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Cover Page Footnote

This project was funded by the Public Service Professorship, Lowell Bennion Community Service Center, University of Utah. The authors want to thank the patients who participated in this study and acknowledge the contribution of the staff and volunteers of the Maliheh Free Clinic. In addition, we thank Nancy Christensen, Javiera Reyes, Natalie Meadows, Lupe Aguilera, and Nick Warren for their help in the development of focus group questions, data collection or translation/interpretation.

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Uninsured free clinic patients' experiences and perceptions of healthcare services, community resources, and the Patient Protection and Affordable Care Act

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Abstract

Free clinics provide free or reduced fee healthcare to individuals who lack access to primary care and are socio-economically disadvantaged. There has been a paucity of free clinic research with the few studies employing a quantitative design. The purpose of this study is to conduct an in-depth qualitative exploration of free clinic patients' experience and perceptions of healthcare services, community resources, and the Patient Protection and Affordable Care Act (ACA). Free clinic adult patients (n=35) participated in four focus groups between June and July 2014 (one Spanish group in June, and two English groups and one Spanish group in July) in a classroom of a free clinic. More than 80% of the participants were non-US born from Mexico, Central/South America, South or East Asia, Pacific Islands, or Western Europe. While participants reported being satisfied overall with free clinic services, they indicated that they desire more specialty services and health education programs. Furthermore, they reported being frustrated by long waiting times- both in the waiting room and when making an appointment, phone communication, and interpreter services. It is necessary to find effective ways to provide information about health education opportunities and the ACA to free clinic patients because participants appeared not to have received sufficient information about available resources. Health education programs for free clinic patients should not only focus on increasing knowledge but also changing behaviors.

Keywords

Patient experience, patient satisfaction, communication, consumer engagement, qualitative methods, free clinics

Acknowledgement

This project was funded by the Public Service Professorship, Lowell Bennion Community Service Center at the University of Utah. The authors want to thank the patients who participated in this study and acknowledge the contribution of the staff and volunteers of the Malihbeh Free Clinic. In addition, we thank Nancy Christensen, Javiera Reyes, Natalie Meadows, Lupe Aguilera, and Nick Warren for their help in the development of focus group questions, data collection or translation/interpretation.

Introduction

Free clinics provide free or reduced-fee healthcare to individuals who lack access to primary care and are socio-economically disadvantaged.¹⁻³ Today, there are approximately 1,200 free clinics in operation throughout the US.³ Most free clinics rely on volunteer providers and staff and have limited financial resources.⁴ The primary reason for using a free clinic is lack of insurance.^{5,6}

Approximately 40% of free clinic patients are immigrants who have unique challenges.⁵ Free clinic patients suffer from a wide variety of medical conditions such as respiratory diseases, circulatory diseases, and mental disorders,⁷ and tend to experience poor physical and mental health as well as low levels of health-related quality of life.^{8,9} The purpose of this study is to investigate free clinic patients' experience and perceptions of healthcare services using an exploratory qualitative approach.

Free clinic patients are highly satisfied overall with the healthcare services that they are able to access at a free clinic.¹⁰⁻¹² However, previous studies that used quantitative design failed to explain the depth of health-related challenges for this population. Nearly 80% of free clinics provide on-site health education,⁵ although there is the possibility of missed opportunities for patient education in a free clinic setting.¹² Few studies have examined how to provide effective health education at a free clinic. It is essential to first increase knowledge about free clinic patients' experience and perceptions of health education in order to inform patients. Language barriers in healthcare should also be investigated, given the gap between the number of patients who are not fluent in English and the number of those who actually used interpreter services.¹¹

Furthermore, both community resources and environment are essential to the health of free clinic patients and the underserved. Neighborhood environment is one of the primary predictors of health-related quality of life among free clinic patients.⁸ In a community with high poverty rates, the availability and affordability of healthy foods tend to be limited.¹³ These neighborhoods have been referred to as food deserts in rural areas and food swamps in more urban environments.¹⁴ Neighborhood environments that are supportive of healthy behaviors are associated with higher levels of physical activity levels among residents.¹⁵ Informal resources (e.g., support from family or friends) are also important because stronger social support is associated with better mental health and less severe levels of depression among free clinic patients.⁹ Some of the free clinic patients, who are not insured or who are under-insured, may be eligible to obtain insurance through the Patient Protection and Affordable Care Act (ACA). The purpose of the ACA is to guarantee health insurance to all American citizens.¹⁶ Legal immigrants are also eligible to purchase insurance through the ACA, though low-income legal immigrants may face some barriers to the insurance because it may not be affordable for them.¹⁷ Although the knowledge about the ACA is important for those who are eligible, the awareness about the ACA among uninsured free clinic patients was lower than that of the national polls without educational efforts.¹⁸ The ACA may change the dynamics of the free clinic population. In the future, free clinics may mainly serve the populations who are unable to obtain insurance through the ACA, such as undocumented immigrants. However, few studies assess how knowledgeable free clinic patients are about the ACA and whether they are interested in learning more about it. Increasing the knowledge about free clinic patients' perceptions of the ACA would be helpful in understanding the overall needs of this patient population – some of whom will likely receive services elsewhere in the future and others will remain as free clinic patients.

This study aims at increasing in-depth understanding of patients' voices rather than seeking to generalize the larger population. Giving a voice to underserved populations is one of the primary goals of social research.¹⁹ A qualitative approach is suitable for investigating patient perspectives and is also useful in understanding these health-related issues in a real setting.²⁰ Focus groups were selected to collect qualitative data because this format allows participants to express their viewpoints in a setting that is close to day-to-day communication.²¹ Our questions and data centered around three areas: 1) free clinic patients' experience and perceptions of healthcare services, 2) community resources, and 3) the Patient Protection and the ACA. To our knowledge, this study is one of the first qualitative studies on free clinic patients and contributes to the knowledge about free clinics, free clinic patients, and the underserved population.

Methods

Overview

The current community-based research project was conducted at a free clinic in the Intermountain West. The clinic staff collaborated with this research team to develop the focus group guide, study protocol, and participant recruitment strategies. Additionally, clinical staff provided input regarding the interpretation of study findings (i.e., focus group responses). The clinic provides free healthcare services, mostly routine health maintenance and preventative care, for uninsured individuals who live below the 150th percentile federal poverty level and do not have access to employer-provided or government-funded health insurance. The clinic has an on-site laboratory, pharmacy, and provides interpreter services in most languages spoken by its patients. The clinic is staffed by six full-time paid personnel and over 300 active volunteers, including approximately 60 volunteer interpreters. The clinic, which has been in operation since 2005, has no affiliation with any religious organizations and is funded by non-governmental grants and donations. The clinic is open five days a week. The number of patient visits was 15,209 in 2012. The clinic serves US citizens, documented immigrants, and undocumented immigrants, as it does not ask patients to provide documentation of legal residency or citizenship. Prior to utilizing the clinic, patients sought healthcare at emergency room units, urgent care facilities, community clinics, and/or through community health screenings.¹¹

Focus Group Procedure and Participants

To develop a focus group guide, the clinic staff initially held a brain storming session to identify their needs and interests for the project, which informed the specific focus group questions. Then, the research team drafted the focus group guide and a demographic questionnaire. After the draft was reviewed and revised between the clinic staff and the research team several times, the final version was

formed (the focus group questions are presented in Table 1). Because approximately half of the clinic patients are Spanish speakers, focus groups were conducted in English and Spanish (two groups in English and two groups in Spanish). A native Spanish speaker, who is fluent in English, translated English materials (a flyer, a consent cover letter and focus group questions) into Spanish. A native English speaker, who is fluent in Spanish, checked the accuracy of the translation.

The institution's review board (IRB) approved this study. Distribution of a flyer in the waiting room of the clinic resulted in a convenience sample of 35 patients aged 18 or older. Four focus groups were held between June and July 2014 (one Spanish group in June, and two English groups and one Spanish group in July). Prior to the start of a group, the study team verified eligibility of potential participants, completed the informed consent process, and asked participants to fill out a short self-administered demographic questionnaire. Participants were told not to

disclose their last name during the focus group discussions in order to maintain confidentiality. Participants received \$20 cash for their focus group participation. The focus groups were held in a classroom at the clinic and lasted 50 to 80 minutes. A bilingual speaker moderated the Spanish groups. Most study team members were at the groups, moderated a group, assisted registration (verification of eligibility, informed consent and a self-administered survey) and check-out (remuneration payment), served light refreshments, and/or took field notes. In addition, one or two Spanish interpreters were present at one of the English groups and both Spanish groups. The staff of the clinic did not attend the focus groups so participants would be able to freely talk about their experiences with the clinic.

Table 1. Focus group questions

Before they came to the clinic:

Can we briefly go around the room and talk a little bit about how you found out about the clinic?

Experience with the clinic:

What do you like most about this clinic?

What do you want or wish this clinic to change?

How friendly or respectful are the clinic staff?

After being seen at the clinic, how were the follow up services?

Health education programs:

We are very interested in developing health promotion programs.

Are there any health topics you would like to learn more about?

What time of the day is best for you for health class?

Language barriers:

If English is not your native language, what difficulties have you experienced when you communicated in English at this clinic?

How about difficulties in communicating in English at other places in the community, for example, other healthcare facilities, workplace, or school?

Resources outside of the clinic:

Now, we would like to know about your health-related life style in the community.

Where can you get healthy and low cost food near where you live?

Where can you exercise near where you live?

What other community organizations or healthcare facilities do you seek help from?

Affordable Care Act:

Finally, we would like to know about your opinion of the Affordable Care Act or the Obama Care.

Can anyone tell me what the Affordable Care Act is?

Have you been able to access any services through the Affordable Care Act? (If anyone said yes) What services did you receive?

Table 2. Participant socio-demographic characteristics (N=35)

	Mean (range)	SD
Age	49.7 (22-68)	13.6
Years in the US (non-US born only)	12.5 (2-32)	7.8
Years as clinic patient	3.4 (less than a month to 8 years)	2.6
	n	%
Female	25	71.4
Race/Ethnicity		
Asian or Pacific Islander	16	45.7
Hispanic/Latino/Latina	15	42.9
White	3	8.6
Native American	1	2.9
Region of birth		
US	6	17.1
Central or South America	11	31.4
South Asia	8	22.9
Pacific Islands	4	11.4
Mexico	3	8.6
East Asia	2	5.7
Europe (West)	1	2.9
Highest education level		
Less than high school	5	14.3
High school diploma	9	25.7
Some college	11	31.4
4 year college	5	14.3
Graduate education	5	14.3
Employment status		
Working full-time	5	14.3
Working part-time	5	14.3
Student	3	8.6
Unemployed	22	62.9
Currently married	12	34.3
Self-rated general health		
Excellent	0	0
Very good	7	20.0
Good	11	31.4
Fair	14	40.0
Poor	2	5.7
Internet access at home	22	62.9
Internet access outside of home	21	60.0
Own cell phone	27	77.1
Internet access on cell phone	14	40.0
Text message on cell phone	26	74.3

Table 2 describes the characteristics of the participants (N=35). The average age was 49.7 (SD=13.6). On average, non-US born participants lived in the US for 12.5 years (SD=7.8). The mean of years of being a free clinic patient was 3.4 (SD=2.6). More than 70% of the participants (n=25, 71.4%) were women. The majority of the participants were Asian or Pacific Islanders (n=16, 45.7%) or Hispanic/Latino/Latina (n=15, 42.9%). Less than 20% of the participants (n=6, 17.1%) were US born. Non-US born participants were from Mexico, Central/South

America, South or East Asia, Pacific Islands, or Western Europe (12 countries in total; data not shown in the table). Approximately 85 % of the participants had a high school diploma or higher educational levels. More than 60% of the participants were not employed. Less than half of the participants (n=12, 34.3%) were married. Forty percent of the participants (n=14) self-rated their health status fair. Approximately 60% of the participants reported to have access to the Internet. While nearly 80% of the participants (n=27, 77.1%) owned a cell phone, 40%

(n=14) had access to the Internet and 74.3 % (n=26) used text messages, on their cell phone.

Data Analysis

All focus groups were audio-recorded and transcribed verbatim. The Spanish recordings were translated into English. To enhance credibility and trustworthiness,^{22,23} the following steps were taken for the data analysis of the focus group responses. After the first group (Spanish) was transcribed and translated into English, two members of the study team individually developed initial codes. The third member of the study team checked agreements and disagreements on the initial codes between the two coders and created the list of codes while reading field notes to review the context of the groups. Several study team members reviewed the first list before the actual analysis started. Using the finalized list of the codes, the transcripts were organized to identify themes and patterns within and across the groups independently by two study team members. The first author reviewed the data and coding structure, explored discrepancies, reconciled the discrepancies, and chose representative quotations to describe main results. Finally, all members of the study team agreed with the interpretations. Data from the demographic questionnaire were analyzed using SPSS (version 19). Descriptive statistics were used to describe the characteristics of the participants.

Findings

Experience with the Free Clinic

The majority of the participants learned about the free clinic from their friends or family members. Few participants indicated that they heard about the clinic in more formalized settings such as faith-based groups (e.g., mosque). The common reasons that the participants identified for what brought them to the clinic included loss of job and insurance and being an undocumented immigrant. Most of all the participants described the clinic using positive terms such as “friendly”, “nice”, “great”, and “clean.”

Long waiting time and phone communication

There were primarily two main negative experiences shared regarding the participants' visits to the free clinic including 1) long waiting time to make an appointment; and 2) difficulty to reach the clinic by phone. The long waiting time to make an appointment was a major concern expressed by the majority of the participants:

On my part I would suggest, uh what struck me first as being not very convenient is the long wait time for an appointment. It's extremely long in my opinion I mean if you have an issue a health issue. . . . I mean I understand a free service you know it's free so you don't have to um you know comment on that but and we're grateful at least I am grateful. But still having a medical problem um

being concerned about your health and waiting 3 weeks almost 4 weeks for an appointment that is scary at one point in time you know.

Likewise, the majority of the participants indicated the problems in phone communication: “*Like the other ideas I agree with it because sometimes the lack of communication when we try to call there's no answer so we have to – to trip down here*” and “*But when we need something to talk to them, we cannot reach them easily*” because no one took the phone call or called back.

Health education

Participants expressed an immense interest in learning about nutrition topics. In particular, non-US born participants wanted to know about nutrition because they eat different kinds of foods in the interest of being healthier.

We carry bad eating habits, but it's not a matter of me wanting to. It is because since I was a child I was taught to eat rice, beans, fat, lard, bread with butter. . . so you naturally eat inadequate things. So, those kinds of classes are good, because they make you conscious, you say to yourself “hey, what am I doing? I am doing this wrong because the right way is over here,” so, eh, those classes are important to remind us of things.

Participants admitted that they understand it is important to eat healthy and exercise regularly, but it is hard to change actual behaviors: “*We know it (the importance of health diet), everybody knows it. Healthy um you know food, and exercise, and everything. And we still like to eat different thing.*”

You know cause like most of the times that we – we eat a different kinds of carbohydrates and you know just like starchy food and all those stuff. And we need to be exercising so that you know burn the fat and all the stuff. But it's hard because it's too hard. So we don't want to do it but everybody knows it. Motivate, like what you said, like um diabetic, everybody knows that know it and they start to understand because the doctors and nurse they explain. But it's hard for us to do it. That's the only thing. If you want to do it, do it.

Although the clinic has offered healthy living education classes over the past five years (twice a month in the evening), the majority of the participants were either unaware of the opportunity or had never attended. The participants indicated that they wanted to obtain more information about available programs at the clinic. The Internet was not the best way to distribute information because some patients do not have access to the Internet or use the Internet very often. Participants suggested that face-to-face interactions and using a flyer would represent the most effective way to receive communication about available opportunities, resources, and information. Distributing a flyer or providing a mini-session (i.e., a 10

minute class) while patients are in the waiting room would provide a plausible solution. However, the challenge becomes how to provide information and/or education to patients who do not frequent the clinic.

It would be good to put out more flyers like the ones they have there, like the one I grabbed. But putting out flyers with all the information and what one can get, that is very important too. And that way we can save them some work, stop asking the receptionist, because sometimes she is very busy setting up appointments or something.

Besides nutrition, participants expressed interest in learning about diabetes, cholesterol, weight loss, HIV/AIDS, prevention of various diseases (e.g. liver, kidneys), women's health (e.g. family planning), mental health (including child mental health), and stress management. Participants also noted that they would like the clinic to offer non-health related classes such as job skills training, "learn to do something" to be more productive, self-help modules, English classes, yoga, Zumba, or other exercise classes at the clinic.

Interpreter services

The free clinic provides interpreter services. Most participants who had used interpreter services were highly satisfied with these services. One participant commented:

Because it is about your health. It has to be a very specific translation so you can understand it. And I have had such fortune; every time that I have been here someone has come to translate. It has always been very specific, very clear, and I have ended up satisfied and happy.

The clinic provides Spanish interpreters; however, interpreters are not always available for Spanish speaking patients who need interpreter services.

I have come and, sometimes, when I have asked for an interpreter, they have told me that they don't have anyone. As they were saying, the medical interpretation is very different, sometimes I don't understand and I am left halfway. I have had times in which there is nobody to do the interpreting.

A native Spanish speaker who speaks English and came to an English focus group noted that he had had concerns about the quality of interpreter services.

But I have the good experience that I could find someone who was here and she, or I don't remember, but she speak both languages. But sometimes when they were translating I noticed that they don't translate exactly what I was saying you know.

Participants whose native language was not English or Spanish perceived that the clinic did not have interpreters

for their language. Interestingly, the clinic provides interpreter services in a wide variety of languages. Some of the participants had been interpreters for their family members who do not speak English. They did not know about the possibility that the clinic offers interpreter services in their language and had never asked about the availability of interpreters.

Additional services

Participants mentioned that they would like the clinic to provide the following additional services: dental care, dermatology, orthopedics, gynecology, vision care, more sample medicine, free mammograms, and urgent care. While most of the services were mentioned in all groups, dental care was the majority of participants' interest. Although the clinic provides services in dermatology, orthopedics, and gynecology (except preventive care), the participants did not recognize that these services were available.

Healthy Lifestyle and Resources in the Community Access to healthy foods

Participants mostly buy foods at large chain retail stores. Although the question was about healthy foods, the main focus of the discussion was price of foods. At least, participants understand eating healthy is important.

Some kind of form of transportation (is important in getting food). The price is very important of course because if the price is right you get more. And the quality of the food I mean if – if it's good or not. I mean fresh – so, all that is important.

Non-US born participants have access to foods from their ethnic backgrounds in the community. In some cases, they realized that their diet became unhealthier after they moved to the US:

"And I think it, for me, I found because when I just came to this country, I was just crazy about, uh, fast food. And I was "Oh, easy for me" . . . But we started getting so much weight."

Exercise opportunities

Overall, participants expressed a keen interest in exercise opportunities. Some of the participants purchase a membership of a gym (\$25-45/ month). Others find free exercise classes or do exercise in the neighborhood or at home on their own. Participants who were currently not exercising gained some information about inexpensive exercise opportunities from those who knew such resources during the focus groups.

Yes, I attend the gym. I didn't know before about why to exercise; a little while ago I didn't know the benefits that it brings. I go daily, on the good times for an hour,

sometimes for 40 minutes. To get here it is 35 minutes walking there, it goes very fast.

Participants feel it is safe to exercise and walk in their neighborhood. Some of them walk regularly:

"I feel safe in my neighborhood even – even though some people may not think [name of the location] isn't that safe. (Laughs) But I walk up and down Main Street for exercise and there's that little park there."

Cultural issues related to exercise were noted. A female participant from South Asia indicated that she would like to go to a women's-only gym. Some other female participants agreed with her.

There should be more women gyms as well I think... You don't – you don't really feel comfortable. You don't really want anyone to watch you working out or that's the way I am. I don't know. I think mostly women are that way. Especially if you're trying to lose weight. . . . Even sections should be separate. Yeah, with a pool and a sauna and elliptical room. Everything. Yeah. I don't think men should be allowed there at all.

Community and informal resources

Participants mentioned a variety of community resources that they have utilized including mobile clinics, health fairs, religious organizations (church, mosque), food banks, national associations, and non-profit organizations that provide various classes to the underserved. Besides formal resources, one of the Spanish groups discussed informal social support in Latin culture: *"my family is very united."* They expressed the impression that American families were not close to each other compared to Latin families and this was unfortunate. While it is good for children to *"mix with people from other countries, I mean, of American race..."* their children do not *"know how to speak Spanish."* Although there are lots of opportunities available for Spanish speakers in the community, not all of them know about the resources.

We have a lot of opportunities, many free services in Spanish, and many times we don't take advantage of them. And it is very sad, very sad that we have no interest in anything. We are more interested in going to work, making money, making money, and making money, and we do not care about becoming educated about our eating, about our health, about educating our children... It is very sad, but we can find so much help in this country if we know how to look for them.

The Patient Protection and Affordable Care Act (ACA)

The majority of the participants have heard about the ACA and described it as follows:

"Like... what is it called? Medicaid, like that"

"It's a health insurance"

"I really think that, more than an insurance, it is more of a regulation of all insurances... I think Obamacare comes to regulate all of this, to prevent abuses in our medical services"

"That is forcing every American to sign up for healthcare"

"so that everyone who is legally here, has insurance, or can get insurance."

Participants noted that the ACA would be too expensive (e.g., *"But right now how do we apply if we don't have an income to pay a monthly payment?"*), and has very complicated process (e.g., *"a lot of stress"* to understand the ACA). Because the ACA does not cover undocumented immigrants, it is pointless for undocumented immigrants to check about it: *"...but if you're here illegally, then you, well, temporarily, then, you, there's no way for them to really check (Obamacare)."* A few participants do want to have the option not to have insurance.

I would say again, even if I repeat myself, and I apologize for that. It should be optional not force us not recruit us, or anything it should be optional. If we want it, we're gonna go and sign up. If we don't, we don't. And that's it. Period.

In any case, participants would like to learn more about the ACA. The clinic actually offered a lecture on the ACA approximately eight months before the focus group began. But because only three patients attended, the clinic no longer holds the lecture. None of the participants had heard about the lecture. Participants would like the clinic to better advertise such lectures to patients and one participant stated that *"maybe a better job of informing patients would help."* Participants stated a preference for learning about the ACA in a face-to-face lecture over an online format: e.g., *"If we have something like this (a focus group) that will be really helpful. You know then – then everybody can ask questions."*

Discussion

This study explored free clinic patients' experience and perceptions of healthcare services, community resources, and the ACA and identified three main findings. First, while participants are satisfied with overall free clinic services, they want more services and are somewhat dissatisfied with the long waiting times, both in the waiting room and when making an appointment, phone communication, and interpreter services. Second, it is necessary to find effective ways to provide information

about health education opportunities and the ACA to free clinic patients because participants seemed not to receive sufficient information of available resources. Third, health education programs for free clinic patients should focus not only on increasing knowledge but also changing behaviors.

In reality, it would be impossible for free clinics to provide all the services which their patients want. Free clinics may utilize resources in the community to meet the patient expectations for additional services such as exercise and nutrition classes. As for long waiting times in the waiting room, there are some strategies to reduce the time suggested by previous studies. Importantly, long waiting times can be issues not only at free clinic but also at any other healthcare facilities. For example, optimizing appointment intervals may reduce wait-times.²⁴ However, when it is not feasible to reduce waiting time for free clinics, it is recommended that health education materials and validated questionnaires (e.g. screening tools) be distributed in the waiting room.²⁵ Reducing time-to-appointment and improving phone communication may be difficult for free clinics, which rely on volunteer providers and staff. Future projects should incorporate management improvement strategies used in general primary care settings such as waiting list management,²⁶ which can be applied to free clinics. Quantity and quality of interpreter services need to be improved, although most patients who actually used interpreter services were satisfied. There is a possibility of unmet needs for interpreter services, problems of using a family interpreter, and difficulties to ensure the quality of volunteer interpreters in a free clinic setting.¹¹ Other types of healthcare facilities also experience challenges in regard to interpreter availability and use.²⁷⁻²⁹ Future research should explore ways to provide improved quality and quantity of interpreter services to free clinic patients.

Participants are interested in learning more about healthy lifestyles and the ACA, but are not obtaining sufficient information about available resources. The Internet is becoming a major source of health information seeking.³⁰ However, the percentage of free clinic patients who have access to the Internet is lower than that of the US national average.³¹ The main problem among an underserved population is not just barriers to access to the Internet, but how to utilize information.³² There is also a possibility of cultural differences in how to perceive online health information seeking – for example, Hispanics are more likely to perceive that Internet health information may negatively affect the patient-physician relationships compared to non-Hispanic white individuals.³³ People with low levels of health literacy may not be able to utilize online health information even if they have access to the Internet.³⁴ Lower income and education levels are also associated with lack of ability to obtain health information.³⁵

The focus group findings suggest that face-to-face flyer distribution at a free clinic would be the best way to deliver health-related information to free clinic patients, though patients who do not visit a clinic very often may still not be able to reach the information. The results are similar to those of a previous study indicating that less educated first generation Hispanic immigrants prefer in-person strategies to obtain health information.³⁶ Interactive sessions and active engagement were found to be useful in delivering health information to the underserved community³⁷ and may be suitable for free clinic patients. Future research should develop and examine the effective methods of information distribution in a free clinic setting.

Based on the findings of this study, health education programs should focus on increasing knowledge and changing health behaviors; free clinic patients are conscious about healthy diet and the importance of physical activity but may have difficulties implementing their health-related knowledge into actual behavioral change. For example, successful outcomes from health education programs for diabetic free clinic patients (e.g. improved hemoglobin A1c values, cholesterol levels, or blood pressure) have been reported.^{38,39} Diabetic free clinic patients should receive education related to increasing knowledge about diabetes as well as diabetes self-efficacy.⁴⁰ Yet, research on health education in a free clinic setting is still limited. Health education models that fit free clinics need to be developed to address the limited research on health education in a free clinic setting. For example, psychological interventions to promote self-efficacy, which are reported to be useful for increasing physical activity⁴¹ may be effective for free clinic patients.

Because participants of this study were recruited using convenience sampling, the demographic characteristics of the self-selected participants could be different from those of the entire clinic patients. The following populations were over sampled: women and immigrants (especially Asian immigrants). The over sampled populations might have affected the findings. For example, participants were motivated or interested in exercise probably because women and immigrants were over sampled: non-US born female free clinic patients are more likely to be motivated to exercise compared to US born female free clinic patients.⁴² Some of the identified patient expectations (e.g., wait times) represent issues at many healthcare facilities regardless of insurance status; however, this study did not attempt to conduct an objective comparison between a free clinic and a regular healthcare facility. Since this study was conducted at one free clinic and used a qualitative approach, generalizability is limited. However, generalizability was not the objective of this study, because this study was looking at “voices” from free clinic patients.

Conclusions

This study is one of the first qualitative studies to explore free clinic patients' experiences and perceptions using a focus group method. Free clinic patients are very satisfied with free clinic services, though there are needs for additional and improved services (i.e. better clinic-patient communication). Free clinic patients mostly rely on informal and face-to-face networks to find resources and information. While free clinic patients are motivated to learn about healthy lifestyles or the ACA, they are limited when it comes to obtaining or using health-related information. It is important to develop effective strategies to deliver information to free clinic patients. At the same time, interventions need to focus on changing behaviors as well as providing information.

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