Barriers to Primary Care Access in Rural Medically Underserved Areas

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Abstract

Purpose: To explore patients' perceptions of factors that combine to limit or prevent access to primary care in rural medically underserved areas or populations (MUAPs).

Sample: Two focus group sessions were conducted with a sample of eight rural community members. Participants were identified as having had a minor illness or injury in the previous six months and having been unable to access their primary care provider (PCP) for care. **Method:** This qualitative study used data generated from comments shared by participants of the focus groups in response to a series of open-ended questions designed to promote meaningful dialogue. The sessions were audiotaped and transcribed by a professional transcription service. The transcribed data was then analyzed by the authors using qualitative content analysis methods

to classify the data into themes.

Findings: Analysis of data generated from the focus groups identified three dominant themes: People living in rural MUAPs have unique health care needs when compared to residents of urban or metropolitan areas; rural community members perceive an inability to access their PCP for sudden or unexpected illness or injury leading to foregone care, delayed care or seeking care in the emergency department for nonurgent problems; and the same-day, walk-in, immediate care model is meeting the needs of these patients.

Conclusion: The 20% of the U.S. population living in rural areas who are being cared for by only 10% of the nation's primary care providers often lack access to safe, timely, effective, efficient, equitable, and patient-centered health care. Implementation of care models similar to the immediate care model in this study may offer rural community members prompt, competent, evidence-based treatment from a nurse practitioner in a timely manner. *Keywords*: rural, healthcare, access, barriers, immediate care, nurse practitioner, APRN

Barriers to Primary Care Access in Rural Medically Underserved Areas

Persons living in rural, medically underserved areas (MUAs) throughout the United States experience more barriers to accessing healthcare than their urban counterparts (Rural Health Information Hub [RHIhub], n.d.a.). Nationally, 20% of the population lives in rural areas but only 10% of physicians practice in rural areas (Hospitals & Health Networks, 2016). Vulnerable populations, including persons living in designated primary care shortage areas, often lack access to safe, effective, timely, equitable, and patient-centered care (Mareno, 2016). As more patients have become insured under the Affordable Care Act (ACA), providers and health professionals are required to see more patients with less time allotted for the encounter (U.S. Health Policy

Gateway, n.d.). Factors that contribute to the shortage of healthcare providers include: (a) the retirement of practicing providers, (b) inability or unwillingness to accept new patients by aging providers seeking to reduce their workload, (c) difficulty in recruiting and retaining new providers to rural areas, and (d) the fact that fewer medical students are pursuing family practice careers, leaving a smaller pool of physicians to serve in rural areas (Ewing & Hinkley, 2013).

The Institute of Medicine published a framework for assessment of quality in health care in 2001, which lists six domains for quality measurement. The six domains of health care quality are known by the acronym STEEEP: safe, timely, effective, efficient, equitable, and patient-centered (Agency for Healthcare Research and Quality [AHRQ], n.d.). Persons in rural, medically underserved areas are frequently unable to access health care in a timely or efficient manner, and may be utilizing the emergency department (ED) inappropriately, which is not equitable, or foregoing care, which is not safe or effective. Additionally, these community members often forego routine preventative exams and screening for preventable or treatable conditions. Leight (2003) applied the Vulnerable Populations Conceptual model (VPCM) to rural health and noted that patients who are unable to access necessary health care are vulnerable to higher rates of chronic illness and disability and higher morbidity rates because of delayed diagnoses and increased illness (Leight, 2003). Flaskerud, who along with Winslow first described the VPCM, noted in 1999 that "research has shown that lack of resources, rather than the presence of risk factors, is the best predictor of illness and premature death in vulnerable populations" (Nyamathi, Koniak-Griffin, & Greengold, 2007, p. 6). Compared to urban areas, rural areas have higher age-adjusted rates of death from the five leading causes of death in the United States: heart disease, cancer, unintentional injury, chronic lower respiratory disease, and cerebrovascular accident or stroke (Moy et al., 2017).

Literature Review

Previous studies of perceived barriers to health care access have been conducted through mail surveys and telephonic follow up and have been largely quantitative. A 2017 study by Allen, Call, Beebe, McAlpine, and Johnson, with a sample size of 2,194, looked at barriers to health care among adults with Medicaid insurance in the state of Minnesota and identified barriers as either patient-related, provider-related, or system-related. Patient-related factors included family or work issues and unavailability of childcare. Provider-related factors included perceived discrimination based on sex, race, ethnicity, nationality, ability to pay, or enrollment in a public health care program. Providers who did not speak the language, understand the culture or understand the religious beliefs of the patient were seen as barriers at this level, as were providers who were not perceived as trustworthy or having a welcoming office. Coverage barriers, financial barriers, and access barriers were all identified as system-level factors: lack of knowledge about services covered by the health plan, worrying about the cost of services or medications, inability to get an appointment, inconvenient office hours, problems with transportation, and inability to see the provider of choice. This study also identified three negative outcomes as a result of barriers to accessing health care in this population: (a) delayed care, (b) foregone care, and (c) no preventative care in the past year.

A second quantitative study, published in 2015 by Hefner, Wexler, and McAlearney, used questionnaires administered to a non-random convenience sample of 859 patients who had sought care for non-urgent complaints at one of two urban emergency departments (EDs). Access was examined using the Aday and Andersen framework. The researchers concluded that uninsured patients cited income and transportation as the greatest barriers while insured patients reported primary care infrastructure barriers such as waiting times and difficulty being seen during business

hours due to employment. An unexpected finding of the study was that 25% of insured respondents felt that they had no barriers to receiving health care in a primary care office, although they were still utilizing the ED for non-urgent complaints.

Mortensen's 2014 quantitative study of 2,733 Medicaid enrollees analyzed the relationship between access to providers and ED utilization and found that age, sex, race or ethnicity, marital status, education and employment status were not predictive of ED utilization but that poor health status, chronic conditions, and the presence of disability were associated with more frequent ED visits. The data showed a correlation between perceived ability to access primary care and the number of ED visits by enrollees. The study reinforces the findings of the later study by Hefner et al. (2015) that Medicaid enrollees who are unable to readily access primary care will seek care in the ED.

Few recent qualitative studies using focus groups to generate data on patients' perceptions of barriers to primary health care access have been published. One very recent study used focus groups to examine the perceptions of 15 socio-economically disadvantaged persons over the age of 65 living in rural England. This study interpreted data in terms of a social contract that the focus group participants expected their practitioners to honor: If the patient didn't "bother" the provider with minor issues, he or she expected to be accommodated promptly when they needed to be seen for an unplanned illness or malady. Patients considered their contract to be breached when they were unable to be seen for episodic illnesses, using the words "unwelcome", "nuisance," and "not worth anything" to describe their feelings of marginalization. These focus group participants specifically cited difficulty in getting through on the phone to make an appointment, unfavorable interactions with receptionists, and a lack of available appointments as the greatest barriers to access (Ford et al., 2018).

Thus, a number of quantitative studies exploring barriers to health care in rural areas were found with the majority of the studies looking specifically at elderly populations. There was only one review article, Douthit, Kiv, Dwolatzky, and Biswas (2016) that examined barriers to health care in rural populations before and after passage of the ACA. In our review of the literature, there were no recent qualitative studies conducted in the U.S.

Purpose of the Study

An evidence-based, qualitative study was designed to increase understanding of the factors that, according to patients' perceptions, combine to limit or prevent access to primary care in one rural MUA in northern California. The question that this qualitative study proposed to answer was "How do patients living in rural, medically underserved areas perceive their ability to access primary care services within their community?" The purpose of the study was to examine perceived access to primary care through data generated from two patient focus groups, and to propose practical solutions to perceived barriers. The study sought to generate data on how patients saw their ability to access primary healthcare, what they perceived as barriers to their ability to access health care, and what they perceived as possible solutions to these barriers. Further, the researchers aimed to utilize the data generated to form the basis for a model of care that can be presented to health care professionals and administrators with the purpose of facilitating access to primary healthcare in this and other similar rural communities.

Methodology

This study used qualitative and quantitative methods of research. Focus group sessions were conducted to gather qualitative data identifying barriers to healthcare access as perceived by community members. A retrospective review of 1,868 Immediate Care patient charts was made to extract data on patient insurance type and patient provider type.

Sample

This evidence-based qualitative research study used data generated through focus group sessions to identify problems with current processes for procuring care in the event of unexpected illness or injury among members of a rural northern California community. Purposive, or purposeful, sampling was utilized to identify those patients who live in the community (as opposed to tourists) and had used a walk-in immediate care clinic within the previous six months for minor medical complaints or injuries that were within the common realm of primary care. Examples of chief complaints included respiratory infections, influenza, ear infections, urinary tract infections, abscess and cellulitis, sprains and strains, and minor wounds.

Twenty-four community members were invited, by e-mail, to participate in the focus groups: Twelve responded that they would participate, four cancelled on the day(s) of the sessions, and eight participated. The study was approved by the California State University (CSU) Fresno School of Nursing Institution Review Board (IRB, Protocol number DNP 1825). Permission to conduct the study was granted in a letter of approval from the participating institution, which has no IRB, deferred to the review and approval by CSU.

The two focus groups were composed of eight participants: five females and three males. One participant was in the 30-44 years age group and the remaining participants were age 65 or older. One group member had private insurance while the remainder were insured through either Medi-Cal or Medicare. All but one participant were retired or unemployed; five were unmarried whereas three were either married or in a domestic relationship, and all participants identified their race as being white or Caucasian. All participants had used the immediate care clinic at least once in the preceding six-month period.

Risks associated with the subject's participation in the study were those inherent in any focus group session: There is always the possibility that a participant will know, or know of, a fellow group member. Participants were advised that if they felt the least bit uncomfortable, the participant could join another group at another time or withdraw from the study. An agreement was made, verbally and in the consent form, that group members would not share information with outsiders or talk between each other. Any opinions given or suggestions made during the group sessions that were used in the final project remained anonymous and personal information was not published.

Setting for Study

The Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) classifies populations into metropolitan (urban) and nonmetropolitan (rural) categories to better monitor the health of urban and rural residents (CDC, NCVS, n.d.). Metropolitan, or urban, areas are further categorized as: (a) large central metropolitan areas with populations of 1 million or more, (b) medium metropolitan areas with populations of 250,000-999,999, and (c) small metropolitan areas, small towns or suburbs with populations of 50,000-249,000. Nonmetropolitan, or rural, areas include: (a) micropolitan areas, rural counties where there may be a small urban cluster of 10.000-49,999 residents; and (b) noncore areas, counties that did not qualify as micropolitan areas. The county where the study took place is classified as a micropolitan area (Hing & Hsiao, 2014).

All of the county in northern California where the study was conducted has been designated a medically underserved population (RHIhub, n.d.b.). The county covers nearly 4000 square miles (Zip-codes.com, n.d.) with a reported 159 providers for a population of 87,497 or a provider-to-population ratio of 1:550. There are three hospitals in the county. The specific area of the county

where this study was conducted was within the primary service area for a 25-bed rural district hospital with critical access status.

Focus group sessions.

The focus group sessions followed a written guideline so that content of the sessions would flow in a similar pattern. The sessions began with a statement of the purpose and goals of the focus group sessions and a brief overview of the project goals. This content was followed by an overview of confidentiality expectations, consent form signatures, and assignment of identifying numbers to members. A number of open-ended questions were asked to move the conversation in a direction that was designed to promote meaningful dialogue. The opening question asked the participant what they would do if they had a minor medical complaint or injury. From there, the conversation was steered toward ease of making appointments, frequency of routine healthcare screening, delayed or foregone care, the need for specialty consults, utilization of the emergency department for non-urgent care, personal barriers to access, barriers related to individual providers or clinics, and systems barriers.

Transcriptions and analysis.

Once a paid professional transcriptionist transcribed the data from the recorded sessions, the primary researcher, her chairperson, and her committee members used a qualitative content analysis technique to analyze the content. Qualitative content analysis requires review of the transcripts, examining the language within the content of the transcripts, and classifying the data into themes relevant to understanding the phenomena being studied (Hsieh & Shannon, 2005). Qualitative content analysis can be utilized through one of three possible approaches: conventional, directed, or summative. The conventional approach was used for this study as it

allows for data collection through open-ended questions, or probes, to develop categories, or themes, derived from actual data (Hsieh & Shannon, 2005).

Results

The results of the retrospective chart reviews, combined with the responses of the focus group participants, yielded three relevant concepts. First, patients with minor illnesses or injuries are choosing to visit the immediate care clinic when they are unable to see their own PCP. Second, patients are visiting this clinic whether they are publicly insured, privately insured, or uninsured. And third, patients are visiting the immediate care clinic regardless of whether they have a primary care provider or not. The logical interpretation of these findings is that immediate care is a viable solution to the problem of foregone care, delayed care, and ED utilization for non-urgent problems.

During the six-month period from August 1, 2018 through January 31, 2019, a total of 1868 patients were seen in the immediate care clinic between the hours of 9:00 a.m. and 6:00 p.m., Monday through Friday. IBM SPSS was used to run frequencies analyses of two demographic variables collected from these 1868 patient encounters. The first variable analyzed was insurance type: Medicare, Medi-Cal, Blue Cross, Blue Shield, commercial, government payer, or uninsured. The largest number of patients, over 44%, were covered by Medicare or Medicare Managed Care. The next largest group, at 30%, was Blue Cross or Blue Shield followed by Medi-Cal and Medi-Cal Managed Care at 14%. Six percent of patients were uninsured and six percent were covered by commercial or government payers.

The second variable analyzed the provider types. Nearly half of the patients seen in the immediate care clinic over this six-month period, almost 48%, reported seeing one of the seven PCPs (four physicians, two nurse practitioners, and one physician assistant) who practice in the same rural health clinic where this immediate care practice is located for their primary healthcare.

Nineteen percent were regular patients at one of the other two rural health clinics in the area. All three rural healthcare clinics are located within a quarter-mile of the area's only hospital. Just over 17% of patients reported having no PCP. Eight percent of patients using the services at the immediate care clinic were established with one of the area's five providers who are in private practice (three physicians and two nurse practitioners) and the remaining eight percent of patients had providers who were outside the local geographical area.

Analysis of the transcribed focus group sessions identified three themes. The most prominent theme was that people living in rural areas or communities have unique health care needs when compared to residents of urban or metropolitan areas. A second theme identified a perceived inability by community members to access care through their primary care providers (PCPs) for sudden, or unexpected, episodic illness or injury and that the inability to access care leads to foregone care, delayed care, or seeking care in the emergency department for non-urgent problems. The third theme, unexpected at the inception of this project, emerged during the focus group sessions and indicated that the same-day walk-in services provided at a local immediate care clinic were meeting the needs of patients who would otherwise have foregone care, delayed care, or sought care in the emergency department for a non-urgent problem.

Patients want to be Seen as Whole and Unique Individuals

Focus group participants described several encounters with providers wherein they did not feel that their unique needs were addressed. One participant stated that he and his wife have had issues with some of the providers which necessitated transferring care to a new provider while another participant expressed "disgust" with a provider who "hardly looked at me, I mean literally looking at the computer instead. Didn't touch me. And I felt like a waste of time." Participants in the focus groups interpreted time spent on the computer as time not spent on their care: A third

group member, noting that the provider spent time on the computer that should have been spent focusing on the patient, suggested the use of an audio-recorder with translation by a scribe. Another group member stated that when her regular PCP became ill and cancelled two appointments, she "finally did get an appointment, it was one of the visiting or rent-a-docs, I call it, and he was terrible. He saw me for 15 minutes exactly, all he did was listen to my heart, he didn't have my lab work, and he didn't know anything about me." This particular patient identified three areas of concern in her statement: the length of time the provider spent with her, the brevity of the physical exam, and the fact that the provider did not appear to know her past medical history including most recent lab results. She also stated that she was so disappointed that she changed from her regular PCP at the hospital clinic to another provider in private practice. She also stated that she took this matter to the hospital board.

All eight focus group members verbalized concern over the shrinking pool of available local providers and acknowledged that there are challenges in recruiting and retaining quality healthcare providers to the area. They also expressed dissatisfaction with the practice of staffing clinics with locums, or temporary healthcare providers. The participant who rated her care from a locum provider as "terrible" went on to say, "It's not as if they've been here a long time and they're going to stay. So I think that has a great effect on the way they treat patients. They're just passing through: I felt totally disrespected. I'm in my 80's, so I have a few problems and he didn't deal with even one of them". This comment is rich in information. It is the perception of the patient that temporary health care providers don't feel the same connection to, or respect for, the community that a more permanent provider may have. This participant also acknowledges that her age and additional health problems are a real concern.

Community Members Perceive Significant Barriers to Primary Care Access

Members of both focus groups, all of whom reported having a regular PCP, were next asked to share their experiences in attempting to make an appointment for an unexpected illness or injury with their PCP. One participant stated "I wouldn't even bother calling (my PCP) …you call your provider and they tell you that you're maybe going to see them in two to three weeks, if you're lucky." This participant, however, also admitted that he has had some success putting himself on the cancellation list and being seen within 24 hours. Other group members did not have experience with the cancellation list. "I normally don't call a provider for anything other than something I know I can wait two weeks for an appointment." A third respondent stated that if she needed to be seen "quickly" (which she quantified as being seen in the next week or two), she would not be able to see her regular PCP and would have to see another provider. A fourth group member related being very sick with bronchitis, having trouble breathing and wheezing, and being told she could be seen in a "couple of weeks." She advised the scheduler that she needed to be seen "now" and "somehow or other they arranged something."

Participants were asked if they could give an example of any time that they, or someone they knew, had a significant delay in receiving medical care or had gone without care because they could not get in to see their PCP. The statement, "if I was bleeding - but not bleeding badly, I'd probably wait a little bit" was echoed by another group member who said, "if it was a cut or rash, unless it was really scary and went on for days, I would probably deal with it myself. I'm not a medical person, but I've been around long enough." These responses are examples where decisions to delay or forego care for injuries with bleeding are being made by persons with no medical background who make reference to "bleeding – but not bleeding badly" and not seeking care unless the condition "was really scary or went on for days." Another member responded that

she "would first try massage, or acupressure, or acupuncture, or a chiropractor, or talk to friends and naturalists," noting that the staff at one local health food store was quite valuable as a source of health care information. The group also shared a mutual respect for the local pharmacists, citing that they are "very, very well-trained and extremely helpful." One participant mentioned that if she is prescribed a new medication, she will ask her doctor about it, "but then I go to the pharmacy, and I ask them about it. And they're very knowledgeable."

Focus group members were asked if they, or someone they knew, had used the ED for non-urgent problems because they could not be seen elsewhere. Several members gave the example of a urinary tract infection (UTI) as a minor but time-sensitive illness for which they would seek care in the ED if they were unable to see their PCP. One participant stated, however, that the wait for care in the ED can be quite long, citing the experience of having a five-hour wait. The participants repeatedly mentioned UTI, which is a medical diagnosis requiring urine culture, when they likely meant symptoms of UTI, which can include dysuria, urinary frequency, urgency and hesitancy. Patients are frequently unable to differentiate between symptoms of a generally benign illness and those of a more serious or emergent nature.

Immediate Care is Meeting the Needs of Community Members Requiring Care for Unexpected or Episodic Illness or Injury

The first question posed to the groups at the beginning of each session was "What would you do if you had a minor medical complaint such as a rash, earache, cough, flu, or urinary complaint, or if you had a minor injury like a sprain or strain, cut or other minor wound, or a back injury?" The unanimous response: "Go to Immediate Care" referring to the Immediate Care Clinic-affiliated with the local Critical Access Hospital (CAH). Specific comments were, "I would

probably go to Immediate Care for that," and "I wouldn't even bother calling (my PCP), I'd just go to Immediate Care."

One participant polled her neighbors prior to coming to the focus group session and presented a list of suggestions to improve health care in the community: Topping the list was the recommendation that "Immediate Care should be available seven days a week from 8:00 a.m. through 8:00 p.m." Other group members commented that it would be helpful if immediate care were available on weekends, even if only for half a day, specifically stating "it would certainly help the community of people who have to work" and that you could "rely on kids getting sick on the weekend." A participant who had moved here from out of state expressed surprise when he "found out there was nowhere to go on Saturday and Sunday for immediate care."

Access to Routine Health Care Screening

All participants reported having received regular medical screening for hypertension, diabetes, and depression as well as applicable screenings for cervical, colon, and breast cancers. The reported barriers arose when these same patients sought care for unplanned medical problems. Two members of one group noted that they were old enough that they were no longer candidates for routine screening colonoscopies "because of perforation problems". The youngest participant, who was in the 30-44 year age bracket, stated that he was "about to be in the age bracket where it'll be worthwhile." This comment is relevant in that it shows that the patient has been made aware of screening guidelines. Participants shared that their providers had regularly discussed with them the recommended clinical preventative services, as identified by Healthy People 2020 (n.d.a.). Contrary to the findings of the study by Allen et al. (2017), which examined barriers to health care among adults with Medicaid insurance, the participants of these focus groups did not forego preventative care because of barriers to primary care access.

Specialty Services

Rural communities frequently lack specialty services that are common in more urban areas. Participants were asked how they felt about their ability to get specialist care if needed. The responses were numerous and emotional. A member of one group started the conversation by stating "I feel like the specialist situation is a disaster, a complete disaster. We live so far from anything else and we don't have people here that are skilled enough or diverse enough to take care of the needs of the young and of the aging population." The fact that the next closest town with more expansive medical specialty services is over two hours away was a special concern for one participant who shared that "since I'm in my 80's, I've gotten very anxious about what I feel is a lack of healthcare here. And I even thought about leaving the area and going to another area where I would be closer to a hospital that is solvent, and specialists, and better healthcare although I really don't want to leave the area." This sentiment was shared by another member whose mother had a heart condition and, although the woman "would have loved for her to move here … (but) the medical care wasn't good enough". For the elderly, proximity to health care services was a significant factor in where they chose to live.

The group discussed the fact that, currently, a cardiologist and a urologist travel to the area two days each month to see patients in the community. Specialty services were once offered in this rural area, but are no longer available. These services included pulmonology, dermatology, gastroenterology, endocrinology, nephrology, and neurology. One participant, who moved to the area within the past few years, stated that people in this area pay a little extra (by purchasing an annual contract) for air medical transport insurance in the event they need to be transferred emergently from the local critical access hospital to a hospital offering specialty services in another town. Another group member mentioned that he had numerous friends who had been hospitalized

out of the area because they needed specialty care and how this geographical separation is detrimental to the recovery of the sick person who may be hours away from members of his or her support system.

Discussion

Focus group participants in this study agreed that they want to be seen as whole and unique individuals by providers they trust, i.e., providers who are permanent, rather than temporary, members of the community and who will spend time listening to them. They understand that living in a rural area presents a unique group of challenges to quality health care including a diminishing number of providers and a lack of local specialty and consult services. While participants stated they were able to access their PCP for routine and preventative care, they unanimously perceived an inability to access primary health care services for sudden, or unexpected, episodic illness or injury which, prior to the establishment of an immediate care clinic, led to foregone care, delayed care, or seeking care in the emergency department for non-urgent problems. All focus group participants stated that their health care needs for these medical conditions had been met by the immediate care clinic.

The diminishing numbers of primary care providers is a problem in this, and other, rural areas across the country. As providers retire, their patients are having to see new providers: sometimes locums or temporary providers who are not as familiar with the patient on an individual level. Section six of the National Clinical Guideline Centre (NCGC) 2012 publication on the patient experience in adult national health services is titled "Knowing the patient as an individual." This section states that being recognized and treated as a unique individual is an important part of the entire patient experience (NCGC, 2012).

Most studies to date cite multiple barriers to primary healthcare access for routine preventative medical care. Allen et al. (2017) specifically list: (a) personal issues such as family responsibilities, work responsibilities, or lack of childcare availability, (b) problems with the individual provider including language barriers, cultural or religious lack of understanding, lack of trust in the provider, or an office environment which seemed "unwelcoming," and (c) system-specific factors related to coverage, financial barriers, inability to get an appointment, inability to see the provider of choice, inability to be seen during regular office hours, and not being familiar with the location of the office. All focus group participants in this study reported having a primary care provider whom they saw on a regular basis for preventative care and chronic medical problems. All participants reported having had clinical preventive services, including screening for the prevention or early detection and treatment of colorectal cancer, breast cancer, and cervical cancer, which are leading health indicators identified by Healthy People 2020 (n.d.) performed where appropriate for age and gender. It was when they sought care for an unplanned or episodic illness or injury that the barriers to care became apparent. Every member of the focus groups reported that, prior to the existence of the immediate care clinic, they would have experienced delays in care for unplanned illnesses or injuries, citing delays of up to three weeks.

None of the respondents answered that they had experienced personal issues as barriers to care, although one participant noted her daughter works all week and that if she takes time off for a medical appointment "she loses money when she has to see a doctor and that's not right." The same woman also stated, "if you're talking to single parents who are working full-time and raising children, they might lose a job if they're not on the job from 8:00 – 5:00 every day, or they might not have a car or money for gas. So there are circumstances, I think, that would affect other people differently." A 2008 study by the National Opinion Research Center at the University of Chicago

found that 16% of workers in low-wage jobs reported that they, or a family member, had been fired, suspended, punished, or threatened with firing for missing work because of personal or family illness (Smith, 2008).

One participant questioned the practice of parents taking their children to the ED for minor problems on the weekends. However, she quickly acknowledged that the only other option was to wait until Monday and run the risk of not being able to get an appointment with the PCP for another two weeks. These reports are consistent with the findings of a study examining ED use for non-urgent complaints resulting from an inability to access primary care published in the American Journal of Medical Quality. The study concluded that both publicly and privately insured patients utilized the ED for minor complaints because they were unable to get an appointment with their provider, they had not been able to establish care with a PCP, or they had difficulty making time for an appointment during traditional business hours (Hefner et al., 2015). Uninsured patients utilizing the ED instead of a PCP had additional barriers related to financial, insurance, or transportation factors.

At the provider level, no discrimination or cultural issues were identified by either group and members specifically stated that they had no knowledge of anyone in the area experiencing discrimination or a lack of cultural respect. However, lack of trust in the provider was cited by half of the group members and their responses indicated that the 15-minute appointment was the reason for this mistrust. They did not feel that 15 minutes was enough time for a provider to properly evaluate and treat them. One patient, who was not a member of the focus groups, presented to Immediate Care for care of a large second degree burn to her forearm. She stated that she had seen her private physician earlier in the day for a well-women exam. At the end of her 30-minute visit, she attempted to show her PCP the burn and was reportedly told that her visit had

already "run over-time" and she would need to "go to Immediate Care" to have the burn looked at. In her visit to the immediate care clinic, the provider spent time getting the history, examining the burn, performing wound care, instructing the patient on home wound care, providing her with the supplies needed for wound care and a prescription for a topical antimicrobial medication, educating her on what to watch for in the event of complications like infection, and giving her follow up instructions.

The Immediate Care clinic profiled in this study is meeting the needs of community members seeking care for unplanned illness or injury, regardless of their insurance or payment type and regardless of their regular PCP assignment. This model of care offers same-day care, with no appointment necessary, for patients experiencing acute, non-emergent medical problems and minor injuries when their PCP is unavailable or if the patient has no PCP. The care provided at an immediate care clinic has been compared to that received from a PCP, but more accessible and convenient for the patient; unlike an urgent care clinic which is generally equipped to handle non-life-threatening emergencies along with basic health care services (George Washington Medical Faculty Associates, 2014).

Strengths and Limitations

The most notable strength of the study lies in the analysis of the qualitative content of the focus group sessions which not only echoed many of the barriers to care noted in the literature review, but also identified immediate care as a real solution to the problem of access to healthcare for episodic complaints. Focus groups proved to be an effective method to explore the participants' perceptions of barriers to health care access as it allowed the group members to share their own experiences and build on shared experiences. The strength of the study is further reinforced by the fact that the researcher is also the lead health care provider in the immediate care clinic and is

involved in direct patient care 32 hours per week, allowing her to integrate the findings of published studies with actual practice.

The small sample size, combined with the homogeneity of participants with respect to age, race, ethnicity, and insurance type, was the most notable limitation of the study. Although the participants were engaged and enthusiastic, eight is minimal for qualitative research using focus groups (Stewart & Shamdasani, 2015). Additional data may have been gathered from younger participants, participants from more diverse racial and ethnic backgrounds, and more participants who were employed on a full-time basis and faced the challenge of making health care appointments during traditional work hours.

Nursing Implications

Advanced practice registered nurses (APRN), especially those with family practice and emergency department experience, are in a prime position to provide safe, timely, effective, efficient, equitable, and patient-centered care to community members who would otherwise not receive it. The immediate care model is an easily implemented and cost-effective strategy to provide this care. The APRN is knowledgeable in evidence-based practice and has the clinical expertise and experience to provide care based on best practice. In addition to critical thinking, clinical judgement, and clinical decision-making skills, the experienced APRN has the additional qualities, developed through nursing practice, of strong communications skills with patients and families as well as other health care professionals.

As of 2019 there are 34 CAHs in the state of California and 1,348 in the entire United States (RHIhub, n.d.a.). Critical Access Hospital EDs across the country struggle with surges in patient flow. In EDs with single physician coverage, one critically ill patient may overwhelm all available resources (e.g., physician, nursing, respiratory therapy, diagnostic imaging, laboratory) for

prolonged periods of time which results in low-acuity patients having extended wait times (Welch, 2017). In facilities where the physical plant cannot accommodate a fast-track or low-acuity throughput process, these patients will continue to wait - leading to a delay in care or, if they are unable to keep waiting, foregone care.

The Immediate Care clinic referred to by focus group participants is located within a suite of outpatient clinical offices on the property of a 25-bed CAH, but physically separate from the hospital itself. Hospital laboratory and diagnostic imaging services are available to immediate care patients. The immediate care practice is open weekdays from 9:00 a.m. until 6:00 p.m. and is closed for one hour at lunch. One APRN sees an average of 20 patients per day. One medical assistant from the outpatient clinic is assigned to the immediate care provider and registration staff is shared with the other outpatient clinics. The four patient exam rooms are in one of the three office suites that also houses seven primary care providers.

Certain new models of ambulatory care including free-standing urgent care clinics, retail clinics, and electronic visit websites have been seen as threats in continuity of care, a disruptive innovation which may erode the relationship between the patient and the primary care provider (Ladapo & Chokski, 2014). Services provided at this immediate care clinic, frequently not provided in other convenient care or urgent care settings, were developed to enhance communication between health care team members and to improve patient outcomes. These services make this clinic stand out when compared to other immediate or convenient care clinics. For the patient reporting that he or she is already established with a PCP, a copy of the encounter document is faxed to that provider. For patients reporting that they do not have a PCP, they will be given a list of area providers or, if they prefer, an appointment with a PCP in the same practice will be made during the visit. If a patient does not have health insurance, an access coordinator

will attempt to see if the patient is eligible for any of the public insurance plans and assist with paperwork. If the APRN determines that a patient would benefit from specialty consultation, such as orthopedic surgery or otolaryngology, the referral can be made during the visit rather than sending the patient back to the PCP for referral.

Conclusions

Physician supply and demand studies have projected that, by the year 2025, there may be a shortage of as many as 31,000 adult primary care providers in the U.S. (Long et al., 2016). Reasons for this projected shortage include the fact that: fewer medical residents are planning to go into primary care or internal medicine, opting instead to pursue specialty practices (Long et al., 2016), there is a shortage of healthcare providers through attrition of practicing providers, and it is difficult to recruit and retain new providers to rural areas (Ewing & Hinkley, 2013). Permanent solutions to the problem will not come quickly.

During the Obama administration, the U.S. Department of Health and Human Services, recognizing the impending shortage of PCPs in rural areas, was tasked with improving recruitment and retention of health care providers in rural areas through the "Improving Rural Health Care Initiative." Several programs oriented toward this goal were developed by the Health Resources and Services Administration (U.S. Department of Health & Human Services [U.S.DHHS], n.d.). Funding opportunities like the Primary Care Training and Enhancement Program have become available to hospitals in rural communities and, while these programs may ultimately benefit the rural community, these benefits are not likely to be realized for many years. Moreover, many rural hospitals and clinics do not have staff with the grant-writing expertise of experience to apply for these programs (U.S.DHHS, n.d.).

Recruitment and retention of health care providers to rural communities can be further compounded by perceptions of the providers themselves. Medical residents have cited professional isolation, lower salaries, the challenges of primary care medicine, and concern for lack of ancillary mental health and social services support in rural communities (Long et al., 2016). In a study of primary care medicine residents, a lower salary was one factor that the residents had initially felt was a fair compromise for the benefit of living in a rural area, but by the end of the study, the residents felt that the lower salaries, coupled with the negative elements of rural practice including stress, personal and professional isolation, and fear of burnout expressed by their mentors deterred them from pursuing practices in rural areas (Long et al., 2016). A 2013 study by Farmer, Prior, and Taylor used a capitals framework to link rural health services to community sustainability. Economic, social and human capitals were analyzed, using measurable indicators, and applied to individuals and institutions to show the added-value contributions of health services. The contributions included jobs for educated, knowledgeable, and skilled community members, a location for people to become skilled, personal and institutional consumption of locally produced goods and services including schools and real estate, attracting new community members while retaining older residents, and helping to maintain a diverse local population (Farmer et al., 2013).

The use of telemedicine should be considered and may be attractive to the provider with concerns about lack of professional support. Other factors include lack of available or affordable housing, few employment opportunities for spouses or partners, limited school options for children, and a lack of cultural outlets (Cohen, 1998). Some of these factors, such as suitable housing, can be addressed with community leaders while other factors will remain deterrents to providers and their families considering relocation to a rural area.

The 20% of the U.S. population living in rural communities who are being cared for by only 10% of physicians (Hospitals & Health Networks, 2016) need options when they experience minor illness or injuries. Delayed care, foregone care, and use of the ED are not efficient or equitable solutions. Prompt, competent, evidence-based treatment provided in a timely manner is a solution and immediate care clinics like the one profiled in this study can provide that care: in many cases with resources that are already available. In the words of community member R. L. Cizek (personal communication, April 17, 2019), "Immediate Care is the best thing to happen to health care in this town."

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