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Perceptions of Primary Care Facilitators and Barriers Among Homeless-Experienced Individuals

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Background

Socially marginalized groups, including homeless individuals, have historically experienced significant barriers and fragmented access to needed healthcare services. This situation is particularly problematic, given the disproportionately high burden of both acute and chronic conditions. Despite increased rates of illness and mortality, most homeless individuals are less likely to have a regular source of primary care than the general population. The Affordable Care Act has expanded coverage to several previously uninsured individuals, such as homeless-experienced individuals, drastically shifting the healthcare delivery context. The implementation of the Affordable Care Act has made obtainable services and supplies once previously unavailable to the uninsured homeless population. However, the impact of the Affordable Care Act on the growing homeless population in the United States remains under-examined, from the participant perspective.

Purpose

The purpose of this study is to explore the perceived facilitators and/or barriers to having a regular source of primary care services among homeless-experienced individuals within the post-ACA United States within a state that has adopted the Medicaid expansion.

Methods

Study Design: This qualitative study employed a directive qualitative content analysis approach. Relevant research was used as a guide for the development of initial codes (Graneheim & Lundman, 2004; Hsieh & Shannon, 2005; Priest, Roberts & Woods, 2002). The University of California, San Diego Brief Assessment of Capacity to Consent (UBACC) Instrument was used to assess decisional capacity to consent.

Participants: This study took place at an integrated health service clinic that primarily serves homeless individuals in Chicago, Illinois, USA. The study population involved utilizers of an urban clinic that provides integrated primary, oral, and behavioral healthcare to homeless participants. The urban integrated health service clinic has three primary care sites, with several community outreach sites. The sampling frame involved utilizers of the one integrated health service clinic site. To be eligible for inclusion, all individuals had to be a participant at the urban integrated health service clinic where the study was taking place; ≥ 18 years of age; able to communicate in English language; and able to demonstrate decisional capacity to consent.

Data Collection: Interviews were conducted with homeless-experienced participants from November – December, 2017, by the principal investigator (KD). The study purpose and aims were explained to each participant by the primary investigator. All twenty participants completed the University of California, San Diego Brief Assessment of Capacity to Consent, achieving a passing score of at least 15. Participants were informed that all semi-structured interviews would be audio-recorded; the principal investigator

began the interview with question one of the interview script and followed-up with probing questions, posing all five questions to each of the 20 participants.

Data Analysis: The principal investigator (KD) transcribed interview audio-recordings, reviewed transcripts for accuracy, and identified key themes. A directive qualitative content analysis approach was employed. The principal investigator (KD) consulted with the second and third investigators (SB, DI) to convey the established coding scheme and to ensure inter-coder agreement. Discrepancies regarding coding scheme and conceptual definitions were negotiated and resolved within the triad. The principal investigator (KD) independently applied the final coding scheme to the entirety of qualitative data. The final coding scheme was then utilized by the third investigator (DI), who independently coded a random sample of 25% of the data (5 interview transcripts); code-recode agreement was then verified by the first investigator (KD), who re-coded 25% of the data (5 interview transcripts). Data were analyzed using the Dedoose qualitative cross-platform application (Dedoose, 2018).

Results

65% of participants identified as male, 35% of participants identified as female. The majority (70%) of participants identified as African American/Black, 25% identified as Caucasian/White, 5% identified as Latino/Hispanic, and 5% identified as Middle Eastern. Eighteen of the twenty participants (90%) reported being enrolled in Medicaid or having a medical card; two of the twenty participants (10%) reported being without medical insurance or other documentation. Nineteen (95%) of participants reported having utilized the site of primary care at least one time prior, with several participants reporting having come to the site for multiple years. In exploring the contributors and deterrents of utilizing a regular source of primary care among homeless-experienced individuals, themes clustered around promoting and inhibiting factors. That is, participants detailed their experiences of individuals and systems that either facilitated or served as barriers to their returning comfortably to a regular source of primary care. Nine themes emerged from the data (5 facilitators, 4 barriers). Facilitators of having a regular source of primary care included experiencing: (a) a sense of community, (b) mutual participant-provider respect, (c) financial assurance, (d) integrated health services, and (e) participant care teams. Barriers to having a regular source of primary care included experiencing: (a) feeling unwelcome or misunderstood, (b) feeling judged and disrespected, (c) a lack of health insurance, and (d) receiving care from multiple care sites.

Discussion

For myriad reasons, barriers to necessary primary care for homeless individuals persist. While the perpetuation of this issue is clearly demonstrated in the literature, the participants in this study represent a sub-sample of the homeless-experienced population that accesses and uses a regular source of primary care. Their voices offer insight into how researchers, clinicians, and policy-makers can address the issues that have allowed decades of disproportionate unmet need, morbidity, and mortality.

Conclusion

To promote equity in access and outcomes, understanding the factors that both promote and prevent access to and use of a regular source of care among homeless-experienced individuals is pivotal. Promoting the systematic presence of facilitators, such as the cultivation of a sense of community, mutual participant-provider respect, financial assurance, availability of integrated health services, and patient care teams can ensure appropriate access to and utilization of primary care services from a regular source of care. Also towards this end, working to minimize barriers by creating welcoming and understanding healthcare contexts and personnel, providing education to decrease attitudes of judgment and disrespect, ensuring access to health insurance enrollment, and eliminating the need to travel to multiple sites for care may also help achieve greater uptake of regular primary care services. Through recognizing and developing strategies to actualize facilitators and minimize barriers to care, the healthcare needs of homeless populations may be more effectively addressed.

Title:

Perceptions of Primary Care Facilitators and Barriers Among Homeless-Experienced Individuals

Keywords:

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References:

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Abstract Summary:

The impact of the Affordable Care Act on the growing homeless population in the United States remains under-examined, from the participant perspective. This qualitative study explored the experiences of healthcare access and use, highlighting the facilitators and barriers to utilizing a regular source of primary care among urban homeless-experienced individuals.

Content Outline:

Background

- Homeless individuals experience barriers and fragmented access to needed healthcare services
- Primary Care Access and Utilization
- Potential Barriers
- Changing Context of Healthcare

Changing Context of Healthcare

- The Patient Protection and Affordable Care Act ("ACA")

Literature Gap

- Perceptions of access to care
- Impact of perceptions on primary care utilization

Purpose

To explore the perceived facilitators and barriers to having a regular source of primary care services among homeless-experienced individuals within the post-ACA United States in a Medicaid expansion state.

Methods

Directed Qualitative Content Analysis

Subjects

Inclusion Criteria

Recruitment, Population, and Setting

- Integrated health service clinic in Chicago, Illinois
- Homeless-experienced adults present for primary care appointments

Data Collection

Interview Script

1. What kind of problems do you go see a primary care provider for?
2. Where do you go when you need to see a primary care provider?
3. Why do you go to this place to see a primary care provider?
4. What is it like when you go to see a primary care provider? Tell me about your experiences.
5. Do you have a medical card? If so, when did you get it? What does the medical card mean for you?

Data Analysis

- Transcribed audio-recordings
 - Reviewed for accuracy
- Developed initial codebook
- Directive Content Analysis Approach
- Established/confirmed coding scheme
- Final coding scheme applied independent (PI)
- Independently coding of a random sample of 25% of the data (5 transcripts) (committee member)
- Code-recode agreement verified by re-coding 25% of the data (5 transcripts) (PI)
- Dedoose qualitative cross-platform application

Results

- N = 20

Themes

Facilitators

1. Sense of Community
2. Mutual Participant-Provider Respect
3. Financial Assurance
4. Integrated Health Services

5. Participant Care Teams

Barriers

1. Feeling Unwelcome or Misunderstood
2. Feeling Judged and Disrespected
3. Lack of health Insurance
4. Receiving Care from Multiple Care Sites

Discussion

- Facilitators supported continuous relationship with integrated health center/primary care provided
- Barriers deterred follow-up care at alternate sites

Limitations

- One clinic site in an urban area
- One principal investigator

Conclusion

- Explore access and use of healthcare among homeless-experienced individuals who are not linked with a regular source of primary care
- Clinical perspectives on facilitators and barriers to a regular source of primary care

Future Directions

- Same considerations with homeless populations unlinked with care
 - Mobile clinics or outreach pop-up clinics, short-term shelters, or meal centers
- Provider perspectives

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Author Summary: Kirsten Dickins, AM, MSN, FNP-C is a PhD student in Nursing Science and a Family Nurse Practitioner. Her research is qualitative in nature and focused on promoting continuous and quality primary care experiences among socially marginalized populations, particularly those with chronic multimorbidities. Her dissertation project is entitled "Exploring Primary Care Experiences among

Homeless Individuals". Kirsten practices primary care with high-risk patients in home-based, outreach, inpatient, and clinic-based settings across Chicago.

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Author Summary: She has served as consultant to the CDC's Division for Heart Disease and Stroke Prevention for several projects. Dr. Braun is an editorial board member for the Journal of Cardiovascular Nursing and the Journal of Clinical Lipidology; she serves as reviewer for numerous other journals. Dr. Braun has been an active volunteer for the American Heart Association since 1980 in numerous capacities. She is the Chairperson of the Illinois Advocacy Committee.

Any relevant financial relationships? Yes

Relationship	Description of Potential Conflict
Consultant and Royalty	UpToDate - Author/Advisory Board

Signed on 05/28/2018 by *Lynne T. Braun*

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Author Summary: Dr. Earle has held leadership positions at several Chicago area hospitals (Columbus Hospital 1994-1997, Swedish Covenant Hospital 1997-2000, Advocate Christ Medical Center 2002-2007) and academic medical centers (Northwestern Memorial Hospital Prentice Women's Hospital (1978-1994 and Rush University Medical Center 2007-2015).

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Author Summary: Since 2006, she worked as a facilitator/moderator using focus group methodology to guide the development and cultural tailoring of behavioral interventions for consumer-based and academic research. Dr. Ingram conducted focus groups to guide the development of tailored interventions including (1) the use of an automated telephone response system to deliver physical activity motivational messages to African American women and (2) the use of a tablet to deliver a diabetic programs in urban and rural settings.

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Author Summary: His research focuses on community-based interventions for high-risk youth with psychiatric and substance use disorders. In the past, he has worked with refugee children on the Pakistan-Afghan border, street children in India, foster youth in Central Illinois, and incarcerated youth in California. He worked at a youth homeless shelter in San Francisco and is continuing this work with homeless youth in Chicago. He is a senior associate editor for Child Psychiatry & Human Development.