups held with the students over a three-year period. Quantitative surveying consisted of a 17-item questionnaire evaluating clinical sites and a 23-item questionnaire evaluating preceptors at the end of each semester and the end of their clinical rotation. The site evaluation survey requested a "yes" or "no" response related to clinic environment and client base. The preceptor evaluation used a rating system (seldom, sometimes, or frequently) in regard to the preceptor's ability to share knowledge, experiences and feedback.

Overall, the students reported positive findings about ANMCs and their preceptor experiences. The preceptors were highly rated and perceived as positive role models. A majority of the students (72 percent) reported that preceptors reviewed diagnoses with them, while 26 percent reported this occurred only sometimes. Although 90 percent ($N = 72$) reported sufficient time for seeing patients, only 27 percent ($N = 21$) felt that there were a sufficient number of patients to see. Site evaluation responses were particularly high with 97 percent indicating that

33

providing health promotion and disease prevention was priority, substantiating the mission of the ANMC. Limitations included the use of focus groups as responses may not represent the population, and potential unreliability of interpretation of the dialogue during qualitative analysis. However, the combination of focus groups and the survey strengthened the study. Further, student focus groups aided in a better understanding of the role of the ANMC in preparing NPs to address diverse community health needs, highlighting the contribution of the ANMC to the student experience (Tanner et al., 2003).

A case study by Van Zandt, Sloand, and Wilkins (2008) described the role of ANMCs to help meet the educational needs of NP students working in resource-scarce settings with vulnerable populations. A patient sought treatment at a primary care clinic, but continued to experience health symptoms that led to seeking treatment elsewhere. Upon recommendation of an acquaintance, the patient then sought treatment at an ANMC which was an educational training site for NP students. The patient was non-English speaking and a translator was provided. The patient reported satisfaction with the comprehensive treatment at the ANMC as compared to the treatment at the separate primary care clinic, as well as satisfaction with the cost-effectiveness of the treatment.

The study reported that one benefit of training at an NP clinic included the opportunity to collaborate in an interdisciplinary environment. Also, NP students reported the opportunity to engage in frequent teaching and prevention activities, and acknowledged the significance of delivering preventative interventions through their role as a primary care provider (Van Zandt et al., 2008). The NP student satisfaction in working in a community-based setting with the opportunity to gain critical comprehensive skills and confidence in treating future vulnerable populations is also a positive outcome for patients. The authors recommended further research in

an effort to support educational experiences that provide NP training and knowledge to enhance and help improve health outcomes.

Study findings highlighted the benefits of an ANMC and recommended the need for research to provide evidence of improvement in health outcomes as a result of patient treatment at an ANMC. The authors encouraged nurse-led research to provide a stronger evidence base that positive health outcomes for underserved populations can result from positive experiences at ANMCs alongside NP students in training. Further, recommendations included awareness and need for academic institutions to further develop these centers through academic and financial support for long-term impact on aiding and improving health outcomes of vulnerable populations (Van Zandt et al., 2008). The case study is useful for an in-depth analysis of a situation and telling a story, one strength of this study. The findings of each of these studies is important in understanding the role of the ANMC as a site for educational preparation and is valuable for understanding the whole of the ANMC.

The purpose of a quantitative study by Pohl et al. (2007b) was to: (1) report survey data about the characteristics of SONs affiliated with ANMCs, (2) describe ANMC funding sources from SONs, (3) describe student clinical experiences and faculty practice participation, (4) compare data with earlier surveys, (5) document reasons of ANMC stability, and (6) identify future research needs of the centers. Ninety-two percent of 565 deans and directors of SONs indicated their schools had one or more ANMCs. Two surveys were utilized in the study: one survey to the dean of the SON and one to the director of the clinic. The sample consisted of 59 respondents.

Education, research, clinical practice, and public service was reported as the mission for the majority of SONs (37 schools, 63.8%). Twenty schools were part of an academic health

center with 19 of these reporting clinical practice as their mission. Twenty-five schools were classified as doctoral, research universities. The average number of students included doctoral (N = 36), master's (N =121), and undergraduate (N = 331) (Pohl et al., 2007b).

There was a total of 98 ANMCs of the 59 SONs reporting data. Most (N = 47, 81%) SONs had one ANMC, and 12 SONs (21%) reported two to 10 ANMC sites. The number of years centers had been opened averaged nine years, with a range between two to 35 years. Only 12% of centers were housed in a SON, whereas 38.8% were located in another agency, and 21.4% were located in a freestanding building. Grants and SON resources were reported as the most common sources for initial and current funding sources, but the exact percentage was unknown. Universities, patient revenues, and contractual sources of funding were common. Forty-two centers (43%) reported patient revenue (fees for service) as their current source of funding, but only 10% of patient revenue was utilized for initial start-up cost. Center space funding was mostly generated through various grants (73.5%) followed by clinical revenues (16.3%). Parent institutions supported center space by only 3.1% (Pohl et al., 2007b).

Provision for center space varied as well as the location for ANMCs. In earlier surveys the physical location of the ANMC was in the SON itself, whereas in this study the majority of ANMCs (60.2%) were located in a physical space other than the SON. The mean age of ANMCs today is three years older than in past surveys. Researchers reported in this study that ANMCs remained open an average of nine years versus six years in past surveys. In any instance, ANMCs have continued to frequently open and close over the past 30 years, but it is unclear as to why. Despite this, SONs continue to fund ANMCs substantially today, although diversity in funding sources has continued to increase beyond only patient revenues and grants. Notably,

clinical practice and public service were important components of SONs with ANMCs (Pohl et al., 2007b).

ANMCs are valuable educational sites for students and practice sites for faculty: Forty-six ANMCs reported 20 (43%) BSN students, 19 (41%) master's students, and 7 (15%) doctoral students engaged in educational experiences. Thirty-four ANMCs reported that 25 (74%) nurse practitioner faculty, nine (26%) clinical nurse specialist (CNS) faculty, and one (3%) nurse midwifery faculty members were practicing in their ANMCs. An overall range of one to 10 nursing faculty members practiced in these centers (Pohl et al., 2007b).

The implication for future research included the need to communicate and provide evidence about the valuable contribution of ANMCs in NP education and in positively impacting health outcomes of vulnerable populations (Pohl et al., 2007b; Tanner et al., 2003; Van Zandt et al., 2008). Research that describes the characteristics of the ANMC will help define the value of this center, and bring an awareness for support to help secure financial resources for the center to continue its work.

Viability. Two studies discussed the financial challenges of ANMCs. The financial viability of NMHCs impacts access to care for vulnerable individuals.

Financial performance. The purpose of a descriptive, retrospective study by Vonderheid, Pohl, Barkauskas, Gift, and Hughes-Cromwick (2003) was to examine the services, funding, and cost structures of ANMCs delivering primary care to diverse populations and compare their performance. A convenience sample consisted of six ANMCs with diverse staffing, funding, sources, and location. These six ANMCs were affiliated with four Midwestern public universities. A standardized reporting form which consisted of a data collection form and

instructions document enabled researchers to systematically collect information about services, funding, and cost categories. The six centers are described as Centers A, B, C, D, E, and F.

The funding sources for Center A included two primary funding streams which included grant funds (61%) and reimbursement (29%). Funding for Center B was primarily from grant funding. The largest percent of funding at Center C was from reimbursement (71%). More than half of Center D's funding was from grants (56%), followed by reimbursement (28%). Three main funding sources for Center E included reimbursement (49%), grants (33%), and university contributions (25%). Data was not available to calculate for Center F. Only Centers A and C were profitable, when unearned income was included. Overall, the total operating costs for the ANMCs were high due to the center's educational mission along with the fact that NPs are not consistently included in the revenue health plan. Also, the uninsured and underinsured populations required resource-intensive services, which contributed to a lower profit. A significant funding stream for the majority of the centers included grants and in-kind contributions. Although a substantial contribution of 25% from one university was reported, the potential for future SON budgetary pressures to hinder financial contributions was great.

In summary, three key factors for financial success included: (1) guaranteed revenue source through contracts, (2) diverse revenue sources from third-party payers credentialing NPs as primary care providers, and (3) development of a sound business plan that routinely tracks financial and coding data. The most profitable center had guaranteed revenue. Study findings recommended developing an organizational model with fewer staff working at greater efficiency, optimizing the utilization of NPs by clinical staff, and streamlining billing and collections processes (Vonderheid et al., 2003).

The authors acknowledged the complexity in understanding the financial performance of ANMCs. One recommendation was for ANMCs to create and share data for a national database of ANMC financial performance measures (Vonderheid et al., 2003). The authors stated that until benchmarks are established, NPs must collect financial data and analyze their own performance measures. A limitation of the study is the small sample size concentrated in one geographical location of the country.

Challenges and strategies. Other evidence important in understanding the NMHC can be found in a longitudinal study by King (2008). The purpose of this study was to identify challenges and survival strategies of four academic nurse-managed centers over a 10-year period. The sample consisted of 10 centers, four of which were ANMCs. Multiple data sources were compiled to include a historical report for each center, documents of grant proposals, reports and articles, and an audio-taped interview with the director, key administrator, and clinical staff to discuss challenges faced by the centers and the resources employed to meet these challenges. Thematic data analysis resulted in organizing the challenges to the resources and strategies used according to a systems theory perspective. The parent organization (academic institution), the community served, and the sociopolitical environment were seen as systems in which the ANMC existed, each representing challenges for the nursing center.

Findings were identified within each system for all 10 centers, with focus on challenges problematic for the four ANMCs. Federal, state, and local level health policies challenged the financial viability of the ANMCs. Although diversification of funding from sources such as research, faculty, and student resources contributed to operational effectiveness, the most effective strategy identified for becoming financially sustainable included obtaining the maximum level of reimbursement. This, in turn, was contingent upon developing and

maintaining community support and trust, critical for building a client base to maximize center revenue (King, 2008).

Further, the organization and cultural characteristics of the academic institutions challenged the centers and affected how the center conducted business. There was difficulty in accounting for reimbursable services, delays in billing and accepting payment, and the belief among the community that the clinic provided free services. In addition, should the center choose to transition to a FQHC, there was conflict between the university government's structure and FQHC governance requirements. However, some centers were unable to compensate for 30% to 50% of uninsured care and sought FQHC status, which brought cost-based reimbursement and the potential for long-term sustainability (King, 2008).

In summary, cultivating professional relationships with leaders of the parent organization, awareness of the sociopolitical environment, and building a client base through community support were three strategies identified as essential to ANMC viability (King, 2008). ANMCs that strived to fulfill the stated service-learning mission of their school were highly valued by their academic entity (King, 2008). Limitations include the small sample size and collaboration with one specific agency in one geographical location in the Northeast.

King (2008) recommended advocating for ANMCs through research that documents the defining characteristics of ANMCs, the cost of operating the centers, and resulting health outcomes. Research faculty in academic programs should collaborate with nursing programs and play a key role in developing a research agenda to generate questions surrounding these recommendations. Nurse leadership is essential in conducting and communicating research that recognizes the contribution of the ANMC in helping to meet healthcare needs of the most vulnerable in our country, and for the growth and survival of these centers.

NMHC Contributions in Improving Primary Healthcare Access

Five articles discussed community-based nurse led clinics increasing access to healthcare for the medically underserved population. The research suggested that the assistance of these clinics could mitigate the expected primary care physician shortage and help bridge the primary care gap for vulnerable populations through supporting and expanding existing primary care services.

Increasing access to healthcare for underserved populations. An interdisciplinary nurse-led care model expanded access to healthcare for low-income, uninsured, and underserved populations through an innovative approach that improved patient care while preparing future NPs (Sutter-Barrett, Sutter-Dalrymple, & Dickman, 2015). Uniting nursing, psychology, social work, medicine, and nutrition, a unique and sustainable healthcare model provided interprofessional education and healthcare in meeting the "real life" (p. 1) of individuals with little to no resources (Sutter-Barrett et al., 2015). This model helped fill the gap in healthcare for low-income, uninsured individuals through built community partnerships, transitioning the individual through the healthcare system to a permanent medical home. The NP students learned the skills of navigating the healthcare system while increasing accessibility of services for patients with minimal resources. This nurse-led model of care links patients and families to needed care, an exemplar model of meeting individual and community needs.

The purpose of a study by Richard et al. (2016) was to identify and implement best practice innovations to improve healthcare access for vulnerable populations. The study targeted PHC researchers, practitioners, policy makers and stakeholders in describing innovative healthcare programs and models of care from 14 countries that increased access to care for vulnerable populations.

The participants described 240 exemplar healthcare programs with the majority of the 744 responses recorded from Canada and Australia. Research methodology included the use of descriptive statistics to characterize the models of care in combination with a qualitative framework to analyze the text that described each care model example. The participants responded to a five-minute online survey which collected data regarding an example of a program, service, or model of care that was innovative in increasing healthcare access to vulnerable populations. The research team piloted an initial survey, which was a strength of the study. However, the survey did not include patients seeking care at any program, service, or model of care described; therefore, no data was gathered on the patient experience or perception of care delivered.

The study revealed that few programs were developed which enhanced patient ability to access healthcare services, and rarely did efforts target both supply-and demand-side access to care. The authors stated the need to determine effective strategies to engage vulnerable groups in a meaningful way – empowering them to become active in "defining their priorities, goals and needs, and reaching out to resources that can help them achieve this" (Richard et al., 2016, p. 18). Phenomenology can give the participant an opportunity to communicate their healthcare experience so that the researcher hears the lived experience – using the information in ways to improve PHC access, health status and quality of life.

Randall, Crawford, Currie, River and Betihavas (2017) reported on patient access, outcomes, and satisfaction alongside cost-effectiveness in a systematic review of community-based nurse-led clinics. The authors analyzed 15 studies of qualitative, mixed-methods, and quantitative methodology. Although some studies reviewed reported improved access to care as patients reported finding convenient locations with reduced waiting times, the search for more

cost-effective nurse-led care services continued. Although studies reported that NMHCs

delivered cost-effective primary care, a limitation of the overall study included that few studies

actually explored the economic benefits of an NMHC. In most studies the patient self-reported

health outcomes via a survey or upon questioning. The researchers recommended utilizing

objective measures rather than subjective measures in building a future evidence-base with

greater methodological rigor to reflect patient health outcomes. Finally, the researchers

recommended the need for a standardized structure to evaluate the cost-effectiveness of NMHCs,

which would serve to provide strong rationale for expanding community-based nurse-led care

clinics. Findings of the review indicated the importance of the NMHC as an important model of

care that helps meet the needs of underserved individuals, contributing to bridging the primary

care gap. Without a doubt, additional NMHCs can support the existing primary care physician

clinics.

In a non-experimental design study, Coddington, Sands, Edwards, Kirkpatrick and Chen

(2011) conducted an assessment and analysis of care provided to medically underserved children

at a pediatric NMHC in Indiana to determine if care received met national pediatric Healthcare

Effectiveness and Data Information Set (HEDIS) quality indicators. The sample consisted of

pediatric patients between birth and 21 years. Data was gathered from 500 chart reviews of

current patients and compared to national pediatric HEDIS indicators. A *t*-test was used to

determine the statistical significance between HEDIS quality data collected at the clinic and the

targets set by the office of Medicaid policy and planning (OMPP). Results were statistically

significant with a *p* less than .05. Research findings included that children's access to care scored

above the 90th percentile for all age groups when compared to the national benchmark standards

(National Committee for Quality Assurance, 2007) for patient access. Treatment of upper

respiratory infections (URIs) without antibiotics exceeded the OMPPs target. Of 50% of children

diagnosed with an URI with no secondary diagnosis ($N = 57$), no antibiotic treatment was given.

The clinic's measure of 100% exceeded OMPP's target measure of 87%. The results of the study

suggested that care delivered by the pediatric NMHC met or exceeded HEDIS benchmark

standards of care and targets set by the OMPP.

Implications for practice included that NMHCs increase access to healthcare for the

medically underserved population, rendering high quality care that exceeds national standards.

Further, evidence suggest that these centers support the pediatric population in the community

thereby, helping to mitigate the local pediatric primary care physician shortage. Emphasized by

the findings was the need for collaboration between NMHCs and physician-managed clinics to

meet the growing demands of the underserved population in need of access to primary care

services in communities across the nation. A limitation of this study was that data were collected

from one local pediatric NMHC.

The purpose of a descriptive study by Auerbach et al. (2013) was to analyze the impact of

NMHCs and patient-centered medical homes (PCMHs) on primary healthcare access, and project

the supply and demand of nurse practitioners (NPs), physician assistants (PA), and physicians for

primary care in 2025. The need for an additional 261,000 primary care physicians by 2025 is

projected due to the growth and aging U. S. population alongside effects of the Affordable Care

Act (ACA, 2010). However, the share of primary care physicians is expected to decrease from

71% to 60%, due to increase in NPs and PAs between 2010 and 2025. The projection of two

physicians per NP in 2025 is less than the four physicians for every one NP reported in 2010.

Using alternative scenarios to forecast the supply and demand of primary care physicians

and NPs, and the impact of NMHCs and PCMHs on primary healthcare delivery, the researcher

forecast scenarios revealed that: (1) a surplus of NPs alongside a shortage of physicians was plausible, (2) a greater ration of NPs to physicians could help expand primary healthcare access, and (3) the physician shortage could be mitigated with growth of the NMHCs and PCMHs, as two emerging models of care. Moreover, study findings reduced the projected physician shortages when greater reliance on NMHCs and PCMHs was envisioned.

A limitation of this study is that the researchers created scenarios to project the impact of these two models on primary health care delivery - some scenarios less plausible than others. The accuracy of projections was dependent upon the accuracy of forecast models utilized. In addition, the researchers did not account for the impact of other models of care such as retail clinics. Nevertheless, the study does yield valuable information regarding future demands on the primary healthcare system and the projected primary care shortage, in which providers can plan and implement changes to improve healthcare access for population health management (Auerbach et al., 2013).

Facilitators and Barriers to Healthcare Access and Experiences of Vulnerable Populations

Ten studies examined multiple barriers to primary healthcare access among vulnerable groups. Seven of these studies addressed healthcare disparities among undocumented immigrants and homeless populations. The authors of two studies sought a deeper understanding of patient healthcare encounters, which included their experiences with language barriers and difficulties attaining health insurance. The final author explored the impact of healthcare insecurity (HCI) on impoverished, uninsured patients seeking care at a free clinic.

Undocumented immigrants. The healthcare needs of undocumented immigrants are a growing concern, as these individuals represent 25% of the uninsured population nationwide (Wallace, Torres, Sadegh-Nobari, Pourat, & Brown, 2012). Tiedje and Plevak (2014) conducted

a case study in a free clinic in southwestern Minnesota serving Latino immigrants of uncertain documentation. Thirty clinic volunteers—including health professionals, administrators, language interpreters, and spiritual leaders—participated in a 14-month study in which data were collected through ethnography and semi-structured interviews. The researchers examined the clinic volunteers' motivations, experiences, spiritual advocacy, and vision. Data analysis included transcript coding, a discussion of emerging themes, and the description of new themes. These steps culminated in a consensus of four final themes: role and mandate, volunteer motivations, faith and medicine, and the right to health and advocacy. The discussion of findings highlighted how the tensions between the volunteers' faith-based medical humanitarianism and issues surrounding humanitarian efforts in high-income countries unexpectedly pushed them into political advocacy roles. One study limitation was the fact that the volunteers had an in-depth knowledge and understanding of the clinic's organizational framework, meaning participant observation could have influenced results (Tiedje & Plevak, 2014).

Many volunteers felt compelled to serve at the clinic due to their spiritual or humanitarian beliefs that undocumented immigrants deserve access to basic healthcare services. However, many other community members held views that did not support their efforts. For example, some local residents and other healthcare institution leaders viewed the provision of medical services to migrants as counter to their ideal of achieving prosperity through hard work. Even some of the healthcare workers did not feel these patients deserved free care in the U.S. Several volunteers felt that such moral and legal principles were held at the expense of migrants' health. In the larger community, the spiritual connection was not strong enough to overcome other community members' desire to withhold healthcare from undocumented immigrants or convince cynics that

46

clinic volunteers view the provision of basic medical services to this population as a moral

commitment and spiritual calling (Tiedje & Plevak, 2014).

Despite these contrary community voices, clinic volunteers put aside community and

political conflicts and chose to focus on caring for the sick and suffering—one strategy for

connecting social justice and the right to health. Clearly, the volunteers' spiritual calling and

ethical commitment to care for the sick was exemplified in their provision of medical services

and community-building efforts. The volunteers acknowledged their commitment to the

undocumented immigrants in the face of the U.S. government and society being unwilling or

unable to provide these basic services (Tiedje & Plevak, 2014).

While these participants volunteered at the clinic to provide healthcare and not participate

in a political debate, they found that the moral and legal principles they held about giving

migrants healthcare access unexpectedly drew them into political advocacy. These researchers

concluded, "While a spiritual calling may initially motivate volunteers to serve, an embrace of

human rights advocacy is important in a sustained effort to provide humanitarian medical care to

individuals who fall outside of the political and moral community in the U.S." (Tiedje & Plevak,

2014, p. 1).

Homeless populations. Two studies discussed challenges and barriers to healthcare

access amid the provision of palliative care for structurally vulnerable (homeless) populations

(Hudson, Flemming, Shulman, & Candy, 2016; Stajduhar et al., 2019). The critical theory

perspectives of equity and social justice informed Stajduhar et al.'s (2019) ethnographic study

conducted in a western Canadian province. These researchers sought to identify barriers to care

for vulnerable, end-of-life (EOL) populations. The study included three participant groups:

structurally vulnerable individuals (either homeless or vulnerably housed as defined by income

level; *N*=19), their support persons (family members; *N*=16), and their service providers (clinicians; *N*=23). Structurally vulnerable populations are individuals experiencing homelessness and living in poverty. Often with a history of trauma or violence, these individuals experience social isolation and racism, along with the stigma often associated with behavioral, mental health, and mobility or disability issues (Stajduhar et al., 2019).

Data collection over 30 months consisted of 300 hours of observations and interviews. Context-specific interview questions included asking participants about their healthcare interactions and decisions surrounding care access. The findings indicated that EOL populations attempting to access EOL care faced significant barriers. Inequities in accessing care included the problem of identification, the normalization of dying, risk and safety management, the survival imperative, and healthcare system gaps. Observations revealed that healthcare providers (HCPs) lacked awareness about how the everyday requirements of food, shelter, and income influenced participants' ability to access palliative care services (Stajduhar et al., 2019).

The structurally vulnerable populations in this study fell between the health and social service systems' defined boundaries. These individuals experienced disorganization in a complex, fractured healthcare system in which they were sent to many different care settings. Despite the challenges, participants described their resilience within the system as they drew upon their past experiences of stigmatization and other forms of injustice. However, because their experiences did not align with those of a normative palliative care population (i.e., they did not follow a predictable trajectory), participants often found that adequate services were not available to them. The researchers concluded that meeting the needs of dying patients required innovative approaches that considered the social determinants of health in addressing the socio-structural inequities that influence care access (Stajduhar et al., 2019).

Hudson, Fleming, Shulman, and Candy (2016) systematically reviewed and analyzed qualitative study data (*N*=9) to develop a deeper understanding of healthcare access challenges for uninsured, homeless people at EOL in order to offer suggestions for providing palliative care for this population. Their data analysis included a three-step inductive process to explore similarities, differences, and relationships between studies employing thematic synthesis. The research studies reported on the views of homeless people (*N*=98), hostel staff (*N*=38), outreach workers (*N*=14), and healthcare and social care professionals (*N*=103; Hudson et al., 2016).

The three broad areas of data derived from the analysis were chaotic lifestyles, the complexity of mainstream healthcare systems, and the delivery of palliative care within a hostel for homeless people. The homeless individuals' social and living conditions complicated their ability to access palliative care. These individuals described the desire for compassion, company, and a familiar environment during EOL. In fact, some homeless people wished to remain in the hostel due to the familiarity of the environment, established relationships, and their dislike of hospital environments. The hostel staff often supported the homeless residents' wishes, viewing them as family. The staff also provided physical and emotional support, and promoted dignity and quality of life for the residents. Some homeless persons were reluctant to discuss death and dying. Their previous experiences trying to access primary healthcare informed their attitude towards healthcare, which included mistrust often shaped by discrimination, disrespect, and disempowerment. This mistrust contributed to their lack of desire and inability to engage with health and social services (Hudson et al., 2016).

Obstacles to healthcare access included competing day-to-day priorities, the burden placed on hostel staff trying to support residents at EOL, the experience of stigma, and difficulty accessing care in mainstream healthcare systems. Unfortunately, participants described being

uncomfortable in institutional settings, generally avoiding medical services and personnel. Consequently, as a marginalized population these individuals experienced high rates of morbidity, often dying young due to complex health problems (Hudson et al., 2016).

A range of individual and systemic factors greatly challenged healthcare access and the provision of palliative care for this vulnerable population. A lack of continuity and planning by healthcare and social care professionals resulted in a scarcity of options for homeless people with advanced care needs. Some hostel staffers and other HCPs did not have the training or experience needed to provide appropriate palliative care to homeless people, and therefore found it difficult to meet their needs. Some healthcare workers described a failure of adequate provision of quality palliative care. Patients described negative attitudes from some HCPs, but the HCP's lack of training could have contributed to their behavior (Hudson et al., 2016).

Changes are to improve and ensure equitable healthcare access for this population. Homeless individuals considered building trusting relationships with healthcare professionals as an essential step. Additionally, professionals collaborating and sharing their views about best practices for supporting homeless people was considered vital in developing consistent, prolonged relationships to benefit this population. Recommendations for future research included ensuring that homeless, uninsured people have a platform to share their views and needs about the complexities of palliative care (Hudson et al., 2016).

Healthcare access among homeless women with a history of intimate partner violence (IPV; defined as being physically assaulted by an intimate partner) was the focus of a quantitative study by Vijayaraghavan et al. (2011). These researchers examined health, healthcare access, and healthcare use among 329 participants interviewed across 28 shelters in New York City. Cardiovascular risk factors (diabetes, hypertension, or obesity), sexually

transmitted infections (STI), and psychiatric conditions were reported among one-third of participants (*N*=108).

Participants with a history of IPV were more likely to report having medical and psychiatric conditions, and being insured compared to those without such history. Despite the surprising majority of participants stating that they had health insurance (approximately 75%; *N*=246), less than half reported having had a primary care (PC) visit in the past year. Furthermore, approximately one-third (*N*=108) of participants reported not having a PC provider. As a result, more than half of the participants (*N*=182) used emergency department (ED) services rather than PC services. The researchers emphasized the need to identify and eliminate barriers to healthcare access among this vulnerable population—individuals with medical and psychiatric illnesses and a history of IPV—to promote their use of PC services rather than costly emergency care services. As noted in previous studies, researchers emphasized the need for HCPs to acknowledge and identify non-financial barriers to PC among their patients. This study's results may be generalized to homeless women living in shelters in other cities across the country (Vijayaraghavan et al., 2011).

In their systematic review of 12 studies with 1,082 homeless persons, McInnes, Li, and Hogan (2013) focused on engaging vulnerable populations in healthcare. The authors sought to understand how the use of information technologies (IT) by vulnerable members of society changed their engagement with health services, treatment adherence, and health behaviors. The study used three research questions: What is the prevalence of access to and use of IT (internet, mobile phones) by homeless populations? What are homeless persons' purposes for using IT?, and What are the barriers to and facilitators of access to and use of IT by homeless populations? (McInnes et al., 2013).

Despite the study population's limited resources and the assumption that homeless persons lack access to communication channels, mobile phone ownership in the sample ranged from 44% to 62% and computer ownership from 24% to 40%. Moreover, computer access ranged from 47% to 55% and Internet use from 19% to 84%. While higher than expected, these rates were lower than those reported in the general U.S. population (McInnes et al., 2013).

The researchers discovered that their rationale for using technology included connecting with family, having a sense of personal safety and security, and maintaining the ability to reach police and medical help quickly. Notably, possessing technologies mitigated the stigma associated with homelessness, as having an e-mail address and mobile phone number suggested stability and normalcy. Conversely, the limited number of public computers was a common barrier to IT, followed by a lack of computer skills and the cost of owning and maintaining technologies, particularly mobile phone fees. Two facilitators of technology use were pay-as-you-go phones (considered more desirable than contracted mobile phone options), and the availability of computer training programs (McInnes et al., 2013).

One study limitation was the fact that the reviewed studies were conducted in a single city neighborhood, with none conducted in rural areas. The researchers noted the importance of increasing homeless persons' access to technologies to address their economic and health disparities. To increase homeless persons' engagement with the healthcare system, the researchers recommended HCPs use technology for appointment reminders and notifications of laboratory test results. Furthermore, IT could be used to reduce risky behaviors (e.g., smoking, alcohol and substance use) through mobile applications that include tailored interventions and motivational interviewing. Such applications could be especially helpful for homeless persons who often have difficulty accessing health centers (McInnes et al., 2013).

In their quantitative study, Parker and Dykema (2013) reported on homeless persons'

health conditions and mobility characteristics. The authors used a convenience sample to recruit

participants (*N*=674) from a homeless registry in a medium-sized southern city in the U.S.

Participants were primarily male (75.93%), with a majority (62.76%) identifying their primary

race as Black American. Of the sample, 16.62% reported having military service (*N*=112), less

than half (36.80%) graduated high school, and nearly one-third (31.90%) had a disabling

condition.

Chronic homelessness, defined as "four or more occurrences of homelessness in the last

three years or one year or more of homelessness" (Parker & Dykema, 2013, p. 686), was

reported by 28.93% of participants. More than one-third (*N*=260, 38.58%) reported experiencing

"first time homelessness" and one-quarter (*N*=171, 25.37%) had "one or two episodes of

homelessness." Reasons given for homelessness included unemployment, under-employment,

and/or low-income (*N*=199, 29.53%); job loss (*N*=93, 13.80%); lack of affordable housing

(*N*=61, 9.13%); and a chronic health condition (*N*=35, 5.24%; Parker & Dykema, 2013).

Interestingly, the authors reported less mobility and lower transiency among homeless

persons than the general state population. This finding challenged the current, conventional

stereotype that homeless populations have high mobility. Chronic homeless persons reported

having fewer financial resources, poorer physical and mental health outcomes, and less family

support than episodic homeless persons. These individuals tended to stay in the state where they

were born due to scarce social support, low socioeconomic status, and fewer essential resources

for relocation. For similar reasons, the chronically homeless were more likely to access the ED

when seeking medical care due to lack of financial resources (Parker & Dykema, 2013).

The standard ED practice of advising patients to return to the ED if symptoms persist for non-emergent issues encourages recurrent ED visits, and increases patient dependence on and overcrowding of the ED. Provider education is essential for ED clinicians who believe that homeless persons would not benefit from PC referral (Parker & Dykema, 2013).

The study findings suggest that connecting homeless persons to the healthcare system through PC clinics could reduce costs, conserve resources, and improve healthcare. With homeless populations more likely to use the ED, these findings could be used to educate healthcare system administrators and clinicians about the homeless population's mobility characteristics in order to improve healthcare delivery. In addition, policy changes are needed to ensure an active link between the healthcare system and programs designed to meet the homeless population's needs (Parker & Dykema, 2013).

While this study used the convenience sampling technique—which can increase the potential for bias—the high sample-to-population percentage (88%) helped mitigate bias in the population sample for the city where the study was conducted. Although generalizability to populations in similar cities may be valid, the authors urged caution in doing so. Future research recommendations included shifting non-acute and chronic care treatment provided by EDs to outpatient and PC approaches (Parker & Dykema, 2013).

Corscadden et al. (2018) investigated multiple barriers to primary healthcare access among vulnerable groups through an international survey of 11 countries including the U.S. Data from participant responses to questions on the *2016 Commonwealth Fund International Health Policy Survey of Adults* (Commonwealth Fund, 2016) regarding access barriers experienced before and after reaching a PC practice. Access to care was defined as a process that began when patients perceiving a need for care and included seeking, reaching, and obtaining care, and then

benefitting from the received services. Vulnerable groups were females and people over age 65, as well as those with lower income, experiencing chronic physical and mental health conditions, and not born in the country where they resided. Multiple barriers across countries were consistent among vulnerable populations (Corscadden et al., 2018).

Participant response rates ranged from 11% to 47% among 1,000 to 7,000 respondents across 11 countries. Multivariable logistic regression was used to determine the percentage of each vulnerable group, access barriers for each country, as well as a country average. Measures were grouped into barriers experienced before and after reaching a PC clinic. Barriers experienced before reaching a PC clinic included difficulty accessing clinics after hours, difficulty getting a timely appointment, receiving no response to calls, skipping recommended tests, not filling medication prescriptions, and not continuing care due to cost. Barriers after reaching a PC provider included regular care provider did not care/listen, and provider did not know patient history, coordinate care, or spend enough time with the patient (Corscadden et al., 2018).

Before reaching PC practices, one in five adults (21%) experienced multiple barriers. On average, 21% of adults experienced two or more barriers before reaching a PC clinic (a 6% to 38% range across countries). Among participants with a regular PC provider, 16% (a 5% to 30% range across countries) experienced two or more barriers after reaching the PC clinic. Overall, seniors (aged 65 years and older) were less likely to experience PC access compared to younger adults (Corscadden et al., 2018).

Participants with lower income were more likely to experience multiple barriers before reaching care. Lower income participants also experienced multiple barriers after reaching care, with an adjusted odds ratio (AOR) of greater than one for all countries. Those born outside their

country of residence experienced disparities in accessing PC, before reaching PC, and after reaching PC. These disparities primarily were related to language and cultural differences between the participant and PC provider. Being born outside the resident's country—particularly after reaching PC in the U.S., Canada, Switzerland, France, and Australia—was associated with multiple barriers (ranging from 1.59 to 3.12, $p < 0.05$). Few significant differences by sex were reported, although females were more likely to experience multiple barriers, particularly before reaching care in New Zealand (AOR 1.99, $p < 0.05$).

Participants with mental health issues experienced greater barriers after reaching care. Furthermore, these individuals experienced additional factors such as stigmatization related to seeking care and PC providers' lack of preparation for addressing mental health issues.

The findings clearly showed that participants experienced care barriers at different points in the pathway to care. Below-average income, immigrant status, and chronic conditions (physical and particularly mental health issues) were key factors associated with multiple barriers. One study limitation was the different number of respondents and response rates for each country. This factor made establishing significant differences between countries difficult. The researchers suggested that future studies be conducted to consider the cumulative effects of multiple factors (low income, and mental and chronic health conditions) on primary healthcare access barriers (Corscadden et al., 2018).

Language barriers. An urban safety-net center in Northern California was the setting for a qualitative study examining patients experiences beyond standardized satisfaction measures (Berkowitz, Phillip, Berry, & Yen, 2018). The purpose of the study was to gain a deeper understanding of diverse patients' healthcare experiences with the aim to build and improve patient-centered quality care. The researchers asked two questions: What makes a clinic

experience positive or negative for a patient? and How do patients' personal, cultural, and historic contexts affect their clinic experience? The research team and their interpreters conducted 19 face-to-face interviews with English-, Spanish-, and Mien-speaking patients. Thematic analysis was used to incorporate the diverse perspectives, resulting in common themes across all three languages (Berkowitz et al., 2018).

The five themes common among all patients regardless of language were feeling cared for and the desire for a personal relationship with the HCP; the importance of HCP knowing their history; the challenges of care performed by resident HCP; communication issues regarding care coordination and following up on treatments and tests; and waiting to get an appointment and be seen by the HCP. The three themes related to language difficulties were the impact of language on relationships, the role of the interpreter as a facilitator of conversations and care between HCPs and patients, and waiting to speak (waiting for interpreter) (Berkowitz et al., 2018).

Study limitations included the potential to lose interview information due to misconstrued translations. Additionally, the short interview length (13 to 60 minutes) precluded exploration of the participants' cultural perceptions of health and well-being. Future, expanded research could add to a broader understanding of the communities' role and engagement in PC, and provide rationale for community-tailored nursing interventions (Berkowitz et al., 2018).

Despite the limitations, the study offered several practice implications. The most signification implication was the receiving of external funding to develop a patient-centered PC council consisting of clinic staff, medical providers, and English-, Spanish- and Mien-speaking patients. Clearly, hearing and gaining a better understanding of the patients' perspectives enhanced their ability to engage in PC visits—an important study finding. Furthermore, the

authors stressed the importance of conducting qualitative research to understand patient perspectives beyond standardized satisfaction measures (Berkowitz et al., 2018).

Health insurance access. The purpose of the quantitative study by Desmond, Laux, Levin, Huang, and Williams (2016) was to elucidate patients' perspectives of their experiences seeking health insurance. Data was gathered from participants (N=80) through a survey administered over a three-month period at a student-run free clinic in Michigan. The seven researcher-created survey questions examined patients' eligibility and activities in pursuing health insurance. Male (N=44) and female (N=36) respondents ranged in age from 20 to 76 years, with a mean age of 47.7 years. Fifty-seven percent of respondents were under the income cutoff for Medicaid eligibility (138% of the federal poverty level [FPL]). Bivariate comparisons were used to analyze responses to close-ended questions in relation to %FPL using Chi-squared tests. The survey included two additional open-ended questions: What prevented you from applying for Medicaid? and What prevented you from looking elsewhere for health insurance? (Desmond et al., 2016).

More than half of the patients cited the perceived expense of Medicaid-expansion insurance as their primary reason for being uninsured. Although 57% of respondents were eligible for the Medicaid expansion program by income (<138% FPL), only 35% had recently applied for coverage. A lack of knowledge about eligibility and income requirements prevented some individuals from accessing Medicaid. However, the Medicaid application rates for those above and below 138% FPL (p=0.901) did not differ significantly. Moreover, individuals above 138% FPL reported looking for insurance elsewhere at over twice the rate of individuals below that income level (p=0.001; Desmond et al., 2016).

Undoubtedly, respondents' primary concern was the cost of insurance. Therefore, many chose not to seek insurance based on their perception of being ineligible for lower cost plans through Medicaid. This choice was the primary barrier to accessing insurance. Other barriers included residency, undocumented immigrant status, and personal or political objections to the existing insurance options. In light of these findings, the authors emphasized the importance of these individuals being guiding through the changing healthcare landscape by healthcare workers who have close relationships with them. Many of these uninsured individuals also had access to PC at free clinics (Desmond et al., 2016).

Study limitations included the small sample size and only using % FPL to estimate Medicaid eligibility. One recommendation for future research was to examine states offering expanded Medicaid coverage (Desmond et al., 2016).

Healthcare insecurity. Tomsik et al. (2014) conducted their quantitative study to define the concept of healthcare insecurity (HCI), validate a new self-report measure, and examine the impact of care provided at an uninsured patients' free clinic in Northeast Ohio. HCI was defined as "feeling uncertain, anxious, and vulnerable about the ability to obtain or sustain adequate healthcare services" (Tomsik et al., 2014, p. 1822). This concept is a measure of an individual's subjective sense of lack of control and worry about obtaining needed healthcare. The authors purported that the data gained from identifying and measuring HCI could be used to detect and reduce sources of unnecessary suffering among the underserved to improve healthcare for this population.

Study participants ($N = 52$) who met the clinic's care requirements of being uninsured and at 200% of the federal poverty level completed a baseline questionnaire that included the Veterans RAND 12-item Health Survey (VR-12), the 10-item Perceived Stress Scale (PSS), and

the 15-item HCI measure. The participants completed the questionnaire at their first clinic visit before receiving care. Next, consecutive study participants ($N = 43$) again completed the HCI four to eight weeks later, either at a follow-up clinic visit or by mail. The lead investigator wrote the 15 items to assess HCI using literature review data and his clinical experience with uninsured and indigent populations. The HCI questionnaire has an internal consistency of alpha = 0.94 and uses a five-point scale, with responses ranging from strongly agree to strongly disagree, with 0 representing low insecurity and 4 representing high insecurity. In addition, a subset of participants (N=15) were interviewed to gain a deeper understanding of how free clinic access affected their HCI.

Chi-square and t-tests were used to compare the scores of participants who did and did not complete follow-up questionnaires (all p-values > than .05). Patient-reported HCI significantly decreased (p< .001) on individual HCI items as well as on HCI, PSS, and VR-12 summary scores (which changed from baseline to follow-up). HCI improvement was positively correlated with PSS improvement (r=0.33, r=.043). The following four HCI items had the greatest change between initial and follow-up assessments: I feel like nobody is looking out for my healthcare needs, I feel secure about how my healthcare needs are met, I would be able to receive non-emergency medical care if needed, and I can easily see a primary healthcare provider.

In addition, data from the debriefing interviews, which averaged eight minutes, confirmed that most participants felt less anxious about their ability to access healthcare after patient establishment at the free clinic, and therefore felt better about their health overall. Their access to treatment as an established patient, along with their reduced uncertainty about receiving healthcare when needed, contributed to several positive participant descriptions: "It's just the

ability to know that if something is wrong, I can come down and we can address the situation," "I just feel better about being able to maintain my health," "I'm comfortable with knowing that I'm going to be taken care of, whatever I need," "I'm not rich but at least know I'm taken care of medically and I have no worries," and "I feel more secure now being able to know that I have healthcare" (Tomsik et al., 2014, p. 1827).

The data confirmed that participants felt less anxious about their ability to access healthcare after becoming a patient at the free clinic. The authors concluded that HCI can be measured readily using the HCI self-report instrument. The authors also reported that vulnerable patients' HCI (stress and worry) improved after they accessed and received healthcare at the free clinic. Moreover, the findings indicated that free clinics offer a source of care that promotes preventive service delivery and decreases emergency room use among uninsured patients. Indeed, the ability to access care at the clinic was shown to reduce suffering among this underserved population.

Study limitations that limited variability were the small sample size and single study site. The researchers recommend continued study of how healthcare reforms affect uninsured and underinsured populations. They recommended researchers focus on cost, access, and quality of care in order to find ways to provide more care uniformity. The researcher also concluded that HCI has the potential to become a key descriptor of patients' perspectives about accessing healthcare as healthcare policy changes continue to affect healthcare reform. The ability to measure HCI among vulnerable populations ultimately may provide information that can be used to design and implement healthcare improvement efforts.

Discussion

Limitations and Gaps in the Literature

The literature review provided evidence that NMHCs contribute to primary healthcare for underserved and uninsured populations through collaborative care models that promote health and wellness. The available professional literature addresses NMHCs community impact on the safety-net population, health promotion among targeted populations with chronic illnesses, and contribution to improving healthcare access for uninsured individuals (Ely, 2015; Mason et al., 2015; Van Zandt et al., 2008). In addition, the expanded literature review focused on facilitators and barriers to healthcare access and vulnerable patients' experiences accessing and receiving primary healthcare (Corscadden et al., 2018; Hudson et al., 2016; Stajduhar et al., 2019). Key limitations to the studies reviewed that could reduce the generalizability of the findings include small sample sizes, single locations, and geographical factors.

In general, this limitation likely reflects the paucity of relevant literature addressing NMHCs over the past 15 years, and more specifically, addressing patient experiences of impoverished, uninsured populations. Although the literature yielded important information about NMHCs and barriers to healthcare access among vulnerable populations, descriptions of the lived experience of uninsured individuals accessing primary healthcare were not found in any of the studies reviewed or cited below.

Clearly, there is a lack of nurse-led research on patient experiences at NMHCs. It is up to nurse researchers to assure that patients' voices are heard. Through the lens of Merleau-Ponty (1945/1962), understanding the meaning of the patients' healthcare experiences can be revealed in the context of nursing practice. Phenomenological inquiry allows researchers to empower and engage with patients to elicit and understand their experiences accessing and receiving healthcare as impoverished, uninsured individuals. The findings of such research could provide valuable

information to build an evidence base of best practices in designing effective healthcare

programs for this economically disadvantaged population.

Implications of Findings

Following is a discussion of the implication of literature findings on NMHCs community

impact, teaching strategies to promote health, viability challenges, population targeting, and

impact on care access. In addition, experiences regarding facilitators and barriers to care access

for impoverished, uninsured individuals is discussed. It is important to note that many of the

studies cited documented more than one of these areas.

Community impact. Study results indicated that, in addition to being important primary

healthcare providers to medically underserved individuals, NMHCs strengthened the healthcare

delivery system, increased healthcare accessibility, and played an important role in community

wellness promotion, disease prevention, and chronic condition management (Pohl et al., 2004).

Although NMHC types varied, common across the studies was the description of NMHC's value

in community outreach and addressing healthcare disparities.

Some studies noted how participants valued these centers. For example, patients,

families, and NP students recognized and supported having an ANMC in their community (Pohl

et al., 2007a; Tanner et al., 2003; Van Zandt et al., 2008). Additionally, patients and families in

one study appreciated the care delivered by their providers, understood the value of ANMC-

delivered continuous care for families and communities, and substantiated the center's ease of

accessibility and its role in addressing community care shortages (Pohl et al., 2007a).

While identifying the main goal for primary care clinics is increasing the number of

patients served, Dols et al. (2018) focused on identifying NMHC's measures of excellence in

care quality, clinical outcomes, and patient satisfaction. In similar findings, Ely (2015) echoed the importance of integrating care to increase patient volume and care access.

Although these two studies emphasized increasing patient volume to increase access to care, there is no inquiry into patients' experiences or their needs in yielding information to improve patient volume and healthcare accessibility. In any case, neither study addresses the question of the patient's healthcare experience in receiving primary care in the community, a justification for the choice of phenomenology for this study.

Teaching strategy. The literature confirmed that ACNMs host educational experiences for undergraduate and graduate students, faculty practice, research, as well as model standards of evidence-based practice (EBP). Of the studies reviewed, the interconnectedness of education, research, and practice is represented best by Van Zandt et al.'s (2008) case study in which students practiced active learning and translated decision-making skills into clinical practice for community residents. Understanding the value and importance of EBP, NP students at ANMCs actively gained awareness of community resources to help meet patient needs (Tanner et al., 2003; Van Zandt et al., 2008).

Certainly, the use of ANMCs as a clinical practice teaching strategy to address health disparities while increasing healthcare access and improving health outcomes among vulnerable populations is well-documented (Pohl et al., 2007b; Tanner et al., 2003), while simultaneously translating evidence-based decision-making into clinical practice. NP students actively play a role in expanding the vision and mission of a SON into the community through their role of providing health promotion and wellness interventions at ANMCs (Pohl et al., 2007b; Tanner et al., 2003). ANMCs are valuable organizations that can stretch into the community and connect

with the target population it serves, while students simultaneously translate evidence-based decision-making into clinical practice.

Although Van Zandt et al. (2008) acknowledged that patients viewed services positively overall, no findings reflected patients' perceptions of their individual healthcare experiences. Notably, these researchers suggested the need for future nurse-led research to provide a stronger evidence base that positive experiences at ANMCs can result in favorable health outcomes for underserved populations. By soliciting and analyzing participants' personal narratives of their healthcare experiences, researchers can gain a deeper understanding of this significant human phenomenon. One of Van Zandt et al.'s (2008) recommendations was to create awareness of these centers' contributions by communicating related evidence-based research findings to healthcare professionals.

Financial challenges and viability. Two studies discussing ANMCs financial challenges emphasized the importance of establishing benchmark performance measures (Vondereheid et al., 2003; King, 2008). Recognizing the need for ANMCs to contribute to a national database of financial performance measures, Vonderheid et al. (2003) reiterated the fact that little is known about ANMCs' financial performance or the financial performance indicators that characterize profitable centers.

Unfortunately, the variety of care delivery methods among ANMCs makes it difficult to establish performance measures. Indeed, before financial performance measures can be established for these centers, the criteria defining a center first must be determined. Esperat et al. (2012) echoed the need to determine and communicate ANMCs defining characteristics so that centers can receive funds and survive in a competitive healthcare market. Clearly, there is a need for further research to define the ANMC. An important issue has emerged from the formidable

challenges that ANMCs face in maintaining balance in the tripartite mission: how to commit resources to advance this agenda. Therefore, communication of a clear definition and description of these centers is essential to describe the ANMC's role in order to obtain financial sustainability.

While Esperat et al. (2012) highlighted ANMCs vital contributions to the safety net population, they also presented surprisingly contrasting information regarding the future of ANMCs. Given ANMCs' financial struggles, Esperat et al.'s (2012) contrasting information that they shift away from their academic roots in order to grow is not surprising. Centers' financial autonomy is constrained by regulatory practices, reimbursement regulations, and other restraints. In any case, moving away from academia jeopardizes the ANMC's mission and main distinguishing feature – to connect education, research, and practice.

Population targeting. Recognizing the need to provide comprehensive healthcare services for chronic mental and physical illnesses is essential in meeting community needs. Two studies provide important evidence of the challenges of including mental health services in all areas of healthcare delivery (Ely, 2015; Nardi, 2011). While Ely (2015) acknowledged that integrating primary and mental healthcare addresses the patient's biological, psychological, social, and spiritual needs, the primary reason for using the integrated model was to increase patient volume to promote center sustainability.

Determining and meeting patient needs is central to the delivery of quality, accessible healthcare. Further, identifying and determining patient needs in advance of developing and implementing community outreach programs is important for designing effective healthcare interventions that improve outcomes. For example, Bucher et al. (2012) and Dyal et al. (2016)

confirmed the value of exploring targeted populations' healthcare experiences when planning

outreach programs for individuals with asthma and HTN.

Improving care access. Randall et al. (2017) and Coddington et al. (2011) reported on

NMHC's favorable patient access, outcomes, and patient satisfaction. Both studies reported on

the delivery of cost-effective primary care and provided rationale for expanding community-

based nurse-led clinics to increase healthcare access for underserved populations. These studies

focused on the NP's role and the NMHC's contribution in influencing health and cost outcomes.

Auerbach et al. (2013) projected NMHCs impact on primary healthcare delivery by

forecasting supply and demand for primary care physicians and NPs. This study provided

valuable information about NMHCs and the impact of the projected primary care shortage on

healthcare access for vulnerable populations, impacting their ability to achieve optimal health.

Selective study findings highlighted how innovative HCPs are using interdisciplinary

care models to expand primary healthcare delivery for vulnerable populations in preventing

health disparities (Mason et al., 2015; Richard et al., 2016; Sutter-Barrett et al., 2015).

Facilitators and barriers for vulnerable populations. The expanded literature review

focused on facilitators and barriers affecting patients accessing and receiving primary healthcare

and their experiences. Researchers sought a deeper understanding of the barriers and challenges

of healthcare access for vulnerable populations (the uninsured and/or homeless; Berkowitz et al.,

2018; McInnes et al., 2013; Parker & Dykema, 2013). These challenges caused individuals to

have difficulty accessing and receiving care in a fragmented healthcare system.

Fragmentation of care—the result of a disorganized, complex, fractured health system—

often challenged patients' ability to access and receive PC in the community (Berkowitz et al.,

2018; Stajduhar et al., 2019). Due to a lack of care coordination and inadequate resources,

patients often were sent to different settings to acquire care, further risking patient safety. Moreover, poor living and social conditions caused shelter, safety, and food needs to supersede healthcare needs, a phenomenon that further complicated the healthcare experience, placing these patients in a more vulnerable situation (Hudson et al., 2016; Stajduhar et al., 2019; Tomsik et al. 2014). Participants in Tomsik's et al. (2014) study "reported feeling uncertain, anxious, and vulnerable about the ability to obtain or sustain adequate healthcare services" (p. 1822). However, these feelings of unease improved after patients established primary care at a free clinic, as one study participant commented, "I feel more secure now being able to know that I have healthcare" (Tomsik et al., 2014, p. 1827). This source of care decreased ED usage among uninsured patients and reduced unnecessary suffering among this underserved population.

Two studies examined barriers to care for EOL populations experiencing homelessness and living in poverty (Hudson et al., 2016; Stajduhar et al., 2019). EOL populations trying to access care face significant barriers due to healthcare system gaps, which lead to healthcare inequities for this population. Generally, these individuals seek healthcare at the ED and only when acute needs arise, a high-cost practice often with poor outcomes. Further fragmentation of care occurs when ED clinicians tell patients with no HCP to follow-up with a primary HCP. This practice leads to vulnerable populations seeking urgent care in the ED rather than PC from an HCP—an example of care fragmentation (Hudson et al., 2016; Stajduhar et al., 2019; Tomsik et al., 2014). Despite the uninsured often having access to PC at free clinics (Desmond et al., 2016), this population continued to seek healthcare at the ED.

Barriers to health insurance coverage included residency, undocumented immigrant status, and personal or political objections to existing insurance options. Citing the perceived high cost of Medicaid-expansion insurance as the primary reason for being uninsured, some

patients chose not to seek insurance, believing they were ineligible for lower cost Medicaid plans (Desmond et al., 2016). The authors stated that such individuals need a trusted HCP to help guide them through the complex healthcare environment. Furthermore, some participants with health insurance still did not have a PC provider. Regardless of the reason, more participants used ED services than PC services. (Vijayaraghavan et al., 2011).

Homeless persons' use of IT despite their limited resources challenged strongly held opinions about this population (McInnes et al., 2013). Given the assumption that homeless persons lack the ability to access communication channels, their ownership and use of mobile phones helped moderate the stigma associated with homelessness. In fact, the use of mobile phones increased patients' engagement with health services, treatment adherence, and health behaviors (McInnes et al., 2013). This finding is of great importance with morbidity and mortality rates so much higher for the homeless than for the sheltered (Hudson et al., 2016). Knowing that the inability to make connections through the healthcare system is a barrier to healthcare access highlights the value of IT in connecting mobility-compromised homeless persons to the healthcare system (Parker & Dykema, 2013).

Researchers underscored three key attributes affecting homeless persons' healthcare outcomes: their difficulty accessing and receiving care in a fragmented healthcare system, their practice of seeking acute care at the ED, and their higher morbidity and mortality rates. In response, researchers emphasized the need to identify and eliminate barriers to healthcare access among this vulnerable population—including those with both medical and psychiatric illnesses— in order to promote their use of PC services rather than costly ED services (Berkowitz et al., 2018; Corscadden et al., 2018; Vijayaraghavan et al., 2011).

The findings clearly showed that participants experienced care barriers at different points in the pathway to care (Corscadden et al., 2018). Such individuals described using their resilience—built from facing stigma and injustice—to face these barriers. Fortunately, some clinic volunteers reported putting aside community and political conflicts in order to focus on caring for the sick and suffering (Tiedge & Plevak, 2014). Their action exemplifies helping to meet population health needs through community-building efforts, and the role that nurses can play in improving community healthcare outcomes.

While this literature review provided some information about facilitators and barriers to accessing care for vulnerable populations, and the current and possible future role of NMHCs in providing primary care for this populations, there were no findings related to the current study's domain of inquiry – the patient's experience. None of these studies used phenomenology as a philosophical and methodological base, and none invited impoverished, uninsured adults to tell their stories about primary healthcare experiences. Clearly, there is a lack of nurse-led research on patient experiences at NMHCs. Phenomenological inquiry allows researchers to empower and engage with patients to elicit and understand their experiences accessing and receiving healthcare as poor, uninsured individuals. The findings of such research could provide valuable information to build an evidence base for designing effective healthcare programs for underserved populations.

Summary

Mason et al. (2015) concluded that promoting health demanded a system that focused on "knowing patients' experiences" (p. 551), building relationships through engaged providers and partners, and embracing an agenda that prioritizes the health of families and communities. Through the lens of Merleau-Ponty (1945/1962), understanding the meaning of the patients'

healthcare experiences can be revealed in the context of nursing practice. The contextual setting of NMHCs – which provide primary healthcare, health promotion, and disease prevention to underserved populations in urban and rural communities – is an important background for understanding the healthcare experiences of individuals seeking care. This understanding can serve as a foundation to communicate needs to both HCPs and healthcare policy makers in planning health programs that improve health outcomes. Thus, this phenomenological study on the patient's experience in accessing and receiving healthcare at NMHCs may help HCPs create and design healthcare programs to improve health outcomes, health status, and quality of life across communities in the U.S.

Highlighting the contextual setting related to barriers in accessing primary healthcare and bringing it to the forefront of nursing, gives support for researchers to examine this topic through the descriptions of those individuals seeking to break through these barriers. Thus, this phenomenological study on patients' experience in receiving primary healthcare is justified and needed. Understanding the meaning of the patients' experiences and perceptions in seeking primary healthcare can aid in efforts to improve community-based nurse-led clinical services and plan health programs tailored to meet the needs of the individual and community.

A review of literature pertaining to the facilitators and barriers to primary healthcare access for vulnerable populations and the impact that nurses and NMHCs make on these individuals' experiences, supports the idea that this phenomenon is an area of concern for the nursing discipline. It is up to nurse researchers to assure that patients' voices are heard. Through the lens of Merleau-Ponty (1945/1962), understanding the meaning of the patients' healthcare experiences can be revealed in the context of nursing practice. Findings may contribute to

71

knowledge needed to develop appropriate interventions for healthcare programs as well as

support current patient interests and interventions.

Chapter 3: Methodology

The purpose of this study was to describe the lived experience of patients as uninsured individuals accessing and receiving primary healthcare at a nurse-managed health center (NMHC). This chapter will describe the qualitative research method and Merleau-Ponty's existential phenomenology approach in greater detail. I will also present the research design to include participant selection, setting of the study, data collection and analysis procedures, ethical considerations, steps utilized to maintain rigor, and strategies for validating findings.

Research Design

This study used a qualitative research approach to gain a deeper understanding of the lived healthcare experience of an uninsured individual accessing and receiving primary care at a NMHC. Qualitative research is suitable for studying topics when little is known about the phenomenon, and has the potential to generate future inquiry into healthcare situations. Through a naturalistic inquiry, qualitative research uses inductive logic to study a topic within its context. Theory may emerge through inductive reasoning while exploring the individual meaning of a phenomenon (Polit & Beck, 2012; Sandelowski, 2008).

The purpose of phenomenology is to discover the underlying structure or essence of a phenomenon (Polit & Beck, 2012). Phenomenology is an appropriate methodology for this study because it focuses on finding the essence and meaning of experiences of the participants regarding their healthcare experiences. The phenomenological research approach states there is no single reality and that each person embraces their own reality. Understanding realities in ways that reflect individual perspectives, the qualitative researcher recognizes that reality is multiple as seen through many views (Creswell & Poth, 2018). Qualitative researchers "give voice to participants so that their voice is not silenced, disengaged, or marginalized," (Creswell, 2015, p.

256). Through a first-person perspective, the narratives voice the meaning of the experience of receiving healthcare at a NMHC.

Existential Phenomenological Philosophy as Applied in the Research Approach

Grounded in the philosophical tradition of Edmund Husserl (1859-1938), and Martin Heidegger (1889-1976), both German philosophers, phenomenology focuses on the meaning of *Being* and human existence (Heidegger, 1927/1962). Initiating the phenomenological movement, Husserl became dissatisfied with scientific laws and wanted to examine things as they are before science reduced them to mere objects. Husserl did not believe that objects in the world existed independently. Husserl argued that anything outside immediate experience must be ignored, which reduced the external world to personal consciousness. Realities are pure phenomena and the only data from which to begin. He named this philosophical method, phenomenology, or the science of pure phenomena (Haas, 2008; Matthews, 2006; Pollio et al., 1997).

Heidegger, who studied with Husserl, built upon Husserl's efforts after his death in 1938. The basic problem of philosophy for Heidegger was in discovering the nature of Being. Heidegger combined the existentialist philosophy of Soren Kierkegaard (1813-1855) with phenomenology to explore the nature of *Being.* Kierkegaard (1813-1855), a nineteenth century Danish philosopher and theologian, considered the father of existentialism, believed that individuals were responsible for giving meaning to their life by living authentically -- that this was not the responsibility of science or religion (Haas, 2008; Thomas & Pollio, 2002). Heidegger introduced the concept of *Dasein* or *Being there* and the dialogue between a person and world. *Dasein* is always there, being in itself, adapting and anticipating situations. For Heidegger, *Being-in-the-world* implies that objects are known by the context in which the object is

experienced. Heidegger's major published work, *Sein und Zeit (Being and Time),* (Heidegger, 1927) greatly contributed to the existential movement (Haas, 2008; Pollio et al., 1997).

Merleau-Ponty (1908-1961), a 20th century French philosopher, began his career studying the work of Husserl, alongside Jean-Paul Sartre (1905-1980) and other French philosophers. Merleau-Ponty combined Husserl's descriptive approach to phenomena along with an existential ground as a result of his association with Sartre (Moran, 2000; Thomas & Pollio, 2002). Parting from traditional philosophy, Merleau-Ponty sought a direct description, not a causal explanation, of experience (Thomas, 2005).

Merleau-Ponty did not think that the theoretical ways of understanding required by the purposes of science were the only ways of understanding the world and ourselves. "Science needs to be understood in terms of its basis in direct human experience, so that it cannot supersede that direct experience" (Matthews, 2006, p. 16). Merleau-Ponty asserted that one must get back to the direct human experience and set aside preconceived ideas derived from scientific theories. Through phenomenological reduction, or *epoche,* (a Greek term meaning "suspension of judgement") (Epoche, n. d.), the phenomenologist sets aside presuppositions and "steps back from theoretical preconceptions" (Matthews, 2006, p. 16). Merleau-Ponty did not hold science as invalid, but that "science is empirical, based on human experience, and human experience is always that of particular human beings who engage with the world in the course of *living in it,* rather than *theorizing* about it" (Matthews, 2006, p. 16).

Merleau-Ponty focused on perception of the lived experience (George & Thomas, 2010; Thomas, 2005). Perception is the foundation of the human experience because it provides "a direct experience of the events, objects, and phenomena of the world" (Sohn et al., 2018, p. 125), where person and world co-construct one another. Human beings are active, not passive,

75

interacting with world stimuli. Merleau-Ponty found this interaction with objects and events, the phenomena of ordinary life, very interesting. Meaning is human and worldly, as one interacts with stimuli in the world, toward objects and events in conscious awareness (Kwant, 1963).

Phenomenologists seek the "essence" of an experience through participants' subjective experiences, in a form that is accessible to consciousness and reason. Phenomenologists perceive reality as that which exists because it is experienced through the essential structure of human subjectivity, studying entities for which there is no other material or social truth than subjective (Haas, 2008; Matthews, 2006; Pollio et al., 1997). Putting essences back into existence, phenomenology "does not expect to arrive at an understanding of man and the world from any starting point other than that of their *facticity*" (Merleau-Ponty, 1962, p. vii). Although experiences vary in their interpretations, the phenomenological approach strives for a rich description that illuminates deep essential structures of human experiences, focusing on the direct human experience of the one who lives it. Gathering the unique perspective of how an individual perceives the phenomenon (the event) rather than how the phenomenon exists, phenomenology provides one with a profound, detailed understanding of a single phenomenon.

These foundational tenets from existential phenomenological philosophy in Europe provided the basis for an applied phenomenological research methodology at Duquesne University in the United States (Giorgi, 1997). The method and procedures developed in the Duquesne psychology department influenced the subsequent development of the approach used in the current study. Developed at the University of Tennessee, Knoxville, the method and procedures of this study were first elucidated in Pollio, Henley, & Thompson (1997), further refined by Thomas & Pollio (2002), and most recently explained in Sohn et al. (2017). These procedures will be described in subsequent sections of the chapter.

Participant Selection

A purposive, convenience sample was used to recruit participants for this study. Purposive sampling is commonly used in qualitative studies in selecting research participants to meet the needs of the study (Creswell & Poth, 2018). The sample represented nine participants that experienced the study phenomenon receiving primary healthcare from urban NMHCs in Mississippi (MS). These clinics offer patients a direct relationship with a team of HCPs to promote wellness and enhance chronic disease management.

To be eligible for study inclusion, participants had to (1) be 18 years of age or older, (2) not be a recipient of Medicare, Medicaid, or any private insurance, (3) possess the ability to comprehend the English language, (4) have experienced the phenomenon (had a healthcare experience with nursing staff), and (5) be willing to talk at length about their healthcare experience to the interviewer. The nursing staff is defined as a licensed practical nurse, a registered nurse, or a nurse working in advanced practice, such as a nurse practitioner, and employed by the clinic. Geographically, the centers were no more than a 45-minute drive for the researcher; therefore, the setting was convenient.

Setting of the Study

This study was set in Mississippi, which is situated in the southeastern section of the U. S. and is one of 17 states in the American South. Unfortunately, Southerners are more likely than are people of other regions in the country to be poor, uninsured, and suffer from chronic health conditions (Kaiser Family Foundation, 2014; Stephens, Artiga, & Paradise, 2014). Furthermore, Mississippians are likely to be among the unhealthiest people in the nation ("America's Health Rankings," 2017).

Poverty is common in MS. In fact, MS is one of four southern states (including Kentucky, Louisiana, and West Virginia) with at least one in five residents living in poverty (Artiga & Domico, 2016). Of the MS population (about 2,889,851 people), approximately 571, 219 are estimated to be living in poverty ("Talk Poverty," 2018). This rate (19.7%) is significantly higher than the national (12.7%) and southern state (14.1%) poverty rates (Semega, Fontenot, & Kollar, 2017). Notably, MS ranked 49th of the 50 states in children under 18 in related families who had incomes below the poverty line (26.7%). Additionally, the state ranked 48th for hunger and food insecurity (17.2%) and 46th for unemployment (5.1%) (Semega, Fontenot, & Kollar, 2017).

In addition to experiencing poverty, many Mississippians lack health insurance. The percentage of the MS population (individuals aged 18 to 64 of both sexes and all races) without health insurance was projected to be 21.23% in 2019 ("Percent Uninsured," 2019). Lack of coverage is particularly concerning in the South, including MS, where Medicaid (CMS, 2016) and Children's Health Insurance Program (CHIPS) eligibility levels lag behind other regions in the country (Artiga & Cornachione, 2016). Moreover, most Southern states have not adopted the Medicaid expansion that offers health coverage access (Artiga & Domico, 2016).

The lack of healthcare coverage – in the south in general and MS in particular – is significant, as uninsured individuals are less likely than insured individuals to access care and receive preventive treatment for chronic conditions (Kaiser Family Foundation, 2018). Additionally, ensuring access to preventive, primary, and ongoing care is important in reducing health disparities across populations.

As a group, Southerners are more likely than are other Americans to experience certain chronic illnesses and worse health outcomes. MS is no exception, as its citizens experience high

rates of cardiovascular disease (CVD; including heart disease and stroke) and diabetes. Indeed, heart disease is the leading cause of death in MS ("Stats of the State of Mississippi," 2018). Additionally, MS is the state with the highest CVD mortality rate, with CVD accounting for one-third of all deaths in MS (MSDH, 2019b). Diabetes also is common. With an estimated 308,295 adults living with diabetes – more than 13.6% of the adult population – MS ranked first in the nation for overall diabetes prevalence in 2016. Many more Mississippians currently live with the complications of type two diabetes, which accounted for 1,083 deaths in 2016 (MSDH, 2019a).

The previously discussed factors (poverty, lack of health insurance coverage, and chronic illness prevalence) combined with the state's high rates of obesity and cigarette smoking contributed to MS being ranked the unhealthiest state in the 2017 America's Health Rankings report. Additionally, MS was ranked 50th in clinical care (one of five ranked categories of determinants of health) due to physician and mental health provider shortages and preventable hospitalizations. In regard to the remaining determent of health categories, the state ranked 49th for behaviors, 44th for community and environment, 47th for policy, and 48th for health outcomes. In addition, MS has the highest state infant mortality rate, with 8.8 deaths per every 1,000 live births ("America's Health Rankings," 2017; Wolfe, 2017).

Nurse-managed health center sites. Two NMHC sites in MS were used for data collection. In seeking clinic participation and permission to recruit participants, I described the study to appropriate administrative staff members. In doing so, I obtained a letter of support from each clinic (see Appendices A and B).

Description of clinics. Both clinics were 501(c)(3) non-profit organizations focusing on improving access to healthcare in MS. Although the rich culture, history, and diversity of the state serves as a vital part of the landscape, many healthcare challenges exist. Residents of MS

suffer from lack of access to primary healthcare services and a critical shortage of physicians in the region continues to worsen the problem. The mission of these clinics is to improve the health and education of the men, women, and children who make MS their home. The clinics offer patients a direct relationship with a team of healthcare providers (HCPs) to enhance chronic disease management and prevention. These HCPs stand on the front line in provision of primary healthcare services to the underserved population.

Suffering from high poverty rates, as well as the lowest health rankings across the nation, the clinics serve communities in MS where residents experience poor health status, with little to no healthcare access for primary care and preventative services. One clinic, located in an impoverished area of an inner city, provides holistic care to neglected inner city residents through charitable work in an area with much homelessness and poverty. The road approaching the clinic is riddled with potholes and debris is strewn along the curb's edge. Several people can be seen sitting on the steps leading to the clinic, holding their personal possessions in large, plastic bags. This non-profit organization depends upon many volunteer nurses to render services. Two full-time family nurse practitioners (FNPs), (one a Sister of the Dominican), and one registered nurse (RN) address health priorities of the community, living the mission of caring for all persons with respect for their personal worth and dignity. In addition, two physicians visit twice monthly to support medical and dental health care needs. In 2016, the clinic saw more than 13,000 individuals for routine check-ups, treatment of acute illnesses, eye exams, chronic care, and nutritional counseling. Educational programs for children and adults are provided in an effort to reduce the incidence of disease and promote health. The goals of the clinic include to (a) provide primary and preventive health care, (b) provide health education and

promote lifestyle changes among people in the community, (c) promote volunteerism through use of skills or volunteers, and (d) promote health and well-being to those who are served.

A second clinic, located next to a large church, provides services to area residents who often do without – the homeless and working poor in the surrounding community. Situated on the outskirts of town, the clinic serves the town as well as the rural area beyond. The clinic, an old house converted into medical space, is in much need of fresh exterior paint as well as interior maintenance. The clinic is staffed with one nurse practitioner, one registered nurse, and several volunteers. "This clinic shows that we [staff] have an open heart for getting out and being willing to help the community; that we've noticed the needs of the community," commented one volunteer. Services focus on treating chronic diseases such as HTN, diabetes and women's health issues. Non-medical volunteers help with patient registration, waiting room management, transportation and other duties. Staff members acknowledged the need to serve their constituency, noting the fact that, without the clinic, the patients would either not receive care or go to the ED due to the challenges of seeing a regular physician. One staff member commented, "I think just being here, we can offer a whole lot to the community… we're going to offer some medical help for folks who couldn't get it anywhere else… we hope they'll see God's love through us."

Recruitment Procedure

Following approval from the Institutional Review Board (IRB) at the University of Tennessee (UT), I communicated with staff at each clinic in regard to setting up convenient dates for participant meetings. Prior to the agreed-upon interview, participants completed a consent form requested by the researcher. Informed consent (which outlined purpose, procedures, risks and benefits of the research) was obtained from each of the nine participants at the clinical

settings. In addition, this consent form outlined the voluntary nature of research participation and procedures used to protect confidentiality (see Appendix C). Following consent, I conducted an open-ended interview, face-to-face, with each participant, adhering to the guidelines from Sohn et al. (2017).

Data Collection

The phenomenological research approach states there is no single reality and that each person embraces their own reality. The essence of participants' healthcare experiences as an uninsured individual was explored through open-ended questioning. The opening research question allowed the participant to share their experience with the researcher regarding their healthcare experience.

Pilot interview. A pilot interview was conducted prior to conducting the research study with a single participant that met inclusion criteria. This pilot interview was audiorecorded, transcribed, and reviewed in the University of Tennessee Transdisciplinary Phenomenology Research Group, to help determine any flaws, limitations, or other weaknesses in the study information that was provided to potential participants and in the interview procedure. The UTK Transdisciplinary Phenomenology Research Group (TPRG) is a group of faculty members and students experienced with methods of conducting existential, hermeneutic phenomenology research. Refining of the interview question and data collection procedure was completed based on this pilot interview before the official study. The pilot interview helped the researcher to improve her interview skills - learning to redirect the participant to recall specific incidents in describing their lived experience - by picking up on a word or phrase used previously in the interview.

Interviews. I conducted face-to-face interviews to access the first-person account of the participant's human experience beginning with the following prompt, "When you think about your experiences receiving health care at this clinic, tell me what stands out to you as you recall this experience." The open-ended question gave the participant the freedom to begin the tone of the conversation, and to discuss the subject as they chose. The participants were allowed to discuss any life experience they perceived as representing their healthcare experience. The use of the words "stand out" in a statement can help elicit what is figural in the participant's perception. In addition, repeating a word or phrase that the participant speaks may be helpful in eliciting specific details about an experience. Comments were followed up with other prompting statements such as "Tell me more about that" and/or "Tell me what that is like." The interviews were 45 minutes to 60 minutes in length. A concluding question, "Is there anything additional you would like to add that I have not asked or that you would like to say?" closed the interview. Broad statements and questions kept the focus on gathering data for an understanding of the essence of the experience, and helped the participant elaborate on their experience (see Appendix D). In qualitative research, the researcher is the instrument collecting the data and doing the interpretation.

Field notes were immediately written after the interview, reflecting on the interview process, surrounding environment, and observed nonverbal behavior of the participant. These methodological notes served as reminders regarding the interview and as a critique for oneself on the research process.

Demographic form. I constructed a simple form to gather demographic information. This information included: 1) participant pseudonym, 2) gender, 3) age, 4) race, 5) education, 6) reason care was sought at the NMHC, 7) if patient were recipient of Medicare, Medicaid, or

private insurance, and 8) whether care was provided by an LPN, RN, NP, Other, or "Don't Know" (see Appendix E).

Data Analysis

The data analysis procedure used the existential phenomenological method derived from the philosophy of Merleau-Ponty, guided by research procedures developed by Thomas and Pollio (2002). All interviews were audiotaped and professionally transcribed verbatim, and transcriptionists signed a confidentiality agreement (see Appendices F and G). Names of places and individuals were replaced by pseudonyms throughout the typed text. I read each participant's transcribed data from the interviews to get a general sense of the whole and ideas presented. The interpretation of the data included relating parts (meaning units) to the whole narrative.

The TPRG assisted with various aspects of the study for feedback and contribution of alternative perspectives on the data during the entire data analysis, although not all transcripts were reviewed during group meetings (Sohn et al., 2017). A confidentiality form was signed by the TPRG (see Appendix H). This interdisciplinary interpretive phenomenology group served as an integral part of the data analysis process and assisted in thematization of the interview transcripts. The perceptions, perspectives, and understandings of the phenomenon (healthcare experience event) were analyzed to create an understanding of what it is like to experience this event (the phenomenon). This increased trustworthiness of the findings. The researcher's goal was to see the world as the study participants perceive it.

The steps used during a phenomenological research project are essential in describing the participants' lived experiences. These steps include (1) reading for sense of the whole, (2) reading and identifying meaning units, (2) clustering initial thematic meaning, (3) developing thematic structure, (4) presenting structure to research group, (5) reporting findings to

participants, and (5) preparing the final report (Thomas & Pollio, 2002). This description will highlight figural themes as contextualized by the four existential grounds: body, other people, time, and world. A figure-ground metaphor is used to understand the human experience as certain events stand out while others recede into the background. The figure and ground are never independent of one another (Sohn et al., 2017; Thomas & Pollio, 2002).

The steps for analysis of themes included: The researcher (1) read transcripts line by line to explore the meaning of the words of the participant and look for similar words in the text, reading for meaning units and sense of the whole, (2) examined transcripts for meaning units, themes, and patterns against the existential grounds of world, time, body and others, and (3) performed interpretive analysis in collaboration with the TPRG. After the interpretive analysis group meeting, I dwelled further with the data to identify meaning units, and search for spoken words that are used more than once which may have similar meanings or be interrelated. I then clustered the meaning units into groups (clustering initial thematic meaning). I looked for principal themes to emerge from each cluster group, and identified global themes across interviews (developing thematic structure). Once data saturation was reached, I developed a thematic structure prior to presenting the structure (findings) back to the research group (Creswell & Poth, 2018; Thomas & Pollio, 2002).

As the primary researcher I was responsible for the overall thematic analysis (meaning units and thematization). Analyzing data line by line, and word for word, I moved from particular to the essential, while paying close attention to all words, metaphorical language, and phrases that the participant used to describe their experience (Sohn et al., 2017; Thomas, 2000). No identified global themes were contraindicated. I did not have the ability to review findings with any participants prior to preparing the final report (Thomas & Pollio, 2002).

Coding the meaning units. The participants' words were highlighted and circled on the transcripts as they were read aloud – to *hear* the transcript. One member of the group read the part of the interviewer and another member read the participant's part. The possible meanings of the text were deliberated as members of the group requested the reader to stop reading when something *stood out* regarding the meaning of the phenomenon. Collaborative discussion among group members led to a rich interpretation of results and an "aha" moment - the goal was to identify consistencies among experiential accounts of the phenomenon that are meaningful. All transcripts, containing the notes made during the reading by TPRG members, were returned to the researcher after the meeting, which enhanced the rigor of the study. This process confirms that findings can be interpreted in similar ways by others and allows the researcher to reflect upon differences in interpretations among the TPRG.

Thematization. During the thematic stage, the researcher progressed toward commonalities in the description of the phenomenon. Themes are patterns of description that repetitively recur as important aspects of the participant's description of his experience. A theme describes an "experiential pattern" exhibited in "diverse situations" (Thomas & Pollio, 2002, p. 37). The analysis moved toward global themes that were not contradicted in any transcript. The themes were evident in each participant's transcript and characterized the phenomenon in question. The thematic interpretations were supported by the text.

Thematic structure. The thematic structure reveals the essence of the experience and its context. The relationships among themes are 'woven together with description of existential grounds against which the phenomenon must be understood" (Sohn et al., 2017, p. 139). The final structure is depicted by a figure appearing in Chapter 4.

Writing the report. I reported the data in a written report that conveyed the phenomenon of interest to the reader, writing and making revisions for completeness. Through interpretive narratives, I described meaning as fully as possible. The final product was a rich description of the participants' experiences that are easily understood by the reader and healthcare clinicians. An implication section for practice and policy was included that reported significance of findings.

Ethical Considerations

Approval was obtained from the IRB at UT, which assured protection of the participants against human rights violations. An informed consent outlined the purpose of the study to the participants at the time of the interview. A written consent form was obtained from each participant at the time of the interview. This form acknowledged protection of participants' rights during data collection with guarantee of confidentiality and anonymity to the participant. I made clear to the participants that they could terminate the interview process at any time. In addition, the transcriptionist and members of the interpretive analysis group signed a certificate of confidentiality (Creswell & Poth, 2018).

I maintained awareness of the risk to vulnerable populations and acted in the best interest of participants at all times. I set relationship boundaries between myself as the researcher, and the participant. Researcher bias was addressed through bracketing past experiences, and examining biases and prejudices that may shape one's view (Morse, 2015). It is important to clarify researcher bias prior to the study because of the tendency to see what is anticipated prior to the interviews, as these biases could impact the inquiry. I monitored for compassion stress, as there was potential for elicitation of powerful emotions during the research process. Two self-

care strategy techniques employed during the study included journal writing and peer debriefing to minimize stress (Thomas & Pollio, 2002).

Rigor and Strategies for Validating Findings

Qualitative validity is determined through the use of strategies to ensure the accuracy of the study findings (Creswell & Poth, 2018). Study rigor was maintained through bracketing, field notes, data saturation, peer debriefing, and the use of direct quotes to support themes. The expertise of the TPRG assisted in reliability of the research findings through reflective practice and constructive feedback, ensuring that the researcher employed steps for a formalized thematic structure. In addition, the transdisciplinary group decreased bias in interpretations as members were from different disciplines, which also increased trustworthiness of research findings. Researcher engagement with participants built trust and allowed the researcher an opportunity to learn the culture and verify any misinformation about the setting. The researcher maintained respect for the content of the data and presented each participant's perspective in an equal and impartial manner. Peer review and debriefing served as an external check of the research process, and written accounts of the debriefing processes were kept. I also maintained and preserved all transcripts, notes, audiotapes, and journaling, which helped establish dependability.

Developing themes and essences that accurately depicted the experience helped establish reliability, and providing a rich, thick description of the narrative also enhanced transferability of the findings (Morse, 2015). The reader must be able to read details to gain a deeper understanding of the essential aspects of the meaning of the phenomenon. The reader is looking for "plausibility and illumination" (Thomas & Pollio, 2002, p. 41). Illuminating essential aspects of the meaning of the phenomenon may resonate with other HCPs in similar healthcare settings

(Sandelowski, 2008). Qualitative studies, "while not intended to generalize to a population, contribute to deeper understanding of human experiences," (Sohn et al., 2017; p. 142).

  Bracketing. I participated in a bracketing interview prior to data collection and analysis to improve the rigor of the study. Bracketing, an essential component of this methodology, is a formal procedure which allows the researcher to develop a heightened awareness of assumptions and expectations, setting aside presuppositions about the phenomenon while conducting the interview with a non-judgmental attitude. Thematization of the bracketing interview occurred prior to data collection. However, the process of bracketing was ongoing throughout data collection and data analysis, as I temporarily set aside knowledge and experiences to understand the meaning of the perceptions of the participants in the study. Establishing and maintaining pure bracketing, however, may not be possible (Husserl, 1999; George & Thomas, 2010; Thomas & Pollio, 2002).

Limitations

  The use of interviews as a data collection method carries certain limitations, but researchers conducting phenomenological studies at UTK trust in the method of dialogue described by Merleau-Ponty, who called language "a magic machine for transporting the 'I' into the other person's perspective" (1973, p. 19). Researcher-induced bias can influence the study, but the researcher continually works toward establishing and maintaining bracketing. Phenomenology typically involves small samples. Therefore, the perceptions of those interviewed for the study may not reflect those of a larger, more diverse sample. Qualitative studies are not expected to be generalized to another population.

Delimitations

The study was delimited to uninsured individuals receiving primary healthcare from nurses at either of two clinics in the state of Mississippi. The participants were English-speaking and willing to discuss their experiences and be recorded during the interview.

Summary

Through phenomenology, this study provided interpretive descriptions that contributed directly to our understanding of how people experience their health and illness and what nursing can do to make a difference. Knowledge gained can serve as a basis to link findings of this work to other settings if they illuminate essential aspects of the meaning of the phenomenon and resonate with other HCPs and healthcare settings. Qualitative findings can contribute to a deeper understanding of the participant's human experience (the healthcare experience) which can help to improve interventions (Sandelowski, 2008). Bringing voices alive in phenomenological writing may also lead to expanded research on perspectives that influence certain practices and patient needs (van Manen, 2014).

Chapter 4: Findings

The purpose of this phenomenological study was to describe the lived experiences of uninsured patients, living in profound poverty, regarding their primary healthcare experiences at a nurse managed health clinic. Nine study interviews were completed over a period of two months from November 2, 2019 to December 21, 2019. The participants, ranging in age from 34 to 65 years, were interviewed about their experiences of accessing and receiving primary healthcare at two nurse-led primary healthcare clinics in a large city in Mississippi. With a historical mission to care for underserved populations, NMHCs are deeply rooted in service to the community and provide much needed health services at the community level (Pohl, Barkauskas, Benkert, Breer, & Bostrom, 2007). The nurse-managed clinics in this study are located in impoverished areas with much homelessness. Providing holistic care, these faith-based non-profit organizations depend upon many nurses to render services to inner city and rural residents in the surrounding poverty-stricken communities.

Using the participants' own words, this chapter presents the thematic structure of the participants' portrayal of their experiences. Four figural themes were identified across the interviews and contextualized against the existential grounds of World, Body, Others, and Time. The existential grounds of the healthcare environment will be described, followed by figural themes with exemplars. Participant demographics and descriptions precede the presentation of the thematic structure (see Table 1). Most participants had chronic diseases such as hypertension in addition to acute symptoms (such as upper respiratory symptoms) that prompted their visit to a NMHC on the day of the interview. The chapter concludes with a summary of the thematic analysis.

Table 1 provides a summary of selected demographic characteristics obtained from the Demographic Form (See Appendix D). All names used are pseudonyms selected by each participant. Interviewees were racially diverse; there were 5 females and 4 males. Further description of each participant beyond the demographic characteristics is provided.

Table 1: Participant Demographic Characteristics

Participant	Reason for Seeking Healthcare	Age	Gender	Race	Education Level	Healthcare Provider
Pat	Arthritis, chronic pain, HTN	65	Female	African American	Highschool	Registered Nurse
Iris	Arthritis, chronic pain, HTN	51	Female	African American	1-year college	Registered Nurse
Frances	HTN and diabetes (glucose monitoring)	56	Female	Hispanic	Highschool	Registered Nurse
Bob	URI, HTN, flu prevention	52	Male	African American	Highschool	Nurse Practitioner
Kevin	HTN	47	Male	African American	Highschool	Nurse Practitioner
Jack	Chronic back pain, Disabled	34	Male	African American	9th grade	Registered Nurse
Marie	URI, HTN	42	Female	African American	Highschool	Registered Nurse
Christo	URI, HTN	50	Male	White	2-year college	Nurse Practitioner
Grace	URI, Thyroid disease monitoring	49	Female	White	Highschool	Nurse Practitioner

<center>**Description of Participants**</center>

Pat, a 65-year-old black female lived in chronic pain. With a history of arthritis and diabetes, Pat described herself as being "sickly all my life." Unable to maintain her previous housekeeping job, Pat had regularly received pain management care at a rheumatoid arthritis specialist's office. However, this specialist's new location had proved inconvenient, preventing her from keeping scheduled appointments. Therefore, Pat had begun to visit the NMHC for care, which filled a gap for much-needed care. On the day of the interview, Pat had been dropped off at the clinic by her sister (who stayed in the same senior citizen building where Pat stayed) to receive help for an acute pain flare up. Sitting in a slouched position, Pat looked down at the floor and described the struggles of living alone and getting dressed daily. Prior to her clinic visit, Pat had sought care at the ED during an acute arthritic flare-up. There she had received a pain injection and oral medication for inflammation, which provided temporary relief. Prior to beginning the interview, Pat expressed appreciation for the services that the clinic offered and the weekly volunteers who offered their time early that Saturday morning.

Iris, a 51-year-old black female with a history of arthritis and HTN, lived in chronic pain. Because her hours were cut, she no longer qualified for medical insurance. The main reason for Iris' healthcare visit was to obtain affordable prescriptions to treat chronic pain and HTN. Iris described her previous clinic visit, where she was offered unaffordable prescriptions. Iris was hopeful that during her healthcare visit she could get much-needed assistance with new affordable prescription, and a referral for CPAP machine repair.

Frances, a 56-year-old Hispanic female, frequented the clinic for HTN monitoring and diabetes glucose checks. The clinic was located on the outskirts of town on the property of a church directly off a main thoroughfare that led to an impoverished area of the city. The church

<center>93</center>

held a weekly faith meeting followed by a hot lunch. Frances worked in the serving line preparing the lunches each week. Shockingly, Frances witnessed a homicide that had occurred at the church in the previous week. As Frances was waiting to see the nurse on the day of the interview, she described her earlier care experiences.

Bob, a 52-year-old black male, had lived in the community near the clinic for more than 10 years. The inner-city clinic was located in an impoverished area with a large homeless population. Providing holistic care, this faith-based non-profit organization depended on many volunteer nurses and physicians to provide services to the inner-city residents in the surrounding poverty-stricken community. The homeless population also volunteered to work at the clinic, as well as the soup kitchen, a clothes closet, and the nearby food pantry. On a cold morning, community residents gathered a few blocks beyond the clinic around a barrel of fire for warmth, waiting for prospective job opportunities that would give them a day of temporary work. Bob had walked into the clinic from this site, stating, "That's why they're burning that barrel out there because they're waiting on folks to come in. They pick them up. And some days, they may come. Other days, they may not. You may catch work out there, you may not. But, at least, go out there and try" (352-354). On this occasion Bob was seeking healthcare for an upper respiratory infection and flu prevention.

Kevin, a 47-year-old black male, had a history of anxiety, depression, and HTN. The nurses previously referred Kevin to a nearby community mental health center for additional psychological support in managing his anxiety and depression. Kevin had been to the center that morning, a short distance away, and then walked down the sidewalk past the armed officer to enter the clinic for his appointment. He was interviewed after a healthcare visit for BP monitoring.

Jack, a 34-year-old black male, became disabled from a motor vehicle accident (MVA) that required numerous surgeries, leaving him in pain and unable to walk with a steady gait. Jack was frustrated by his inability to maintain a permanent job due to physical disabilities sustained in the MVA. Without a job, he also was uninsured. Despite this, he continued to seek temporary work and disability insurance. While Jack was a strength trainer prior to the accident, his disability and chronic pain affected his ability to participate in regular exercise. After seeking help at the clinic for his chronic pain and disability, Jack received physical therapy at appointments set up through the clinic. Jack commented positively about these appointments. The difficulties of living in chronic pain with a physical disability had left him feeling powerless. However, the physical therapy contacts that the clinic made for him had helped tremendously.

Marie, a 42-year-old black female with a history of HTN, had come to the clinic to seek care for an upper respiratory infection and a prescription for HTN medication. At the time, Marie was appealing a denial in insurance coverage. Because her employer had reduced her full-time working hours, she no longer met the criteria for maintaining healthcare insurance coverage. During the interview, Marie clutched a pouch containing several bottles of medication she had used in the past to treat her HTN. After her healthcare visit, Marie described her care experience and the information she received.

Christo, a 50-year-old white male, lived near the clinic in a medically underserved area of the community. With a history of anxiety, depression, HTN, and Crohn's disease, Christo visited the clinic frequently. He quickly became well known in the community while managing one of three homeless shelters. In addition, Christo volunteered at an opportunity center near the clinic where nearby residents were taught computer skills and training. On the day of the interview, Christo had come to the clinic for an upper respiratory infection and blood pressure monitoring.

Grace, a 49-year-old white female, had immigrated from Czechoslovakia. Speaking in a soft, low voice, Grace had come to the clinic for treatment of an upper respiratory infection. The clinic provides services to individuals in the high-need community where Grace resides. She also had a thyroid disorder—requiring close monitoring for medication adjustment—that frequently brought her to the clinic. Carrying a bag of cookies as a token of appreciation to the clinic staff, Grace entered the clinic with a smile.

Existential Grounds

In existential phenomenology, participant perceptions (figural) are understood within their environmental contexts (grounds) of world, body, time and others (Thomas & Pollio, 2002). These existential grounds contextualize this phenomenological study of patients' descriptions of a healthcare experience at a primary healthcare clinic. All healthcare experiences described by participants occurred within a primary care clinic environment, and the world of the clinic and surrounding community is the contextual ground within which the experiences of patients accessing and receiving health care takes place. Existential grounds were presented in greater detail in Chapter 1. In this chapter, the existential grounds that contextualize the healthcare experience are presented followed by discussion of the figural themes of the experience.

World

The participants described the *world* in which their healthcare experience occurred, including the world inside and outside the clinic. The world inside the clinic was safe and comfortable. Participants noted the caring behaviors by nurses during their clinic experiences and expressed gratitude for this care. Participants described the outside world as a place where they lacked resources for accessing healthcare. The world of uninsured patients, with challenging living and social conditions, was complicated, and further impeded their ability to access and

receive healthcare. For impoverished homeless participants, the need to secure food, shelter, and personal safety superseded and hindered healthcare experiences. The caring, warm clinic world represented security and the freedom for the participants to be who they were.

Outside the clinic, homeless participants lived in an unsheltered world with no structural or health security. Marginalized from society, participants lacked opportunities to change their situations. What's more, the world outside the clinic was often unsafe—even dangerous—for participants, especially those who were homeless. Recently, a community resident had lost his life to a horrendous crime. Excluded from the mainstream of society and living in poverty, participants had a diminished sense of security with little hope for change.

Others

The existential ground of *others* was a prominent contextual aspect of participants' narratives. Others included the healthcare staff (nurses), other clinic patients, and acquaintances in the surrounding community. These others formed a network of relationships, or "knots," in which participants experienced their lives. As the first "objects" seen at the clinic, understandably the nurses were the most prominent others in participants' narratives, often described as kind and smiling. Participants described a warm, welcoming clinic setting where they visited and talked to the nurses, often described them as caring, attentive, and willing to listen. Building personal relationships, the participants were keenly aware of the time that nurses took to listen to them during their encounters. They described a closeness with the nurses and feeling part of a family. Additionally, participants found camaraderie with other patients in the waiting room as they shared stories and exchanged healthcare advice.

The participants also described supporting one another in the community, and encouraging and helping others to take advantage of the healthcare services. The participants

cared for one another and felt a sense of belonging within the community as they shared similar background (socially and culturally) experiences. Unfortunately, other community members threatened their safety, as the impoverished area around the clinic was sometimes unsafe.

Body

The major ground of *body* emerged as participants described the physical symptoms experienced prior to seeking healthcare at the clinic. The clinic staff were dedicated to helping participants work towards overall health and well-being. Many references to the body occurred throughout the interviews as participants discussed acute physical symptoms affecting their daily lives and the reasons for seeking care. Some participants had symptoms lasting for weeks and even months from chronic conditions requiring follow-up and ongoing monitoring to maintain health. All participants expressed concerns related to their uninsured status and inability to secure consistent full-time work to gain health insurance benefits. Furthermore, participants worried about accessing pharmaceutical resources for managing chronic illnesses.

Participants also discussed the reality of homelessness and its physical and psychological effects on the "body subject" in need of healthcare. One participant described the physical pain experienced as an uninsured individual. For each participant, the clinic was the only accessible healthcare option. "It is the nature of the universe to strive for, and slowly, but in ever-increasing measure, to attain wholeness," (Smuts, 1926, p. 345). Surrounded with the clinic's calming effect, participants trusted the nurses to nurture and help heal their bodies.

Time

The existential ground of *time* was a prominent aspect of participants' narratives. Several participants described clinic nurses' willingness to spend time listening to them and explaining their medical conditions. Promoting a calm and relaxing environment, the nurses welcomed the

participants and enjoyed spending time talking and listening so they would know their patients' needs.

Participants also reported spending time with other patients in the waiting room, sharing stories, and giving and receiving advice from those with similar health experiences. Conversing with other patients while waiting at the clinic was supportive, helped pass the time, and served to assure participants they were not alone in their physical illnesses or need for healthcare. Participants had grown accustomed to long wait times to receive health care, perceiving that such wait times were to be expected. Many patients were willing to wait to receive healthcare, despite the inconvenience.

Merleau-Ponty stated, "time in the widest sense… is a setting to which one can gain access and which one can understand only by occupying a situation in it" (1945/1962, p. 332). Participants compared hectic, rushed clinic visits at previous doctor's offices to the clinic nurses' practice of taking sufficient time to listen to them and their concerns. Spending time with patients meant that nurses were engaged and interested in each patient's healthcare situation. It takes time to listen to a patient's reason for seeking care at the clinic, and the nurses were willing to slow down and invest their time listening in order to meet their patients' healthcare needs.

Figural Themes

There were four figural themes in the patients' experience of accessing and receiving primary healthcare that emerged from analysis of the interviews: The four figural themes included: *(1) A Safe Place, (2), "They Make You Feel Like You are a Loved Human Being," (3) "They Just Ain't in a Rush" versus "In and Out,"* and *(4)My Whole Body is Being Considered.*

Theme One: *A Safe Place*

Theme One depicts perceptions of the safe world of the nursing clinics. Surrounded by a poverty-stricken community, the two clinics served many inner-city residents, some that were homeless. Approaching a clinic, participants walked past a security officer. Once inside, the safety and security of the clinic was evident as two participants described. *"The staff is friendly, no violence... and, it's first come, first serve."* (Iris, 17). *"Nobody is fighting or arguing"* (Christo, 21). Participants spoke of the clinic atmosphere as "calming the nerves." The following account illustrates Kevin's perceptions of the atmosphere inside the clinic versus outside the clinic, and other healthcare settings.

> *"I mean they have time to listen, and you get to know them because you come here regularly... this is your primary care... you get to know them a little bit better than you would seeing a doctor once or twice a month... I don't know... this is a more personal deal, I guess,... they're professional... it's professional, but it's personal professional or something like that... it just makes you feel more comfortable... that's what I'm trying to say... it makes us feel more comfortable than just sitting in another office... me... I get real nervous when I'm in hospitals and regular doctor offices... this place just calms the nerves down a little bit"* (Kevin 39–45).

With a history of Crohn's disease, Kevin was no stranger to hospitals. For him, the clinic's calm, relaxing atmosphere was reassuring and comfortable, notably quite different from that of the hospital. The comfort experienced inside the clinic made Kevin feel supported and safe. Inside the safe space of the clinic, participants found support and reassurance.

Participants knew the world outside the clinic offered inadequate healthcare protection. Quite simply, there was no other HCP or clinic nearby. Moreover, this vulnerable population faced other concerns which included finding and keeping jobs, safe shelter, and sufficient food.

Without question, healthcare in the world outside the clinic was unaffordable. Frances asserted, *"I don't want to go to the hospital… if my BP gets higher, they're going to want me to go to the hospital, and I can't afford that"* (Frances, 245–247). Participants often felt powerless in the outside world. Because the clinic had limited hours, participants sometimes had no choice but to sit and wait in another healthcare setting—most often the ED of a nearby hospital. However, participants did not like seeking care outside the clinic. Christo shared the reasons that people preferred the clinic.

> *"There's quite a few people who do feel more comfortable coming here and that's what they do… not just for safety, but you know, just like I said, I guess the atmosphere within the clinic is more conducive to that bedside manner I was talking about… I think that in the healthcare industry, the bond between the provider and the person who's receiving [care], if there is a bond between, then that's when you're going to get better healthcare because the person feels more comfortable about what they're feeling bad about… they feel more open and able to discuss, because a lot of people don't like them [HCPs in other settings]"* (Christo, 298–306, 311–315).

The clinic and its nurses offered a safe, reliable source of care to Christo and other vulnerable individuals. Furthermore, the patients felt protected by having caring and nurturing nurses offering them the healthcare security they needed. The presence of the clinic eased participants' feelings of uncertainty and anxiety by removing barriers to care and promoting enduring relationships with healthcare providers (nurses). Two participants (Grace and Kevin) shared positive experiences related to the care and comfort they received at the clinic.

> *"We feel like it's a blessing… places like this for people who have low income or no access to healthcare… I know some medical places make you feel kind of lost, like they*

don't really care much about you except sending you the bill... it's how I feel most

places... so, this place is kind of like very, as I said, it makes you feel very cared for...

besides, they don't send any bills... it's just like a really big blessing" (Grace, 48 – 49,

126–134).

"It's good... it's a good experience... for me, like I said, I'm scared of needles and stuff

like that... so, I have had bad experiences at different places, but not here, at least not so

far... but I don't think I would anyway... it just puts you at ease while they're doing all

the medical stuff... you don't worry about nothing when you come here because you know

that you're going to get took care of like you're supposed to be... that's the most

important thing... they care... I mean it's their job, but it's also you got this deal where

they're doing their job, but they care how they do their job... they actually like doing

what they're doing, and that makes the patient feel at ease, at least in my opinion... that's

what it do for me" (Kevin, 102–109).

Another participant commented on the clinic's benefits and described her feelings about

seeing familiar others in the waiting room. *"It's definitely helping me... I saw a friend over there*

[points toward waiting room] ... you come in and say hey... see somebody you know... in the

same shape and predicament you're in... so, it's kind of uplifting" (Iris, 89–91). Camaraderie

could be found inside the safe space of the clinic as participants felt supported and described a

family type atmosphere. Participants were observed conversing with one another in the waiting

area, which validated that knowing and interacting with others was valuable in providing

sustenance and finding support. On the whole, the clinic was a safe place in which nurses were

kind and caring, were willing to listen, provided shelter from the outside world, and helped heal

the body.

Yet, participants also spoke of barriers encountered in the outside world that left them unable to access care, such as not having a job, money, or insurance. Two participants talked about what the clinic support (assistance) meant to them as they were unable to access healthcare through other means. Because Marie's employer recently reduced her hours, she no longer qualified for insurance benefits. For Marie, the clinic provided much-needed healthcare access. *"I am very appreciative of it [the clinic] because, like I said, I don't have the insurance to cover me at the time, so any help would be appreciated"* (Marie, 204–205). For Bob, the world outside the clinic held no hope of health or healthcare. *"I don't have the assets, no insurance or nothing like that… I can't go to a doctor… oh, thank the Lord for places like this… it really makes a difference to those who can't afford it"* (Bob, 14–16).

Bob was homeless and part of the community that extended beyond the nucleus of the clinic, a sometimes perilous environment offering no assistance for health. For Bob, the clinic provided shelter, both physically and emotionally. The physical structure housed the clinic where he received reassurance and emotional support from the nurses. With no job or insurance, the feelings of hurt were soothed by the compassionate nurses waiting to attend patients' needs.

> *"Well, that is… it really hurts you when you got to have insurance just to go to a doctor, and for homeless folks, they can't do this because they ain't got enough places…, enough money to get a place to stay at, and without the nurses being here, a lot of us would be in bad shape. A lot of us will, and to me…[silence] I just say thank you…, because I can't afford no medicine. I couldn't afford it, and I still can't afford it…, how can you afford something and you don't have a job?"* (Bob, 28-32)

Vividly depicting the unsafe and dangerous world outside the clinic, both Frances and Christo recounted how an acquaintance (a clinic patient) lost his life to violence.

"We need to move out of this trailer park... I live in a trailer park and it's... you can't

rest... you get even shots, you know, fired, and I just went to a service here at this

church... they killed a man and I held his hand before he died... and all that stresses...

they had a killing here at the back where we have church, back here in the gym, they

killed a man" (Frances, 275–282).

Anxious and fatigued, this event had greatly stressed Frances. Christo recalled the event and

supported Frances' narrative.

"It was one of the fellows that was a regular client. He come in here all the time.

Everybody knew him... one morning at church, he got into it with someone, and someone

stabbed and killed him..." (Christo, 223–225).

Describing the surrounding community, Christo commented,

"It hasn't been too great here..., down in the city over the last couple of weeks with all

the shootings and everything else. And last thing I want to do is be out on the streets at

night. I think there's been a shooting every day for the last week and a half.... you

have to be watchful of it (crime)" (Christo, 204 – 206, 210, 261)

Frances spoke of her world as chaotic and noisy, making rest difficult. She appeared fatigued

upon entering the clinic and said, *"Yeah, I haven't been resting too good... I had my neighbors*

on this side fighting, and banging the doors" (Frances, 200–201). On a cold morning, stepping

into the warmth of the clinic was comforting for Frances. She perceived the nurses as respectful

and looked forward to their kind, welcoming words. For Frances, this act of human kindness

meant someone cared about her and that she was worthy of respect. Frances found solace in the

clinic and felt safe.

This theme contrasted the safe, comfortable world inside the clinic to the unsafe, often dangerous world outside the clinic. The clinic was a safe place, with an armed guard at the door, that offered patients protection from the outside world, reduced their risk of potential injury during the time they spent at the clinic, and helped meet their needs for healthcare. The homeless participants were especially vulnerable to the dangerous world outside the clinic. Overall, participants perceived that they received high quality patient-centered care at the clinic, which they viewed as a safe place. Participants contrasted the safety of the clinic with the dangers they often faced outside.

Theme Two: *"They make you feel like you are a loved human being"*

The theme, *"They make you feel like you are a loved human being"* (named with a verbatim quote from Grace) describes patients' experiences as they accessed and received primary healthcare at the clinic. The participant quotes supporting this theme highlight their perceptions of the nurses' behavior toward them, such as kindness, caring, listening, attention to details, and authenticity. When asked what stood out about her healthcare experience, Grace stated, *"Kindness… their kindness and they make you feel like you are a loved human being."* Grace perceived the nurses' caring through their sincere, kind behavior, which kept her coming back to the clinic.

> *"They are always so kind and sincere… I've been coming here for years… they know you by name, so they always greet you, and they make you feel like you are welcome… and, of course, the same nurse has been here pretty much every week, and she's very kind and professional… she always checks your blood pressure and checks you out physically, too… so, it makes you feel good, like they get, they get it… they care about your well-being"* (Grace, 4–9).

For Grace, kindness meant being greeted in a friendly and polite manner when she arrived at the clinic. The nurse checked her blood pressure each visit, and there was a familiarity among the patients and nursing staff. The experience felt personal because the nurses knew her by name. There was kindness—a feeling of closeness—that evoked the emotion of love, which Grace translated to feeling cared for.

Kevin also described the kindness and familiarity of the nurses, *"They talk to you like a caring family member would talk to you about your health... that's the way they talk to you"* (Kevin, 257–258). In sharing his healthcare experience, Kevin described his deep emotions about the nurses' caring behaviors.

> *"Just how much they care, it's like they care more about the patients than the patient cares about themselves... I mean, it's real nice... I like coming here better than going to the hospital... it's more like a one-on-one deal, more like families, in a certain sense, than a doctor-patient deal, as well... I think that's why a lot of people come here because they really actually care, and they do all they can to help"* (Kevin, 5–9).

In fact, throughout the study, participants commented many times about the nurses' personable natures that welcomed them to the clinic and made them feel comfortable. Bob's perception of kindness was the personal care he received from compassionate and trusting nurses. These nurses were authentic and genuine. Bob described his experience in detail.

> *"They are real, and the people that's working in here in the clinic are real... all you got to do is be real with them... anytime you can receive help, knowing you can't afford it, that's a good thing... and this place can provide that for a whole lot of them, and that's a good thing about it... that's what stands out to me... if you need help, you can get it from in here, you can get it"* (Bob 216–217, 511–513).

Bob felt confident that he would receive quality care at the clinic.

Overall, participants knew that the nurses would care for and support them; they felt safe and trusted the nurses. The nurses' deep caring and interest in their well-being reassured the patients and strengthened the bond between nurses and patients.

"Most of their patients, they know them by name… they basically know… you don't really have to tell them anything when you come… they pretty much know why you're here and things of that nature" (Kevin, 89–91).

For Kevin, the nurses and clinic atmosphere encouraged him to return to the clinic. "*I look forward to my appointments… it's an indescribable feeling… I mean I actually want to meet my appointments… sometimes, I'll come early… it's a good atmosphere*" (Kevin).

Frances also described the nurses' warm welcome at her healthcare visits, *"Both of them [the nurses] are nice people… like I said, they always been nice to me, they ain't [sic] rude"* (Frances, 31, 42). For Frances, the nurses' graciousness was an act of human kindness showing that someone cared for and supported her. Their actions made her feel respected. The nurses conveyed this respect by establishing personal relationships with patients, enhancing patients' illness knowledge, and promoting patients' health and well-being.

Most participants reported receiving positive support from the nurses. Iris offered her perspective of the clinic after suffering a long history with chronic pain. *"You have to think positive… don't nothing change overnight, but thank God for this place and the nurses here… we can count on them"* (Iris, 79–84). For Iris, kindness and caring translated to dependability and loyalty. She knew the nurses would be there for her and that she could depend on them. Because the nurses kept appointments and followed through on their commitments to helping patients seek additional care resources, Iris found the nurses to be trustworthy and loyal. For example, the

nurses helped Iris obtain affordable pharmaceutical supplies and an at-home assistive breathing device. Moreover, the clinic opened promptly at 8 a.m. each Saturday, a time convenient for Iris' work schedule. She knew they would be faithful in their commitment to welcome her back each visit.

Overall, the patients perceived that the nurses' behaviors (kindness and understanding) expressed that they were valued and cared for as human beings. Grace verbalized this feeling. *"They are taking care of your health and well-being, but also, you can feel the love and the care because you know it's a Christian environment… so, they make you feel like you are important to them… if you could share the information with someone trustful who cares, it's good"* (Grace, 126–130, 155). It was evident that participants desired a close, personal relationship with a nurse with whom they could share information.

Recently uninsured, Marie shared her experience and perception of caring and compassion by the nurse as she described how the clinic opened one Saturday morning, on the day of her interview.

> *"Like I said, when I came in, they were real people-friendly… she greeted us with prayer and she offers water or whatever… I mean I thought it was different because I've never been to one that they did this… they offered it, but it was a nice experience"* (Marie, 279–280, 292–293).

Although Marie was surprised by the clinic's opening morning prayer, she found it enjoyable. For Marie, the affable nature of the nurse holding the prayer in the waiting area conveyed caring and kindness.

With certainty, the kindness of the clinic nurses made the patients feel part of a family. Patients felt free to come to the clinic and talk to nurses about what was going on in their lives.

Kevin further expressed what this kindness meant for him, *"Sometimes, even if I don't have an appointment, if I come past the building, I just walk in and speak and say, 'Hey'"* (Kevin, 150). Kevin knew he was always welcome at the clinic. The human connection between the patients and nurses was perceived as caring. These positive experiences promoted patient health and affirmed their personal worth.

Another participant, Christo, expressed what it meant to him when the nurses took time to talk with him, even remembering minor details from past visits.

> *"But coming here it's so... it's like there's a better bedside manner, which just seems to lack in healthcare to me... in my view, it's become more business orientated... it's about, seems to be about, in and out, your numbers... you know, when somebody takes the time to sit down and talk to you or they remember just something, something that you might have talked about, a minor detail, because that means a lot to the people that come in... it really does, because it shows that it's not just about business and money, but it's about the people, and taking care of the people well"* (Christo, 47–48, 54–59).

This quote shows that nurses did not view patients as objects (numbers), but cared for them as people by promoting their health and affirming their personal worth.

The patients' perceptions illustrated the meaning they derived from their healthcare experiences. The quotes show the array of care experiences that each participant experienced and how they felt during their clinic visits. The theme of *"they make you feel like you are a loved human being"* is evident in the participants' descriptions of feeling cared for by kind nurses who made them feel loved. This theme highlighted participant quotes which described perceptions of nurses' behavior. such as kindness, sincerity, caring and listening. These behaviors encouraged patients to return to the clinic not only for care, but to engage in meaningful conversations and

build supportive relationships in which they could share their needs. Finding the nurses trustworthy and loyal, the participants felt valued and cared for as a human being. The descriptions of these feelings are evident throughout the many participants' quotes.

Theme Three: *"They Just Ain't in a Rush" versus "In and Out"*

There is polarity in the theme, *"They Just Ain't in a Rush versus "In and Out,"* as participants contrasted present and past healthcare experiences with regard to the existential ground of Time. The participants' narratives highlighted nurse-patient interactions during lengthier clinic visits, in which nurses took time to listen while teaching patients about illness prevention and management; but also expressed the experience of previous rushed healthcare visits in other settings wherein they were quickly "in and out." Keenly aware of the amount of time they spent with the nurses, patients perceived them as caring and willing to spend the time required to teach them about their healthcare needs. Through participants' narratives, it was evident that nurses effectively employed teaching strategies designed to improve patients' health status. These strategies helped increase the patient's illness knowledge and empowered them to take responsibility for their health. This knowledge and empowerment, in turn, helped patients improve their health status.

The nurses readily built relationships with the patients, which motivated patients to return to the clinic for care. Clearly, the nurse-patient relationship was foundational for building trust and helping patients achieve their fullest health potential. Kevin discussed his healthcare experience.

> *"Yeah, well, when I first came in, my blood pressure was way out of control… I noticed, at the beginning, they started trying to get me on my medicine and things, stuff like that… they set me up for another appointment to come back to check on it… so, I didn't show*

up... but then, I came back a couple of days after my appointment was supposed to be because I was feeling bad, and I wanted to get my blood pressure checked... the way they talked and acted, it showed that they cared about me missing my appointments... I was like, 'Well I didn't think it really did matter to you all if I came back or not'... they were like, 'No, that's not why... we're here because we care, and we want you to be healthy... you're at stroke level with your blood pressure, and you have to make your appointments... we can't help you if you're not here" (Kevin, 120–128).

The nurses encouraged Kevin to adopt self-management activities such as exercise and weight maintenance. Once engaged in his care, Kevin described his participation and involvement in managing his chronic illness.

"It's almost like I want to come in and get a good blood pressure check, so I won't let them [nurses] down because they did a lot of hard work to get it down to where it's supposed to be... I mean, I have to hold up my end of the bargain because they're surely holding up their end of the bargain... they taught me about the weight and the exercise; I didn't know that blood pressure affects your kidneys... they pointed that out to me... I never heard of blood pressure affecting your kidneys until they said something about it" (Kevin, 136–138, 168–170).

Kevin appreciated the nurses taking the time necessary to educate him about his illness. Overall, participants perceived that the nurses respected them because they spent time with them and showed genuine interest in their health and well-being. In turn, patients trusted the nurses, which encouraged compliance with their recommendations as positive behavioral changes began to improve their health.

Two other participants shared their experiences with the nurses' teaching strategies that empowered them to choose healthy behaviors. Such behaviors could prevent worsening of their current illnesses and decrease their risk of developing additional chronic diseases.

> *"I was eating everything and I love spicy foods and that's not good... and I found out also that I was taking an over-the-counter cough medicine that raises your blood pressure up... she [the nurse] just told me what I weighed the last time I was here and I've lost... she asked if I was trying to lose and I told her I was, and she told me that plays a role in your blood pressure—eating right... and then she asked me what I had taken lately for the cold and I told her over-the-counter medications"* (Marie, 327–328, 340–343).

Unknowingly, Marie had taken over-the-counter medications that could exacerbate her HTN. Expressing trust and confidence in the nurses, Maria acknowledged the educational information she received and complied with the nursing interventions. She declared, *"So, she told me not to take those medications."* Needless to say, Marie did not take those medications again. Marie's choice is an example of a nursing intervention (an effective teaching strategy) that kept a patient safe through medication regimen instructions. The clinic nurses promoted patient health through education and advice. Marie affirmed the importance of this teaching, as she described learning safe medication regimens for her current blood pressure medication.

For Grace, being cared for meant more than gathering blood pressure numbers. Understanding the full implications of a healthy diet, Grace commented,

> *"Sometimes she [the nurse] even talks to me about the diet, what to do to be healthy, a lifestyle, you know... she's willing to even talk to you extra about the issues, not just measuring numbers"* (Grace, 9–12).

Grace appreciated the time the nurse spent educating her about healthy lifestyle choices. Many

participants perceived that the nurses respected them by taking time to teach them, showing

genuine interest in their health and well-being. This reassured the patients as they began to

exhibit self-motivation and compliance.

Participants expressed appreciation for the nurses taking time to deliver care to

individuals with few to no resources. Frances described what this care meant to her.

> *"Well, it means a lot to me because I couldn't afford to go to a regular doctor… $175 a*
>
> *visit? I can't because I couldn't pay them because I don't have Medicare or Medicaid,*
>
> *and I don't think I'm going to get any"* (Frances, 253–254).

The nurses volunteered their time to open the clinic on a Saturday morning and care for patients,

such as Frances, who were unable to come at other times. Because the patients were an important

part of the nurses' lives, they consistently helped identify available health options and tailored

care to meet each patient's needs.

In contrast, participants described hectic, rushed clinic visits at previous doctors' offices,

that differed greatly from the clinic nurses' willingness to spend time listening, teaching, and

explaining. Undoubtedly, participants were unaccustomed to the personal and caring healthcare

experiences they had at the clinic compared to those at the hospital. The nurses' practice of

taking sufficient time to listen to them was crucial. For Christo, the time the nurse spent with him

showed she cared for him. Christo described his personal experience at the clinic.

> *"Well, it's like they just ain't in a rush—rush deal to get this patient in and out… they got*
>
> *more time to listen to you and listen to your problems and find the best solution than it*
>
> *would be if you were in a hectic hospital or a doctor's office where you've got 10 or 12*

people just lined up waiting and waiting and waiting… you know what I'm saying?"

(Kevin, 28–30).

This narrative revealed there was variability regarding how much caregiver time they received in different care settings. For Kevin, time spent equaled a caring visit in which a personable nurse took the time necessary to meet his healthcare needs. In the previous quote, Kevin describes the relationship between the caring world of the clinic and time. Showing an interest in each individual, the nurses used their time to create relationships and provide support for each patient's level of well-being. Subsequently, the patients felt valued and respected by the nurse. They were never hurried during their clinic visits.

Furthermore, the patients grew accustomed to the nurses' assurance that they would continue to care for and support them. The nurses' genuine caring and interest in their daily lives reassured the patients that they were important to the nurses. The nurses kept appointment times, maintained loyalty, and stayed abreast of their patients' daily struggles. The following narrative describes what these actions meant to Bob.

"… and she [the nurse] helps with me… well, she helps a whole lot of folks… because I come in here sometimes just to sweep up and stuff… if they need me to do it, I say… why not? You're helping me, and she [the nurse] … throws a few dollars in my pocket or something like that there… 'Thank you, ma'am'… she knows I don't got no job, and all of them do… they know me… I don't mind doing nothing they ask me to do" (Bob, 18–22).

With dedication, the nurses invested their time to build relationships with the patients. In turn, the patients—regardless of their backgrounds—felt they were important to the nurses who listened to their concerns. The participants felt respected and described feeling close to the nurses. Kevin described such a relationship.

114

"I mean, it was learning the stuff that I didn't know... you always can... I mean, if you listen... I guess I would have heard it from the other doctors if I would listen... but they [other doctors] acted like they didn't care, and I was just ready to get on out, you know what I'm saying... just get in and out... but here, to me, they go above and beyond showing that they care for their patients... that means a lot to patients, especially people that come from my background... it's a good thing" (Kevin, 193–197).

This theme brings to light present and past healthcare experiences in which participants' narratives highlighted nurse-patient interactions describing nurses that took time to listen while teaching patients about illness prevention and management. However, participants also expressed the experience of previous rushed healthcare visits in other settings wherein they were quickly "in and out." Perceiving the nurses as caring and willing to spend time to teach them about their healthcare needs, patients became empowered to take responsibility for their health in improving their health status. Foundational for building trust, the nurse-patient relationship was essential in educating the patients about disease prevention, management, and discussing healthy lifestyle choices. Dedicated nurses conveyed a sense of respect toward the patients, which helped promote a close and effective nurse-patient relationship.

Theme Four: *My Whole Body is Being Considered*

The final theme, *My Whole Body is Being Considered,* relates to the bodily distresses described by patients that led them to the clinic. This theme illustrates patients' perceptions of nursing care that considered the effects of illness on the whole body. Nurses strived to deliver holistic care, to the extent that was possible with clinic resources, by addressing the whole person and respecting the uniqueness of each patient - taking into account mental and social factors.

All study participants had chronic diseases and bodily suffering. Some participants described having difficulty walking and standing, and excruciating pain. Among their chronic diseases were rheumatoid arthritis, gout, diabetes, and hypertension (HTN). For many participants, chronic pain and compromised mobility diminished their lifeworld and restricted their ability to engage in daily living activities. Two participants shared chronic pain experiences that affected their daily living. Pat stated, *"I had to go to the emergency room because I was hurting so bad… I couldn't even lift my shoulders up… they gave me a shot… that's all they did"* (Pat, 215–217, 287). After seeking care at the ED during an acute arthritic flare-up for which she received a pain injection and oral medication for inflammation, Pat commented that the ED intervention provided only temporary relief. Sent from the ED with instructions to follow-up at a nearby clinic, Pat came to the clinic seeking additional pain relief measures. Clearly, the gap in Pat's patient services impeded her continuous care, as evidenced by her statement, *"I just have to do the best that I can do"* (Pat, 122). The fragmented healthcare system left Pat struggling through daily activities while suffering from chronic pain. *"I hurt so bad, and I have to have my cane with me all the time"* (Pat, 34–35), Pat stated, as she pointed to the cane. Pat then sat with her hands folded in her lap to hide the physical deformities in her fingers during the interview, a result of crippling arthritis. Crying from pain during her interview, Pat stated, *"Well, I be thinking I wish I could do something to better my situation… then, I pray a lot, too, and ask the Lord why I'm in the situation that I am, but you don't suppose to question the Lord"* (Pat, 372–374).

For Iris, the lived experience of chronic pain from arthritis meant that her body's functional ability was interrupted by more than just her knees, as her previously prescribed medication caused gastrointestinal distress. Fortunately, the nurse intervened with much-needed

medication education for Iris. She said, *"Because it's like my knees is just bone to bone... and I come up with another pain in my side where my back is... it's torture, just torture... one minute, I was taking aspirin for the pain... but that's going to mess up the lining of my stomach... she [the nurse] told me* (Iris, 172–174). Both Pat and Iris were keenly aware of their bodies, as simple daily activities resulted in pain and stress. Their freedom to move was also greatly restricted, shrinking their lifeworld.

Although the most frequent initial reason for seeking care at the clinic was for upper respiratory infection symptoms, six participants also needed HTN monitoring and management.

> *"I had high blood pressure when I first come here, and she done just took me off of my high blood pressure medicine... she say I'm doing good... I said okay... I said to the nurse, 'Are you sure?'... as it went along, now this has just been recent, and my blood pressure ain't went up now... I keep coming back getting it checked, making sure it's still okay... and it hasn't been going up"* (Bob, 6–16).

Trusting the nurse, Bob complied and returned to the clinic for BP monitoring.

For Christo, access to care meant more than receiving prescriptions for HTN management. He also sought care for another chronic illness. Christo described the embodiment of holistic healthcare through his clinic experience.

> *"I have Crohn's disease on top of that [HTN]... So, she always asks me about that... I've been a lot of places where they don't... you're just there for whatever you're there for and that's it... but, like she told me, she wants me to come back so she can check my blood pressure again, because it varies up and down quite a bit... it makes a huge difference, especially for somebody who's not feeling well or balanced, something that's chronic... I've been fighting Crohn's disease since I was 20 and luckily, I haven't had any*

bouts with it lately... but I know if I do, I can come down here and they'll help me...

they'll set me in the right path on what I need to do, where I need to go" (Christo, 21–25,

63–67).

For Christo, care access was extremely important given his experience of living with a chronic

illness for almost 30 years. He expressed how important the clinic access was with the bodily

imbalance of living with the chronic illness of Crohn's disease.

Most participants knew the importance of HTN management. In particular, two

participants shared their desire to avoid going to the hospital due to improper HTN management.

"I don't want to be put in the hospital... if my BP gets higher, they're going to want me to go to

the hospital, and I can't afford that" (Frances, 245–247).

While Iris was aware that a proper medication regimen was key to HTN management, the

medications' cost posed a burden for her. Iris reported having trouble affording the several

medications she was taking daily to manage her HTN and avoid hospital admission. Because the

chronic condition would continue for her entire lifetime, Iris needed a workable solution to

finding affordable medication.

> *"I come here for high blood pressure because... I take a lot of different medications...*
>
> *they have seemed to get my blood pressure down, because one minute they were talking*
>
> *about putting me in the hospital... but, we [the clinic nurses] didn't do the hospital thing,*
>
> *they just give me some medication... they will give you some samples, or can send you to*
>
> *a drugstore... sometimes, I go to get the medicine, and of course, if it's extremely high, I*
>
> *have to come back and get another prescription... yes, overall, it's been a pretty good*
>
> *experience because I really never knew a lot of places that would see you without*
>
> *insurance"* (Iris, 8 – 14).

The cyclical process of seeking affordable prescriptions was frustrating for Iris. She felt a fear of the unknown each time she received a prescription, as she was powerless over medication cost.

>*"I had to leave them [the prescribed medications] there before [at the pharmacy] because they was extremely high—$280… it might seem cheap compared to some other medicine, but I can't give no $280 for one 30-day supply of medicine… yeah, because sometimes I get samples here at the clinic, but then the only thing about that is, I may need some more… like I say, if I get these prescriptions, and you pay your money for it… sometimes certain medicine won't agree with you… of course, if you get an allergic reaction or they're not helping, that's medicine gone down the drain… you got to toss it, you got to put it in the toilet… so, like I say, hopefully I can get a decent price and after I get it at a decent price, it works with me, not against me"* (Iris, 113–133).

In this illustrative quote, Iris describes the uniqueness of her body in regards to finding medication that is physically agreeable to and provides pain relief.

For two participants, the chronic condition of HTN was invisible. Their body was silent, offering no outward physical disruption as with the participants who had experienced chronic pain. Marie said, *I mean, I feel fine… I mean, I wouldn't have known my blood pressure was up today if the nurse hadn't checked it… I check it periodically, but I hadn't checked it lately"* (Marie, 187–188). Kevin also discussed his HTN.

>*"She [the nurse] says, 'It sneaks up on you, that's why they call it the silent killer because it just sneaks up on you.' I told her, I was like, 'I feel good.' She goes, 'A lot of people feel good, and a lot of people have strokes and don't know why because they don't know their blood pressure is up.' She's like, 'Well, that's why you should get an exam'…*

a regular exam annually or something like that. That way you can catch problems before

they get too bad" (Kevin, 238–242).

Kevin also acknowledged that he had not experienced any physical changes from HTN. Despite

the fact that the HTN had no outward manifestations, both Kevin and Marie understood the

complications of persistent, untreated HTN after receiving education from the nurses.

For another participant, the nurses acquired a series of physical therapy appointments that

allowed him to engage in activities to become stronger. With appreciation, Jack commented, *"I*

get that connection to physical therapy, and the nurses work on doing that" (Jack, 62). Jack

appreciated the nurses' efforts in making this vital contact for him.

Jack had become disabled secondary to a motor vehicle accident (MVA) that required

numerous surgeries, which left him in pain and unable to walk with a steady gait. Uninsured,

Jack was frustrated by his inability to maintain a permanent job due to physical disabilities.

Although he continued to seek temporary work and had recently applied for disability insurance,

Jack longed to resume his previous active lifestyle of daily exercise, including jogging, and

provide for his family. Jack felt disconnected from his previous world. He chose not to use an

assistive device for walking so as not bring attention to his disability. Jack feared limitation and

incapacity. However, once inside the clinic, jack felt freedom to discuss his disability.

"The symptoms, they slow me down, and like… I've had a concussion, and have

seizures… When I have a seizure, I can't remember anything when I wake up, so, that's…

I'm [afraid] I'm going to be brain-dead and get a stroke" (Jack, 16–19).

In this final theme, the participants gave meaning to their perceptions of holistic nursing

care, which addressed the uniqueness of the whole body in distress. Describing living with

chronic conditions, the lifeworld of some participants was greatly diminished from unending

pain which restricted their daily activities. Although nurses assisted patients in obtaining prescriptions for pain relief as well as HTN management, for the most part, patients received episodic care at the clinics. Unfortunately, there was a lack of care continuity that resulted in patients frequenting the ED during the week to fill in care gaps. Healthcare for this vulnerable population remains fragmented as healthcare system gaps challenge their care access. Still, the nurses at these clinics endeavored to expand access to primary healthcare for low-income, uninsured, and underserved individuals, taking into account the whole body.

Thematic Structure

After analysis of all nine transcripts, the essence of participants' healthcare experiences as poor, uninsured individuals may be summarized in the following statements. I live in a world of homelessness and poverty. I do not have steady work; therefore, I cannot access healthcare, nor can I afford to pay for a clinic visit. I am appreciative of the nurses who provide healthcare for me in a safe and secure place. The world outside the clinic is often dangerous, and I must protect myself daily. I feel safe and protected when around the caring nurses, inside the clinic. The clinic gives me shelter. I feel fortunate that kind, sincere nurses are willing to spend time with me and provide holistic care. I am always welcomed and never hurried during my appointment. I have learned valuable information about my health to keep me safe. Without fail, the nurses consistently address my healthcare needs in a calm and compassionate manner. I feel free to talk to the nurses about anything concerning my healthcare needs. I have experienced genuine, caring behaviors by the nurses and feel reassured through their support and concern for me. I feel important to the nurses, cared for, and loved. Both my mind and body are healed by the nurses at the clinic.

The thematic structure of uninsured patients' experiences accessing and receiving

primary healthcare is shown in Figure 1 below. This figure illustrates each of the four

interconnected global themes, which appear in each participant's transcript describing their

healthcare experience, contextualized by the existential grounds of Body, Time, Others, and

World.
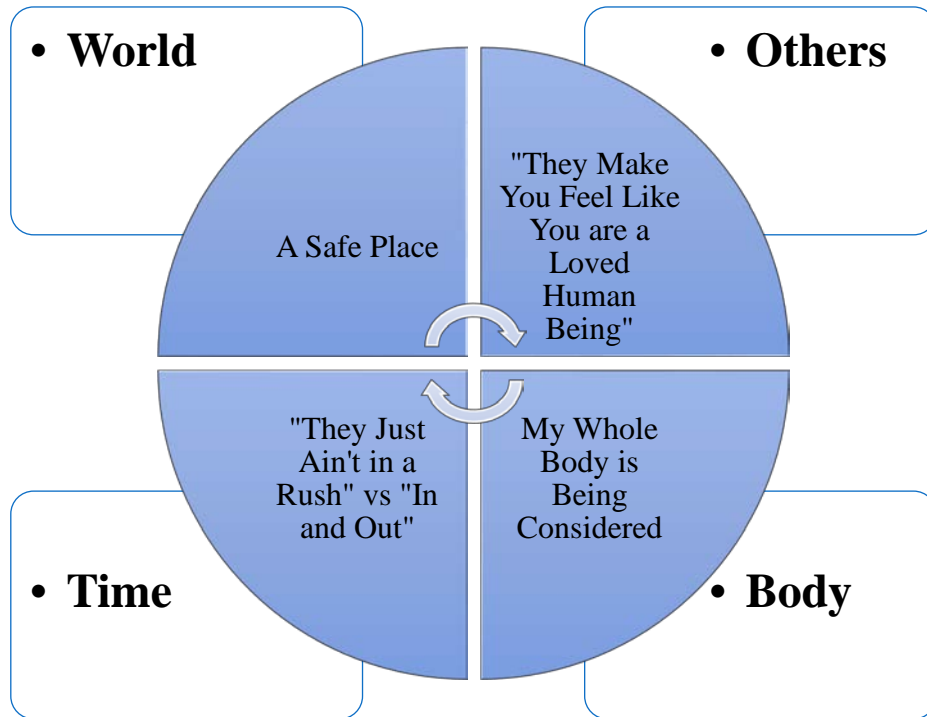
Figure 1: Global themes for the phenomenon of primary care clinic experiences of uninsured patients living in poverty

Summary

The four themes that emerged from these nine interviews are contextualized within a

world where participants lived in profound poverty. All theme names were chosen from

participants' actual words. Each theme provides a better understanding of the meaning of

patients' perceptions of their primary healthcare experiences in nurse-managed clinics in MS.

Although rich in culture, MS is characterized by much poverty with limited employment

opportunities. Without a doubt, the inability to access primary healthcare and preventative services contributes to a poor health status for Mississippians, with little to no hope of acquiring health insurance. Ranking 49th (26.7%) among US states in children under 18 in related families who had incomes below the poverty line, 48th (17.2%) for hunger and food insecurity, and 46th (5.1%) for unemployment, the percentage of Mississippians without health insurance was projected at 21.23% in 2019 ("Percent Uninsured," 2019; Semega, Fontenot, & Kollar, 2017).

More likely than other Americans to experience certain chronic illnesses and worse health outcomes, citizens in MS experience high rates of cardiovascular disease (CVD, including heart disease and stroke) and diabetes. With heart disease the leading cause of death in MS, CVD accounted for one-third of all deaths; highest among the 50 states ("Stats of the State of Mississippi, 2018; MSDH, 2019b). Notably, among participants, the most commonly reported reason for seeking care included the need for hypertension monitoring and treatment (seven participants). In addition, an estimated 308,295 adults live with diabetes today in MS – more than 13.6% of the adult population, ranking first in the nation for overall diabetes prevalence in 2016 (MSDH, 2019b). Further, in 2016, the complications of type two diabetes accounted for 1,083 deaths (MSDH, 2019a). Two participants in this study required glucose monitoring for diabetes. Regarding chronic illness, overall, three of the nine participants reported two chronic conditions each, and five participants reported one chronic condition.

All participants shared positive experiences regarding their healthcare visits. The first theme, *A Safe Place,* was evident in the participant descriptions contrasting the safe world inside with the dangerous world outside of the clinic. Highlights of shared experiences of participants' healthcare experiences revealed a feeling of safety during their clinic visit. The participants were either homeless or vulnerably housed, and food, shelter, and personal safety superseded and

hindered healthcare experiences. Importantly, patients encountered clinic experiences in which they were warmly received regardless of their background or lack of resources.

In a safe and secure space to seek care, the patients were supported by caring nurses that rendered patient-centered holistic care. The clinic was protective in that it was safe for each participant to enter and access healthcare; none were turned away, regardless of their background. Welcoming all patients, *A Safe Place* is directly related to *"They Make You Feel Like You Are a Loved Human Being.* The *participants perceived the "kind and sincere"* behavior of the nurses as warm and welcoming. Cared for by attentive nurses, participants perceived the nurses as caring, with a willingness to take time to listen and teach about their health conditions. In *"They Just Isn't in a Rush" versus "In and Out"* the patients perceived the nurses' attentiveness as respecting their health and well-being. Nurses were not in a *"rush-rush"* and took time to deliver holistic care in promoting their health versus "*in and out*" care in other facilities where they were a number and no one knew their name. Nurses fully embraced the nurse-patient relationship and valued their time together, using the time to teach about their health, illnesses, and medication regimens, which helped keep patients physically safe.

During time with the nurses, participants reported numerous bodily distresses that brought them to the clinic. Although a fragmented healthcare system challenged care delivery, nurses remained dedicated to care for the entire body in *"My Whole Body is Being Considered."* The caring interventions by the nurses helped create a safe and secure healthcare experience for the patients. Study participants expressed trust and confidence in the nurses, acknowledging the information given, and complying with nursing interventions to improve their health. Participants consistently spoke of the compassion, love and caring of the nurses. Moreover, participants desired to return back to the nurse-led clinics having had positive experiences, where

nurses were *"not just measuring numbers."* Overall, the clinic was perceived as a safe space that promoted health and built relationships one could depend upon, keeping the patient at the center of care.

In the next chapter, findings of this study will be compared to previous research, noting areas of commonality and uniqueness. Recommendations for future research and implications for nursing practice, education, and health policy will be presented.

Chapter 5: Discussion

The purpose of this existential phenomenological study was to gain an understanding of uninsured patients' perceptions of their primary healthcare experiences at NMHCs. Each participant shared their healthcare experience willingly, providing insight into a phenomenon that lacks qualitative research. This chapter reviews the thematic structure of patients' perceptions of healthcare experiences and discusses how the findings relate to nursing literature. Nursing practice, education, and health policy implications are presented as well as recommendations for future research, followed by study strengths and limitations.

Study Findings Related to Literature

Current nursing literature does not fully describe the meaning of uninsured patients' perceptions of primary healthcare experiences at NMHCs. Related nursing literature focused on facilitators and barriers to primary healthcare access for vulnerable populations, and NMHCs' community impacts and contributions in improving healthcare access for this population. However, none of these studies used phenomenology as a philosophical and methodological base, and none invited uninsured adults living in poverty to tell their stories about primary healthcare experiences. Therefore, this study's thematic findings help fill a nursing knowledge gap and add to the body of research surrounding this phenomenon. In the sections below, these findings – as revealed in participants' rich descriptions—are discussed in relation to previous literature.

Theme One: *A Safe Place*

In the theme *"A Safe Place,"* participants contrasted the safe, comfortable world inside the clinic with the unsafe, often dangerous world outside it. Participants described the clinic as a safe place that offered them protection from the outside world, reduced their risk of potential

injury, and helped secure their health. These feelings resonated strongly with homeless patients who are especially vulnerable in the precarious world outside the clinic. These findings support several previous studies showing the significance of having nurse-led clinics to care for vulnerable populations. Esperat et al.'s (2012) findings highlighted NMHC staff's dedication to care for the nation's most vulnerable populations to alleviate community care gaps. NMHC services have been shown to be vital for safety-net populations with limited medical resources.

The findings for this theme support those of existing literature highlighting the importance of caring for safety-net populations in nearby clinics that provide shelter within the community (Pohl et al., 2007a; Sutter-Barret et al., 2015), as expressed in this study by Christo, *"For homeless folks, they ain't got enough places… and without the nurses being here, a lot of us would be in bad shape."* For Christo, the safety of the clinic meant shelter. The current study participants were similar to vulnerable populations in earlier studies who appreciated the value of NMHCs and emphasized their role in increasing access to safe, quality care (Pohl et al., 2007a).

Grace commented, *"We feel like it's a blessing… places like this for people who have low income or no access to healthcare."* Similarly, Tomsik et al. (2014) reported that vulnerable patients' healthcare insecurity (HCI; i.e., stress and worry about healthcare) improved after they received care at a free clinic. "I feel more secure now being able to know that I have healthcare" commented one participant from Tomsik's et al. (2014, p. 1827) study. Obviously, these participants felt less anxious when they could access care at a free clinic (Tomsik's et al., 2014), a finding consistent with the current study's results.

Current study participants felt powerless in the outside world because they could not afford to go to the hospital. Frances asserted, *"I don't want to go to the hospital… if my BP gets higher, they're going to want me to go to the hospital, and I can't afford that"* (Frances, 245–

247). These findings are similar to those from Hudson's et al.'s (2016) study in which homeless participants expressed strong dislike for hospital settings, instead desiring a familiar environment with established relationships.

Current study participants felt clinic nurses offered a safe, reliable source of care. The clinic's presence eased their feelings of uncertainty and anxiety by removing some barriers to care and promoting sustainable relationships with nurses. Although Stajduhar et al.'s (2019) study results identified care barriers for vulnerable EOL populations, those findings are comparable to current study participants who also faced significant obstacles to healthcare access (e.g., lack of food, shelter, and income). Furthermore, economic and cultural determinants of health and healthcare system gaps caused these participants to experience health inequities. After facing so many health and healthcare difficulties, these participants felt protected by the clinic's caring nurses who offered them a level of healthcare security they lacked before.

Contrary to the present findings, Hudson's et al. (2016) previous study, which systematically reviewed studies across four countries (majority in U.S.) of homeless people and the healthcare professionals working to support them, reported that some patients avoided healthcare services due to mistrust of their primary HCPs. These HCPs included healthcare and social care professionals, outreach workers, and hostel staff. Their study participants, uninsured, homeless, and at end-of-life (EOL), also described the challenges of receiving care in a complex healthcare system, while living in a hostel. Consistently, current study participants described challenges in accessing and receiving care in a complex healthcare system. However, in contrast to Hudson's et al. (2016) study, current participants reported that clinic nurses were sincere, capable, and trustworthy; acknowledged their station in life; and accepted them for who they are.

Furthermore, this marginalized population reported feeling safe and comfortable in the clinic setting, facing no stigma or judgement there, and returning for follow-up appointments and care.

Addressing the sociocultural inequities influencing care access is an important endeavor for the nursing profession. Stajduhar et al. (2019) found it critical that populations experiencing homelessness and poverty receive safe, reliable primary healthcare. This previous study also sought to identify care barriers for vulnerable EOL populations and understand healthcare access challenges of uninsured homeless people. Stajduhar's et al. (2019) findings are consistent with the present study whose participants were served by nurses committed to caring for vulnerable populations at faith-based NMHCs. Indeed, these nurses' work was deeply rooted in the historical nursing mission of caring for the underserved or individuals who ordinarily "fall outside the political and moral community in the U.S." (Tiedje & Plevak, 2014, p. 1).

These findings also support those from Tiedje and Plevak's (2014) study in which clinic volunteers serving undocumented immigrants put aside community and political conflicts to heed the spiritual call and ethical commitment to care for the sick, which promotes individual and community health. In another study, Mason et al. (2015) concluded that promoting health demanded a system focused on "knowing patients' experiences" (p. 551), building relationships through engaged providers and partners, and prioritizing family and community health. In addition, King (2008) stated that clinic sustainability was contingent upon maintaining community support and trust. Because NMHCs provide primary healthcare, health promotion, and disease prevention to underserved populations in urban and rural communities, they offer an important setting for exploring and understanding the healthcare experiences of the individuals who seek care there. The overall theme of *a safe place* conveys an important insight into how patients' experiences care at such clinics.

Theme Two: *"They Make You Feel Like You Are a Loved Human Being"*

The second theme of *"They make you feel like you are a loved, human being,"* (Grace, 4) highlighted participants' perception and appreciation of positive nurse behaviors and characteristics, such as kindness, caring, listening, attention to details, and authenticity. Based on patients' narratives, we concluded that feeling cared for and developing a personal relationship with the nurse were of paramount importance to these vulnerable individuals. These two participant desires are consistent with findings from several previous studies (Berkowitz et al., 2018; Mason et al, 2015; Pohl, 2007a).

Several studies' findings indicated that the nurse's behavior toward patients (e.g., displaying kindness and authenticity) played an important role in them feeling cared for (Berkowitz et al., 2018; Dols et al., 2018; Mason et al., 2018). Current study participants' quotes about nurse behaviors support this theme. For example, Grace commented, *"They are taking care of your health and well-being, you can feel the love and the care."* She perceived the nurses' caring through their sincere, kind behavior, which kept her coming back to the clinic. This theme supports previous study findings that patients valued HCPs caring, listening, and taking time during healthcare visits (Pohl et al., 2007a).

Berkowitz et al. (2018) described the feeling of being cared for as a positive patient experience that came from having trusted and committed nurses. Similarly, current study participants reported that the clinic nurses were trustworthy and loyal. *"If you could share the information with someone trustful who cares, it's good"* (Grace, 126). Notably, community support and trust—considered important for clinic sustainability—also were found to be critical for building a clinic's client base (King, 2008). Likewise, this study's participants returned to the clinic for follow-up appointments and reported consistently receiving a warm welcome.

One element that impressed study participants was the nurses' personable natures. Participants were impressed that the nurses cared enough to take time to listen to their concerns and remember small details about them. These behaviors made the healthcare experience feel like a personal encounter, not a business transaction. Similar to participants in Berkowitz et al.'s (2018) study, current study participants placed a great deal of importance on nurses' knowing their history. Finally, current and previous study findings validated patients' desire to be cared for by kind nurses (Dols et al., 2018; Esperat et al., 2012). Cited earlier, Berkowitz et al. (2018) indicated that patients desired a personal relationship with their HCP, a common theme among current study participants.

Theme Three: *"They Just Ain't in a Rush vs "In and Out"*

The theme, *"They Just Ain't in a Rush vs. "In and Out,"* highlights the importance of nurses taking the time needed to interact with patients while teaching them illness prevention and management strategies. Current and previous literature findings provided evidence that patients value patient-centered care provided by an HCP who cares, listens, and takes their time during visits without rushing (Pohl et al., 2007a). The current study indicated that patients were able to build strong, personal relationships with their nurses during regular clinic visits that took place in a familiar environment. Kevin summed up his nurse-patient relationship as a "*one-on-one deal.*" This description differed from Kevin's previous healthcare experiences, "*…they [other HCPs] acted like they didn't care, and I was just ready to get on out, you know what I'm saying… just get in and out.*"

Building relationships through engaged nurse-patient partnerships has been showcased in previous literature (Berkowitz et al., 2018; Ely, 2015; Mason et al., 2015). Similar to current study participants, targeted populations in these studies required frequent clinic visits for chronic

131

conditions such as cardiovascular disease, HTN, diabetes, and obesity. Current study findings showed that nurses tailored teaching strategies to each patient's individual needs. Several participants reported on the effective teaching strategies the nurses used to empower them with the knowledge and desire they needed to take responsibility for their health.

Current study findings are consistent with those of Bucher and Thompson (2012) and Dyal et al. (2016) who implemented disease screening and management programs for asthma and HTN patients at targeted community clinics. These clinical outreach efforts resulted in the implementation of evidence-based HTN guidelines and an asthma education program. In the current study, clinic nurses' efforts to provide primary care and chronic illness education encouraged patients to adopt lifestyle changes that could promote their health and well-being. These participants had many positive reactions to the educational information they received from the nurses, which encouraged healthy lifestyle choices. Commenting again, Kevin stated, *"they taught me about the weight and the exercise; I didn't know that blood pressure affects your kidneys... they pointed that out to me."* Another participant said, *"I found out also that I was taking an over-the-counter cough medicine that raises your blood pressure..."* (Marie).

Several previous studies emphasized the importance of determining patient and family needs before developing and implementing specific community outreach programs using best practices to meet patient needs (Bucher & Thompson, 2012; Dyal et al., 2016). For example, Dyal et al. (2016) recommended increasing care access for underserved populations by first collaborating with nurses, nursing faculty, and nursing students to determine current EBP guidelines for HTN management in a community population.

Two studies reported on implementing best practices in primary healthcare delivery at NMHCs by first educating nurses and nurse practitioners (Pohl et al., 2007b; Van Zandt et al.,

2008). During their educational training, nurses acquired effective teaching strategies for future

practice. One case study described using an ANMC as an educational training site for nursing

students to implement an illness prevention and medication program. The patients at this ANMC

reported satisfaction with the comprehensive treatment provided during this program including

the amount of time nurses spent with them (Van Zandt et al., 2008). These patients felt

comfortable returning to the clinic where their nurse-patient relationship had been established

(Van Zandt, 2008). Community-based programs at clinics are best practice exemplars of ANMCs

promoting health in low-income communities. Using NMHCs as clinical practice teaching sites

increases vulnerable individuals' healthcare access and helps improve their health outcomes.

Van Zandt et al. (2008) noted that vulnerable populations viewed nurse-provided services

positively, as their teaching strategies increased their healthcare access, addressed their health

disparities, and helped improved their health outcomes. The nurses and NMHCs, such as those in

the current study, are effective at reaching into communities and connecting with target

populations to address health disparities and provide health promotion and wellness interventions

(Dols et al., 2018; Ely, 2015; Mason et al., 2015). Clearly, the nurse-patient relationship was

foundational for building trust and helping patients achieve their fullest health potential. For

example, Kevin stated *"…so I won't let them [nurses] down because they did a lot of hard work

to get it [BP] down to where it's supposed to be… I mean, I have to hold up my end of the

bargain because they're surely holding up their end of the bargain."* These current study

findings are also consistent with previous literature in which homeless individuals found support

through building trusting relationships with HCPs, an essential step in promoting health and

improving health outcomes (Hudson et al., 2016). Vulnerable groups must be engaged in a

meaningful way that empowers them to become active in "defining their priorities, goals and

needs, and reaching out to resources that can help them achieve this" (Richard et al., 2016, p. 18).

Theme Four: *My Whole Body is Being Considered*

Unfortunately for vulnerable populations, care remains fragmented as healthcare system gaps challenge their access. In the final theme, *My Whole Body is Being Considered,* participants described the bodily distresses that led them to the clinic and how the nurses delivered holistic care, treating the whole person, not just physical symptoms of the disease, including mental and social factors. As cited in Thomas and Pollio (2002), the nursing profession has espoused a holistic philosophy since the writings of Levine and Rogers in the 1970s. The word holism can be traced even further back to Smuts (1926) who coined the term and said "the whole is in the parts and the parts are in the whole, and this synthesis of whole and parts is reflected in the holistic character of the functions of the parts as well as of the whole" (p.86).

For many participants, chronic pain and compromised mobility diminished their lifeworld and restricted their ability to engage in daily living activities. When acute care needs arose, they often sought care at the ED. However, ED interventions often provided only temporary relief, with patients then being instructed to follow-up at nearby PC clinics for additional pain relief measures. In a fragmented healthcare system, gaps in patient services impeded continuous care, as Pat declared, *"I just have to do the best that I can do"* (Pat, 122). This finding supports other studies of vulnerable populations compelled to seek care at EDs for acute care needs (Desmond et al., 2016; Ely, 2015; Parker & Dykema, 2013).

Uninsured individuals living with poverty and homelessness often seek healthcare at the ED, typically at a high cost and with poor outcomes, thereby experiencing care fragmentation (Hudson et al., 2016; Stajduhar et al., 2019; Vijayaraghavan et al., 2011). *"I had to go to the*

emergency room because I was hurting so bad… I couldn't even lift my shoulders up… they gave

me a shot… that's all they did" (Pat, 215–217, 287). After seeking care at the ED during an

acute arthritic flare-up, Pat received a pain injection and oral medication for inflammation, an

intervention providing only temporary relief. She was sent from the ED with instructions to

follow-up at a nearby clinic. Clearly, the gap in health services impeded continuous care for Pat.

Furthermore, the fragmented healthcare system left Pat struggling through daily activities while

suffering from chronic pain, a scenario supported by previous studies.

Episodic care and limited clinical hours contributed to fragmented care. One participant

commented on the lack of care available throughout the week: "*It's only on Saturdays, which is*

nice… but sometimes when you get sick during the week, it's kind of hard to wait until

Saturday," (Grace). Moreover, healthcare staff told patients to seek care at the ED for BP

monitoring, pain alleviation, and infections-related symptoms (e.g., elevated temperature) prior

to their next clinic appointments. Despite knowing that this pattern of care increased ED usage,

with resultant higher care costs and the potential for diminished resources, these patients had no

other option. The current body of literature reported that available nurse-led primary healthcare

services could help decrease urgent care clinic and ED usage among vulnerable populations,

reducing their hospital admissions and readmissions. Such care is important for achieving

clinical outcomes that support positive health outcomes and promote population health (Dols et

al., 2018; Vijayaraghavan et al., 2011).

For Christo, care access was extremely important given his experience of living with a

chronic illness for almost 30 years. Although he had come to the clinic for an upper respiratory

infection and HTN management, he expressed how important clinic access was with the bodily

imbalances that come from living with Crohn's disease. Christo stated, *"I've been fighting*

Crohn's disease since I was 20 and luckily, I haven't had any bouts with it lately… but I know if I do, I can come down here and they'll help me…" Two other studies described an integrative approach to care that considers patients' biological, social, psychological, and spiritual needs (Ely, 2015; Nardi, 2011). Knowing that populations with chronic conditions require frequent visits, targeting these patients could help reduce care fragmentation (Ely, 2015; Nardi, 2011).

Literature findings indicated that free clinics offer a source of care that improves preventive service delivery and decreases ED use by uninsured patients (Mason et al., 2015; Tomsk et al., 2014). Participants surveyed by Dols et al. (2018) reported that primary health care services reduced hospital and ED admissions and readmissions. NMHCs also were found to reduce urgent care and ED use and help achieve clinical outcomes that promote population health. The clinics' outcome goals focused on diabetes and HTN prevention, screening, and management (Dols et al., 2018).

Current study findings indicated that the most common reason patients sought care at the clinic was HTN management and medication regimens. Notably, participants surveyed by Parker and Dykema (2013) reported a chronic health condition as one reason for their homelessness, in addition to job loss, unemployment, and lack of affordable housing. Current study participants faced these same challenges. Furthermore, the chronically homeless (those experiencing more than one homeless episode) were more likely to access the ED when seeking medical care due to their lack of financial resources.

Dols et al. (2018) reported that increasing access to prescription medications and convenient, available clinic hours helped promote positive health outcomes. Current study participants described their difficulty in obtaining affordable prescriptions—a formidable care barrier for them. Unfortunately for Iris, this trouble was ongoing, resulting in her not taking her

medications consistently. Iris said, *"I had to leave them there [at the pharmacy] because they was extremely high... $280... it might seem cheap compared to some other medicine, but I can't give no $280 for one 30-day supply of medicine... I'll have to leave the prescription there... if it's something I can afford, of course, I'm going to get them."* For Iris, the unending process of seeking affordable prescriptions was frustrating, as she experienced fear of the unknown with each prescription. Powerless over medication cost, she commented, *"I had to leave them there before, because they was extremely high—$280."*

Iris' experience is consistent with the barriers experienced by participants in Corscadden et al.'s (2018) study. These participants reported having difficulty accessing clinics, experiencing trouble getting appointments, skipping recommended testing, and being unable to fill medication prescriptions. These examples show participants experiencing care barriers at different points in the pathway to care. Other reported barriers included immigrant status, homelessness, chronic conditions, physical disabilities, and mental health issues. Current study participants faced similar barriers. Jack was a disabled individual in chronic pain who lacked steady work and had no way to acquire insurance to cover physical therapy costs. The cumulative effects of these multiple barriers Jack experienced were consistent with the reported primary healthcare access barriers experienced by Corscadden et al.'s (2018) participants.

In the current study, vulnerable populations experienced care gaps as a result of the disorganization found in our complex, fractured healthcare system. As previously noted, participants sought acute care in the ED, and were released with instructions to follow-up with a primary care physician, to which they did not have access. This lack of continuity in care risks patient health (Stajduhar et al., 2019). Randall et al.'s (2017) study findings encourage the expansion of community-based nurse-led clinics, such as NMHCs, to increase healthcare access

for underserved populations; expand primary healthcare delivery; provide cost-effective primary

care; and improve patient outcomes and satisfaction (Coddington et al., 2011; Randall et al.,

2017). Sutter-Barrett et al. (2015) supported a nurse-led model of care as an exemplar that can

meet individual and community needs by improving care access for low-income, uninsured, and

underserved populations. This endeavor is achieved by meeting the "real life" (Sutter-Barrett et

al., 2015, p.1) of individuals with few or no resources, and helping fill the healthcare gap by

partnering with other community healthcare resources. Table 1 provides a summary of

facilitators and barriers to primary healthcare access and the experiences of vulnerable,

uninsured populations identified in the previous literature and supported by current study

findings.

Table 1: Facilitators and Barriers to Primary Healthcare Experiences

Theme	Facilitators	Barriers
Theme One: A Safe Place	Safe, accessible, convenient clinic in community setting Increased access to safe, quality care, established clinic as home Committed nurses caring for underserved population, guiding community behavior	Lack of insurance and resources, poverty Loss of job, unsteady work Homelessness and precarious housing Food, shelter, and loss of income supersede healthcare
Theme Two: "They Make You Feel Like You are a Loved Human Being"	Patient-centered care Nurses' behavior including kindness, caring, authenticity Personable nature of the nurse, building relationship	Episodic care Business-oriented, extended wait times, focus on numbers not patient Uncaring bedside manner

Table 1 (Continued)

Theme	Facilitators	Barriers
Theme Three: "They Just Ain't in a Rush vs "In and Out"	Taking time to teach Individual, tailored care empowered patient Interpersonal skills of nurses Nurse-patient partnerships Community outreach Effective teaching strategies	Rushed visits Limited clinic hours Difficulty obtaining appointments Extended wait times Lack of positive provider behaviors, not taking time to listen and teach
Theme Four: My Whole Body is Being Considered	Delivery of holistic care Considering uniqueness of each patient Targeted patients with chronic conditions to manage care Multicultural competence of provider	Healthcare system gaps, fragmented care Lack of continuity in care ED usage to fill care gaps Difficulty obtaining affordable medications Lack of follow-up visits, limited access to primary care provider

Nursing Implications

This study's findings offer uninsured individuals' perceptions of their primary healthcare experiences as gleaned from their first-person narratives. The knowledge gained from this research study has relevance to nursing practice, education, and healthcare policy.

Practice

These findings have important implications for practicing nurses. They affirm nurses'

crucial role of supporting and improving community-based, nurse-led clinical services by

planning health programs tailored to meet individual and the community needs. The knowledge

gained through patients' perceptions of effective interventions at NMHC could help practicing

nurses promote health and prevent illness individually and in the community; serve vulnerable

populations, and help fill a primary care gap for underserved populations.

Nurses can put the knowledge gained from participants' accounts into practice to enhance

chronic disease prevention and management for vulnerable populations. These findings

emphasized the significance of nurses spending time with patients—listening and teaching—to

promote health. Nurses in this study also were able to motivate positive behavior changes in

patients and encourage their return to the clinic for routine visits to monitor chronic illnesses

such as HTN and diabetes. Overall, these findings support best practices for providing quality

healthcare and critical health services to underserved populations.

Most study participants were able to achieve their desire of establishing a personal

relationship with their nurse, a desire documented by Berkowitz et al.'s (2018) findings.

Participant quotes for Theme Two, *"They make you feel like you are a loved human being,"*

highlighted patients' perceptions of nurse behavior they appreciated: kindness, caring, listening,

attention to details, and authenticity. Nurses in practice should adopt these behaviors and engage

in collaborative relationships with their patients, which are foundational for informing patients

about chronic conditions and achieving compliance with medication regimens.

This study's findings show that—as part of their role in meeting population health

needs—nurses should work to build strong relationships with their patients, as such relationships

are essential for monitoring patients' chronic illnesses, improving their health, and preventing future illnesses (Caires, 2017). By increasing patients' awareness of their elevated risk for future adverse health outcomes, nurse-led educational interventions can improve patient care for underserved populations. With 593,000 Mississippians having a pre-existing condition—most commonly asthma, diabetes, and cancer—and five rural hospitals closing since 2010, accessing healthcare in MS is a challenge. As safety-net providers, practicing nurses should aim to build and improve patient-centered care at NMHCs and other settings.

Designed to provide primary and preventive care services, NMHCs have long been considered an important component of the healthcare community. This study sheds light on the additional nursing considerations and commitments needed to sustain these NMHCs and enhance the quality of care experienced by the uninsured individuals served there. These centers play a significant role in improving patient outcomes, promoting health for target populations, helping identify and decrease healthcare disparities, and guiding community behavior.

Using the open-ended questioning style of phenomenology helped the patients in this study communicate their unique healthcare experiences. Armed with such knowledge, nurses can create and support existing healthcare frameworks that address individual and community needs, improve health outcomes, and help close the primary care gap. This information also can help nurses plan health programs tailored to individual and community needs.

Furthermore, the knowledge gained from this study can help nurses understand the facilitators and barriers vulnerable populations encounter when seeking healthcare, especially in settings where the practice of *hearing the experience* is lacking. In this way, this study's findings can be used to help narrow the gap between existing HCP-provided primary healthcare services and those required to meet the needs of underserved individuals.

Together, previous literature findings and this study's participant narratives support the idea of listening to patients' healthcare experiences. Doing so can help members of the nursing discipline implement innovative methods that align with individual and community needs and improve patient health outcomes. Equally important, these patients' perspectives can help nurses develop respectful interventions that respond directly to patients' needs and values.

These study findings and those of other relevant studies also highlighted the importance positive nurse behaviors and traits—kindness, caring, listening, attention to details, and authenticity—played in building strong, effective nurse-patient relationships. Consistent with literature findings, caring nurses in such clinics offer a source of care that can enhance primary care delivery and help decrease emergency room usage among uninsured patients (Tomsik et al., 2014). "It's just the ability to know that if something is wrong, I can come down and we can address the situation," commented one participant in Tomsik's et. al. (2014, p.1827) study, reiterating the efficaciousness and value of the nurse-patient relationship in practice. By providing quality care to vulnerable populations, these centers help reduce health disparities in underserved communities.

This study's findings confirm the fact that nurses at NMHCs can provide primary care, health promotion, and disease prevention services to underserved populations. Such services help increase healthcare access, improve health outcomes, and reduce health disparities. It is vital for nurses to continue to promote the use of PC services rather than costly ED services in order to improve health outcomes, bridge the primary care gap, strengthen the healthcare system, and support the most vulnerable in the nation (Ely, 2015; Mason et al., 2015; Vijayaraghavan et al., 2011). Primary healthcare, health promotion, and disease prevention services at NMHCs must

continue to be offered to underserved populations in urban and rural communities with large, underserved populations.

Moreover, practicing nurses can help NMHCs promote primary care to help improve population health outcomes, enhance the patient experience, and reduce healthcare costs. For example, providing access to prescription medications and offering convenient clinic hours are two factors that can help achieve clinical outcomes that promote population health. These health services can also help to reduce hospital admissions, and readmissions, a focus of primary health clinical outcomes (Dols et al., 2018).

Education

Study findings suggest that patient-provider trust was established through the process of forging mutually respectful relationships. Such relationships are foundational in encouraging patients to make lifestyle changes that promote individual and community health. The theme, *"They make you feel like you are a loved human being,"* reflects the overall meaning of caring participants felt when nurses took the time to teach and educate them.

Previous literature and current study findings support the importance of NMHC nurses and NPs addressing diverse community healthcare needs through effective teaching strategies, which substantiate the mission of providing community-based primary care services that emphasize health education, health promotion, and disease prevention (Mason et al., 2015; Van Zandt et al., 2008). Available literature findings indicate that NMHCs are valuable sites for vulnerable populations to receive education from nurses and NPs, which help improve health outcomes (Pohl et al., 2007b). This literature supports current study findings, particularly data for the theme, *"They Just Ain't in a Rush vs In and Out."* It was evident that the nurses in the current study educated patients on preventive care and health promotion practices, information

imperative for this population given their disparities in equitable access to healthcare. Nurses are unique in their role as leaders in patient and family health education, as they can guide vulnerable patients in developing self-care management strategies.

The themes derived from study narratives could be integrated into a nurse education program designed to promote awareness of this phenomenon among both student and practicing nurses. Nurses should be educated about the healthcare needs and access disparities experienced by vulnerable, uninsured individuals. As patient advocates, nurse educators can design curricula that support emancipatory and caring praxis, and role model to students care that supports social justice for vulnerable and marginalized society members. Students can learn to embrace and value emancipatory knowing or "the ability to recognize social and political problems of injustice or inequity, to realize that things could be different, and to identify or participate in social and political change to improve people's lives" (Chinn & Kramer, 2011, p. 64). Those who do so are likely to continue this praxis, uncovering social inequities related to healthcare disparities among racially and ethnically diverse patients.

The current study brings attention to the continued need for members of the nursing profession and faculty to prepare undergraduate students to provide quality, sensitive care to vulnerable populations. In fact, emancipatory knowing resonates across all four current study themes. Before having access to the NMHC, these participants clearly struggled to access care due to difficulties in their living and social conditions (i.e., homelessness and poverty). For this reason, modern nurse leaders must be well-educated on the challenges this population faces and be prepared to advocate for them. Multiculturally competent HCPs experienced in caring for racially, ethnically, and linguistically diverse patients are better equipped to address health disparities to improve health outcomes.

Policy

Nurse leaders can help reduce healthcare barriers through several actions: participating in public health leadership, health policy, and advocacy efforts; working with community stakeholders; and putting community needs above individual needs. Building relationships is key to gaining access to a community and cooperation from its members. Clinic staff in this study clearly had strong community ties and supported health promotion among community residents. This connection, built on trust, allowed for the delivery of high quality, patient-centered care.

Achievable progress is possible amidst a complex healthcare system when stakeholders identify one common goal to support: improving community health outcomes by delivering high quality, cost-effective care that is accessible to vulnerable populations. Having this common goal creates a shared identity among the group, builds partnerships, and promotes the work of NMHCs. In service to their community, these nurse-led clinics provide healthcare coverage in a community setting. Therefore, it is essential that nurses have awareness of and cultural commonality with the community served (Lyons et al., 2013). Further, it is important that all stakeholders are aware of and understand the nurse's role in our complex healthcare system.

Nurses must advocate to improve health outcomes among communities that are disenfranchised from traditional healthcare delivery systems (Yu, Hill, Ricks, Bennet, & Oriol, 2017). Social justice advocacy for vulnerable populations includes being aware of persistent barriers and promoting policy changes. For example, one important implication of this study is the need to support policies that remove barriers to APRNs providing primary care, as such care is paramount to the development and long-term viability of NMHCs. Restrictive scope of practice laws and inadequate reimbursement policies limit NMHC viability. State laws and federal policies prevent NPs from practicing with complete professional autonomy, which affects

healthcare access at NMHCs. Various state-level regulations on full-practice authority (FPA) and other legislative restrictions to clinic viability impede care access for vulnerable populations (Hanson-Turton, Sherman, & King, 2015). Advancing population health will require active nurse leaders to support policy efforts at both state and national levels.

Indeed, policy changes are needed to pave the way for nurse-led care to improve the health of MS citizens by increasing their access to safe and quality healthcare. As noted, allowing APRNs to practice to their fullest extent of their training can help bring more healthcare services to areas most in need. Given that MS is ranked last in the nation for healthcare accessibility, supporting these policy changes can make quality care more available in rural and underserved communities. These policy changes are essential to assuring that NMHCs continue to play a major role in delivering healthcare for vulnerable populations. Nurses need to be at the forefront of efforts to catalyze these changes.

After forming long-term relationships with homeless patients that allow them to develop mutual trust and understand individual needs, nurses then can advocate for this population in healthcare situations, even facilitating their care access (Hudson et al., 2016). For example, it is important that the uninsured be guided through the changing healthcare landscape by healthcare workers with whom they have close relationships. The role of patient advocate requires nurses to help patients find affordable insurance, an achievement that benefits both patients and the healthcare system at large. Current study participants were disempowered and unable to obtain the resources needed to acquire healthcare. Nurses need training to help them manage the emotional and practical burdens faced by homeless and uninsured individuals.

From an emancipatory perspective, nurses must understand the significance of related theory including its potential to create social change and their power in helping to create such

146

change. Chinn and Falk-Rafael's (2015) Peace and Power theory is a group process used to connect members of the nursing profession with individuals involved in research, classroom teaching, hospital committees, and public health agencies. Through their professional practice, nurses are placed in positions that can reveal social injustices. The current study constitutes an additional investigation of a vulnerable population living in impoverished conditions, the homeless and uninsured, thereby extending the current body of research.

Smith (2019) contended that nurse leaders must be aware of the importance of promoting social justice in healthcare. Indeed, nurses play an important role by advocating for social justice and human rights on behalf of patients, a practice that can help improve healthcare outcomes in underserved communities. Viewed through a social justice lens, it is evident that nursing interventions can address health disparities. In order to realize their full potential and influence in the healthcare system, such interventions must be population-focused, embrace holistic care concepts, foster healthcare team coordination and collaboration, and help providers advocate for patients in all areas of practice (Kagan & Chinn, 2010; Pearl & MacKinnon, 2018; Varcoe, Browne, & Cender, 2014).

Nurses dedicate their professional lives to healing and protecting others. The NMHC nurses in this study were dedicated to serving poverty-stricken populations and certainly faced a number of challenges. Of foremost concern, these patients had little to no hope of paying for healthcare services. Esperat et al., (2012) encouraged nurses to advocate for the nation's most vulnerable populations by promoting health policy changes that provide access quality care that addresses their health disparities. By sharing strategies and interventions that advance healthcare access, nurses can help create a healthcare advocacy agenda in the current political landscape.

Recommendations for Future Research

With no other studies elucidating uninsured patients' perceptions of primary healthcare experiences, there was a need for further exploration of this phenomenon. Gaining an understanding of this phenomenon in one disadvantaged area can be foundational to further research on underserved populations' access to quality care in other geographic regions. Each new level of understanding of this phenomenon will further explicate the nurse's multifocal role in the complex public health and healthcare system. Such knowledge can be used to develop policies and practices to support current and advance future healthcare delivery to underserved populations.

Research also is needed to address vulnerable groups' barriers to care access and understand their experiences of living in poverty. Acknowledging and understanding the individual implications of living in poverty can help nurses develop appropriate care that considers the patients' social circumstances (Corscadden et al., 2018; Richard et al., 2016). Continued research to gain a deeper understanding of the challenges involved in delivering primary healthcare to underserved populations, achieved through hearing the peoples' stories, is important for building and improving quality patient-centered care. Therefore, future research should continue to document and explore patient experiences in the endeavor to achieve better clinical outcomes, improved patient satisfaction, and lower usage of unnecessary healthcare services.

Examining the nurses' behavior toward vulnerable patients in a traditional, bureaucratic NMHC setting would be useful. In addition, research might also include interviewing nurses to gather their perceptions regarding the significance of exhibiting empathetic behavior to promote positive patient outcomes. Finally, an intensive study of one clinic, traditional or faith-based, and

its surrounding community could help explicate the complex phenomena of vulnerable patients' clinic experiences and the clinic-community partnership. Ultimately, these recommended research studies could help support and improve quality, patient-centered, accessible, and affordable care for the target population.

<center>**Study Strengths**</center>

This study had a number of strengths regarding its value within the body of nursing knowledge. One strength is the researcher's use of Merleau-Ponty's existential phenomenology as applied to nursing research by Thomas and Pollio (2002). Since little was known about the phenomenon being investigated, the use of non-structured qualitative interviews was appropriate. Although the study was conducted at only two nurse-led clinics in one large southern city, one clinic was located in the inner city, while the other clinic sat at the edge of the city, drawing patients from the city itself and the rural area beyond. The researcher was able to recruit participants from different races/ethnicities and disadvantaged sociocultural circumstances including homelessness or precarious housing. The qualitative research approach acknowledged these participants as the experts, soliciting their individual voices and stories which are seldom heard in rushed emergency department visits experienced by uninsured individuals. This study supported the contribution of conducting qualitative research to understand patient perspectives beyond standardized satisfaction measures (Berkowitz et al., 2018). Participants in the present study valued *"not just being measured by numbers"* (Grace, 10–11).

Several strategies were used to ensure rigor, another study strength. In accordance with Thomas and Pollio's (2002) procedural guidelines, the researcher completed a bracketing interview to minimize bias prior to and during the study. The TPRG group critiqued the researcher's interview technique to improve the richness of the interview data elicited.

Participants were interviewed until data saturation was reached. The researcher then collaborated with the TPRG to identify and agree upon the final thematic structure.

Previous researchers have focused primarily on NMHCs' community impacts, health promotion among targeted populations, and contributions to improving healthcare access (Dyal et al., 2016; Ely, 2015; Mason et al., 2015; Richard et al., 2016). None of these studies used phenomenology as a philosophical and methodological base or invited uninsured adults living in poverty to tell their stories about primary healthcare experiences. Clearly, these individuals need to be given a voice, as they have a valuable contribution to make in improving primary healthcare.

The researcher is unaware of any other study that explored via phenomenology patients' experiences in seeking, accessing, and receiving primary care as an uninsured individual, particularly in MS. Therefore, these study findings add to the limited body of nursing research about this topic. These study findings also give voice to the voiceless in order to validate, support and help to improve primary healthcare programs for this population. In addition, these findings illuminate NMHCs' contributions to addressing the primary care shortage, strengthening the healthcare system, and supporting our nation's most vulnerable citizens.

The researcher elicited valuable information about patient perceptions of interventions that were effective in promoting health and preventing illness. This information can be used to plan health programs tailored to individual and community needs using community-based, nurse-led clinical services. Overall, this study's findings contribute to a richer understanding of this social phenomenon and help support nurse-led care at NMHCs, which emphasize health promotion, health education, and disease prevention; provide quality care to vulnerable populations; and help reduce health disparities in underserved communities.

Summary

      The purpose of this study was to describe the lived experiences of uninsured poverty-stricken patients seeking primary healthcare at NMHCs. The lens of Merleau-Ponty served as the framework for this phenomenological study. The information gained by this study can be used to support and improve community-based nurse-led clinical services and plan health programs for similar individuals and the communities. Four figural themes emerged from participant interviews: *A Safe Place, "They Make You Feel Like You Are a Loved Human Being," "They Just Ain't in a Rush... In and Out,"* and *"My Whole Body is Being Considered."* These research findings provide a rich understanding of the investigated phenomena, add to the nursing literature about this topic, and have implications for nursing practice, education, policy, and research. These findings can help improve primary healthcare, health promotion, and disease prevention services to underserved populations. Providing primary care access to marginalized populations is pivotal to reducing the risk factors that jeopardize individual and community health and well-being. Nurses play a significant role in improving the health of vulnerable populations and improving population health. This role can be expanded through their work in NMHCs.

References

America's Health Rankings. (2017). *United health foundation.* Retrieved from

assets.americashealthranking.org

American Nurses Association. (ANA). (1987). American Nurses Association Task Force to

Develop Guidelines for Nurse-Managed Centers. *The nursing center: Concept and*

design. Kansas City, MO: American Nurses' Association

Artiga, S., & Cornachione, E. (2016). The Kaiser Family Foundation. *Trends in Medicaid and*

CHIP Eligibility Over Time. https://kff.org/medicaid/report/trends-in-medicaid-and-chip-

eligibility-over-time

Artiga, S., & Damico, A. (2016). The Kaiser Commission on Medicaid and the Uninsured.

Health and Health Coverage in the South: A Data Update.

https://www.kff.org/disparities-policy/issues-brief/health-and-health-coverage-in-the-

south-a-data-update

Association of American Medical Colleges (AAMC). (2018, April 11). New research shows

increasing physician shortages in both primary and specialty care. AAMC News-Press

Releases, 1-2. Retrieved from https://news.aamc.rg/press-releases/article/

Workforce

Auerbach, D. L., Chen, P. G., Friedberg, M. W., Reid, R., Lau, C., Buerhaus, P. J., & Mehrotra,

A. (2013). Nurse-managed health centers and patient-centered medical homes could

mitigate expected primary physician shortage. *Health Affairs, 32*(11), 1933-1941. doi:

10.1377/hlthaff.2013.0506

Berchick, E., Hood, R., & Barnett, J. C. (2018). Current population reports, P60-264. *Health*

Insurance Coverage in the United States (2017). Washington, D. C.: U. S. Government

Printing Office

Berkowitz, R. L., Phillip, N., Berry, L., & Yen, I. H. (2018). Patient experience in a linguistically

    diverse safety net primary care setting: A qualitative study. *Journal of Participatory*

    Medicine, 10(1), 1-15. doi: https://doi-org.hindscc.idm.oclc.org/10.2196/jopm.9229

Bodenheimer, T., & Bauer, L. (2016). Rethinking the primary care workforce – an expanded role

    for nurses. *New England Journal of Medicine, 375,* 1015-1017. doi:

    10.1056/NEJMp1606869

Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim. Care of the patient requires

    care of the provider. *Annals of Family Medicine, 12(*6), 573-576. doi: 10.1370/afm.1713

Bucher, J. A., & Thompson, C. W. (2012). Promoting health in low-income communities: The

    asthma safe kids program delivered by an Academic Nurse Managed Center. *Journal of*

    Asthma and Allergy Educators, 3(5), 215-220. doi: 10.1177/2150129711434082

Caires, A. (2017). Mobile health care for people who are homeless. *Creative Nursing, 23*(3),

    152-157. doi: 10.1891/1078-4535.23.3.152

Centers for Disease Control. (CDC). (2019). Emergency preparedness and vulnerable

    populations: Planning for those most at risk. *Center for Preparedness and Response.*

    https://www.cdc.gov/cpr/whatwedo/vulnerable.htm

Centers for Medicaid and Medicare Services. (CMS), (2016). *Transforming clinical practice*

    initiative. Retrieved from https://innovation.cms.gov/initiatives/Transforming-Clinical-

    Practices

Chinn, P., & Falk-Rafael, A. (2015). Peace and power: A theory of emancipatory group process.

    Journal of Nursing Scholarship, 47(1), 62-69. doi: 10.1111/jnu.12101

Chinn, P.L., & Kramer, M.K. (2011). *Integrated theory and knowledge development in nursing*

    (8th ed.). St Louis, MO: Mosby

Chokshi, D. A., Chang, J. E., & Wilson, R. M. (2017, October 18). Health reform and the

    changing safety net in the United States. *NEJM Catalyst.* Retrieved from

    https://catalyst.nejm.org

Coddington, J., Sands, L., Edwards, N., Kirkpatrick, J., & Chen, S. (2011). Quality of health care

    provided at a pediatric nurse-managed clinic. *Journal of the American Academy of Nurse*

    Practitioners, 23(12), 674-680. doi: 10.1111/j.1745-7599.2011.00657.x

Commonwealth Fund. (2018). *First look at health insurance coverage in 2018 finds ACA gains*

    beginning to reverse – May 2018.

    http://www.commonwealthfund.org/publications/blog/2018/apr/health-coverage-erosion

Commonwealth Fund. (2016). *The 2016 Commonwealth Fund International Health Policy*

    Survey of Adults. http://www.commonwealthfund.org/data/2016

Corscadden, L., Levesque, J. F., Lewis, V., Strumpf, E., Breton, M., & Russell, G. (2018).

    Factors associated with multiple barriers to access to primary care: An international

    analysis. *International Journal for Equity in Health, 17*(28), 1-10. doi:

    http://dx.doi.org/10.1016/j.socscimed.2014.05.018

Creswell, J. W. (2015). *Qualitative inquiry and research design: Choosing among five*

    approaches. Thousand Oaks, CA: Sage Publications

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among*

    five approaches. Thousand Oaks, CA: Sage Publications

Delta Health Alliance (2016). *The Delta health alliance: Solutions for a healthy tomorrow.*

    Retrieved from http://www.deltahealthalliance.org

Desmond, B. S., Laux, M. A., Levin, C. C., Huang, J., & Williams, B. C. (2016). Reasons why

    individuals remain uninsured under the Affordable Care Act: Experiences of patients at a

student-run free clinic in Michigan, a Medicaid expansion state. *Journal of Community Health, 41,* 417-423. doi: 10/1007/s10900-015-0112-3

Dols, J. D., Beckmann-Mendez, D., DiLeo, H. A., Weis, K. L., & Medina-Calvo, M. (2018). Nurse-managed health centers: Measures of excellence. *The Journal for Nurse Practitioners, 14*(8), 613-619. doi: 10.1016/j.nurpra.2018.05.008

Dyal, B., Whyte, M., Blankenship, S. M., & Ford, L. G. (2016). Outcomes of implementing an evidence-based hypertension clinical guideline in an academic nurse-managed health center. *Worldviews on Evidence-Based Nursing, 13*(1), 89-93. doi: 10.111/wvn.12135

Ely, L. (2015). Nurse-managed clinics: Barriers and benefits toward financial sustainability when integrating primary care and mental health. *Nursing Economics, 33*(4), 192-202.

Epoche. (n. d.). In *Merriam-Webster Online.* Retrieved August 7, 2019, from http://www.merriam-webster.com/dictionary/citation

Esperat, M. C., Hansen-Turton, T., Richardson, M., Debisette, A. T., & Rupinta, C. (2012). Nurse-managed health centers: Safety-net care through advanced nursing practice. *Journal of the American Academy of Nurse Practitioners, 24*(1)*,* 24-31. doi: 10.1111/j.1745-7599-2011.0067.x

George, S. R., & Thomas, S. P. (2010). Lived experience of diabetes among older, rural people. *Journal of Advanced Nursing, 66*(5), 1092-1100. doi: 10.1111/j.1365-2648.2010.05278.x

Giorgi, A. (1997). The theory, practice, and evaluation of the phenomenological method as a qualitative research procedure. *Journal of Phenomenological Philosophy, 28,* 235-260.

Guba, E., & Lincoln, Y. (1989). *Fourth generation evaluation.* Newbury Park, CA: Sage

Haas, L. (2008). *Merleau-Ponty's philosophy.* Bloomington: Indiana University Press

Hansen-Turton, T., Bailey, D. N., Torres, N., & Ritter, A. (2010). Nurse-managed health centers. *American Journal of Nursing, 110*(9), 23-26. doi: 10.1097/01.NAJ.0000388257.4180.41

Hansen-Turton, T., Sherman, S., & King, E. S. (2015). *Nurse-led health clinics: Operations, policy and opportunities.* New York: Springer Publishing Company

Heidegger, M. (1927/1962). *Being and time.* New York: Harper & Row

Holt, J., Zabler, B., & Baisch, M. J. (2016). Evidence-based characteristics of nurse-managed health centers for quality and outcomes. *Nursing Outlook, 62,* 428-439. doi: http://dx.doi.org/10/1016/j.outlook.2014.06.005

Hudson, B. F., Fleming, K., Shulman, C., & Candy, B. (2016). Challenges to access and provision of palliative care for people who are homeless: A systematic review of qualitative research. *BMC Palliative Care, 15*(96), 1-18. doi: 10.1186/s12904-016-0168-6

Husserl, E. (1913/1931). *Ideas: General introduction to pure phenomenology*. New York: Collier Books

Institute of Medicine (IOM). (2000). *America's health care safety net: Intact but endangered.* Washington, D. C.: National Academy Press

Institute of Medicine (IOM). (2009). *America's uninsured crisis: Consequences for health and health care. Report Brief.* Washington, D.C.: National Academies Press

Institute of Medicine (IOM). (2015). *Assessing progress on the IOM report the future of nursing.* Washington, D. C.: The National Academies of Sciences, Engineering, and Medicine

Kagan, P. N., & Chinn, P. L. (2010). We're all here for the good of the patient: A dialogue on power. *Nursing Science Quarterly, 23*(1), 41-46. doi: 10.1177/0894318409353808

Kaiser Family Foundation (2014, October). Kaiser Commission on Medicaid and the

    underinsured population: Key facts about the uninsured population. *Fact Sheet.* Retrieved

    from https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population

Kaiser Family Foundation (2018a). Kaiser Family Foundation analysis of 2017 American

    Community Survey (ACS), 1 – Year estimates. *Key Facts About the Uninsured*

    Population. Retrieved from https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-

    uninsured-population

Kaiser Family Foundation (2018b). Status of state action on the Medicaid expansion decision.

    State Health Facts. https://www.kff.org/health-reform/state-indicator/state-activity-

    around-expanding-Medicaid-under-the-affordable-care-act

Kindig, D. A., & Stoddart, G. (2003). What is population health? *American Journal of Public*

    Health, 93(3), 380-383.

Kwant, R. C. (1963). *The phenomenological philosophy of Merleau-Ponty*. Pittsburgh, PA:

    Duquesne University Press

Lyons, H. Z., Bike, D. H., Ojeda, L., Johnson, A., Rosales, R., & Flores, L. Y. (2013).

    Qualitative research as social justice practice with culturally diverse populations. *Journal*

    for *Social Action in Counseling and Psychology, 5*(2), 10-25.

Martsolf, G. R., Gordon, T., May, L. W., Mason, D., Sullivan, C., & Villarruel, A. (2016).

    Innovative nursing care models and culture of health: Early evidence. *Nursing Outlook,*

    64, 367-376. doi: 10.1016/j.outlook2016.02.009

Mason, D. J., Jones, D. A., Roy, C., Sullivan, C. G., & Wood, L. J. (2015). Commonalities of

    nurse-designed models of healthcare. *Nursing Outlook, 63,* 540-553. doi: https:

    dx.doi.org/10/1016/j.outlook2015.04.009

Matthews, E. (2006). *Merleau-Ponty: A guide for the perplexed.* London: Continuum

McInnes, D. K., Li, A. E., & Hogan, T. P. (2013). Opportunities for engaging low-income,

vulnerable populations in health care: A systematic review of homeless persons' access to

and use of information technologies. *American Journal of Public Health, 103*(2), 11-23.

Merleau-Ponty, M. (1945/1962). *The phenomenology of perception.* London: Routledge and

Kegan Paul

Merleau-Ponty, M. (1973). *The Prose of the World* (J. O'Neill, trans.) Evanston, IL:

Northwestern University Press.

Mississippi State Department of Health. (MSDH, 2019a). *Diabetes prevention and control.*

Retrieved from https://msdh.ms.gov

Mississippi State Department of Health. (MSDH, 2019b). *Heart disease and stroke prevention*

program. Retrieved from https://msdh.ms.gov/msdhsite_static/43,0,297.html

Moran, D. (2000). *Introduction to phenomenology.* London: Routledge

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry.

Qualitative Health Research, 25(9), 1212-1222.doi: 10.1177/104973231588501

National Nurse-Led Care Consortium (NNCC). (2017). Available at URL: http://www.nncc.us.

Accessed September 30, 2017

Nardi, D. (2011). Integrated physical and mental health care at a nurse-managed clinic: Report

from the trenches. *Journal of Psychosocial Nursing and Mental Health Services, 49*(7),

28-34. doi: 10.3928/02793695-20110609-02

Parker, D. R., & Dykema, S. (2013). The reality of homeless mobility and implications for

improving care. *Journal of Community Health, 38(*4), 685-689. doi: 10.1007/s10900-013-

9664-2

Patient Protection and Affordable Care Act of 2010. (PPACA). (ACA, 2010). *Pub. L. No. 111-*

    148, S.5208, 612 Stat.124

Pearl, J., & MacKinnon, K. (2018). Cultivating praxis through Chinn and Kramer's

    emancipatory knowing. *Advances in Nursing Science, 41*(4), 351-358. doi:

    10.1097/ANS.0000000000232

Percent Uninsured (2019). *Percent Without Health Insurance Data for Mississippi Health.*

    Retrieved from

    https://www.opendatanetwork.com/entitiy/0400000US28/Mississippi/health.health_insur

    ance

Pohl, J. M., Barkauskas, V. H., Benkert, R., Breer, L., & Bostrom, A. (2007a). Impact of

    academic nurse-managed centers on communities served. *Journal of the American*

    Academy of Nurse Practitioners, 19(5), 268-275. doi: 10.1111/j.1745-7599.2007.00224.x

Pohl, J.M., Sebastian, J. G., Barkauskas, V. H., Breer, M. L., Williams, C. A., Stanhope,

    M.,…Rayens, M. K. (2007b). Characteristics of schools of nursing operating academic

    nurse-managed centers. Nursing Outlook, 55)6), 289-296. doi:

    10.1016/j.outlook.2007.07.004

Pohl, J. M., Vonderheid, S. C., Barkauskas, V. H., & Nagelkerk, J. (2004). The safety net:

    Academic nurse-managed centers' role. *Policy, Politics, & Nursing Practice, 5(*2), 84-94.

    doi: 10.1177/1527154404263892

Polit, D., & Beck, C. (2012). *Nursing research: Generating and assessing evidence for nursing*

    practice (9th ed.). Philadelphia, PA: Lippincott, Williams, & Wilkins

Pollio, H. R., Henley, T., & Thompson, C. B. (1997). *The phenomenology of everyday life.*

    Cambridge: Cambridge University Press

Randall, S., Crawford, T., Currie, J., River, J., & Betihavas, V. (2017). Impact of community-

    based nurse-led clinics on patient outcomes, patient satisfaction, patient access and cost

    effectiveness: A systematic review. *International Journal of Nursing Studies, 73,* 24-33.

    doi: 10.1016/j.ijnurstu.2017.05.008

Richard, L., Furler, J., Densley, K., Haggerty, J., Russell, G., Levesque, J. F., & Gunn, J. (2016).

    Equity of access to primary healthcare for vulnerable populations: the IMPACT

    international online survey of innovations. *International Journal for Equity in Health,*

    15(64), 1-20. doi: 10.186/212939-0160351-7

Sandelowski, M. (2008). Justifying qualitative research. *Research in Nursing and Health, 31,*

    193-195. doi: 10.1002/nur.20272

Semega, J. L., Fontenot, K. R., & Kollar, M. A. (2017). Current population reports, P60_259.

    Income and Poverty in the United States (2016). Washington, D. C.: U. S. Government

    Printing Office.

Shi, L., & Singh, D. A. (2017). *Essentials of the U.S. health care system.* Burlington, MA: Jones

    & Bartlett Learning

Smith, M. A. (2019). The promotion of social justice in healthcare. *Nursing Made Incredibly*

    Easy!, 17(2), doi: 10.1097/01.NME.0000553091

Smuts, J. C. (1926). *Holism and evolution.* New York: Macmillan Company.

Sohn, B. K., Thomas, S. P., Greenberg, K. H., & Pollio, H. R. (2017). Hearing the voices of

    students and teachers: A phenomenological approach to educational research. *Qualitative*

    Research in Education, 6(2), 121-148. doi: 10.17583/qre.2017.237

Stajduhar, K. I., Mollison, A., Giesbrecht, M., McNeil, R., Pauly, B., Reimer-Kirkham,

    N.,…Rounds, K. (2019). "Just too busy living in the moment and surviving": Barriers to

accessing health care for structurally vulnerable populations at end-of-life. *BMC*

   Palliative Care, 18(11), 1-14. doi: https://doi.org/10.1186/s12904-019-0396-7

Starfield, B. (1992). *Primary care: Concept, evaluation, and policy.* New York, NY: Oxford

   University Press

Stats of the State of Mississippi. (2018). Centers for disease control and prevention (CDC).

   National Center for Health Statistics. Retrieved from

   https://www.cdc.gov/nchs/pressroom/states/mississippi/mississippi.hitm

Stephens, J., Artiga, S., & Paradise, J. (2014, April). *Health coverage and care in the South in*

   2014 and beyond. Washington, D.C.: Kaiser Commission on Medicaid and the

   Uninsured.

Sutter-Barrett, R. E., Sutter-Dalrymple, & Dickman, K. (2015). Bridge care nurse-managed

   clinics fill the gap in health care. *The Journal for Nurse Practitioners, 11*(2), 262-265.

   doi: 10.1016/j.nurpra.2014.11.012

Talk Poverty. (2018). Talk poverty topics. *Mississippi Report-2018-Talk Poverty.* Retrieved from

   https://talkpoverty.org/state-year-report/mississippi-2018-report

Thomas, S. P. (2000). A phenomenological study of chronic pain. *Western Journal of Nursing*

   Research, 22(6), 683-705. doi: 10.1177/01939459000220060

Thomas, S. P. (2005). Through the lens of Merleau-Ponty: Advancing the phenomenological

   approach to nursing research. *Nursing Philosophy, 6,* 63-76. doi: 10.1111/j.1466-

   769X.2004.00185.x

Thomas, S. P., & Pollio, H. R. (2002). *Listening to patients: A phenomenological approach to*

   nursing research and practice. New York: Springer Publishing

Tiedje, K., & Plevak, D. J. (2014). Medical humanitarianism in the United States: Alternative

    healthcare, spirituality and political advocacy in the case of Our Lady Guadalupe Free

    Clinic. *Social Science & Medicine, 120,* 360-367. doi: http://dx.doi.org/10/1016

Tomsik, P. E., Smith, S., Mason, M. J., Zyzanski, K., Stange, c., Werner, J. J., & Flocke, S. A.

    (2014). Understanding and measuring health care insecurity. *Journal of Health Care for*

    the Poor and Underserved, 25(4), 1821-2832. doi: https://doi.org/10.1353/hpu.2014.0180

Van Manen, M. (2014). *Phenomenology of practice: Meaning-giving methods in*

    phenomenological research and writing. Walnut Creek, CA: Left Coast Press

Van, Manen, M. (1990). *Researching lived experience: Human science for an action sensitive*

    pedagogy. New York: State University of New York

Van Zandt, S. E., Sloand, E., & Wilkins, A. (2008). Caring for vulnerable populations: Role of

    academic nurse-managed health centers in educating nurse practitioners. *The Journal for*

    Nurse Practitioners, 4(2), 126-131. doi: 10.1016/j.nurpra.2007.09.017

Varcoe, C. M., Browne, A., & Cender, L. (2014). Promoting social justice and equity by

    practicing nursing to address structural inequities and structural violence. In P. Kagan, M.

    Smith, & P. Chinn (Eds.), *Philosophies and Practices of emancipatory nursing: Social*

    justice as praxis (pp. 266-284). New York: Routledge

Vijayaraghavan, M., Tochterman, A., Hsu, E., Johnson, K., Marcus, S., & Caton, C. (2011).

    Health, access to health care, and health care use among homeless women with a history

    of intimate partner violence. *Journal of Community Health, 37*(5), 1032-1039. doi:

    10.1007/ss10900-011-9527-7

Vonderheid, S., Pohl, J., Barkauskas, V., Gift, D., & Hughes-Cromwidk, P. (2003). Financial
    performance of academic nurse-managed primary care centers. *Nursing Economic$,
    21*(4), 167-175.

Wallace, S. P., Torres, J., Sadegh-Nabari, T., Pourat, N., & Brown, E. R. (2012). *Undocumented
    immigrants and healthcare reform. UCLA Center for Health Policy Research.* Retrieved
    from http://healthpolicy.ucla.edu/publications/Documents/PDF/undocumentedreport-
    aug2013.pdf

Wolfe, A. (2017, December 13). Mississippi again unhealthiest state in the country. *Clarion
    Ledger.* Retrieved from
    https://www.clarionledger.com/story/news/politics/2017/12/12/mississippi-again-
    unhealthiest-state-country/943720001

World Health Organization. (WHO). (2018). *Health topics: Main terminology.* Retrieved from
    https://www.uro.who.int

Yu, S., Hill, C., Ricks, M. L., Bennet, J., & Oriol, N. E. (2017). The scope and impact of mobile
    health clinics in the United States: A literature review. *International Journal for Equity in
    Health, 16*(178), 1-12. doi: 10.1186/s12939-017-0671-2

Appendices

Appendix A: Letter of Support 1

2235 Terry Road   Jackson, MS. 39204
September 7, 2019

The Institutional Review Board of the University of Tennessee, Knoxville
Knoxville, TN. 37996

Dear Institutional Review Board Members,

I am writing to enthusiastically offer my support and grant permission for Linda Banks to conduct a study at Craft House Ministry; regarding patient's health care experiences, as it pertains to her dissertation.

Linda has met with me and described the purpose and significance of the study to nursing practice. I understand Linda will be interviewing clients that come to our free clinic.

Sincerely,
Catherine Cheney RN/ Director

Appendix B: Letter of Support 2

St. Dominic's

August 22, 2019

Dr. Sandra Thomas PhD,RN.FAAN

University of TN-College of Nursing

1200 Volunteer Blvd.

Knoxville, TN 37996

Dear Dr. Sandra Thomas

I am writing to offer support and grant permission for Linda Banks, candidate in the PhD program at the University of Tennessee, College of Nursing to conduct a study at St. Dominic's Community Health Clinic, Jackson, Mississippi, regarding patients' health care experiences, as it pertains to her dissertation. Linda has met with me and described the purpose and the significance of the study to nursing practice

I understand Linda will be interviewing patients from this clinic and we will work to determine a best time for the interviews. I look forward to working with her to make this study a success.

Sincerely,

Sister Mary Trinita Eddington MSN,APRN

Family Nurse Practitioner

Consent for Research Participation

Research Study Title: The Lived Experience of Uninsured Patients Seeking Primary Healthcare in Mississippi: A Phenomenological Study

Researcher(s):   Linda Banks, MSN, MS, RN, University of Tennessee, Knoxville
Sandra Thomas, PhD, RN, FAAN, University of Tennessee, Knoxville

---

Why am I being asked to be in this research study?

We are asking you to be in this research study because you are a patient visiting a clinic receiving primary healthcare. We believe you have important things to say about your experience.

What is this research study about?

We want to understand your health care experience and what it has meant to you as a patient.

How long will I be in the research study?

If you agree to be in the study, we will only interview you once. The interview will usually last about one hour, but it will last as short or as long as you need for it to be for you to share your experience with us. It will be over when you decide it's over. There are no right or wrong answers to any question; you tell us what you think is important to us.

What will happen if I say "Yes, I want to be in this research study"?

If you agree to be in this study, we will ask you to:
- Read this Informed Consent or have the consent form read to you. If you agree, sign it with your name.
- Allow us to audio record the interview. We want to remember exactly what you said. This will help us make sure there are no mistakes in what we hear you say. Once we finish, we will type the interview on a computer. We will not use your real name or the clinic so that you cannot be identified. There will be no way to connect you with what you have said.

What happens if I say "No, I do not want to be in this research study"?

Being in this study is up to you. Your decision won't affect your relationship with the researchers or the University of Tennessee. Your decision will not affect your relationship with the clinic.

What happens if I say "Yes" but change my mind later?

Even if you decide to be in the study now, you can change your mind and stop at any time.

If you decide to stop before the study is completed, you may contact the Principle Investigator (PI).

If you start the interview, but decide to stop it early, we will keep the information we have up to that point and use it for our study. If you wish to remove your interview from the study completely, contact the researcher. Your interview will be removed as you have requested.

Are there any possible risks to me?

There is no physical risk to you in this study. Talking about a health care experience as an uninsured individual may be upsetting for some people, but others may find it a relief to tell their story. You are always free to refuse to answer any question, change the subject, or withdraw from the interview.

Are there any benefits to being in this research study?

We do not expect you to benefit from being in this study. However, your interview will help us learn more about this topic. Your participation may help us to learn more about patients' healthcare experiences. We hope the knowledge gained from this study will benefit others in the future.

Who can see or use the information collected for this research study?

Only members of the research team can see your interview. All information will be kept private. Voice recordings and consent forms will be kept in a locked file as well as a password protected computer.

If we publish or share findings from this study at scientific meetings, your name and other personal information will not be used.

While it is rare, there are times when others may need to see the information we collect about you. These include:

- People at the University of Tennessee, Knoxville, who oversee research to make sure it is done properly.
- People who are responsible for watching over the safety of the research.
- If a law or court requires us to share the information.

What will happen to my information after this study is over?

We will keep your information to use for future research. Your name and other personal information will be removed from your interview. We will not share your interview with other researchers.

Will it cost me anything to be in this research study?

It will not cost you anything to be in this study.

What else do I need to know?

We may need to stop your participation in the study if you are no longer eligible.

If we learn about any new information that may change your mind about being in the study, we will tell you. If that happens, you may be asked to sign a new consent form.

If emotional distress occurs, we will let you pause during the interview, change the topic, take a break, or stop the interview. If needed, we can refer you to a local counselor for mental health care. If you are at home and experience distress in your mind, you can contact your health care provider and inform the researcher as soon as possible.

The University of Tennessee does not automatically pay for medical claims or give other compensation for injuries or other problems.

Who can answer my questions about this research study?

If you have questions or concerns about this study, or have experienced a research related problem or injury, contact the researchers.

Researcher: Linda Banks, email **lbanks5@vols.utk.edu**

Faculty Advisor: Sandra Thomas, email **sthomas@utk.edu**

St. Dominic's Community Health Clinic: (601) 944-0091

For questions or concerns about your rights or to speak with someone other than the research team about the study, please contact:

Institutional Review Board
The University of Tennessee, Knoxville
1534 White Avenue
Blount Hall, Room 408
Knoxville, TN 37996-1529
Phone: 865-974-7697
Email: **utkirb@utk.edu**

Appendix D: Study Script

"Welcome to the interview, my name is Linda. Thank you for choosing to talk with me today. I am looking forward to hearing what you want to share. I will audio record this interview so I can be sure that I hear all of your words as you are saying them, without any mistakes. I will start with a broad opening question, and all other questions will be based on your responses. Are you ready to begin?"

Opening question:

"When you think of a time you came to the clinic for health care; can you tell me what stands out to you as you recall this time (experience)?"

- Tell me more about that.
- What does healthcare mean to you?
- What do you mean by (topic)?
- Can you say more about that experience?
- Tell me what that is/was like.
- Can you give me an example?
- What was happening at the time?
- I would like to understand more about how this issue/example relates to (topic).

Concluding question:

"Is there anything else you would like to add that I have not asked or that you would like to say?"

Closing statement:

"Thank you for agreeing to talk with me today, and participate in this study."

Appendix E: Demographic Form

Interview date: _____   Pseudonym name: _____
DEMOGRAPHICS SHEET
Please do not write your name on this form. It will be stored separately from your interview and will not be linked to your responses in any way. The information will allow us to accurately describe the group of participants interviewed.

For the following questions, please answer as you are comfortable in doing so.

What is your gender? Female ____ Male ____

How old are you?   18-25 ____
                     26-49 ____
                     50-64 ____
                     65 and older ____

What is your Race/Ethnicity?
             Asian or Pacific Islander _____
             African American Hispanic _____
             Latino American Indian _____
             Native American White _____
             Caucasian Other _____

What is your education level? _____
What is your reason for seeking care at the clinic?
_____
Are you the recipient of Medicare, Medicaid or any private insurance?   Yes _____   No _____
Who was your care provided by? LPN _____
                               RN _____
                               Nurse Practitioner _____
                               Other _____
                               "Don't know" _____

Appendix G
Appendix H

Appendix F: Transcriptionist Confidentiality Agreement

The Lived Experience of Uninsured Individuals Seeking Primary Healthcare in Mississippi: A Phenomenological Study

Principal Investigator: Linda Banks, MSN, RN
Faculty Advisor: Sandra Thomas, PhD, RN, FAAN

As a transcriptionist working on this research study, "The lived experience of uninsured individuals seeking primary healthcare in Mississippi: A phenomenological study", I understand that I will be seeing information about the participants that have sought healthcare in Mississippi. This information will contain a description of a wide range of participants' experiences seeking, accessing, and receiving primary healthcare. The information I will see and hear has been revealed by participants who have been assured that their personal information would remain strictly confidential.

I hereby agree not to share any information about these participants with anyone except the primary researchers for this project—now or at any time in the future. Any violation of this agreement would constitute a serious breach of ethical standards, and I pledge not to do so. I understand that I have a responsibility to honor this confidentiality agreement.

Appendix G: Client Non-Disclosure Agreement

CLIENT NON-DISCLOSURE AGREEMENT

This CLIENT NON-DISCLOSURE AGREEMENT, effective as of the date last set forth below (this "Agreement"), between the undersigned actual or potential client ("Client") and Rev.com, Inc. ("Rev.com") is made to confirm the understanding and agreement of the parties hereto with respect to certain proprietary information being provided to Rev.com for the purpose of performing translation, transcription and other document related services (the "Rev.com Services"). In consideration for the mutual agreements contained herein and the other provisions of this Agreement, the parties hereto agree as follows:

1. Scope of Confidential Information

1.1. "Confidential Information" means, subject to the exceptions set forth in Section 1.2 hereof, any documents or other text supplied by Client to Rev.com for the purpose of performing the Rev.com Services.

1.2. Confidential Information does not include information that: (i) was available to Rev.com prior to disclosure of such information by Client and free of any confidentiality obligation in favor of Client known to Rev.com at the time of disclosure; (ii) is made available to Rev.com from a third party not known by Rev.com at the time of such availability to be subject to a confidentiality obligation in favor of Client; (iii) is made available to third parties by Client without restriction on the disclosure of such information; (iv) is or becomes available to the public other than as a result of disclosure by Rev.com prohibited by this Agreement; or (v) is developed independently by Rev.com or Rev.com's directors, officers, members, partners, employees, consultants, contractors, agents, representatives or affiliated entities (collectively, "Associated Persons").

2. Use and Disclosure of Confidential Information

2.1. Rev.com will keep secret and will not disclose to anyone any of the Confidential Information, other than furnishing the Confidential Information to Associated Persons; provided that such Associated Persons are bound by agreements respecting confidential information. Rev.com will not use any of the Confidential Information for any purpose other than performing the Rev.com Services on Client's behalf. Rev.com will use reasonable care and adequate measures to protect the security of the Confidential Information and to attempt to prevent any Confidential Information from being disclosed or otherwise made available to unauthorized persons or used in violation of the foregoing.

2.2. Notwithstanding anything to the contrary herein, Rev.com is free to make, and this Agreement

does not restrict, disclosure of any Confidential Information in a judicial, legislative or administrative investigation or proceeding or to a government or other regulatory agency; provided that, if permitted by law, Rev.com provides to Client prior notice of the intended disclosure and permits Client to intervene therein to protect its interests in the Confidential Information, and cooperate and assist Client in seeking to obtain such protection.

3. Certain Rights and Limitations

3.1. All Confidential Information will remain the property of Client.

3.2. This Agreement imposes no obligations on either party to purchase, sell, license, transfer or otherwise transact in any products, services or technology.

4. Termination

4.1. Upon Client's written request, Rev.com agrees to use good faith efforts to return promptly to Client any Confidential Information that is in writing and in the possession of Rev.com and to certify the return or destruction of all Confidential Information; provided that Rev.com may retain a summary description of Confidential Information for archival purposes.

4.2. The rights and obligations of the parties hereto contained in Sections 2 (Use and Disclosure of Confidential Information) (subject to Section 2.1), 3 (Certain Rights and Limitations), 4 (Termination), and 5 (Miscellaneous) will survive the return of any tangible embodiments of Confidential Information and any termination of this Agreement.

5. Miscellaneous

5.1. Client and Rev.com are independent contractors and will so represent themselves in all regards. Nothing in this Agreement will be construed to make either party the agent or legal representative

LIBC/4524740.1

Doc ID: d1125c5587e657f1d7c3d08a0885fc59ded10963

of the other or to make the parties partners or joint venturers, and neither party may bind the other in any way. This Agreement will be governed by and construed in accordance with the laws of the State of California governing such agreements, without regard to conflicts-of-law principles. The sole and exclusive jurisdiction and venue for any litigation arising out of this Agreement shall be an appropriate federal or state court located in the State of California, and the parties agree not to raise, and waive, any objections or defenses based upon venue or forum non conveniens. This Agreement (together with any agreement for the Rev.com Services) contains the complete and exclusive agreement of the parties with respect to the subject matter hereof and supersedes all prior agreements and understandings with respect thereto, whether written or oral, express or implied. If any provision of this Agreement is held invalid, illegal or

6.

unenforceable by a court of competent jurisdiction, such will not affect any other provision of this Agreement, which will remain in full force and effect. No amendment or alteration of the terms of this Agreement will be effective unless made in writing and executed by both parties hereto. A failure or delay in exercising any right in respect to this Agreement will not be presumed to operate as a waiver, and a single or partial exercise of any right will not be presumed to preclude any subsequent or further exercise of that right or the exercise of any other right. Any modification or waiver of any provision of this Agreement will not be effective unless made in writing. Any such waiver will be effective only in the specific instance and for the purpose given.

   IN WITNESS WHEREOF, the parties have caused this Agreement to be executed below by their duly authorized signatories.

CLIENT   REV.COM, INC.

By: By:

   Name: Name: David Abrameto

   Title: Title: CFO

   Date: Date:

Address for notices to Client: Address for notices to Rev.com, Inc.:

                                          222 Kearny St., STE 800

                                          San Francisco, CA 94108

LIBC/4524740.1

Appendix H: Confidentiality Agreement Phenomenology Research Group

The Lived Experience of Uninsured Individuals Seeking Primary Healthcare in Mississippi: A Phenomenological Study

Principal Investigator: Linda Banks, MSN, RN
Faculty Advisor: Sandra Thomas, PhD, RN, FAAN

As a member of the Phenomenology Research Group, analyzing transcripts from this research study, "The lived experience of uninsured individuals seeking primary healthcare in Mississippi: A phenomenological study", I understand that I will be seeing information about participants that have sought healthcare in Mississippi. This information will contain a description of a wide range of participants' experiences seeking, accessing, and receiving primary healthcare. The information I will see and hear has been revealed by participants who have been assured that their personal information would remain strictly confidential.

I hereby agree not to share any information about these participants with anyone except the primary researchers for this project—now or at any time in the future. Any violation of this agreement would constitute a serious breach of ethical standards, and I pledge not to do so. I understand that I have a responsibility to honor this confidentiality agreement.

Signature: _____   Date: _____

Vita

Linda Hale Banks was born on October 13, 1956, to Milton and Mary Hale in Jackson, MS. She graduated from Callaway High School in Jackson, MS in 1974. She received a Bachelor of Science in Nursing from University of MS Medical Center (UMMC) in 1979, and a Master of Science in Nursing from UMMC in 1992.

She began her professional nursing career as a staff nurse in an intensive care unit, followed by a management position in a post-anesthesia care unit. In 1992, she began a teaching career which has spanned over 27 years. Her research interests include vulnerable populations and healthcare inequality. Holding a BSN and MSN from the University of Mississippi Medical Center, she also holds an M.S. in Teaching English to Speakers of Other Languages (TESOL) and a post-master's certificate in Global Disaster Nursing.

As both a nurse and educator, she has worked in management positions in the classroom and clinical settings, with clients and students across a variety of backgrounds. Her nursing expertise is in the medical-surgical arena, specifically neurology, cardiology and orthopedics, as well as distance education. Additionally, she is skilled in curriculum design, management, and legal-ethical issues.

She has taught English as a Second Language to students in Taiwan, and the underserved Latino population of Washington Heights in New York City. She has also led students on transcultural healthcare trips to Guatemala and Costa Rica. She also enjoys coordinating conversation partners to assist new immigrants as they transition to life in an English-speaking culture. Her motivation to work in these areas stems from her passion to make a difference in the lives of underserved, vulnerable populations. She is a Jonas Scholar Leader.