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Walden University

College of Health Sciences and Public Policy

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Taquisha A. Howard-Sanders

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Walden University
2025

Abstract

Telehealth, Access to Care, and Perceived Lived Experiences of Seniors Living in Sumter, South Carolina

by

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MPhil, Walden University, 2022

MHA, Webster University, 2011

MPA, Troy University, 1998

BS, Knoxville College, 1992

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

December 2025

Abstract

Telehealth has emerged as a transformative approach to healthcare delivery, particularly for populations facing geographic, financial, and mobility-related barriers. In rural communities such as Sumter, South Carolina, seniors 50 and older continue to experience challenges in accessing timely care, including limited transportation, provider shortages, digital illiteracy, and financial constraints. Conducted by Andersen's Behavioral Model of Health Services Use (ABMHSU), this qualitative phenomenological study explored the lived experiences of seven seniors in Sumter to understand how telehealth influences engagement in healthcare. This study was guided by three research questions (RQ) that examined seniors' experiences using ABMHSU, focusing on predisposing factors, enabling resources, and perceived needs. Data were collected through semistructured Zoom interviews and analyzed using a thematic analysis approach. Sixteen themes emerged across the three RQ, illustrating both the benefits and limitations of telehealth. RQ1 revealed six themes, with convenience as the most significant. RQ2 identified five themes, notably transportation barriers. RQ3 exposed five themes, with digital literacy as a key factor. While seniors valued the convenience and reduced travel, concerns persisted about the use of technology, the impersonality of virtual interactions, and the adequacy of diagnostic tools. Access was further shaped by financial resources, provider availability, and social support systems. Findings underscore the importance of digital literacy initiatives, age-friendly platforms, and empathetic provider communication. The study's implications for positive social change include advancing equitable, person-centered healthcare strategies that reflect the needs of older adults in underserved communities.

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Dedication

First and foremost, I dedicate this work to my Lord and Savior, Jesus Christ. Your grace has carried me, Your wisdom has guided me, and Your love has sustained me through every step of this journey. I give You all the glory. “And we know that all things work together for good to them that love God, to them who are called according to His purpose.” —Romans 8:28.

To my beloved husband, thank you for being my rock, my encourager, and my constant source of support. Through late nights, long days, and the balancing act of work, home, and school, you have been my emotional compass and my laughter at just the right moments. Your unwavering love, patience, and strength have kept me steady when I needed it most. I am endlessly grateful for your presence in my life.

To my three incredible children, this dissertation is for you. May it remind you that no dream is too big and no goal is out of reach when you walk in faith and determination. I hope my journey inspires you to pursue your passions with bold confidence and to always believe in your purpose.

To my grandmothers and grandfathers, I treasure the memories of your warm hugs, stories, and unwavering love. Your legacy lives on in me, and I honor each of you through this work.

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To my loving mother, your prayers, sacrifices, and unconditional love have been my foundation. You represent the three shared heartbeats of our family.

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Finally, this dissertation is dedicated to the resilient seniors of Sumter, South Carolina, whose voices, experiences, and stories inspired every page of this research. Your courage in navigating healthcare challenges and embracing new technologies like telehealth is a testament to your strength and adaptability. I am deeply grateful for your willingness to share your journeys and for trusting me with your truths. This work is a tribute to your lived experiences and a call to honor your well-being.

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Chapter 1: Introduction to the Study

Telehealth is an approach to addressing barriers to access to care, particularly among vulnerable groups such as seniors. With the rise of telecommunication technologies, remote healthcare services have become increasingly accessible, offering potential solutions to seniors' geographical and logistical challenges in accessing traditional healthcare services. Telehealth can enhance access, convenience, and continuity of care by letting seniors consult healthcare providers from a distance. According to the Institute of Medicine (2019), access to care involves promptly utilizing healthcare services to achieve the best possible health outcomes. For seniors, accessing healthcare encompasses numerous obstacles, including physical limitations, transportation issues, financial constraints, and cognitive impairments, all of which could exacerbate existing health disparities (Centers for Disease Control and Prevention, 2020). In Sumter, South Carolina, where a substantial portion of the population comprises seniors who have encountered various health-related hurdles, understanding the utilization of telehealth services, access to care, and its impact on seniors' perceived lived experiences becomes paramount. The unique challenges faced by seniors seeking medical assistance in Sumter are due to its rural landscape and dispersed healthcare facilities. Telehealth, which entails various remote healthcare services provided through telecommunications technologies, has promised to address these challenges.

Moreover, telehealth interventions have shown efficacy in managing chronic conditions, reducing hospital readmissions, and enhancing seniors' overall quality of life (Bashshur et al., 2016). The adoption and utilization of telehealth among seniors are

influenced by technological literacy, attitudes toward telemedicine, trust in healthcare providers, and the perceived efficacy of remote consultations. Rural areas like Sumter experience greater inequality due to differences in access to high-speed internet, digital devices, and technological infrastructure. The implementation of telehealth, therefore, must consider seniors' lived experiences and preferences. Phenomenological inquiry can be utilized to gain insight into seniors' perceptions and interpretations of telehealth interactions. This study was conducted to expand literature on telehealth implementation and its impact on seniors' access to care in rural communities such as Sumter, South Carolina, by exploring seniors' subjective experiences, attitudes, and challenges related to telehealth utilization.

Background

The research focused on various aspects of telehealth and access to care for older adults in Sumter County, South Carolina. Research has shown that telehealth offers significant benefits for improving access to care among seniors, particularly in rural communities where geographic and logistical barriers persist. Telehealth interventions have demonstrated effectiveness in managing chronic conditions, reducing hospital readmissions, and enhancing quality of life for older adults (Bashshur et al., 2016; Şahin et al., 2021). Studies by Barbosa et al. (2021) and Polinski et al. (2016) reported that telehealth improves convenience, reduces travel burdens, and increases patient satisfaction, with many seniors expressing positive attitudes toward virtual consultations. These findings collectively underscore telehealth's potential to address mobility and transportation challenges among aging populations.

Despite these benefits, research also highlights persistent barriers to telehealth adoption among older adults. Kruse et al. (2017) and Lam et al. (2021) identified digital literacy gaps, unreliable broadband access, and skepticism toward virtual care as major obstacles. Sociocultural factors, such as generational attitudes toward technology and trust in healthcare systems, further complicate telehealth engagement (Payán et al., 2022; Zhang et al., 2021). While national and regional studies have explored these issues broadly, few have examined the lived experiences of seniors in Sumter, South Carolina, where cultural norms, economic constraints, and infrastructural limitations may uniquely shape healthcare decisions.

This gap in the literature—specifically the absence of qualitative research on seniors' perceptions of telehealth and access to care in Sumter, South Carolina—underscores the need for this study. By exploring these lived experiences through Andersen's Behavioral Model of Health Services Use (ABMHSU), this research aims to provide insight into how predisposing factors, enabling resources, and perceived needs influence healthcare utilization. Understanding these dynamics is essential for designing culturally responsive, equitable strategies that improve access to care and promote positive health outcomes for older adults in underserved rural populations.

Problem Statement

The issue that prompted the literature search was that many older adults in Sumter, South Carolina, experience barriers to healthcare access, lower rates of video-based telehealth use, patient-level barriers, and digital illiteracy in using telehealth and accessing care. Despite existing research on the topic, there is currently no literature

examining the firsthand experiences of seniors in Sumter, South Carolina, regarding their use of telehealth and access to care. This gap in knowledge highlights an exacerbated disparity in healthcare access quality for marginalized patients who have not utilized telehealth services. The research problem addressed in this study focuses on exploring how seniors in Sumter, South Carolina, can benefit from accessing telehealth services for their healthcare needs.

Purpose of the Study

This qualitative study aimed to explore the lived experiences of seniors 50 and above living in Sumter, South Carolina, to understand whether telehealth improved access to care. The study was conducted to investigate the lived experiences of seniors in Sumter, South Carolina regarding their access to care, utilization, and perception of telehealth services. This phenomenological research will explore seniors' subjective experiences and perspectives, aiming to understand their interactions with healthcare services, the challenges and barriers they face in accessing care, and their lived experiences with telehealth within the specific geographic context of Sumter, South Carolina. As a research methodology, phenomenology allows for the exploration of the subjective experiences of individuals, in this case, seniors in Sumter, South Carolina, when interacting with healthcare services and telehealth. This approach emphasizes understanding the lived experiences of the participants, aiming to capture their nuanced viewpoints and challenges (Creswell et al., 2013).

Research Questions

The study was driven by the following research questions (RQs):

RQ 1: What are the perceived experiences of seniors living in Sumter, South Carolina, with telehealth utilization?

RQ 2: What are the perceived experiences of seniors with access to care living in Sumter, South Carolina?

RQ 3: What factors influenced telehealth use and access to care?

Theoretical Framework for the Study

This research utilized Andersen's behavioral model of health services use (ABMHSU) as its theoretical framework, comprehensively examining healthcare access. Andersen's framework critically reviews attempts to conceptualize and operationalize access to medical care, constructs an integrated theoretical framework for studying access, and proposes methods for deriving empirical indicators of this concept. Access could be evaluated based on whether the system can be accessed by those who require care. It is crucial to acknowledge that there may be differences in how patients perceive needs and how practitioners evaluate them. Moreover, while various factors may influence whether an individual initially accesses the healthcare system, the organization of the system in delivering care and the level of satisfaction experienced by the consumer are crucial in determining whether they continue to seek services (Andersen & Aday, 1978). The system and population descriptors are viewed as process indicators, and utilization and satisfaction serve as outcome indicators within a theoretical model of the access concept (Andersen & Aday, 1978).

Nature of the Study

The study investigates the interaction between telehealth usage, care access, and

the subjective experiences of elderly residents in Sumter, South Carolina. The study investigates the interplay between telehealth utilization, access to care, and the subjective experiences of seniors living in Sumter, South Carolina. To investigate the research questions in this qualitative study, the chosen research design was a phenomenological approach, utilizing interview questions to explore telehealth usage and access to care through the participants' lived experiences. Creswell (2013) outlined a phenomenological framework facilitating a deep exploration of seniors' experiences. This method emphasizes understanding their subjective perspectives, perceptions, and interpretations of telehealth and care accessibility. The research design drew upon existing literature and studies related to telehealth adoption among seniors, barriers to access care, phenomenological research methodologies, and experiences of seniors in similar geographical settings (Zhang et al., 2021).

By studying the lived experiences of seniors living in Sumter, South Carolina, the research will contribute to the literature on telehealth and access to care. In this study, the research design was closely connected to the research problem and purpose, aimed to provide a complete depiction of the lived experiences of seniors in Sumter, South Carolina. By focusing on the experiences of seniors in Sumter, South Carolina, with telehealth and access to care, this research fills a crucial gap in the literature, as there is currently no literature on how seniors in Sumter, South Carolina, navigate healthcare services mainly in the context of telehealth. Sumter, South Carolina, presents challenges and opportunities regarding access to care and utilization among seniors. Overall, this research contributes not only to academic literature but also to understanding how

telehealth and access to care impact the lives of seniors in Sumter, South Carolina. The quality of healthcare services and outcomes for seniors in Sumter, South Carolina, can be improved through informed healthcare policies, programs, and interventions tailored to their needs.

Definition of Terms

The following were definitions and explanations for each of the keywords relevant to the research study.

Access to care: An individual can access healthcare services when necessary. The scope of healthcare services includes the availability, affordability, geographic proximity, and cultural acceptance (Li C. et al., 2023).

Andersen behavioral model of health services use (ABMHSU): Andersen's behavioral model was a theoretical framework used to understand the utilization of healthcare services. It recognizes three characteristics shaping healthcare utilization: predisposing factors, enabling resources, and need factors (Andersen et al., 1995).

Barriers to access to care: Barriers to access to care refer to obstacles or impediments that prevent individuals or communities from obtaining necessary medical care and services (Shi et al.,2022).

COVID–19 Coronavirus Disease: A new viral infection emerged in Wuhan City, China, and initial genomic sequencing data indicated that this virus differed from previously identified coronaviruses, suggesting a novel strain (2019-nCoV), now termed severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). While COVID-19 is presumed to have originated from an animal host (zoonotic origin) and spread through

human-to-human transmission, other potential transmission routes should not be discounted (Dhama et al., 2020).

Disparities in access to care: Disparities in access to care refer to variations or inequalities in individuals' or populations' ability to obtain healthcare services, which are frequently influenced by factors such as race, ethnicity, socioeconomic status, geographic location, and other social determinants of health (Nelson, A., 2002).

Elderly adults/older adults/seniors: These terms refer to individuals in the later stages of life, 50 and above. They were used interchangeably to describe this demographic group.

Geriatrics: A branch of medicine that focuses on healthcare for older adults, including the diagnosis, treatment, and prevention of diseases and disabilities in later life (Kang et al., 2010).

Healthcare facilities: Encompass establishments that offer healthcare services, including hospitals, clinics, outpatient care centers, and specialized facilities such as birthing centers and psychiatric care centers (Chen et al., 2021).

Lived experiences: Lived experiences refer to an individual's personal, subjective encounters, perceptions, and interpretations of events, circumstances, or phenomena (Given, 2008).

Telehealth: Refers to using digital communication technologies to deliver healthcare services, consultations, and information remotely (Barreiro et al., 2020).

Telemedicine: Refers to the remote diagnosis and treatment of patients using telecommunications technology (Barreiro et al., 2020).

Vulnerable and marginalized communities: Vulnerable and marginalized communities include groups with higher risks of experiencing adverse health outcomes due to social, economic, environmental, or political disadvantages (Braverman, 2006).

Assumptions

Several assumptions could be behind a research study that centers on telehealth, access to care, and the perceived lived experiences of seniors in Sumter, South Carolina. Assumptions are restricted to a specific discipline or subdiscipline and reflected unproven facts about the phenomenon (Sonuga-Barke, 2011). The following assumptions were made in this study. First, it was assumed that the study participants responded truthfully and openly to the best of their capabilities. Any deception at any stage would have compromised the credibility of this study. It was also assumed that the participants could accurately remember their access to care, utilization, and perception of telehealth services, even though some of these experiences might have happened numerous months or years past. Third, I assumed that the COVID-19 pandemic (2019 Novel Coronavirus) caused external stressors. It is possible that this had an impact on how seniors in Sumter, South Carolina, responded to the introduction or expansion of telehealth. These assumptions formed the foundational framework for investigating and interpreting seniors' lived experiences, challenges, and perceptions regarding telehealth and access to care in Sumter, South Carolina. They offer a lens for researchers to explore, analyze, and comprehend the diverse nature of seniors' engagement with healthcare services and telehealth technologies in this context.

Scope and Delimitations

This study was centered around the lack of research on telehealth, access to care, and the perceived lived experiences of seniors in Sumter, South Carolina, which led to the scope of the qualitative research design. While there have been quantitative studies on telehealth utilization and access to care, there is a shortage of research focusing on seniors' telehealth utilization, access to care, and perceived lived experiences. This study explored participants' lived experiences with telehealth services related to access to care. The study obtained data by conducting semistructured interviews with open-ended questions created by the researcher, surveys, and secondary data. The study aimed to provide valuable insights into healthcare providers, policymakers, and stakeholders in Sumter, South Carolina, aiding in improving telehealth services and care accessibility and addressing the specific needs of seniors in the community.

The study's delimitations were created based on the study objectives of examining seniors' lived experiences through telehealth usage and access to care. To gain perspective from seniors in Sumter, South Carolina, I delimited this study to a sample of seniors located in the rural region of the Southeast Atlantic United States. When delimiting the study, it is crucial to establish the boundaries, constraints, and scope of the research. The delimitations for a study on telehealth, access to care, and the perceived lived experiences of seniors in Sumter, South Carolina, are geographical boundaries, age groups, healthcare facilities, and technology platforms. Study participants include seniors living within the geographical confines of Sumter, South Carolina. It excludes seniors living in neighboring areas or regions outside Sumter County. The research explicitly

targets seniors 50 and over within Sumter. It excludes younger age groups or individuals outside this age bracket. The study considers telehealth and access to care within Sumter's healthcare facilities, including hospitals, clinics, and associated services. However, it only encompasses specialized care or services within the scope of these facilities. Finally, the research may focus on specific telehealth platforms or technologies commonly used in Sumter but may only cover some available telehealth services or emerging technologies. The findings need to be more generalized. In qualitative research (Patton, 2015), generalizability was more important than credibility and transferability in quantitative research. The dissemination of the study findings through academic publications, presentations, or community engagements could promote awareness and make necessary changes in healthcare services for seniors in Sumter.

Limitations of the Study

The study has limitations, such as getting permission to conduct interviews, interviewing participants at specific times, and participants quitting during the research process. The IRB approval for recruiting participants was a significant challenge for this proposed study. Ethical consideration will focus on ensuring participant confidentiality, informed consent, and ethical handling of sensitive information, which were critical aspects of the study. Maintaining respect, sensitivity, and transparency towards participants' experiences was paramount (Creswell et al., 2013). The study's data collection and analysis were limited to a specific period, which might affect the representation of ongoing changes in telehealth usage or access to care for seniors in Sumter. The study was conducted primarily in English and might only partially capture

the experiences of seniors who communicate in languages other than English or those from diverse cultural backgrounds.

The data collection method employed in this study involved interviews, which posed a limitation potentially affecting trustworthiness. Qualitative interviewing aimed to capture the interviewee's worldview, vocabulary, and judgments, providing insights into the intricacies of their perceptions and experiences (Patton, 2015). I relied on participants to honestly share their experiences concerning telehealth and access to care throughout the study.

Significance of the Study

This study was significant in addressing the lack of knowledge regarding telehealth usage and access to care among seniors in Sumter, South Carolina, and recognizing that older adults in the United States are confronted with barriers to healthcare access, such as decreased usage of video-based telehealth, patient-level barriers, and lack of digital literacy when it comes to using telehealth and receiving care. Additionally, this study's findings could benefit other older adults who want to gain or have adequate access to care and telehealth usage. According to Bashshur et al. (2016), telehealth holds promise in overcoming barriers to access care for seniors, including mobility and transportation challenges. This study explores seniors' perceptions of telehealth, shedding light on its potential benefits and limitations in Sumter, South Carolina. As Creswell (2013) outlined, phenomenological research seeks to understand individuals' lived experiences of a particular phenomenon. By employing a phenomenological approach, this study delved into the subjective experiences of seniors

regarding telehealth and access to care, providing rich insights into their perspectives and realities. The study's findings can have significant policy implications, aligning with the objectives of the Health Resources and Services Administration's (HRSA) Rural Health Strategy. By identifying barriers to access to care and seniors' perceptions of telehealth, policymakers could develop targeted interventions to improve healthcare delivery in rural areas like Sumter, South Carolina (HRSA, 2020). The potential implications for positive social change by focusing on a specific geographic area (Sumter, South Carolina) and population (seniors), this study contributes to the growing body of literature on telehealth and access to care. It adds nuance to our understanding of how these factors intersect and influence seniors' healthcare experiences, filling a gap in the existing research literature.

Summary

The chapter began by highlighting the significance of understanding seniors' perceptions and experiences with telehealth in Sumter, South Carolina. Such services may be particularly crucial in this region due to geographical and demographic factors. The research problem was clearly stated, focusing on the gap in the literature regarding the lived experiences of seniors with access to care and telehealth services in Sumter, South Carolina. The chapter outlined the specific aims and objectives of the study, emphasizing the need to explore seniors' perspectives to inform healthcare policies and practices. Theoretical frameworks and concepts underpinning the study were introduced, including phenomenology as the guiding methodology. The chapter discussed relevant literature on telehealth, access to care for seniors, and phenomenological research in

healthcare contexts, providing a theoretical foundation for the study. Research questions addressed vital aspects such as seniors' experiences with telehealth, barriers to access, and implications for healthcare delivery. At the end of the chapter, an overview of the significance of the study was provided, emphasizing its potential to improve healthcare services for seniors in Sumter, South Carolina. The literature review in Chapter 2 includes the most recent research on telehealth, access to care, and the lived experiences of seniors 50 and over as the basis for my research study.

Chapter 2: Literature Review

In recent years, the integration of telehealth into care systems has seen a rapid evolution, offering an innovative approach to care service delivery using technological advancements (Bashshur et al., 2011). Telehealth encompasses a range of services, such as remote monitoring, virtual consultations, and telemedicine, offering a chance to overcome geographical and logistical challenges. This mainly benefits vulnerable populations like seniors (Dario et al., 2016). Seniors represent a significant demographic group in the United States. According to the 2020 Census, individuals 65 and older in the United States numbered 55,892,014, comprising 16.8% of the total population of 331,893,745. Barriers to access to care concern seniors who face unique challenges in accessing care services due to mobility limitations, chronic health conditions, and limited proximity to care facilities (Institute of Medicine [IOM], 2012).

This phenomenological study was conducted to investigate seniors' lived experiences and perceptions about telehealth and its impact on their access to care, focusing on the senior population living in Sumter, South Carolina. Sumter, with its diverse demographic composition and distinct care ecosystem, supplies an intriguing context for understanding the interplay between telehealth use, access to care, and the lived experiences of seniors (Hsiao et al., 2021). As a research approach, phenomenology allows for a deep exploration into the essence of lived experiences, enabling a nuanced understanding of individuals' perspectives and the meanings they attribute to phenomena (Creswell & Poth, 2018). Seniors living in Sumter, South Carolina, offer diverse demographics and a distinct care ecosystem. By adopting this research approach, this

study provides context for understanding the interplay between telehealth use, access to care, and the lived experiences of seniors (Hsiao et al., 2021). This exploration is crucial for shaping tailored policies and care interventions catering to these demographics' needs and preferences.

Understanding how seniors perceive and use access to telehealth services could offer invaluable insights into designing telehealth initiatives that align with their unique care requirements. For example, to understand the potential impact of telehealth on seniors' access to care, Polinski et al. (2016) conducted a conceptual study presenting survey results illustrating the expected relationship between telehealth use and enhanced care accessibility for seniors in South Carolina. The survey was completed by 1,734 patients, or 54%, out of 3,303. The proportion of women was 70%, and 41% had no usual place of care. The satisfaction level for all telehealth attributes was between 94% and 99%. One-third thought that a telehealth visit was better than a traditional in-person visit. Telehealth received a positive response from 57%. The probability of choosing telehealth increased due to the lack of medical insurance. Females were the ones who liked telehealth most, and they were very content with their overall understanding of it, the quality of care received, and its convenience.

This study contributes to the growing body of literature by shedding light on the perceptions and lived experiences of seniors in Sumter, South Carolina, regarding telehealth and access to care by answering the following research questions: (a) What are the perceived experiences of seniors living in Sumter, South Carolina, with telehealth utilization?; (b) What are the perceived experiences of seniors living in Sumter, South

Carolina, with access to care?; and (c) What factors influenced telehealth use and access to care? In this phenomenological research, the literature review highlights the value of qualitative inquiry in exploring individuals' lived experiences and perspectives.

Literature Search Strategy

Developing an effective literature search strategy for the dissertation involves systematically identifying relevant and up-to-date academic sources. This literature review synthesizes existing research on telehealth, its impact on access to care, telehealth services, and the lived experiences of seniors in Sumter, South Carolina. Different databases from 2018 to 2022 were used to collect, review, and synthesize the literature review content. These articles were sourced from the Walden University Library and other peer-reviewed scholarly sources, including Google Scholar. Google Scholar hosts many electronic peer-reviewed academic articles and journals from institutions such as the NIH National Library of Medicine, Thieme Connect, the JAMA network, PubMed, and the Dissertations and Theses databases available through the Walden University Library. The search guidance for this research included the keywords *telehealth, telemedicine, access to care, barriers and disparities to access to care, vulnerable and marginalized communities, perceptions of telehealth usage, seniors, elderly adults, Sumter, Sumter County, South Carolina, geriatrics, lived experiences,* and *Andersen Behavioral Model of Health Services Use*. Most articles addressed telehealth and access to care, while others included information on barriers and disparities in access to care, vulnerable and marginalized communities, and perceptions of telehealth usage. The reviewed articles included studies involving seniors focusing on telehealth and access to

care.

Theoretical Foundation

The ABMHSU is a well-established framework that I used as the theoretical foundation to explore the lived experiences of seniors using telehealth and access to care in rural areas of Sumter, South Carolina. This model offers a comprehensive approach to understanding care utilization and access to care, taking into account various individual, social, and healthcare system factors that influence health-seeking behaviors and experiences (Andersen & Aday, 1978). Integrating this model into the study provided valuable insights into the complex interplay of factors that shape seniors' lived experiences with telehealth and access to care in Sumter, South Carolina.

The model's three components guided the exploration of various elements affecting seniors' use of telehealth services and access to care. The data collected were relevant to the systematic design concept of access to care using the model's three primary components: predispositions, enablers, and needs (Andersen & Aday, 1978). Andersen and Davidson (2007) described the three primary components as:

1. Predisposing factors: These factors refer to individual characteristics that influence care utilization, such as age, gender, education level, social structure, and health beliefs. In this study, predisposing factors will shed light on how seniors' attitudes toward telehealth and care services affect their willingness to engage with these technologies and seek care.
2. Enabling factors: Enabling factors encompass the resources and barriers that affect care access. Enabling factors include financial resources, health

insurance coverage, transportation availability, and access to technology. Understanding the enabling factors will help to identify the specific challenges seniors in Sumter, South Carolina, face in accessing telehealth services and traditional care.

3. Need factors: Factors that pertain to an individual's perceived health status. This component assesses seniors' health conditions and medical needs, which might impact their preferences and decisions regarding telehealth utilization and seeking care.

By applying the Andersen behavioral model, the dissertation could identify the predisposing factors influencing seniors' attitudes towards telehealth and care utilization in Sumter, South Carolina. I was also able to explore the enabling factors that facilitate or hinder access to telehealth services for seniors in the area. The model also allowed me to examine the need factors that impact seniors' decisions to adopt telehealth or pursue traditional care options. Finally, I could understand how the interaction of these factors shapes seniors' lived experiences with telehealth and access to care in Sumter. The phenomenological approach in this study allows for a deep exploration of seniors' subjective experiences and perceptions related to telehealth and access to care. Incorporating the ABMHSU enhances the rigor and depth of the phenomenological study, providing a comprehensive understanding of the lived experiences of seniors in Sumter regarding telehealth and access to care.

Literature Review Related to Key Concepts

Telehealth

Telehealth, also known as telemedicine, involves using technology to provide remote care services. The convergence of technology and healthcare has led to the rapid expansion of telehealth services, revolutionizing how individuals access and experience healthcare (Chen et al., 2021). Fundamentally, telehealth aims to provide more convenient access to healthcare, save time, and lower healthcare expenses, particularly for elderly patients (Kang et al., 2010; Martínez-González et al., 2014).

Telehealth is particularly beneficial for seniors, especially those in rural areas, enhancing access to care, health outcomes, and quality of life indicators. The global populations of seniors and life expectancy at birth have steadily risen. As the aging population grows and the demand for timely and appropriate healthcare services increases, telehealth has emerged as a vital method of delivering essential medical care (Şahin et al., 2021). This literature review aims to examine key concepts related to telehealth and their implications in the healthcare landscape through the following:

- Accessibility: Telehealth can help people in remote or underserved areas access healthcare services more efficiently. Bashshur et al. (2021) study highlighted its potential to reach populations with limited access to traditional healthcare facilities.
- Patient-centered care: Telehealth facilitates patient-centered care by enabling convenient access to healthcare professionals, enhancing patient engagement, and promoting self-management of health conditions (Kruse et al., 2020).

- Telehealth integration and innovation: The scope of telehealth applications has been expanded through the introduction of innovative technologies such as wearable devices, remote monitoring systems, and artificial intelligence, which have contributed to their integration and innovation. These technologies enhance remote diagnosis, real-time data collection, and personalized treatment recommendations, which impact the quality of care (Woods, 2023).
- Regulatory and policy framework: Regulatory frameworks play a crucial role in shaping the adoption and implementation of telehealth services. Recent policy changes caused by the COVID-19 pandemic have relaxed telehealth reimbursement and licensure restrictions, leading to the rapid expansion and acceptance of telehealth techniques (Loucks et al., 2021).
- Cost-effectiveness and sustainability: Telehealth can reduce healthcare costs by minimizing travel expenses, hospital readmissions, and unnecessary emergency department visits. However, telehealth interventions have different cost-effectiveness across healthcare settings and require careful consideration of factors like reimbursement models and infrastructure investments (Connolly& Hwang, 2021).

Telehealth is a powerful tool for changing healthcare delivery through accessibility, patient-centered care, fostering technological innovation, and addressing regulatory challenges. To successfully integrate telehealth into mainstream healthcare, it was necessary to address privacy concerns, ensure provider readiness, and establish sustainable reimbursement models.

Four Key Dimensions of Access to Care

The growing concern about adequate access to healthcare for rural and remote populations brings with it the need to explore how the four critical dimensions of access to care help to shape access to care for seniors living in South Carolina. Access to healthcare services for seniors could be understood and evaluated through the four key dimensions (see Table 1): geographical access, financial access, temporal access, and social or cultural access (Kirby & Yabroff, 2020). Geographical access refers to the physical accessibility of healthcare services near seniors' homes. This dimension of access to care considers factors such as the location of healthcare facilities, the distribution of healthcare providers, and transportation options. Geographical access could be a significant concern for seniors, particularly those in rural or underserved areas. Public transportation, long-distance travel, and limited healthcare facilities in the vicinity were some barriers to seniors' geographical access.

Table 1

Four Key Dimensions of Access to Care

Dimension	Definition	Example
Geographical Access	Availability of healthcare services in a particular area	Number of hospitals, clinics, or healthcare providers per region
Financial Access	Ability to afford healthcare services	Health insurance coverage, out-of-pocket costs, and income level
Temporal Access	Availability of healthcare services over time	Waiting times for appointments, availability of emergency care
Social/Cultural Access	Acceptability of healthcare services based on social or cultural factors	Language barriers, cultural appropriateness, and trust in healthcare providers

Financial access is related to the affordability of healthcare services for seniors. This dimension of access to care considers healthcare costs, including insurance premiums, deductibles, co-pays, and out-of-pocket expenses. Fixed income limits financial resources, and the challenge of covering healthcare-related costs, including medications, medical equipment, and transportation to healthcare appointments, could be challenging for seniors.

Temporal access is centered on the timely availability of healthcare services. Seniors need access to care as soon as needed without any unnecessary delays. This dimension of access to care addresses long wait times for appointments, delayed referrals, and limited availability of healthcare providers, which are some of the barriers to temporal access. For seniors, managing chronic conditions, preventing health deterioration, and addressing acute healthcare needs requires timely access to care.

The extent to which care services are sensitive to seniors' cultural, social, and linguistic needs is considered in cultural and social access. This dimension encompasses factors such as language barriers, cultural competency of healthcare providers, and the accessibility of support services that address social determinants of health. Healthcare services that do not consider seniors' unique needs and preferences from diverse cultural backgrounds might lead to barriers to accessing care (Kirby & Jaroff, 2020).

By evaluating access to care for seniors using these four key dimensions, it was possible to identify and address the various barriers or obstacles they might face. Adopting this framework and implementing targeted strategies can help healthcare stakeholders create a healthcare system that is accessible, inclusive, and equitable for all

seniors. By ensuring that seniors receive timely, affordable, culturally sensitive, and geographically feasible care services that meet their specific needs, we can achieve optimal health outcomes and improve this vulnerable population's overall quality of life.

Access to Care Through Telehealth

Telehealth has emerged as a transformative approach to care delivery, offering promising solutions to enhance access to care for diverse populations, including seniors and those living in underserved areas (Payán et al., 2022). Telehealth has been viewed as a method of providing care at a low cost. By reducing overall costs for the patient, telehealth allows patients to access care at an affordable cost. We cannot mention the cost savings associated with travel expenses while reviewing the affordable cost of telehealth. When examining telehealth as an exemplary place of service, we can see that its benefits and affordable cost make it a reliable option for many seniors. (Connolly & Hwang, 2021).

A key method for assessing sufficient healthcare access involves evaluating the presence of primary care providers and specialists (Ingram et al., 2022). Nevertheless, it may be argued that a more comprehensive approach is necessary, extending beyond solely measuring access based on primary care availability and specialists' availability, to depict healthcare access or primary care availability accurately (Ingram et al., 2022). The issue of primary care provider shortages in the United States has been extensively documented, with rural areas accounting for 65.6% of these shortages as of September 2022 (Ingram et al., 2022). Numerous studies have highlighted the potential benefits of telehealth in improving access to care, especially for underserved populations (Smith et

al., 2020; Johnson & Brown, 2019), including rural or remote areas, individuals with chronic conditions, and survivors of domestic violence. These research studies consistently demonstrate that telehealth interventions, particularly those employing real-time video communication, can significantly improve access to healthcare for underserved and vulnerable populations while offering cost-effective solutions. Wade et al. (2010) concluded that telehealth services are economically viable, especially in reducing barriers for patients in remote areas. Similarly, Dorsey et al. (2016) found that virtual house calls for individuals with Parkinson's disease enhanced access to specialized care for patients with mobility challenges or those residing in rural communities. Beyond physical health, Crawford et al. (2017) emphasized telehealth's ethical role in supporting survivors of domestic violence by providing safe and remote access to care. Furthermore, Sisk et al. (2019) highlighted that telehealth tools, such as electronic medical records, empower patients with chronic conditions like diabetes to engage in self-management, reinforcing telehealth's potential to reduce health disparities. Collectively, these findings underscore telehealth's dual benefit: expanding equitable access and improving patient-centered care across diverse contexts.

Telehealth has been found to reduce travel time and costs for seniors living in rural areas, facilitating access to specialists and care providers remotely (Jones et al., 2018). However, exploring the barriers seniors encounter in utilizing telehealth services was essential to ensure its successful implementation. For seniors, access to care through telehealth can address numerous barriers they often face in traditional healthcare settings, including transportation challenges, mobility limitations, and geographic isolation. By

providing remote consultations with healthcare providers, telehealth allows seniors to receive timely medical attention without needing physical travel, which is especially beneficial for those residing in rural or medically underserved areas like Sumter, South Carolina. Moreover, telehealth can allow seniors to access specialty care, mental health services, and chronic disease management, which may not be readily available in their local communities. Through virtual visits, seniors can consult with specialists located elsewhere.

Perceived Lived Experience of Telehealth

The representation of a person's experience and choices, the knowledge gained from those experiences and choices, is known as the perceived lived experience in qualitative phenomenological research (see Table 2). Cultural and linguistic factors play a significant role in shaping patients' experiences with telehealth. Patients from diverse cultural backgrounds might have unique preferences, expectations, and communication styles that should be considered to ensure culturally competent care delivery via telehealth. Many perceive telehealth as convenient and accessible, particularly for individuals with mobility limitations, transportation barriers, or who live in remote areas. Home privacy and confidentiality were essential considerations in telehealth. While certain patients value the privacy afforded by telehealth consultations conducted at home, others raise concerns regarding the security of their personal health information transmitted via digital platforms (Frishammar et al., 2023).

Table 2

Perceived Lived Experience of Telehealth

Dimension	Definition	Example
Geographical Access	Availability of healthcare services in a particular area	Number of hospitals, clinics, or healthcare providers per region
Financial Access	Ability to afford healthcare services	Health insurance coverage, out-of-pocket costs, and income level
Temporal Access	Availability of healthcare services over time	Waiting times for appointments, availability of emergency care
Social/Cultural Access	Acceptability of healthcare services based on social or cultural factors	Language barriers, cultural appropriateness, and trust in healthcare providers

Phenomenology as a scientific discipline investigates the structure and content of human experience, utilizing various methods such as epoché or eidetic variation (Given, 2008). Recently, telehealth has become more common and crucial. Remote care can be provided through the use of technology. Patient perspectives play a crucial role in the successful implementation of telehealth. Overall, the lived experiences of telehealth could vary based on individual circumstances, technological ability, health conditions, and preferences. As technology evolves and telehealth becomes more integrated into care systems, these experiences will evolve (Greenhalgh et al., 2016).

Telehealth Implementation During the COVID-19 Pandemic

Before the COVID-19 pandemic, telehealth adoption was gradually increasing and seen as a potential solution to various healthcare challenges. However, telehealth services were not as widely utilized or integrated into mainstream healthcare delivery compared to their increased adoption during and after the pandemic. This disparity was particularly noticeable in rural areas, where more than a quarter of patients reported

difficulties accessing healthcare in 2019 (NPR et al., 2019). Telehealth services before COVID-19 were often used for specific purposes, such as remote monitoring of chronic conditions, virtual consultations for minor acute illnesses, behavioral health counseling, and follow-up visits for certain specialties. These services were typically provided through video conferencing, telephone consultations, or secure messaging platforms (Moynihan et al., 2021). My research on telehealth implementation and access to care encompasses telehealth's significant role during this unprecedented time.

As documented by multiple articles, the pandemic has led to the rapid expansion of telehealth services. Examples of these articles, Keesara et al. (2020) highlighted the digital revolution in healthcare spurred by COVID-19, with telehealth becoming a primary mode of delivering care. The pandemic saw a significant surge in telehealth utilization worldwide. For instance, in the United States, telehealth visits surged from around 1% of total pre-pandemic visits to as many as 70-80% during the pandemic's peak in April 2020. Policy changes, such as relaxed regulations and increased reimbursement for telehealth services, facilitated its widespread adoption (Keesara et al., 2020). Healthcare providers rapidly adopted telehealth technologies to continue delivering care while minimizing in-person contact. Telehealth usage by physicians increased from 22% in 2019 to 85% in 2020, according to the American Medical Association (AMA).

Additionally, Ohannessian et al. (2019) emphasized the importance of global telemedicine implementation to combat the pandemic's challenges, underscoring telehealth's role in maintaining continuity of care while minimizing infection risks. Pre-COVID-19, telemedicine regulations varied by state and country, with some jurisdictions

having stricter rules governing telehealth practice. Licensing requirements, reimbursement policies, and restrictions on the kinds of services that could be offered through telehealth differed across regions, creating challenges for healthcare providers seeking to offer telemedicine services across state or national borders. Telehealth pre-COVID-19 was an emerging approach that needed to be utilized more in healthcare delivery, with limited adoption and integration into mainstream practice.

Several studies provided quantitative data on pre- and post-COVID telehealth use and the surge in telehealth utilization during the pandemic. Research by Mehrotra et al. (2020) reported a significant increase in telehealth visits in the United States, from 1% of total visits in February 2020 to 43.5% in April 2020. This exponential growth underscored the transformative impact of COVID-19 on telehealth adoption. Despite widespread adoption, telehealth exacerbates existing disparities in access to healthcare services. Marginalized communities are disproportionately affected by the digital divide, which includes limited access to technology and internet connectivity. The Federal Communications Commission (FCC) reports that approximately 21 million Americans cannot access broadband internet, which impedes their ability to use telehealth services. Evidence suggests that seniors have increasingly adopted telehealth during the COVID-19 pandemic, although reported usage rates vary across studies. For example, Lam et al. (2021) found that the use of telehealth among older adults surged during the pandemic. Additionally, their study reported that seniors expressed high levels of satisfaction with virtual care delivery.

According to a Lam et al. (2021) study, patient satisfaction with telehealth

services increased from 11% in 2019 to 76% in 2020. Moreover, 74% of patients who had used telehealth during the pandemic expressed high satisfaction levels and intended to continue using it after the pandemic. These statistics highlight the COVID-19 pandemic's rapid adoption and transformative impact while highlighting the need to address access disparities to ensure equitable healthcare delivery.

The pandemic catalyzed the rapid expansion of telehealth services, leading to significant changes in healthcare delivery and patient expectations regarding virtual care. Telehealth implementation during the COVID-19 pandemic facilitated healthcare access and maintenance and reduced virus transmission. Remote healthcare services utilize technologies like video calls and remote monitoring to deliver care from a distance. Understanding how telehealth was implemented and its impact during the pandemic offers valuable insights into its adaptability amongst seniors. Seniors represented a significant portion of the population who often have unique healthcare needs, and their acceptance of telehealth was crucial for its widespread success (Moynihan et al., 2021).

Expansion of Telehealth Services

Healthcare delivery was forced to undergo a rapid transformation as COVID-19 spread globally. Telehealth, which offers healthcare consultations via telephone, video conferencing, or electronic messaging, has historically encountered adoption challenges, including patient and insurer acceptance (Friedman et al., 2022). Its impact on stakeholders has been substantial, enabling care provision while promoting social distancing to prevent disease transmission. In response to the COVID-19 pandemic, the CDC recommended transitioning from face-to-face to remote visits in late February 2020.

Subsequently, Independence Blue Cross announced on March 13, 2020, that telemedicine visits across various services would be reimbursed. Four days later, federal changes allowed Medicare beneficiaries to be reimbursed for telemedicine visits using non-certified communication applications like Zoom and FaceTime, exempting them from Health Insurance Portability and Accountability Act enforcement concerns. These significant policy shifts, coupled with state stay-at-home orders and changes in provider and patient behavior, have reduced the risk of viral transmission and prioritized care for vulnerable patients, thereby fostering the expansion and adoption of telemedicine (Friedman et al., 2022).

During the pandemic, healthcare providers quickly expanded their telehealth services to reach patients. This expansion included various medical specialties and services such as primary care, specialty care, and mental health support (Anthony Jnr et al., 2020). Telehealth significantly impacted the improvement of healthcare access in rural and underserved areas where healthcare facilities and specialists were scarce. Patients in remote locations could consult with healthcare providers elsewhere, reducing the need for long-distance travel and overcoming geographical barriers to care. Telehealth services were expanded through various online tools (Payán et al., 2022).

Virtual Consultations offered a telehealth platform that allowed patients to schedule and conduct virtual consultations with care providers, reducing the need for in-person visits (Bagchi, 2019). Remote Monitoring tools and wearable devices offer a convenient telehealth platform for tracking vital signs and health data, enabling care providers to remotely monitor patients and make informed healthcare decisions (Bagchi,

2019). Mental Health Support through telehealth played a significant role in providing mental health services, including therapy and counseling. Seniors at risk of social isolation and loneliness benefited from telehealth's ability to provide mental health services, including treatment and counseling; this level of support was crucial for addressing the mental health challenges exacerbated by the pandemic. Patients could request prescription refills through telehealth consultations or online telehealth platforms, minimizing the need for physical pharmacy visits (Bagchi, 2019).

Medication Management through telehealth allowed seniors who often required multiple medications to fill prescriptions remotely. Telehealth can be used to request prescription refills and provide the ability to discuss medication management with care providers. Medication Management through telehealth reduced the need for seniors to visit pharmacies frequently. Many seniors had chronic health conditions that required ongoing management. Chronic Health Management, through telehealth, allows seniors to check in with care providers regularly. The expansion of the telehealth platform helped seniors track chronic diseases by monitoring their vital signs and health metrics with remote devices, providing valuable data for care provider management (Bagchi, 2019). Telehealth helped seniors access healthcare services without traveling to healthcare facilities, reducing exposure to COVID-19. For seniors with mobility issues or who live in rural areas, telehealth offered a convenient way to receive care.

Integration with In-Person Care

Healthcare delivery systems have started integrating telehealth into their long-term care models to provide a hybrid approach that combines virtual and in-person care.

Healthcare providers and telehealth platforms recognized the need to tailor their services to seniors. Telehealth platforms offered user-friendly interfaces, accommodated hearing and vision impairments, and provided clear instructions for virtual visits (Barnett et al., 2021). As the pandemic made in-person visits riskier for this vulnerable population, many seniors turned to telehealth as an alternative means of accessing care services.

The COVID-19 pandemic significantly changed how healthcare services were delivered in the United States. As in-person outpatient visits declined, many clinicians turned to telehealth for the first time, driven partly by regulatory changes that expanded reimbursement from public and private insurers for a wider array of telehealth services (Mehrotra et al., 2020; Verma, 2020). Barnett et al. (2021) investigated how telehealth helped counterbalance the decline in outpatient visits and the geographic variations in changing outpatient care patterns. Their nationwide study included 16.7 million individuals with commercial or Medicare Advantage insurance in 2020. During the pandemic, there was a notable increase in telehealth usage among seniors, as evidenced by this national study. The findings among the 16,740,365 enrollees showed that the weekly rate of telehealth visits surged during the pandemic, reaching its peak during the week of April 15, 2020, before gradually declining by June 10, 2020. From January 1, 2020, to June 10, 2020, telehealth visits increased significantly from 0.8 to 17.8 visits per 1000 enrollees (a 2013% increase); in-person visits decreased from 102.7 to 76.3 visits (a decrease of 30.0%); and total visits (combining telehealth and in-person visits) decreased from 103.5 to 94.1 (a decrease of 9.1%).

During the final four weeks of the study, from May 20, 2020, to June 16, 2020,

significant geographic disparities were observed in the proportion of total visits conducted via telemedicine, ranging from 8.4% in South Dakota to 47.6% in Massachusetts. The percentage change from baseline in total visit rates varied widely, from a decrease of 73.2% in Hawaii to a decrease of 16.0% in Alaska. Certain states, particularly in the South, experienced a slight decrease in total visits and lower rates of telehealth utilization. The number of total visits in Tennessee grew by 23.6%, with telehealth being the most common type of visit. Alabama saw a 21.5% and 13.4% increase, and South Carolina saw a 24.2% and 11.4% increase, respectively. According to Barnett et al. (2021), the rate of decline in telehealth usage during the pandemic was attributed to the following reasons: (a) patients preferred in-person consultations for specific medical examinations or procedures, leading to decreased telehealth usage, (b) prolonged exposure to virtual interactions for work, education, and socializing might contribute to "digital fatigue," leading some individuals to prefer in-person healthcare visits, (c) some temporary regulatory waivers that facilitated telehealth adoption during the pandemic's peak expired or were scaled back, potentially reducing its accessibility and utilization, and (d) vaccination campaigns and public health measures reducing infection rates made patients more comfortable returning to in-person care. This led to a decrease in demand for telehealth services.

Long-term Impact of Telehealth and Adoption

The experiences of seniors during the pandemic influenced the long-term acceptance of telehealth. According to early evidence from ambulatory practices, the increase in telemedicine visits was not enough to counteract the decrease in in-person

visits. Research has identified gaps in the practice and adoption of telehealth. Friedman et al. (2022) report emphasized the need for more examination to determine if there are disparities in telemedicine access between age, race, ethnicity, and socioeconomic status that extend to the new wave of unplanned telemedicine expansion. The adoption of telehealth during the pandemic accelerated its integration into healthcare systems and was expected to have a lasting impact on healthcare delivery. Telehealth has made it easier to access care, especially in rural or underserved areas, and has made routine appointments more convenient. Telehealth became necessary during the pandemic, and seniors, like other age groups, had to adapt to it to access healthcare services. This forced adoption made many seniors familiar with telehealth platforms and technology. While many seniors embraced telehealth during the pandemic, there were still barriers to its adoption. These barriers included issues related to digital literacy, access to technology, and concerns about the value of virtual care (Friedman et al., 2022).

Barriers to Access to Care in Telehealth Programs

Facilitating access to care involved assisting individuals in accessing appropriate healthcare resources to maintain or enhance their health. The concept of access is complex and requires evaluating at least four aspects (Gulliford et al., 2002). Healthcare is possible if services are readily available and in sufficient supply, and a person has access to them. The range in which people can access telehealth services depends on financial, economic, social, cultural, and technological barriers limiting their use (Gulliford et al., 2002). While telehealth programs have potentially improved access to healthcare for many individuals, including seniors, several barriers limited or impeded

access to care through telehealth (Gulliford et al., 2002).

Economical Barriers

The economic barriers to accessing care telehealth programs for seniors in South Carolina were parallel and overlapping with the barriers relating to sociocultural and technological factors. Several economic barriers impacted access to care for seniors living in South Carolina. Chen and Barath (2021) examined the adoption of telehealth in both rural and urban areas, identifying barriers to improving telehealth capabilities in patient engagement and health information exchange. The authors noted that approximately 46 million people, constituting 15% of the population as of the 2010 Census, resided in rural areas, encompassing over 72% of the United States' land area. Rural areas, compared to urban counterparts, exhibited a higher proportion of older adults, greater incidence of health disparities, lower patient volumes in healthcare facilities, and notably deficient healthcare infrastructure. This included challenges in adopting telehealth, health information technology, and system capabilities.

The economic barrier of limited insurance coverage makes it necessary for seniors to receive assistance in accessing necessary technology like smartphones and computers with internet access, which could be expensive to purchase and maintain. Access to the internet is a necessity today, but unfortunately, many seniors living in rural South Carolina were burdened by the high cost of internet services. Chen Barath (2021) stated that seniors unfamiliar with digital devices such as smartphones or telehealth platforms required training or assistance, leading to unforeseen costs. Telehealth had the advantage of reducing the need for in-person visits. However, seniors still had to travel to a location

with internet access or transportation to a local clinic for telehealth appointments. The added cost of travel imposed an economic barrier for many seniors. Seniors faced costs associated with obtaining prescription medications if telehealth appointments required prescription drugs, especially if they lacked insurance coverage. Some telehealth programs required seniors to purchase or rent medical equipment or devices, such as blood pressure monitors or glucose meters.

Besides the financial barrier of expensive medication, seniors could not afford medical equipment to monitor and treat their health conditions. Even working seniors have lost their income because they had to take time off from work for telehealth appointments. Seniors requiring interpretation services or translation during telehealth visits incurred additional expenses. These specific economic barriers seniors face in accessing telehealth programs in South Carolina varied depending on their circumstances, location within the state, and the telehealth program itself. These economic barriers limit seniors' ability to access care services, particularly for those with limited financial resources (Chen & Barath, 2021).

Sociocultural Barriers

Sociocultural barriers to seniors' access to telehealth programs in South Carolina were influenced by various social and cultural factors that affected how seniors engaged with and benefited from remote or telehealth services (Barreiro et al., 2020). Cultural beliefs and values influence seniors' care decisions. Some cultural groups prefer in-person care and can be hesitant to adopt telehealth. Seniors might prefer care providers who understand and respect their cultural backgrounds. The lack of cultural competency

among telehealth providers was perceived as a barrier (Hilty et al., 2020). Seniors from specific cultural backgrounds required additional support services, like transportation or home assistance, to participate in telehealth appointments, which might not always be readily available. (Gajarawala and Pelkowski, 2021). Cultural norms influenced the roles of family members and caregivers in the care decisions of seniors. In some cultures, family members played a central role in care choices, which affected telehealth utilization (Hilty et al., 2020).

Socio-economic status intersects with cultural factors, as low-income seniors face additional challenges accessing technology and telehealth services (Chen & Barath, 2021). In South Carolina, as in many other places, seniors encounter multiple sociocultural barriers that hinder their ability to use telehealth programs. Scott Kruse et al. (2018) identified several key barriers. Many older adults have limited digital literacy, making it difficult to navigate telehealth platforms or feel comfortable using digital devices. Access to technology is another challenge, as seniors from low-income households often lack smartphones, computers, or reliable internet connections. Language and cultural differences also play a role; seniors who speak languages other than English may experience communication barriers when interpretation services are unavailable, and cultural beliefs about healthcare can influence willingness to engage with telehealth.

Health literacy further complicates access, as some seniors struggle to understand the purpose and process of telehealth appointments, follow provider instructions, or communicate health concerns effectively. Transportation and mobility issues remain

significant, with seniors who rely on public transportation or have physical limitations finding it difficult to attend in-person visits and equally challenged to use telehealth without adequate support at home. Financial constraints exacerbate these issues, as seniors on fixed incomes may be unable to afford internet service, digital devices, or out-of-pocket costs not covered by insurance. Additionally, lack of social support can lead to feelings of isolation or anxiety about using telehealth without assistance, particularly when privacy concerns arise. Finally, resistance to change persists among some seniors who prefer the familiarity and personal interaction of traditional in-person visits over adopting new technologies (Scott Kruse et al., 2018).

Technological Barriers

Scott Kruse et al. (2018) studied barriers to technology and access to technology. The authors documented how technology and access to technology significantly impacted the care individually and collectively. The technological barrier also co-mingled with economic and sociocultural barriers in many ways. These barriers significantly impacted seniors' access to telehealth programs in South Carolina, especially when they lacked the necessary technology or faced challenges in using it effectively. Economic barriers impacting technology, such as internet cost and device affordability, offered a different perspective on technology. Technical glitches, such as software crashes or audio/video problems, disrupted telehealth sessions and reduced the quality of care provided. Technological barriers to access have developed due to an inadequate internet connection. Even if someone had access to the internet, their connectivity was unstable or lacked high-speed connections. In rural areas, internet infrastructure was often lacking,

resulting in poor video and audio quality during telehealth sessions (Scott Kruse et al., 2018). Many people, particularly older individuals, needed to be more comfortable using technology or navigating telehealth platforms. The lack of digital literacy became a significant barrier to accessing care remotely. Additionally, telehealth platforms were not compatible with all devices and operating systems.

On a global level, Scott Kruse et al. (2018) examined 30 articles that addressed significant obstacles to implementing telehealth worldwide. The review highlighted common terminology across studies and identified seven critical areas of concern encompassing 33 barriers mentioned over 100 times. Financial barriers were among the most frequently cited, including the initial investment in telehealth infrastructure, ongoing maintenance costs, and uncertainties regarding reimbursement policies and coverage for telehealth services. Challenges related to provider and patient engagement were also prominent, reflecting resistance to change, skepticism about telehealth's effectiveness, and concerns about patient acceptance and compliance. Legal and regulatory issues emerged as another major obstacle, given the complexity of licensure requirements, privacy and security concerns, liability issues, and jurisdictional challenges across different regions and healthcare systems. Technical infrastructure and interoperability posed additional difficulties, such as limited access to high-speed internet, outdated or incompatible electronic health record systems, and interoperability gaps hindered the seamless exchange of health information between platforms and providers. Workflow integration and usability concerns further complicated adoption, with difficulties incorporating telehealth into existing healthcare processes, disruptions to

workflow, and the need for additional training and support for providers. Quality and safety concerns were also noted, including issues related to diagnostic accuracy, patient confidentiality, data security, and the potential for medical errors or adverse events in remote care settings. Finally, patient acceptance and adoption were influenced by perceptions of reliability and trustworthiness in virtual consultations, barriers to communication and rapport-building with providers, and preferences for traditional in-person care (Scott Kruse et al., 2018).

Both globally and locally, telehealth platforms created barriers for individuals with older devices or using less common operating systems. Technology was heavily impacted if seniors' devices needed to be updated or were incompatible. Addressing these technological barriers was essential to ensure telehealth was accessible to a broader range of individuals and the potential benefits of remote care could be realized more fully. It was essential to address barriers through policy changes, investment in technology infrastructure, digital literacy programs, cultural competency training, and outreach efforts to educate seniors about the benefits and limitations of telehealth to improve access to care in telehealth programs (Angelopoulou et al., 2022). These barriers included limited reimbursement by insurance payers, concerns about the quality and safety of virtual care, resistance from healthcare providers accustomed to traditional in-person care models, and technological barriers for patients lacking access to reliable internet connectivity or digital devices. Unequal access to telehealth services resulted from disparities in access to technology and internet connectivity. While internet usage among adults in the U.S. has increased, disparities persist based on age, income,

education level, and rural residence (Angelopoulou et al., 2022).

Disparities in Telehealth Access and Usage

Telehealth is capable of delivering tremendous benefits in terms of access to care and outcomes, particularly when it comes to reaching underserved or remote populations. Health disparities related to telehealth access have been investigated, particularly in rural and low-income communities. These studies underscore the importance of addressing inequalities in technology access, infrastructure, and awareness to ensure equitable use of telehealth services (Perzynski et al., 2017; Lin et al., 2019). However, telehealth access and usage disparities persisted and exacerbated healthcare disparities, including quality of care, care costs, and technology literacy (Hsiao et al., 2021).

Quality of Care

The quality of care in telehealth access and usage has been a critical concern in modern healthcare, particularly in light of the COVID-19 pandemic, which accelerated the adoption of telehealth services (Malani et al., 2020). Ensuring that telehealth maintained or improved the quality of care compared to traditional in-person healthcare was essential. Research by Hsiao et al. (2021) emphasizes that several factors, including effectiveness, safety, patient satisfaction, adherence to clinical guidelines, communication, and overall patient-lived experience, determine the quality of care in telehealth.

The quality of care effectiveness was vital in achieving the desired healthcare outcome when utilizing telehealth services. Şahin et al. (2021) provided well-documented studies and systematic reviews evaluating the clinical effectiveness of telehealth

interventions for various medical conditions, which were essential in assessing the quality of care. These studies evaluated the impact of telehealth on patient outcomes, the management of chronic conditions, and preventive care. Safety was a fundamental aspect of healthcare quality. Telehealth platforms and practices should prioritize patient safety, ensuring that the care supplied was proper, accurate, and did not harm patients. Patient safety measures were implemented to prevent misdiagnoses, medication errors, and other potential safety risks associated with remote consultations (Sundstrom et al., 2019).

Patient satisfaction was a crucial indicator of quality care. Şahin et al. (2021) evaluated patient satisfaction with telehealth services to help assess the ease of use, convenience, communication, and overall experience of patients using telehealth. The study comprised a total of 22 articles. In most disciplines, evidence has demonstrated that telemedicine was equally effective as conventional care in terms of feasibility, chronic disease management, and patient satisfaction among older adults. Challenges have been reported in a few studies, including technological difficulties, hearing problems, and physicians' reluctance to perform hands-on examinations. According to this review, healthcare providers can utilize telehealth to support elderly individuals in conjunction with traditional healthcare services. Future research is needed to address the identified barriers to increasing telehealth use among older adults. Telehealth services should adhere to established clinical guidelines and best practices when delivering care via telehealth to ensure consistent, evidence-based care. A study by Polinski et al. (2016) reported that one-quarter of U.S. patients were unable to find a primary care provider or had limited access to one. Finding convenient and accessible care is also a struggle due to

work and personal obligations. Telehealth services facilitated patients' access to care, but whether patients were satisfied with telehealth was still being determined.

Effective communication and continuity of care were essential. Donaghy et al. (2019) emphasized the advantages of telehealth in enhancing communication and maintaining continuity of care, particularly for individuals with chronic respiratory conditions. The adoption of visual platforms like Skype and FaceTime for online communication was on the rise. With increasing pressures on primary care services, alternative approaches to patient care were being explored, including Internet-based video consultations. Effective communication between healthcare providers and patients was crucial for quality care. Telehealth platforms should facilitate clear and meaningful communication, enabling providers to gather relevant medical history, conduct assessments, and establish appropriate treatment plans.

Additionally, Donaghy et al. (2019) identified that telehealth should support continuity of care by ensuring seamless information sharing and follow-up care. Primary care clinicians were equipped with virtual reality equipment and utilized the 'Attend Anywhere' web-based platform to conduct follow-up consultations with patients online. Patients needed a smartphone, tablet, or computer with video capability to participate. Semi-structured interviews were conducted with 21 patients and 13 primary care clinicians following these virtual consultations, and the results were analyzed thematically. The research revealed that virtual consultations had a positive impact on participants, benefiting those who work, have mobility issues, or experience mental health challenges. Compared to telephone consultations, virtual consultations were

preferred for their ability to convey visual cues, offer reassurance, establish rapport, and enhance communication. However, technical difficulties were noted as everyday issues. Clinicians emphasized the need for more reliable virtual consultation systems integrated into routine appointment processes, suggesting upgrades to current technology systems.

Donaghy et al. (2019) concluded that video consultations have distinct advantages over telephone consultations due to their visual component. Virtual consultations were a time-saving alternative to face-to-face consultations when formal physical examinations were not necessary, when integrated with existing systems, particularly for working individuals. There will likely be a rise in demand for V.C. services in primary care; however, improved technological infrastructure is necessary to make V.C. a routine practice. For complex or sensitive issues, face-to-face consultations were still the best option.

The patients' overall lived experiences and the quality of care in telehealth access and usage were crucial in assessing the effectiveness and acceptance of telehealth services. Payán et al. (2022) described patients' perceptions as crucial in shaping the future of telehealth, making it patient-centric, accessible, and effective. The study captured the patients' perspectives using interview scripts that included questions about their telehealth experiences, technology, resources, and needs, as well as barriers, facilitators, language access, and a deductive approach. A thematic analysis of the transcript content was also conducted. Patient surveys and research studies were crucial for gaining insights into patients' perspectives on the quality of care provided through telehealth, which could be used to enhance service quality. It was important to note that

the quality of care in telehealth varies depending on the specific telehealth platform, the healthcare provider's proficiency in using the technology, and the nature of the healthcare service being provided. Ongoing research and continuous improvements in telehealth technology and practices were essential to maintaining and enhancing the quality of care in telehealth services.

Care Cost

Telehealth has gained significant popularity and usage in recent years, particularly with the advancement of technology and the growing need for accessible healthcare services, especially during the COVID-19 pandemic (Alsabeeha et al., 2022). The care cost associated with telehealth access and usage varied from consultation fees, insurance coverage, copayment and deductibles, out-of-pocket cost to care, and subscription-based models. Barbosa et al. (2021) described how telehealth platforms charged a consultation fee for a virtual visit with a healthcare professional. These fees varied depending on the type of consultation, such as primary care, specialist, mental health, and the platform being used. Health insurance plans may or may not cover the cost of telehealth visits. Many insurance providers expanded coverage for telehealth services, especially during the pandemic, to encourage remote consultations and reduce in-person visits. Depending on the health insurance plan, some patients had to pay copayments or meet deductibles for telehealth visits, just as they would for in-person visits. The amount varied based on the insurance plan and telehealth service.

Individuals without insurance coverage or opting for services not covered by insurance had to pay the total cost of the telehealth out of pocket. These costs vary based

on the healthcare provider and the type of consultation. Moreover, some telehealth platforms offer subscription-based models where patients paid a regular fee to access a certain number of virtual consultations each month, which were more cost-effective for frequent users. Individuals needed to consider their insurance coverage, specific healthcare needs, and budget when evaluating the cost of telehealth access and usage. Healthcare policy changes and advancements in telehealth technology have impacted the cost landscape.

Technology Literacy

Technology literacy was crucial in enabling seniors to access and utilize telehealth services effectively. As the world increasingly moves towards digital healthcare solutions, addressing technology literacy among seniors becomes essential to bridging the digital divide and supplying fair access to care (Malani et al., 2020). The availability of reliable internet, computers, or smartphones required for telehealth is not universal. Rural areas and low-income communities were particularly affected. Seniors faced challenges navigating telehealth due to limited familiarity with technology. Reliable technology and internet connectivity were essential to ensure high-quality telehealth services. The use of secure and user-friendly platforms was crucial. Technological reliability and usability are essential for a positive user experience (Malani et al., 2020). Dinesen et al. (2016) discussed the importance of usability and technological reliability in telehealth. Rural or underserved areas lacked the necessary digital infrastructure, including reliable high-speed internet connections, which limited seniors' access to telehealth services in these regions. A limited understanding of

telehealth benefits or how to utilize telehealth services deterred people from seeking care through these means. Mobility issues, arthritis, or impaired vision made it difficult to navigate digital platforms. Hearing loss made it challenging to engage in virtual conversations without proper accommodations. Cognitive impairments associated with aging impacted seniors' ability to understand and follow instructions during a telehealth consultation. Memory issues or difficulty concentrating affected their ability to provide accurate medical histories or comply with treatment plans (Cimperman et al., 2013).

Perceptions Influencing Seniors' Usage of Telehealth

Seniors' perceptions significantly influence their willingness to use and engage with telehealth services (Alsabeeha et al., 2022). Understanding these perceptions was crucial for designing effective telehealth strategies tailored to the needs and concerns of older adults. For this study, it was essential to understand how perceptions influence seniors' use of telehealth in relation to their level of education, socio-economic status, family beliefs, and support.

Level of Education

Alsabeeha et al. (2022) identified that the education level could influence seniors' use of telehealth. Education affects digital literacy, familiarity with technology, comfort with online interactions, understanding of telehealth benefits, and the ability to navigate and utilize telehealth platforms effectively (Payán et al., 2022). Seniors with a higher level of education had a better grasp of technology concepts and terminologies. They felt more comfortable using telehealth services due to their understanding of how these technologies work (Payán et al., 2022). Education enhanced critical thinking and

problem-solving skills, allowing seniors to effectively navigate telehealth platforms, troubleshoot issues, and resolve challenges that might arise during usage (Payán et al., 2022). Education resulted in a greater willingness and ability to explore and utilize various features of telehealth platforms, enhancing the overall user experience.

However, it is essential to note that education was just one factor influencing seniors' use of telehealth. Access to technology, socio-economic status, health status, geographic location, and cultural factors also play significant roles in determining telehealth utilization among seniors (Payán et al., 2022). Tailored interventions are crucial to promoting equitable access and usage of telehealth services among seniors. These interventions should be designed to bridge potential gaps and address the unique needs of this demographic (Payán et al., 2022).

Socioeconomic Status

Socio-economic status influenced seniors' use of telehealth services in several ways. Telehealth, which included remote healthcare services and virtual doctor visits, offered numerous benefits to seniors, such as increased access to healthcare, especially for those with mobility or transportation limitations. However, socio-economic status could affect seniors' ability and willingness to use telehealth. Seniors with limited financial resources needed help with transportation to physical healthcare facilities. Barbosa et al. (2021) described how telehealth was a valuable alternative and how socio-economic factors could determine the extent to which transportation was a barrier for a particular individual. Socio-economic status influenced the living conditions of seniors. Individuals with lower incomes may have less stable or comfortable living environments,

which can impact the feasibility and comfort of telehealth visits (Barbosa et al., 2021).

Seniors from different socio-economic backgrounds had varying language and cultural barriers that affected their willingness to use telehealth services. Cultural perceptions of healthcare and language proficiency played a role in cultural barriers. Socio-economic status influenced seniors' level of health literacy, which, in turn, affected their ability to engage effectively with telehealth services. Individuals with lower socio-economic status require more health literacy, which makes it more challenging for them to understand and follow medical advice delivered remotely (Barbosa et al., 2021).

Family Belief and Support

Family, friends, or support groups influenced the perceptions of seniors. They encouraged family members and caregivers to help seniors become familiar with telehealth platforms and devices and supplied ongoing support and guidance. Positive feedback and encouragement from their social circles promoted the adoption of telehealth (Alsabeeha et al., 2022). Family beliefs and support significantly influenced seniors' use of telehealth positively or negatively. The role of the family in shaping seniors' perceptions and decisions about telehealth was essential because of the trust and bond seniors have formed with their families and caregivers.

Zhang et al. (2021) examined family beliefs and support through multiple lenses, emphasizing the critical role families play in seniors' adoption of telehealth. Family members with a positive attitude toward telehealth encouraged seniors to use these services by highlighting convenience, accessibility, and potential health benefits. Active encouragement and reassurance from family helped alleviate seniors' hesitations, while

education about telehealth functions and advantages increased understanding and comfort with virtual care. Families also explained practical benefits such as reduced travel time, quicker access to healthcare, and the ability to manage chronic conditions from home. Technical assistance was another key factor; many seniors lacked experience with technology, so family members helped set up devices, download applications, and navigate telehealth platforms.

When technical issues arose during sessions, families provided troubleshooting support to ensure a smooth experience. Building trust was equally important, as seniors often relied on family judgment; when family members trusted telehealth systems and providers, seniors were more likely to feel secure and willing to participate. Families also created comfortable environments for virtual appointments, alleviating anxiety and fear by offering emotional support and reassurance about the safety and effectiveness of telehealth. In some cases, family members joined telehealth appointments to provide moral support and assist with communication. Finally, cultural and religious considerations influenced family attitudes toward telehealth, underscoring the importance of understanding and respecting these beliefs to encourage seniors' engagement with virtual care (Zhang et al., 2021).

Vulnerable and Rural Communities

Vulnerable Communities

According to Bhatt and Bathija (2018), vulnerable communities are typically groups of individuals who face elevated risks of health disparities due to various factors like socio-economic status, race, ethnicity, geography, age, disability, and other social

determinants of health. These populations frequently encounter barriers to accessing high-quality healthcare services, resulting in poorer health outcomes. Accessing healthcare services has posed considerable challenges for vulnerable communities. Telehealth has emerged as a promising solution to these issues, facilitating improved access to care for these communities.

Telehealth in Rural Communities

Zhang et al. (2021) studied the impact of telehealth services among seniors in rural communities, which gained importance in recent years, especially in improving access to care, managing chronic conditions, and addressing the unique healthcare needs of aging populations. Zhang et al. (2021) concluded that telehealth addressed the issues of limited access to healthcare services in rural areas, where seniors often live far from medical facilities. Accessing healthcare is challenging for seniors in rural communities due to geographic, economic, and cultural barriers. These challenges contribute to health disparities. Seniors who reside in rural areas may encounter more significant barriers to accessing care than those in urban areas.

Telehealth has shown potential in bridging this gap, but its implementation in rural settings poses significant challenges. Limited internet connectivity and technological infrastructure hindered the seamless delivery of telehealth services in rural communities. Moreover, rural seniors' cultural perceptions and attitudes toward telehealth influenced their willingness to adopt these services (Hsiao et al., 2021). It was crucial to comprehend how telehealth affected the access to care for rural seniors, as this understanding would guide the customization of interventions to address their particular

requirements.

Access to Care in Rural Communities

Hron et al. (2020) found that multiple studies explored the impact of telehealth usage among vulnerable populations. These studies provided a broad overview of research focusing on telehealth's effects on vulnerable populations, with a particular emphasis on rural communities. However, none of these studies specifically addressed the issue of seniors' access to care and telehealth in rural areas. Several notable investigations have explored telehealth's impact on rural healthcare more broadly. For example, the RAND Corporation conducted a comprehensive study examining telehealth's influence on rural communities, focusing on access to care, patient outcomes, and cost-effectiveness. Their findings provided valuable insights into how telehealth interventions can improve healthcare access and outcomes for rural populations. Similarly, researchers at the University of Iowa evaluated the effectiveness of telehealth in managing chronic diseases among rural patients, highlighting the role of remote monitoring and virtual consultations in improving disease management and reducing healthcare disparities. The University of Nebraska Medical Center investigated telehealth's application in addressing mental health needs among rural residents, demonstrating the efficacy of telepsychiatry and teletherapy in providing timely and accessible mental health services. Johns Hopkins University researchers assessed the impact of telehealth on healthcare access and outcomes for rural veterans, showing how telehealth interventions integrated into the Veterans Health Administration system enhanced access to specialty care and alleviated travel burdens. Additionally, the

National Rural Health Association (NRHA) published reports synthesizing research findings on telehealth's impact on rural healthcare access and outcomes, frequently highlighting challenges and opportunities associated with telehealth adoption in rural settings and offering recommendations for policymakers and healthcare stakeholders (RAND Corporation; University of Iowa; University of Nebraska Medical Center; Johns Hopkins University; National Rural Health Association).

These studies represented a growing body of research examining the effects of telehealth on vulnerable populations, including those in rural communities. These studies provided valuable insights into how telehealth interventions addressed healthcare disparities and improved access to care for underserved populations. Early evidence suggested that communities in disadvantaged areas faced challenges due to limited technological literacy and a requirement for immediate medical attention, due to their disproportionate impact on the COVID-19 pandemic. However, Eyrich et al. (2021) noted that dependence on technology introduces pressures that may exacerbate disparities in access to care among vulnerable populations. The COVID-19 pandemic has significantly redefined vulnerability within society, with technology exacerbating these disparities. According to the 2018 American Community Survey, over 600,000 Medicare beneficiaries in communities lacked access to a computer with high-speed internet or a smartphone with a wireless data plan. Factors such as age, race (Black or Hispanic), marital status (widowed), and educational attainment (less than a high school diploma) were associated with limited digital access. Additionally, during this period, millions of individuals in the U.S. faced unprecedented financial, emotional, and physical challenges

(Roberts et al., 2020).

Summary and Conclusion

According to Chen et al. (2021), a review of the literature on telehealth and healthcare access for seniors in Sumter, South Carolina underscored the potential of telehealth to alleviate healthcare disparities and enhance accessibility for elderly populations, especially in rural regions. Understanding the lived experiences of seniors in accessing telehealth services can inform policies and interventions that catered to their specific needs ultimately enhanced healthcare delivery for this vulnerable population. Although dedicated studies specific to Sumter, South Carolina, are lacking, existing research on telehealth and seniors offers valuable insights into the advantages and difficulties of deploying telehealth solutions in comparable settings.

Telehealth has been shown to enhance seniors' access to healthcare by overcoming barriers such as transportation limitations, mobility issues, and geographic distance from healthcare facilities. Remote monitoring, virtual consultations, and care coordination via telehealth platforms have enabled seniors with chronic conditions, who need continuous management and monitoring, to access healthcare services conveniently and promptly.

However, the successful implementation of telehealth for seniors in rural areas, like Sumter, South Carolina, will depend on addressing challenges, including technological literacy, access to internet-enabled devices, and limitations in broadband infrastructure. Policies supporting telehealth reimbursement and licensure flexibility were crucial in promoting the adoption of telehealth among healthcare providers and ensuring

sustainable access to telehealth services for seniors.

In conclusion, telehealth held great promise for improved access to care for seniors living in Sumter, South Carolina, and similar rural communities. By leveraging telehealth technologies, healthcare providers overcame geographic barriers and delivered high-quality healthcare services to elderly populations, enhancing their overall health outcomes and quality of life. Moving forward, efforts to promote telehealth adoption among seniors in Sumter focused on addressing technological barriers, expanding broadband infrastructure, and implementing supportive policies and reimbursement mechanisms. Collaborative initiatives involved healthcare providers, policymakers, community organizations, and telecommunication companies are essential to ensure equitable access to telehealth services for seniors and maximize telehealth's benefits in improving healthcare delivery for elderly populations in rural areas.

Chapter 3: Research Method

This qualitative study was conducted to evaluate the effects of telehealth on access to care by examining the experiences of seniors 50 and over who reside in Sumter, South Carolina. The purpose of the study was to analyze the lived experiences of seniors in Sumter, South Carolina, about their access to care, use, and perception of telehealth services. This phenomenological research explored seniors' subjective experiences and perspectives, aiming to understand their interactions with healthcare services, the challenges and barriers they face in accessing care, and their lived experiences with telehealth within the specific geographic area of Sumter, South Carolina. The exploration of the subjective experiences of individuals, specifically seniors in Sumter, South Carolina, who accessed healthcare services and telehealth, was facilitated by phenomenology as a research methodology. This approach emphasized understanding participants' lived experiences and aimed to capture their nuanced viewpoints and challenges (Creswell et al, 2013). To justify why the research approach was appropriate, the chapter outlined the study's research design and rationale. The chapter equally included a discussion of the researcher's role, applicable methods for the research, recruitment of participants, procedures for data collection, information about the instrumentation used for the study, data collection, analysis of the data, issues of trustworthiness, and ethical considerations.

Research Design and Rationale

The research was guided by the following set of RQs:

- RQ 1: What are the perceived experiences of seniors living in Sumter, South

Carolina, with telehealth utilization?

- RQ 2: What are the perceived experiences of seniors with access to care living in Sumter, South Carolina?
- RQ 3: What factors influenced telehealth use and access to care? Appendix B contains the survey demographic questions for the study.

The study adopted a phenomenological approach to investigate seniors' subjective experiences and perceptions of telehealth use and access to care in Sumter, South Carolina. This approach enabled a thorough exploration of the meaning and essence of these experiences from the participants' perspectives, leading to a deeper understanding of their healthcare needs and challenges. The study's focus on subjective meaning attributed to these experiences allowed me to uncover nuanced insights that quantitative methods alone cannot.

Purposeful sampling was employed to identify individuals who could offer diverse and valuable insights into the phenomenon under study. Purposely sampling seniors 50 and over living in Sumter, South Carolina, ensured representation across demographic factors, including age, gender, socioeconomic status, and health conditions. Participant perspectives and lived realities are prioritized in phenomenology, making their voices the center of the research process. Through this participant-centered approach, the study was conducted to understand the perceptions and experiences of seniors in their unique social and cultural contexts. To explore the experiences, perceptions, and challenges related to telehealth and access to care, semistructured interviews were used for collecting data. Participants were allowed to freely express

themselves and provide rich narratives through the flexibility of questioning provided by this method.

Thematic analysis was selected as the data analysis method to identify patterns, themes, and meanings within the interview data. Through this approach, participants' narratives were systematically explored, leading to the emergence of critical themes that captured the essence of their lived experiences with telehealth and access to care. The semistructured interviews enabled the collection of rich, qualitative data, providing a detailed account of the participants' experiences, emotions, and perspectives. Thematic analysis increased comprehension by systematically organizing and interpreting data to reveal hidden themes and patterns. The relevance to healthcare practice and the rationale for focusing on telehealth utilization, access to care, and perceived lived experiences led the study to aim for findings directly relevant to healthcare practitioners, policymakers, and stakeholders involved in addressing the healthcare needs of seniors in Sumter, South Carolina.

Role of the Researcher

I played a crucial role in the research process, helping to collect, analyze, and interpret data while maintaining ethical standards and rigor. I needed to be receptive to recognizing personal biases, assumptions, and preconceptions that affected the study's outcomes (Finlay, 2002). Phenomenological inquiry necessitated that I move beyond data collection to incorporate reflexivity and interpretation. In this way I was able to gain a deeper understanding of seniors' lived experiences with telehealth by acknowledging and addressing their biases (Haque, 2021). The findings demonstrated the need for targeted

interventions to address disparities in telehealth access among seniors in Sumter, South Carolina.

I facilitated the entire research process, from conceptualization to dissemination of findings. I was responsible for designing the study, selecting appropriate methods, and overseeing data collection and analysis. I created a supportive and non-judgmental atmosphere to foster open communication and ensure that participants felt comfortable sharing their experiences. The study's success depended on establishing rapport and trust with the participants. Semistructured interview techniques were used to conduct interviews with seniors in Sumter, South Carolina. Active listening techniques helped to obtain detailed narratives and insights from participants about their telehealth experiences, access to care, and perceived lived experiences. I also ensured that ethical principles were upheld. Obtaining informed consent from all participants is essential while respecting their autonomy and right to privacy. Participation is carefully analyzed and communicated while keeping participants' information confidential and identifying potential risks or benefits.

I also conducted a thematic analysis of interview data, identifying patterns, themes, and meanings in the participants' narratives. It was important to approach data analysis with openness and curiosity, allowing emergent themes to guide the interpretation process. Member checking was done to ensure that the interpreted themes were accurate and reflected the participants' voices. Through the research process, the study provides valuable insights into the telehealth experiences and healthcare needs of seniors in Sumter, South Carolina.

Methodology

Participant Selection Logic

This phenomenological study's participant selection and recruitment process aimed to capture diverse experiences and perspectives related to telehealth utilization, access to care, and perceived lived experiences among seniors living in Sumter, South Carolina. Seniors 50 and over were included in the study to ensure that the participants fell within the target demographic group. This excluded individuals who were either younger or outside of this age bracket. The participants who resided in Sumter, South Carolina offered insights specifically to the local healthcare context and resources available in the community. Efforts were made to incorporate participants from varying socio-economic backgrounds, ethnicities, and health statuses to portray a broader range of seniors in Sumter. The selection criteria ensured a diverse demographic profile, capturing a variety of viewpoints on telehealth and access to care among seniors in the community.

Purposive sampling was employed to select participants who could provide rich and varied insights into the phenomenon being studied. This approach enabled the deliberate selection of participants based on their relevance to the research objectives (Creswell & Poth, 2018). The focus of recruitment efforts was collaboration with local senior centers, healthcare facilities, and community organizations in Sumter, South Carolina. Using this approach facilitated access for potential participants and established rapport with the target population. Referrals from healthcare providers, community leaders, and existing study participants were also used to recruit participants. This

strategy enhances the study's credibility, and seniors who may otherwise be hesitant were encouraged to participate. Efforts were made to include seniors from diverse socioeconomic backgrounds to ensure that the study captured the perspectives of individuals with varied access to resources and healthcare services. The study aimed to investigate the relationship between telehealth and access to care as well as the diverse healthcare needs and experiences of participants with varying health conditions and utilization levels. The sample size was determined by data saturation, indicating that additional interviews ceased to yield new information, signifying the achievement of thematic saturation (Guest et al., 2012).

The study focused on six to eight participants, with the possibility of adjusting the sample size based on emerging findings. The study's purpose, procedures, risks, and benefits were clearly explained to all participants to ensure they provided informed consent. Steps were implemented to ensure that participants' personal information and interview data remained confidential and anonymous, thereby protecting their privacy. The participants were assured that they were entirely free to participate and could resign from the study at any time without repercussions. By employing this participant selection logic, the study aimed to gather comprehensive insights into the telehealth experiences, access to care, and perceived lived experiences of seniors in Sumter, South Carolina, thereby contributing to a deeper understanding of healthcare delivery in the community.

Instrumentation

The most effective qualitative research methods used to gather data for this research objective included semi-structured interview questions, face-to-face and

teleconferenced interviews, and surveys (for demographic information). The primary data collection tool was a semistructured interview guide featuring open-ended questions. These questions aimed to explore participants' experiences, perceptions, and challenges related to telehealth utilization, healthcare access, and their overall experiences with healthcare services. The questions were customized to elicit detailed narratives and reflections from participants while providing room to explore emergent themes (Guest et al., 2012). Adams (2015) suggested that semistructured interviews, which include both open-ended and closed-ended questions, should not exceed one hour to avoid fatigue for both the researcher and respondents. For this study, the duration of interviews for each respondent will be approximately one hour.

Procedures for Recruitment, Participation, and Data Collection

The Recruitment Process

To recruit participants, I collaborated with local senior centers, healthcare facilities, and community organizations in Sumter to access potential participants. Information was provided about the study and contact details for participation inquiries by distributing recruitment flyers or posters in community spaces that are popular with seniors. I also used referrals from healthcare providers, community leaders, and existing study participants to identify eligible seniors interested in participating. Outreach efforts were also conducted through community events, social media platforms, and local newspapers to raise awareness about the study and encourage participation.

Participant Screening

I screened potential participants based on inclusion criteria, including age (50 and over), residency in Sumter, and willingness to share experiences related to telehealth and access to care. Participants' eligibility was determined, and I obtained informed consent before collecting data.

Informed Consent Process

Potential participants were provided with a comprehensive overview of the study's objective, methods, hazards, and advantages. I confirmed participants' rights, including confidentiality, voluntary participation, and the option to leave the study without any consequences. I also addressed any questions or concerns raised by participants regarding the study before obtaining their written or verbally informed consent. Finally, participants' consent was documented through signed consent forms or recorded verbal consent, ensuring compliance with ethical guidelines.

Data Collection

Interviews were conducted using a semi-structured format that allowed participants to feel comfortable and share their experiences either in person or via telecommunication platforms, based on their preferences and accessibility. The interview guide was followed to explore participants' telehealth experiences, access to care, and perceived lived experiences in depth, encouraging open-ended responses and probing for detailed narratives. Each session was recorded using audio recording equipment to ensure accuracy and completeness of data capture, and notes were taken during interviews to document critical points, observations, and participant responses, which aided in

interpretation and analysis. Throughout the data collection process, participants' privacy and confidentiality were respected, and sensitivity to their experiences and perspectives was maintained. Multiple interview sessions were conducted as needed to capture diverse viewpoints and achieve data saturation, ensuring that no new information emerged..

Participant Compensation

Participants were offered small incentives or compensation for their dedication and valuable contributions to the study, which could include gift cards or reimbursement for travel expenses. The compensation arrangement was communicated clearly during the informed consent process to ensure transparency and fairness.

Data Management

Collected data were safeguarded by storing audio recordings, transcripts, consent forms, and other study-related documents in secure electronic databases or file storage systems. Confidentiality and anonymity of participants' personal information were maintained by assigning unique identifiers to each participant to protect their privacy. Additionally, research data were regularly backed up to prevent loss or unauthorized access, adhering to established data management protocols and ethical standards.

Researcher Reflexivity

Adhered to and critically examined the researcher's biases, assumptions, and preconceptions that may influence data collection and interpretation throughout the research process, maintaining reflexivity. Documented reflexive insights and considerations in research journals or reflective memos, enhancing transparency and rigor in the research process. Following these procedures, the study aimed to recruit eligible

participants, facilitate their meaningful participation, and collect rich qualitative data on telehealth, access to care, and perceived lived experiences of seniors in Sumter, South Carolina, contributing valuable insights to healthcare research and practice.

Data Analysis Plan

Phenomenological data analysis was utilized to examine the interview data. Conducted a thematic analysis to identify recurrent patterns, themes, and interpretations within participants' narratives. This iterative process involved coding, categorizing, and interpreting the data to uncover underlying phenomena (Moustakas, 1994) through the following:

Transcription

Transcribed the interviews, accurately capturing the participants' responses, expressions, and nuances. Used transcription software or services to expedite the transcription process while ensuring the quality and fidelity of the transcripts.

Data Familiarization

Immersive engaged with the interview transcripts to comprehensively understand participants' narratives, experiences, and perspectives. Identify key themes, patterns, and significant statements that emerge from the data through repeated reading of the transcripts.

Initial Coding

Conducted initial transcripts coding by systematically identifying and labeling meaningful segments of text related to telehealth utilization, access to care, and lived experiences. Employed inductive coding techniques to capture anticipated and

unexpected themes, allowing for flexibility and openness in data analysis.

Thematic Analysis

Organized coded segments into preliminary themes and sub-themes based on their content, relevance, and frequency across the data set. Iteratively refined and consolidated themes by constantly comparing coded segments within and across transcripts, seeking convergence and divergence in participants' experiences. Used memos to document analytical insights, connections, and interpretations, facilitating reflexivity and transparency in the analytic process.

Interpretation and Meaning-Making

Engaged in in-depth interpretation of identified themes, seeking to understand the underlying meanings, contexts, and implications of participants' experiences with telehealth and access to care. Explored how participants' lived experiences shaped their perceptions, attitudes, and behaviors regarding healthcare utilization and engagement. Considered the influence of sociocultural, economic, and environmental factors on participants' experiences, recognizing the complexity and interconnectedness of their lived realities.

Synthesis and Reporting

Synthesized the interpreted themes into a coherent narrative that reflects the richness and diversity of participants' lived experiences with telehealth and access to care. Created a comprehensive research report that presents the study's outcomes, interpretations, and implications in an easy-to-understand format. Situated the findings within the existing literature on telehealth, healthcare access, and aging, highlighting their

contributions to knowledge, practice, and policy. Discussed the study's shortcomings, methodological considerations, and suggestions for future research to ensure transparency and reflexivity in reporting.

Demographic data were collected for study participants, which included basic statistics such as age, gender, ethnicity, and geographic location. In addition to basic demographic information, intended to gather comprehensive demographic information that included education level, socioeconomic status, technology experience, healthcare accessibility, family beliefs, and support. By collecting this demographic data, you can identify patterns or trends within the responses and recognize if certain themes or experiences are more prevalent among specific groups, such as age-related differences in the perceived lived experiences. Additionally, collecting demographic data will help ensure diversity in the sample, as the aim is to include participants from various demographic groups to capture a more comprehensive range of experiences and perspectives. Moreover, the data may help conduct comparative analyses to understand how different demographic groups experience the same phenomenon, which can lead to valuable insights into disparities or commonalities in their experiences. The study participants will be given a unique de-identified code to protect their anonymity. By following this data analysis plan, the study aimed to uncover the nuances and complexities of seniors' experiences with telehealth, access to care, and healthcare engagement in Sumter, South Carolina. This resulted in valuable insights that could be utilized to improve healthcare delivery and address the needs of aging populations.

Issues of Trustworthiness

Trustworthiness is essential to maintaining the credibility and validity of the results in qualitative research, particularly in a phenomenological study that explored subjects such as telehealth, access to care, and senior lived experiences. Recognizing the role of trustworthiness in this process is crucial, given the significant impact of this research on the field. To ensure the study's reliability and rigor, member checking was conducted, allowing participants to review and validate the findings (Lincoln & Guba, 1985). The credibility and dependability of the research were enhanced by collaborating with peers and maintaining an audit trail of decisions and processes (Creswell & Poth, 2018). Through rigorous methodological approaches and ethical considerations, the study aimed to address these trustworthiness issues and maintain the integrity and validity of its findings. This effort contributes valuable insights into understanding telehealth, access to care, and the lived experiences of seniors in Sumter, South Carolina. The study will specifically focus on ensuring credibility, transferability, dependability, and conformability, key components of research trustworthiness.

Credibility

In qualitative research, credibility corresponds to internal validity in quantitative research. The credibility of a study's results is important to readers and researchers. Engage in a collaborative member-checking process by involving participants in validating findings. Through this process, study participants can review and confirm the accuracy and relevance of identified themes, thus validating the preliminary results and interpretations. Incorporate participants' feedback and perspectives into the final analysis,

enhancing the credibility and trustworthiness of the study findings. The study's credibility was enhanced by participants being able to confirm the accuracy and authenticity of the interpretations through this collaborative approach. The triangulation method employs multiple data sources and methods (e.g., interviews, observations, and documents) to verify findings and perspectives, thereby reducing the risk of bias and enhancing the credibility of the research.

Transferability

Transferability ensures external validity by focusing on the applicability and relevance of findings beyond the specific study population. It enriches understanding by contributing new insights into existing knowledge. Detailed descriptions of the research context, participants, data collection methods, and analysis procedures enable readers to assess the study's relevance to different contexts. However, the thick description, a key method in this research, truly brings the study's richness to life. It presents thick, context-rich descriptions of participants' experiences, including direct quotations and illustrative examples, to convey the depth and complexity of their lived realities. This method enhances the transferability of our findings, allowing the audience to truly grasp the richness of this study.

Dependability

In qualitative research, dependability is assessed similarly to the reliability in quantitative research. It is deemed dependable when other researchers can replicate the data collection methods established by the original researcher. Transparent reporting of the study procedures can directly address the dependability issue, facilitating future study

replication, even if it does not necessarily yield identical results (Shento, 2004). All decisions, processes, and changes made during the research process were documented in a detailed audit trail maintained by the researcher. The study's procedures and findings can be replicated and verified through this thorough documentation, which enables transparency and accountability. Ask for input and feedback from colleagues and peers who are well-versed in qualitative research methods. Peer debriefing sessions enhance the study's dependability and instill confidence in the research process among the audience. These sessions offer opportunities for critical reflection and validation of analytical interpretations.

Confirmability

Confirmability is the process of verifying or corroborating the results with others. Lincoln and Guba (1985) asserted that audit trails were a key method for verifying qualitative findings. Engage in reflexivity by critically considering the researcher's biases, assumptions, and perspectives influencing the research process and findings. Documenting reflexive insights and considerations enhances transparency and self-awareness, contributing to the confirmability of the study. The researcher's positionality, including their background, experiences, and potential biases, should be acknowledged and transparently disclosed, allowing readers to assess how their standpoint affects the study outcomes.

Ethical Procedures

Ethical considerations were integral to every stage of the research process, from its design to implementation (Liu et al., 2019). The Institutional Review Board (IRB)

served as the initial measure to address any ethical concerns arising from the study. The expectation is for clear accountability to safeguard the rights and welfare of research participants, regardless of the type of research. The Walden Institutional Review Board (IRB) justifies ethical compliance when conducting research. Without exception, this research study will adhere to the ethical standards set by the IRB for approval by Walden University. Otherwise, credit will not be granted for the work done.

The research process was conducted in accordance with ethical guidelines. All participants were asked for informed consent, and their confidentiality will be safeguarded. Participants were guaranteed the option to withdraw from the study at any time without facing repercussions (Guest et al., 2012). They provided informed consent after understanding the study's objectives, procedures, risks, and benefits. I honored the participants' autonomy to withdraw from the study without consequence. By securely storing and anonymizing research data and safeguarding the privacy and sensitive information of participants, I ensured the confidentiality and anonymity of the participants.

Summary

The first part of this chapter introduces my research design. Exploring subjective experiences involved adopting a phenomenological approach. The focus is on understanding how seniors in Sumter, South Carolina, utilize telehealth, access to care, and their perceived lived experiences. The participants are seniors 50 and over in Sumter, South Carolina. Age, residency, and willingness to share experiences are the inclusion criteria used in the purposive sampling method for diverse demographic representation.

The primary approach for data collection included semi-structured interviews conducted face-to-face, via teleconference, and through online surveys (for demographic information). The purpose of this interview guide was to encourage responses that are not predetermined. Interviews are conducted either in person or through telecommunication platforms. Data capture can be achieved through audio recording and note-taking. A phenomenological data analysis approach was also used in this study. The transcription of interview recordings was documented. Identifying and interpreting patterns and meanings is achieved through thematic analysis. Throughout the analysis process, reflexivity remains intact. Trustworthiness strategies include member checking, peer debriefing, and maintaining an audit trail, all of which ensure credibility, transferability, dependability, and confirmability.

Ethical considerations were addressed through the use of informed consent. The confidentiality and privacy of participants' information are safeguarded. The participant's autonomy and right to withdraw are respected. Acknowledging the potential limitations of qualitative research, which include sample size constraints and inherent biases. A robust research methodology was employed in this phenomenological study to investigate the experiences of seniors in Sumter, South Carolina, regarding telehealth, access to care, and their perceived lived experiences. By employing rigorous data collection and analysis techniques, adhering to ethical guidelines, and ensuring trustworthiness, the study aimed to provide valuable insights into the healthcare needs and realities of seniors in the community, thereby contributing to the enhancement of healthcare services and policies.

Chapter 4: Results

The purpose of this qualitative phenomenological study was to explore the lived experiences of seniors 50 and older residing in Sumter, South Carolina, specifically in relation to their utilization of telehealth and access to care. Through in-depth interviews, I sought to uncover the lived experiences, emotions, and underlying motivations that shaped their perspectives, contributing to a nuanced understanding of the complex interplay between personal beliefs, professional obligations, and external influences in the context of telehealth usage among seniors in Sumter, South Carolina. Utilizing the qualitative phenomenological approach, I recruited seniors who have lived these experiences provided insight into the multifaceted dynamics influencing this critical decision-making process.

This chapter discusses the pilot study, the participants and their setting, data collection, data analysis, issues of trustworthiness, results, and a summary. The results are based on the study's three core research objectives or questions:

- RQ 1: What are the perceived experiences of seniors living in Sumter, South Carolina, with telehealth utilization?
- RQ 2: What are the perceived experiences of seniors with access to care living in Sumter, South Carolina?
- RQ 3: What factors influenced telehealth use and access to care?

The chapter begins with a description of the pilot study, which involved three senior participants residing in Sumter, South Carolina. The purpose of the pilot was to assess the feasibility and effectiveness of the research procedures, including the interview protocol

and data collection methods, prior to launching the main study. However, due to limited engagement—only three eligible participants responded—an alternative recruitment strategy was implemented. I then used snowball sampling, which was subsequently employed to expand the participant pool.

Data were collected through semistructured interviews conducted via Zoom, followed by a thematic analysis of the data. The thematic analysis provided an in-depth understanding of the data by identifying and analyzing patterns, themes, and meanings that emerged from participants' responses to the research questions. Quirkos-Web software was used to analyze the interview transcripts and generate codes, which were then developed into themes. This approach provided a comprehensive understanding of seniors' lived experiences with telehealth and access to care in rural Sumter, South Carolina. In addition to Quirkos Web, Google Forms was used to collect participant responses during the interview process, and Google Sheets was employed to organize and sort the data prior to importing it into Quirkos for analysis. These tools facilitated the structured collection and management of qualitative data, ensuring consistency across the dataset. The chapter concludes with a discussion of trustworthiness strategies employed to ensure the credibility, transferability, dependability, and confirmability of the findings.

Pilot Study

A pilot study was conducted to evaluate the effectiveness of the data collection tools and procedures in preparation for the main phenomenological investigation. Following Institutional Review Board (IRB) approval, three senior residents of Sumter, South Carolina, were invited via email to participate in the pilot study. These individuals

met the inclusion criteria of being 50 years or older, residing in Sumter County, and having had at least one experience using telehealth services within the past 12 months. Each participant received a notification letter that included a secure Qualtrics link with instructions to review and complete the informed consent form, followed by a brief demographic pre-screen and the interview scheduling process. The pilot interviews were conducted via Zoom beginning on September 13, 2024. The goal of this pilot phase was to enable me to engage with participants on a one-on-one basis and to evaluate the clarity, relevance, and sensitivity of the interview questions in capturing the lived experiences of seniors who use telehealth. The consent form, pre-screening questions, and interview protocol used in the pilot were identical to those planned for the main study, ensuring consistency in data collection. The only minor adjustment in the main study was the inclusion of a small participation incentive for those recruited through local senior centers.

The pilot study was instrumental in refining the research design. It confirmed that the interview guide was appropriate and aligned with the study's objectives, and that the Zoom platform was a viable and comfortable medium for participants to share their experiences. One challenge identified was the variability in internet connectivity, which occasionally disrupted the flow of conversation. This insight emphasized the importance of ensuring participants had access to stable internet connections for the main study. Overall, the pilot confirmed the clarity and relevance of the interview questions and the suitability of the Zoom platform for data collection.

Research Setting

Sumter, South Carolina, served as the setting for this research. Located in the central part of the state, Sumter is a small city with a population of approximately 40,000 residents, a significant portion of whom are elderly and reside in rural or suburban areas. This setting is particularly relevant for a study on telehealth and access to care, as rural communities frequently face challenges such as limited healthcare infrastructure, provider shortages, and long travel distances to medical facilities. In response to these longstanding barriers—and further catalyzed by the COVID-19 pandemic—the city has made efforts to expand access through telehealth initiatives (Hoffman, 2020).

Sumter's healthcare landscape includes a mix of local clinics, private practices, and regional hospitals, which together form the foundation of medical care in the area. Despite the increased availability of telehealth services during the pandemic, older adults continue to encounter significant obstacles, including limited broadband access, insufficient technological infrastructure, and challenges related to digital literacy. These factors pose critical barriers to equitable telehealth utilization among seniors, making Sumter a compelling and contextually rich location for exploring the lived experiences of elderly individuals navigating remote healthcare options (Hoffman, 2020).

Virtual meetings were conducted Zoom, which enabled the phenomenological exploration of telehealth, access to care, and the perceived lived experiences of seniors residing in Sumter, South Carolina. This virtual format facilitated in-depth interviews with seniors from diverse backgrounds and life experiences, providing a convenient, accessible, and safe environment for participants to engage in the study. The online

setting fostered open dialogue, allowing for a comprehensive examination of the complex interplay between personal beliefs, institutional policies, and broader societal influences that shape seniors' engagement with telehealth and their ability to access healthcare services.

Purposive sampling was employed to ensure a diverse representation of participants across various demographic factors, including age, race, gender, socioeconomic status, and health conditions. The aim of purposive sampling was to intentionally select individuals who could offer meaningful insights and represent critical perspectives relevant to the study's research questions (Kalu, 2019). This strategic selection process enriched the depth and breadth of the data collected, capturing a wide range of lived experiences and viewpoints.

Ethical considerations were carefully integrated into every stage of the research process to protect participant rights and uphold the integrity of the study. Informed consent, confidentiality, and data security protocols were strictly observed. Prior to the interviews, participants received a Qualtrics link that provided detailed information about the study, including a consent form that outlined the purpose, procedures, potential risks, and participant rights. This platform provided participants with the opportunity to review the inclusion criteria, ask questions, and confirm their voluntary participation. By combining a flexible, participant-centered virtual format with a purposeful and ethically sound research approach, the study generated rich, nuanced data that captured the lived experiences of seniors navigating telehealth and accessing care in Sumter, South Carolina.

Demographics

Demographic data were collected to provide contextual depth to the lived experiences of seniors 50 and older residing in Sumter, South Carolina. This information supported the interpretation of findings related to telehealth access, healthcare engagement, and perceived barriers to care. The demographic questionnaire included 13 items designed to capture participants' personal, socioeconomic, and healthcare-related characteristics. Participants were categorized into age groups to assess the distribution of older adults across the various stages of late adulthood. Age ranges included 50-59, 60-69, 70-79, and 80-89 years. This stratification allowed for comparative insights into how age may influence telehealth usage and access to care.

Race and ethnicity were self-reported. Although recruitment of the participants was designed to target all races and ethnicities, all participants identified as Black or African American, and none identified as Hispanic or Latino. This homogeneity in racial identity provided a focused lens on the experiences of Black seniors in Sumter, South Carolina, where historical and structural disparities in healthcare access may be more pronounced. Educational attainment was assessed based on the highest level of education completed. Participants reported a range of credentials, including associate degrees, bachelor's degrees, and graduate or professional degrees. This diversity in educational background offered insight into digital literacy and readiness for telehealth engagement.

Gender identity was also recorded, with participants identifying as either male or female. The sample included both genders, with a majority identifying as female. This distribution allowed for gender-based comparisons in perceptions of care and technology

use. Participants reported their current relationship status, including married, single, divorced, and widowed. These data provided context for understanding social support systems, which may influence healthcare decision-making and telehealth adoption.

Household income was assessed based on total combined earnings over the past 12 months, including income from employment, retirement benefits, and other sources. Income levels ranged from under $30,000 to over $90,000, reflecting a broad spectrum of financial circumstances among older adults. Employment status was self-reported, with participants indicating whether they were employed full-time, part-time, or retired. This data helped contextualize time availability, insurance coverage, and access to healthcare services. Health insurance coverage was examined through three questions: whether participants were insured, the type of coverage they held, and whether there were any gaps in coverage over the past 12 months. All participants reported continuous coverage, with types including private insurance, Medicare, TRICARE/VA, and other plans. Telehealth utilization was assessed by asking participants whether they had used telehealth services to consult with a healthcare provider in the past year. All participants confirmed at least one instance of telehealth use, indicating familiarity with virtual care platforms.

Finally, participants were asked whether they had access to technology and/or the internet. All reported having the necessary digital tools to engage in telehealth services, including smartphones, tablets, or computers with internet connectivity. The demographic data provided a foundational understanding of the participants' social, economic, and healthcare contexts. These insights were essential for interpreting the nuanced

experiences shared during interviews and for identifying patterns in telehealth engagement among older adults in Sumter.

Participant Profiles

The study included a total of seven participants, all of whom were Black seniors 50 and older. The age distribution was as follows: five participants (71.4%) were between 50 and 59 years old, and two participants (28.6%) were between 60 and 69 years old, with no participants in the 70–79 or 80–89 age ranges. Regarding sex, six participants (85.7%) were female, and one participant (14.3%) was male. All participants (7; 100%) identified as Black. Educational attainment varied among the participants: one (14.3%) held an associate degree, four (57.1%) held a bachelor's degree, and two (28.6%) had attained graduate or professional-level education. Marital status consisted of five participants (71.4%) who were married and two (28.6%) who were single.

Income levels spanned several categories, with one participant (14.3%) earning between $30,000 and $49,000, one participant (14.3%) earning between $50,000 and $69,000, one participant (14.3%) earning between $70,000 and $89,000, and four participants (57.1%) reporting incomes of $90,000 or more. Regarding employment status, five participants (71.4%) were employed full-time, and two participants (28.6%) were retired; none were employed part-time or unemployed. All participants (7; 100%) had health insurance coverage, with four (57.1%) enrolled in private plans, two (28.6%) covered by TRICARE or VA programs, and one (14.3%) covered by Medicare. No participants had other government-sponsored health plans. Technology access was universal among the group, with all seven participants (100%) reporting reliable access to

the internet and digital devices. Notably, four participants experienced a lapse in healthcare coverage within the past 12 months, a factor that may influence their use of telehealth services.

Data Collection

Data collection for this phenomenological study focused on capturing the lived experiences of seniors 50 and older residing in Sumter, South Carolina, their use of telehealth, and access to care. A total of 10 individuals expressed interest in participating, and seven met the inclusion criteria and were enrolled in the study. To ensure accessibility and accommodate participants' varying mobility and geographic constraints, interviews were conducted remotely using the Zoom platform. Zoom provided a secure and user-friendly environment for in-depth, one-on-one conversations. Each interview was conducted separately to maintain confidentiality and facilitate individualized engagement. Audio recordings of the interviews were captured using the Olympus WS-852 digital voice recorder, which ensured high-quality sound and reliable documentation of participant responses. Interviews were conducted over a three-month period, allowing for timely data collection and the systematic organization of materials for analysis.

Prior to each interview, participants were reminded of the voluntary nature of the study and their right to withdraw at any time or ask questions for clarification. Informed consent was reviewed verbally, followed by a written copy via email, and participants were given the opportunity to confirm their understanding before proceeding. Each interview lasted between 35 and 60 minutes, providing sufficient time to explore the study's core topics. A semistructured interview format was employed, allowing for both

consistency and flexibility in data collection. The interview protocol was guided by three central research questions and included 13 open-ended questions designed to elicit rich, descriptive narratives. Participants and I had opportunities for follow-up questions, which were used to explore emerging themes and clarify participant responses.

This approach enabled participants to share their perspectives, lived experiences, and insights in their own words. The use of open-ended and follow-up questions facilitated deeper exploration of individual viewpoints, particularly around telehealth utilization, barriers to care, and perceptions of healthcare access in Sumter, South Carolina. Upon completion of each interview, audio files were securely stored and later transcribed verbatim for analysis. The data collection process successfully captured the depth and nuance of participants' experiences, laying the foundation for thematic analysis and interpretation in subsequent chapters. Transcriptions were generated using Google Forms and manually reviewed for accuracy. Participants were invited to review their transcripts to ensure credibility through member checking.

Recording Device

I utilized the Olympus WS-852 digital voice recorder to capture voice recordings and written transcriptions of the interview responses. The recording device was used in the following manner. I recorded participant interviews using the digital voice recorder. The digital voice recorder was selected for its ease of use, portability, and high-quality sound capture capabilities. Before each interview, I would ensure the digital voice recorder's battery was fully charged and that the recording features were fully functional. The digital voice recorder was placed in a position where it could capture the

participant's responses while maintaining a comfortable interview environment. During the interview, the digital voice recorder recorded the participant's verbal responses to the interview questions, including any clarification answers to the follow-up questions asked by me. The device captured high-quality audio with minimal disruption, allowing for precise transcription later.

Transcription Process

After recording the interview, I auto-transcribes the data using Google Forms' built-in features to generate a preliminary transcription. Google Forms had automated transcription capabilities, to review and edit the generated text for accuracy and clarity. Using the digital voice recorder, I effectively captured the data needed for analysis while ensuring ease of access and accurate transcription. These tools enabled efficient and reliable documentation of the interviews, thereby contributing to the overall validity and rigor of the phenomenological study.

Data Analysis

The data collected from participant interviews were transcribed and analyzed using a thematic analysis approach. This process was guided by Creswell's (2013) qualitative data analysis framework, which involves systematic steps of data reduction, categorization, and theme development. To facilitate the organization and analysis of qualitative responses, I utilized Google Forms to collect and structure participant responses during and after the interview process. This digital tool allowed for efficient input of narrative data and ensured consistency in formatting across all participants. Once the responses were compiled, the data were exported into Google Sheets, where I

conducted an in-depth coding process.

Using Google Sheets, I applied open and axial coding techniques to identify recurring patterns, significant statements, and emerging themes. Codes were grouped into categories that reflected shared perceptions, experiences, and attitudes toward telehealth and healthcare access. These categories were then synthesized into broader thematic themes that captured the core of participants' lived experiences. This digital workflow not only streamlined the data management process; it enhanced the transparency and traceability of the analysis. Ultimately, the use of Google Forms and Google Sheets supported a rigorous and organized approach to uncovering the nuanced ways in which seniors in Sumter, South Carolina, perceive and experience telehealth as part of their healthcare journey. Thematic analysis was conducted using Google Sheets to organize and code the data. Open and axial coding techniques were applied to identify patterns and themes. Data saturation was achieved after seven interviews, with no new themes emerging. Sixteen distinct themes were identified and organized according to the study's three research questions. These themes were derived from three research questions:

- RQ 1: What are the perceived experiences of seniors living in Sumter, South Carolina, with telehealth utilization?
- RQ 2: What are the perceived experiences of seniors with access to care living in Sumter, South Carolina?
- RQ 3: What factors influenced telehealth use and access to care?

Coding Process and Generation of Themes

The coding process and theme generation involved several systematic steps to analyze the qualitative data collected from seniors regarding their experiences with telehealth. Data saturation marked a critical milestone in the code creation and theme generation process, indicating that the exploration of code creation and theme generation had been sufficiently comprehensive. It signified the point of data redundancy, where additional data collection provided no further insight, and a sufficient amount of data had been collected to thoroughly explore and understand the lived experiences of seniors in Sumter, South Carolina, and the decision to use telehealth services.

The study gathered data through in-depth interviews with seniors from Sumter, South Carolina. These interviews aimed to capture the participants' lived experiences with telehealth services, perceptions, challenges, and benefits. I initiated the open coding process once the data had been transcribed. This involved reading through the interview transcripts and identifying significant phrases, words, or statements directly related to seniors' experiences with telehealth. These initial codes were often descriptive, highlighting aspects such as "technology barriers," "provider communication," or "comfort with telehealth." After identifying initial codes, I grouped similar codes to form broader categories. For example, various codes related to technology challenges or issues with internet connectivity were grouped under "Technology Barriers."

The categories were further analyzed and refined, leading to the identification of key themes. I identified patterns in the data and linked the categories to more comprehensive themes that captured the essence of the participants' experiences. These

themes reflected recurring elements, including the accessibility of telehealth, the perceived effectiveness of virtual care, the role of caregivers, and the emotional impacts of telehealth services. To ensure the validity and reliability of the identified themes, I engaged in member checking, asking seven participants to review the themes and confirm if they accurately represented their experiences. This process helped refine the themes and provided additional insights into the seniors' perspectives.

The final analysis yielded 16 key themes that encapsulated the varied experiences and perceptions of seniors using telehealth services. These themes represented telehealth's positive and negative aspects, such as its convenience and potential for improved care, alongside technology, communication, and trust challenges, and are summarized in Table 3.

Table 3

Summary of Themes and Codes

Theme	Number of Codes
Navigating the Digital Healthcare Landscape: Challenges and Adaptations	5
Perceptions and Knowledge of Telehealth as a Care Option	4
Weighing the Benefits and Drawbacks of Telehealth	6
Perceived Limitations of Telehealth Compared to Traditional Care	5
Trust and Credibility in Virtual Healthcare	4
Influences of Trust in Healthcare Providers and Technology	3
Encouraging or Resisting the Expansion of Telehealth	4
Peer Influence on Healthcare Decisions	3
Skepticism and Confidence in Telehealth Outcomes	4
Financial Barriers to Healthcare Access	3
Social Support and Healthcare Access	3
Employment and Healthcare Accessibility	2
Community Resources and Healthcare Infrastructure	3
Other Structural or Personal Barriers to Care	3
Social and Cultural Influences on Telehealth Adoption	3
Barriers to Telehealth Utilization: Personal and Systemic Challenges	4

Note. Total number of themes = 16; total number of codes = 59.

Text Organized by Thematic Category

This section presents the findings organized by thematic category, allowing for a structured interpretation of participants' experiences. Grouping the data thematically highlights recurring patterns, shared meanings, and variations across narratives. Each theme represents a central idea that emerged from the analysis, supported by direct participant quotations to illustrate depth and context. This organization provides a clear framework for understanding how the data collectively address the study's research questions.

Table 4

List of Themes and Excerpts

Theme	Excerpts
Theme 1: Navigating the Digital Healthcare Landscape: Challenges and Adaptations	"Honestly, I find it pretty simple now. It became easy once I understood how to use the video call system. The hardest part is making sure my internet connection is strong. If it is not, everything starts freezing, and I get frustrated. However, when it works, I am satisfied because I can talk to my doctor without having to drive across town." (Participant 5e) "At first, I thought it would be complicated, but I was surprised how easy it was to set up the appointment. I still have trouble with the sound sometimes. I do not think telehealth is perfect, like when I must describe symptoms without a physical exam, but I do feel it helps me get care quicker than waiting for an in-person visit." (Participant 7g)
Theme 2: Perceptions and Knowledge of Telehealth as a Care Option	"I did not know much about telehealth before I started using it. I thought it was just for simple things like check-ins or prescriptions. I did not realize that I could talk to my doctor about most of my health issues through video calls. It has opened up more options for me, but I still wonder if it is as effective as seeing the doctor in person." (Participant 1a) "I had never heard of telehealth before last year. At first, I thought it was just a gimmick. I was unsure how a doctor could help me if they could not see me face-to-face. However, after using it for a while, I have come to understand that it is pretty convenient, especially for minor issues. I still prefer in-person visits for serious matters, though." (Participant 2b)
Theme 3: Weighing the Benefits and Drawbacks of Telehealth	"The biggest benefit of telehealth for me is that I can talk to my doctor without leaving the house. That is a huge convenience, especially in bad weather or when I am not feeling well. On the downside, though, I do not always feel like I get the personal touch that an in-person visit provides. I miss the connection of being in the same room with my doctor." (Participant 2b) "I appreciate the time saved with telehealth. No traveling, no waiting in the office—it is all much quicker. However, sometimes I feel like the doctor cannot really see everything that is wrong with me, especially with things that require a physical exam. I am still a bit skeptical about how well they can help me with serious issues without being able to touch or see me up close." (Participant 3c) "I think telehealth is a great option for seniors who have trouble getting out. It is convenient and saves time. However, I am not sure it is the right choice for all situations. For example, when I had an issue with my foot, I felt like the doctor could not truly diagnose it over the phone. It felt a little like I was getting rushed through. There is a place for it, but I am not ready to rely on it entirely." (Participant 5e) "The convenience of telehealth is undeniable. I do not have to leave home, and I can speak to my doctor without all the hassle of going to the clinic. However, sometimes the technology gets in the way—connections drop, and the video freezes. I also have doubts about whether it is as good as seeing the doctor in person for important health issues. Overall, it is good for some things, but I think there are still limitations." (Participant 6f)
Theme 4: Perceived Limitations of Telehealth Compared to Traditional Care	"One thing I worry about with telehealth is that the doctor cannot really examine me properly. For example, when I had an issue with my knee, I felt like it was hard for the doctor to understand how bad the pain was without physically touching it. I think that makes it harder to get an accurate diagnosis, and I am not sure how dependable that is." (Participant 1a) "I am concerned that telehealth is not as thorough as seeing a doctor in person. Sometimes, I need a hands-on examination to really understand what is going on with my health. Also, there is a bit of a disconnect when you are talking through a screen. It does not feel as personal, and I worry that important details might be missed during the conversation." (Participant 2b) I just do not feel as confident that I am getting the right care as I would with in-person visits." (Participant 4d)
Theme 5: Trust and Credibility in Virtual Healthcare	"I worry that the doctor might miss something important because they cannot examine me physically. I also wonder if they really know who I am, since I am talking to them through a screen and not face-to-face." (Participant 4d) "That makes me hesitant to trust telehealth completely. I think it can work for some things, but for anything serious, I want to see my doctor in person, where I feel like they can assess me better. I also worry about whether the doctor is really paying attention to me if they are distracted by the technology." (Participant 5e) "While I have used telehealth a few times, I still have concerns about how safe my personal information is. I have heard about all these cyberattacks and data breaches, and I am not sure how secure the telehealth platforms really are. I trust my doctor, but I do not know how much control they have over the platform's security. I wish they would explain that to me more clearly." (Participant 6f) "I have had some bad experiences with technology, like freezing screens or blurry video, and that makes me nervous. What if I miss something important or cannot explain my symptoms

Theme	Excerpts
	properly because the video is glitching? I do trust my doctor, but the technology behind telehealth makes me uneasy. I also wonder if the doctor really gets a full picture of my health without being able to physically check me out." (Participant 7g)
Theme 6: Influences of Trust in Healthcare Providers and Technology	"I trust my doctor, but I'm not sure I trust the technology behind telehealth. I have had good experiences with my doctor in person, but when it comes to telehealth, I am not always confident that the platform will work right. I trust the doctor to give me the best care, but I do not know if the technology can always help them do that as effectively." (Participant 1a) "I trust my healthcare provider because they have always treated me well, but I am a little skeptical about the telehealth platform they use. I know they have partnered with a well-known company, but I am still not sure if my information is secure. I have concerns about whether the company that runs the platform is invested in making sure everything works correctly, especially when it comes to protecting my personal data." (Participant 3c) "I trust my doctor, but I do not always trust the system that is set up for telehealth. It seems like the technology is not always reliable, and I do not feel like the hospitals or government agencies involved are doing enough to ensure the platforms are working smoothly. I worry that if there is a technical glitch or problem, I might not be able to get the care I need." (Participant 4d)
Theme 7: Encouraging or Resisting the Expansion of Telehealth	"I am actually all for the expansion of telehealth. It is so much more convenient for me, especially since I do not have to leave my house. There are a lot of people like me who struggle with transportation, and telehealth helps them access care without having to go anywhere. I think it is a great option that should be available to everyone." (Participant 1a) "I think telehealth is fine for some situations, but I am not sure it should be expanded too much. For things like minor check-ups, it is great, but when it comes to serious issues, I feel like in-person visits are necessary. I am worried that if we rely too much on telehealth, we will miss out on the personal connection with our doctors and the more thorough examinations that can only happen face-to-face." (Participant 2b) "I would encourage its expansion, but I do think there needs to be more education and training for seniors, especially those who are not very tech-savvy. If they can learn how to use it, I think telehealth can really make healthcare more accessible for everyone." (Participant 3c)
Theme 8: Peer Influence on Healthcare Decisions	"My son has been pushing me to try telehealth, saying it is so much easier and safer, especially with everything going on. I trust him, so I decided to give it a shot. He has always been a big advocate for technology, so it was hard to say no when he kept suggesting it. I do not know if I would have used it if he had not been so persistent." (Participant 4d) "I have heard some of my friends say that they tried telehealth and really liked it. They mentioned how convenient it was, especially not having to sit in a waiting room for hours. However, I am still a little skeptical. I think if more people I trust had better experiences with it, I might be more willing to try it. It seems like a good idea, but I am just not sure about it yet." (Participant 5e) "I was pretty against telehealth at first, but then my sister, who is a nurse, told me about how it works and how safe it is. Her opinion really mattered to me because I know she is knowledgeable about healthcare. After talking to her, I felt a lot more comfortable with the idea and ended up scheduling my first appointment. I think if she had not encouraged me, I might still be hesitant." (Participant 6f)
Theme 9: Skepticism and Confidence in Telehealth Outcomes	"There is definitely some skepticism on my part. I do not feel 100% sure that the treatment I am getting through telehealth is as effective as an in-person visit. Even if the doctor seems knowledgeable, how can I trust that they are making the right call based on just what I am saying over the phone or through a screen? I do not have the same level of confidence in the outcomes." (Participant 7g) "I have used telehealth for some basic consultations, and they have worked out okay, but I cannot help but wonder about the reliability of the whole process. Can the doctor really trust what I am telling them about my symptoms? And can they be sure of their diagnosis when they do not have the ability to see me face-to-face? I think the technology has a long way to go before I am completely confident in it." (Participant 6f) "I feel like telehealth might work for small problems, like a cold or getting a prescription refill, but for something more serious, I am not confident in its outcomes. How can a doctor make sure I am getting the right treatment if they cannot physically examine me? I feel like there is always that risk of them missing something important, and I am just not comfortable with that." (Participant 5e)
Theme 10: Financial Barriers to Healthcare Access	"Insurance is a big issue when it comes to telehealth. A lot of times, my plan does not cover virtual visits, or they only cover a limited number. I also must pay out-of-pocket for things like technology or internet if I do not already have them, and that can get expensive. I feel like healthcare is too costly, whether in person or through telehealth." (Participant 3c) "I have found telehealth to be a more affordable option in some cases, but it still is not cheap. Between paying for insurance and then dealing with co-pays or even the cost of my phone or internet to access the service, it all adds up. I am on a tight budget, so even small costs can

Theme	Excerpts
	make me hesitant to use telehealth. I feel like healthcare is getting increasingly expensive for us seniors." (Participant 4d) "It is not just the doctor's visit I worry about; it is all the other hidden costs. Some telehealth platforms are not covered by my insurance, and I end up paying extra for a consultation. On top of that, I must pay for internet service, which is not always affordable. I feel like there are so many financial barriers that prevent me from using telehealth regularly, even though I would like to." (Participant 5e)
Theme 11: Social Support and Healthcare Access	"I do not have family nearby, so I depend on my neighbors and a couple of friends to help me get to doctor's appointments. Sometimes it is difficult to ask for help, but I have learned that I need it. It is not always easy to make it to appointments on my own, especially when I am not feeling well, so their support really makes a difference." (Participant 2b) "I have a caregiver who helps me with things like transportation and making sure I take my medications on time. She has been such a great support system. Sometimes she even comes with me to my appointments, which is helpful because she can take notes and remind me of things I might forget. Having someone by my side makes a huge difference in how I feel about going to the doctor." (Participant 3c) "If it were not for my son, I would not be able to get the care I need. He helps me with transportation, especially for those who are far away. It can be hard to rely on others, but I really do not have any choice. He also provides emotional support, which I appreciate because going to appointments can be stressful. It is nice to have someone there to calm me down." (Participant 4d)
Theme 12: Employment and Healthcare Accessibility	"I still work part-time, and my job does not give me paid sick leave, which makes it hard to go to doctors' appointments. I cannot afford to take time off without losing income, so I often must schedule appointments around my work hours, which is not always possible. It is frustrating because I know I need to see a doctor, but work is a constant barrier." (Participant 1a) "I work full-time, and my employer provides insurance, but the co-pays and deductibles are so high that I often delay going to the doctor. It is hard to find time during the workday, and even when I do, I must deal with the financial burden of the visits. If my insurance were more affordable or my schedule more flexible, I would be able to get the care I need without stressing over how I am going to pay for it." (Participant 2b) "I used to work full-time, but I had to retire early because I could not keep up with the demands of my job and the healthcare I needed. I did not have sick leave, and I often had to choose between going to work and going to the doctor. I had to miss appointments many times because I could not afford to take time off. It was a tough situation, and it impacted my health." (Participant 3c)
Theme 13: Community Resources and Healthcare Infrastructure	"I live in a rural area, and access to healthcare is a real issue. The nearest clinic is over 30 miles away, and there is no public transportation to get there. If I need to go, I must rely on family or friends to drive me, which is not always possible. I wish there were more local healthcare resources or clinics that could help people like me who do not have easy access to transportation." (Participant 1a) "The community healthcare resources are lacking, and that makes things difficult for me. There is a pharmacy nearby, but it is hard to get the medications I need in a timely manner, especially if they are not in stock. There are also no affordable clinics around, and I do not qualify for some of the programs that could help me with healthcare access. I really wish there were more support here for seniors who struggle with transportation and limited options." (Participant 4d) "The local policies do not help either, as there is a lack of funding for programs that could assist with transportation or make healthcare more accessible." (Participant 5e)
Theme 14: Other Structural or Personal Barriers to Care	"I have trouble with my knees, so it is hard for me to get around. I struggle with walking long distances, and even getting to the car can be painful. I have missed appointments because of it, and sometimes I must reschedule because I physically cannot make it to the clinic. If the doctor's office had more accessible transportation or could help with mobility, it would make a huge difference." (Participant 2b) "I have no one to help me with transportation. I used to drive, but my vision is not what it used to be, and I cannot trust myself behind the wheel anymore. I have had to miss doctor's appointments because I cannot get there on my own. It is frustrating because I know I need to see a doctor but getting there is a constant struggle." (Participant 5e) "I have tried to use telehealth before, but I am not very good with technology. I get frustrated trying to set it up, and sometimes I give up. My computer is not easy to use, and the programs they use for telehealth visits are confusing to me. I wish they would offer more in-person visits because I know I would get the care I need if I could get there." (Participant 6f)
Theme 15: Social and Cultural Influences on Telehealth Adoption	"I have heard a lot of mixed opinions about telehealth from my church community. Some people think it is a great way to get healthcare, but others are skeptical because they believe it is too impersonal. I am still not convinced. I feel like seeing a doctor in person is better, but I am slowly warming up to the idea because of what people around me are saying." (Participant 2b)

Theme	Excerpts
	"The media portrays telehealth as being convenient and high-tech, but I am not sure I believe all of it. I have seen ads and news stories that make it sound like the perfect solution, but I am not completely sold. My neighbor, a bit older than I, is against it, and her views have influenced my thinking. I have decided to wait a little longer before I try it." (Participant 3c) "I come from a very traditional family, and we have always preferred face-to-face interactions. My family still thinks that seeing a doctor in person is the best way to go. I have had some conversations with them about telehealth, and they do not see the benefits. Their opinions have made me cautious, even though I know telehealth might be easier for me in some situations." (Participant 4d) "It makes me nervous, too. If I had more support from my community and trusted sources, I would be more likely to use it, but I am a bit hesitant." (Participant 5e)
Theme 16: Barriers to Telehealth Utilization: Personal and Systemic Challenges	"I do not know much about computers, and every time I try to use telehealth, I get frustrated. The technology is difficult for me to understand, and it takes a long time to figure things out. I have tried calling customer support a few times, but it is different from seeing a doctor in person. I do not feel comfortable using it at all." (Participant 1a) "I have had some bad experiences with telehealth in the past…I prefer the face-to-face interaction because it is easier to communicate, and I feel more comfortable." (Participant 2b) "Every time I try to join a telehealth appointment; the connection is so bad that it is not even worth it. If I had better access to the internet, I might feel differently, but right now, it is just not practical." (Participant 3c) "I really do not trust telehealth. I have seen all these stories on the news about people's personal information being stolen or misused online. I do not feel secure with virtual consultations, and I do not think I would get the same quality of care that I do when I see my doctor in person. Plus, I do not think my insurance covers telehealth well enough for me to want to pay for it." (Participant 4d)

Thematic Analysis

Thematic analysis of the interview data yielded 16 distinct themes that reflect seniors' lived experiences with telehealth and access to care. These themes illuminate how older adults perceive, navigate, and respond to telehealth as a mode of healthcare delivery. The findings offer nuanced insights into both the benefits and barriers associated with telehealth utilization, particularly in the context of accessibility, trust, technological literacy, and social support. The results are organized by research question to ensure clarity and alignment with the study's purpose. Participant narratives support each theme and reflect recurring patterns across the dataset. Themes of the first research question- RQ1: What are the perceived experiences of seniors living in Sumter, South Carolina, with telehealth utilization?

Theme 1: Navigating the Digital Healthcare Landscape: Challenges and Adaptations

This theme captures the participants' initial struggles and gradual adjustment to using telehealth platforms. Many described early difficulties with logging into systems, unreliable internet connections, and a general lack of familiarity with digital tools. These technical challenges often led to frustration, embarrassment, and communication barriers—such as poor audio quality and video glitches. Participants also expressed concerns about the limitations of remote care, particularly the inability to receive physical examinations. Participant 1a shared,

> At first, I had trouble understanding how to log into the system and connect with my doctor. I am not very tech-savvy, so it was frustrating. However, I got the hang of it after a couple of appointments. The video calls are nice, but sometimes the connection is shaky, and I cannot hear the doctor. It is easier than going to the clinic, but I prefer in-person visits.

Similarly, Participant 2b stated,

> I do not mind using telehealth, but I initially had issues getting the right technology. I did not have a good camera on my phone, so I had to get a new one. Now, I am okay, but I still do not like it when there are glitches. I often ask the doctor to repeat things because the sound cuts out. It works, but not always as well as I would like.

Participant 3c reflected on a particularly difficult start:

> My first experience was a disaster! I could not figure out how to connect to the

> call. I kept getting disconnected and felt embarrassed because I did not know what I was doing. After that, I got help from my daughter to set it up, and it has been smoother. However, there is still the issue of not being able to have the doctor physically examine me, which makes me nervous.

Despite these obstacles, most participants described becoming more comfortable with telehealth over time. Some upgraded their technology or sought help from family members, which improved their experience. Although telehealth was not viewed as a complete replacement for in-person care, it was generally appreciated for its convenience and accessibility, especially when the technology functioned reliably. These reflections highlight the complexity of navigating digital healthcare services and the adaptive strategies employed by older adults to engage in remote care.

Theme 2: Perceptions and Knowledge of Telehealth as a Care Option

This theme captures the evolving understanding and attitudes among seniors toward telehealth. Participants expressed a range of perceptions—from early confusion and skepticism to growing trust and appreciation of telehealth's role in improving healthcare access. Several participants initially lacked clarity about what telehealth entailed or doubted its effectiveness for comprehensive medical care. Participant 4d admitted,

> I do not understand how telehealth works, to be honest. I know I am supposed to see a doctor through the computer, but I still do not know what can be treated this way. I guess I still think of telehealth as something for minor check-ups or follow-ups, but I am not sure it can replace regular doctor visits.

Similarly, Participant 5e shared assumptions about telehealth being limited to younger or urban populations, stating,

> When I first heard about telehealth, I thought it was just for people in the city or younger people who are good with gadgets. However, I have learned it is beneficial, especially for people with trouble getting out. I still have many questions, though, like whether it is okay for serious issues and if the doctor can understand everything without seeing me in person.

Over time, however, some participants reported a shift in their understanding as they gained more experience with telehealth. Participant 6f reflected,

> I have been using telehealth for a few months and have grown to trust it. I thought it was mostly about prescriptions or simple advice, but I can talk much more. My doctor listens to me just as much as they would in person, and I appreciate that. It is a great option for people like me who no longer drive.

These narratives illustrate how perceptions of telehealth evolve with exposure and use. While initial concerns centered on unfamiliarity, perceived limitations, and questions about effectiveness, direct experience often led to increased confidence and acceptance. This theme emphasizes the importance of ongoing education and support in enabling older adults to better understand and adopt telehealth as a viable and valuable healthcare option.

Theme 3: Weighing the Benefits and Drawbacks of Telehealth

This theme captures the nuanced and often ambivalent perspectives seniors hold toward telehealth as a mode of healthcare delivery. While participants consistently

acknowledged its convenience and efficiency, they also expressed reservations about its ability to fully replace in-person care—particularly for more complex health concerns. Participant 3c emphasized the time-saving nature of virtual visits, stating,

> No traveling or waiting in the office makes it much quicker.

Similarly, Participant 5e noted,

> It is convenient and saves time, especially for those with mobility challenges.
>
> These comments reflect a shared appreciation for the logistical ease telehealth offers, particularly for routine check-ups and medication consultations.

However, participants also voiced skepticism about the clinical adequacy of telehealth. Participant 7g articulated this tension clearly:

> Honestly, I like the idea of telehealth, and it is great for check-ups or talking about medication. However, it is not always as effective as an in-person visit. She added, I sometimes feel like I am not being fully heard or examined, highlighting concerns about the emotional disconnect and lack of attentiveness in virtual interactions.

Participant 5e shared a similar experience, recounting a situation where telehealth fell short:

> When I had an issue with my foot, I felt like the doctor could not truly diagnose it over the phone. These reflections underscore a recurring sentiment among seniors—that while telehealth is efficient, it may lack the tactile and visual cues necessary for thorough assessment.

Taken together, these perspectives suggest that seniors view telehealth as a

valuable complement to traditional care rather than a complete substitute. Its strengths lie in accessibility and convenience, but its limitations in physical examination and emotional engagement temper enthusiasm. The theme reveals a thoughtful weighing of benefits and drawbacks, pointing to the need for a balanced integration of telehealth within broader healthcare strategies.

Theme 4: Perceived Limitations of Telehealth Compared to Traditional Care

This theme highlights seniors' concerns about the adequacy of telehealth when compared to traditional, in-person care. While participants acknowledged the convenience of virtual visits, they consistently emphasized what telehealth lacks—particularly in terms of physical examination, emotional connection, and diagnostic confidence. Participant 3c captured this sentiment, stating,

> Telehealth is convenient, but I do not think it is enough when I have a health problem that needs a physical check. If I am having chest pain, I need someone to listen to my heart or check my blood pressure.

Her comment reflects a broader unease about the limitations of telehealth in providing hands-on assessments, which many seniors view as essential for accurate diagnosis and reassurance.

Participant 4d echoed this concern, noting,

> I have had a couple of telehealth appointments where I felt like the doctor did not understand the severity of my symptoms because they could not see or touch me. She added, There is always the risk of misdiagnosis when the doctor is just going off what I say and cannot physically examine me, underscoring the perceived

limitations of virtual care in capturing the full scope of a patient's condition.

Communication challenges were also a recurring theme.

Participant 5e observed,

> When I use telehealth, I sometimes feel like I am not communicating as well as in person. It is harder to explain exactly how I feel when I cannot point to something or show the doctor in real time. Her experience illustrates how the absence of face-to-face interaction can hinder clarity and increase the risk of miscommunication.

Taken together, these reflections reveal that while telehealth offers practical benefits—such as accessibility and time savings—it is not perceived as a complete replacement for traditional care. Seniors value the sensory, relational, and diagnostic dimensions of in-person visits, and their comments suggest that telehealth should be positioned as a complementary tool that enhances access while respecting the need for physical presence in specific healthcare scenarios.

Theme 5: Trust and Credibility in Virtual Healthcare

This theme captures the layered and conditional nature of seniors' trust in telehealth, focusing on both the reliability of the technology and the perceived credibility of healthcare providers operating through virtual platforms. While participants acknowledged the potential of telehealth to deliver care, they also expressed reservations about its security, diagnostic accuracy, and the emotional quality of virtual interactions. Participant 3c reflected this duality, stating,

> I have had a few telehealth appointments now, and while I trust my doctor, I am

> unsure how secure the platform is. Her concern about data privacy—despite assurances of encryption—reveals a persistent skepticism about the safety of personal health information online. She also noted a diminished sense of connection, adding, Some of the personal connection I have with my doctor is lost when we are not in the same room together, highlighting how virtual care can feel impersonal.

Participant 4d echoed these concerns, questioning the clinical reliability of telehealth:

> I do not know if I trust telehealth to give me the same level of care as an in-person visit. She worried that the lack of physical examination could lead to missed diagnoses and described the screen as a barrier to authentic engagement: Sometimes, I feel like the technology is more of a barrier than a help.

Participant 5e added another layer to the issue, citing stories of misdiagnosis and inattentiveness during virtual consultations:

> I have heard of cases where people got the wrong treatment because they were misdiagnosed over the phone or through a video call. She emphasized the importance of face-to-face care for severe conditions and expressed concern about whether doctors are fully present during virtual visits: I also worry about whether the doctor is paying attention to me if they are distracted by the technology.

Together, these reflections reveal that seniors' trust in telehealth is not automatic—it must be earned through secure platforms, attentive care, and meaningful interactions. While provider credibility can help mitigate concerns, technological unfamiliarity and emotional distance remain significant barriers. For telehealth to be fully

embraced, it must not only function reliably but also foster a sense of safety, personal connection, and professional competence.

Theme 6: Influences of Trust in Healthcare Providers and Technology

This theme captures how seniors' trust in healthcare providers and the digital platforms used to deliver care jointly shape their willingness to engage with telehealth. Trust was not viewed as a singular concept tied solely to technology; instead, it was relational, experiential, and conditional—built through familiarity with providers and mediated by the perceived reliability of the tools used. Participant 1a reflected this dynamic, stating,

> I trust my doctor, but I am not sure I trust the technology behind telehealth. While her confidence in the provider was strong, she expressed uncertainty about the platform's ability to support effective care, especially in terms of functionality and reliability.

This distinction between provider trust and technological trust was echoed by Participant 2b, who noted,

> I feel good about using telehealth because my healthcare provider has been offering it for a while now, and they have always been reliable. However, she added a layer of skepticism about the broader system, saying, I am unsure if I trust the insurance or tech companies behind it… I wonder if they focus more on saving money than ensuring the service is safe and effective.

Participant 3c further emphasized concerns about data security and corporate responsibility:

> I trust my healthcare provider because they have always treated me well, but I am skeptical about their telehealth platform. Despite the provider's partnership with a reputable company, she remained uneasy about whether her information was truly secure and whether the platform developers were committed to maintaining high standards.

Together, these reflections reveal that seniors' trust in telehealth is multifaceted. While strong relationships with providers can encourage engagement, concerns about the motives and reliability of technology companies and insurers can undermine confidence. For telehealth to be fully embraced, it must not only be delivered by trusted professionals but also operate on secure, transparent, and responsive platforms that cater to the emotional and cognitive needs of older adults.

Theme 7: Encouraging or Resisting the Expansion of Telehealth

This theme captures the diverse and sometimes conflicting attitudes seniors expressed toward the broader adoption of telehealth. While many participants recognized its potential to improve healthcare access—particularly for those with mobility or transportation challenges—others voiced hesitation, citing concerns about technological reliability, quality of care, and generational fit. Participant 3c reflected a supportive stance, stating,

> I have had positive experiences with telehealth, and I think it is a great option for people who have trouble getting to appointments. She emphasized the importance of digital literacy, suggesting that more education and training for seniors could help bridge the gap for those less familiar with technology. Her comments

> highlight a belief that telehealth can be empowering if seniors are equipped with the tools and knowledge to use it effectively.

In contrast, Participant 4d expressed resistance to telehealth's expansion, citing technical issues and doubts about its clinical reliability:

> It is less reliable than in-person care, especially for complicated health problems. She recounted experiences with dropped calls or fuzzy videos, raising concerns that such disruptions could compromise care quality and deter others from embracing the technology.

Participant 5e offered a balanced perspective, supporting telehealth's growth in underserved areas while cautioning against its overuse:

> I support telehealth and think it should be expanded, especially in rural areas with limited healthcare access. However, she stressed that it should be an option, not the only option, underscoring the need to preserve in-person care for situations where physical presence is essential.

Together, these reflections reveal that seniors' attitudes toward telehealth expansion are shaped by personal experience, perceived technological competence, and the nature of their healthcare needs. While many view telehealth as a valuable tool for increasing access, especially in cases of logistical or geographic constraints, others remain wary of its limitations. The theme suggests that future telehealth models must strike a balance between innovation and empathy—ensuring that technological progress enhances, rather than replaces, meaningful patient-provider relationships.

Theme 8: Peer Influence on Healthcare Decisions

This theme captures the significant role that social networks—friends, neighbors, family members, and community peers—play in shaping seniors' decisions about engaging with telehealth. The data revealed that peer influence often carried more weight than formal healthcare messaging, particularly when participants were uncertain or unfamiliar with virtual care. Seniors frequently relied on the experiences and endorsements of those around them to assess the credibility, usefulness, and accessibility of telehealth services. Participant 7g described how social media exposure influenced her decision:

> I do not know anyone who uses telehealth, but I have seen many people discussing it on social media. The more I saw others posting about their good experiences, the more curious I became. Her comment illustrates the power of social proof—seeing others succeed with telehealth sparked her curiosity and ultimately led her to try it herself.

Participant 3c shared a similar experience rooted in face-to-face community interaction:

> My neighbors were talking about telehealth at our local community center, and they all seemed to have positive things to say about it. Their endorsement, especially in the context of shared mobility challenges, made her more open to exploring telehealth as a viable option.

Participant 5e offered a more cautious perspective, noting,

> Some friends said they tried telehealth and liked it… However, I am still skeptical. If more people I trust had better experiences with it, I might be more

willing to try it. Her statement reflects the conditional nature of peer influence—while positive feedback can encourage openness. Trust must be built through repeated and reliable experiences within one's social circle.

Together, these reflections underscore the significant role of peer influence in the adoption of telehealth among seniors. Encouragement from trusted individuals—whether through direct conversation or online sharing—can ease skepticism and foster engagement. This theme suggests that community-based outreach and peer-led education may be especially effective in promoting telehealth among older adults, as relational trust often proves more persuasive than institutional messaging.

Theme 9: Skepticism and Confidence in Telehealth Outcomes

This theme encompasses the diverse range of beliefs seniors hold regarding the clinical reliability and effectiveness of telehealth. While some participants expressed growing confidence in virtual care for routine needs, others remained skeptical—particularly when it came to diagnosing complex conditions or receiving thorough treatment. Their reflections reveal that confidence in telehealth is conditional, shaped by the nature of the health concern and the perceived limitations of remote assessment. Participant 1a voiced strong reservations about telehealth's diagnostic capabilities, especially for severe conditions:

I am just not sure about the accuracy of telehealth. If I am dealing with something serious, like a heart issue, I do not think a doctor can diagnose it properly without physically examining me. Her concern centered on the absence of tactile and auditory assessments, such as listening to the heart or checking blood pressure,

> which she felt were essential for accurate diagnosis.

Participant 2b echoed this skepticism, noting that while telehealth worked well for routine follow-ups, its effectiveness for more complex problems remained questionable:

> I am not convinced that telehealth is the best way to treat serious health issues, especially if a doctor cannot do a thorough physical exam. This statement reflects a broader uncertainty about whether virtual care can match the diagnostic precision of in-person visits.

Participant 3c added to this concern, focusing on the perceived gap in care quality:

> I find it hard to trust that the diagnosis is correct when the doctor relies on a screen. I feel like they might miss something that they would catch during a physical examination. Her comment underscores a lack of confidence in the depth and attentiveness of virtual interactions, particularly when physical cues are absent.

Together, these reflections illustrate that seniors' trust in telehealth outcomes is highly context-dependent. While virtual care may be accepted for routine consultations, it is not widely viewed as a complete substitute for traditional, in-person visits. The perceived lack of sensory engagement and potential for misdiagnosis contribute to ongoing skepticism. This theme suggests that telehealth should be positioned as a complementary tool—effective for certain types of care, but not a replacement for the thoroughness and relational depth of face-to-face medical encounters.

Theme 10: Financial Barriers to Healthcare Access

This theme captures how financial constraints shape seniors' engagement with

telehealth and their broader perceptions of healthcare affordability. While participants acknowledged the potential of virtual care to reduce certain costs, they also highlighted persistent financial barriers—including insurance limitations, out-of-pocket expenses, and the affordability of necessary technology—that complicated access and decision-making. Participant 4d reflected on the mixed affordability of telehealth, stating,

> I have found telehealth to be a more affordable option in some cases, but it still is not cheap. She emphasized that even minor expenses—such as co-pays or the cost of internet access—can be prohibitive for seniors on fixed incomes*:* I am on a tight budget, so even small costs can make me hesitant to use telehealth.

Participant 5e expanded on this concern, noting that hidden costs often go unnoticed until they accumulate:

> My insurance does not cover some telehealth platforms, so I pay extra for consultations. On top of that, I have to pay for internet service, which is not always affordable. Her experience illustrates how gaps in coverage and access to technology can undermine the promise of telehealth as a cost-effective alternative.

Participant 6f added that even when insurance covers part of the visit, the remaining out-of-pocket burden can be significant:

> I would use telehealth more if it were more affordable… It is a tough decision when I must pay for a doctor's visit or other necessities. Her comment underscores the difficult trade-offs seniors often face between healthcare and other essential expenses.

Together, these reflections reveal that seniors are not resistant to telehealth's

future—they are pragmatic about its potential and clear-eyed about its limitations. Their experiences suggest that for telehealth to be genuinely inclusive, it must evolve in ways that reduce financial strain and accommodate the economic realities of aging populations. Affordability, coverage transparency, and equitable access to technology are essential components of a telehealth model that works for everyone.

Theme 11: Social Support and Healthcare Access

This theme captures the critical role of social support—both formal and informal—in shaping seniors' access to healthcare services, including telehealth. The data revealed that family members, neighbors, and caregivers often serve as essential facilitators, helping older adults overcome logistical, emotional, and technological barriers to care. Whether through transportation assistance, emotional encouragement, or help navigating appointments, these support systems have a significant impact on healthcare engagement. Participant 1a described the indispensable role her daughter plays in her healthcare routine:

> Without her help, I could not get to my doctor's appointments. She drives me wherever I need to go… and that emotional support is so important. Her comment highlights how social support extends beyond logistics, offering reassurance and guidance during medical encounters.

For seniors without a nearby family, community ties become vital. Participant 2b shared,

> I depend on my neighbors and a couple of friends to help me get to the doctor's appointments… their support makes a difference. She acknowledged the emotional difficulty of asking for help, but emphasized how essential it is,

especially when facing health challenges on one's own.

Participant 3c emphasized the value of professional caregiving, noting,

> I have a caregiver who helps me with transportation and ensuring I take my medications on time. She added that having someone accompany her to appointments helps with communication and memory, saying, She can take notes and remind me of things I might forget.

Together, these reflections illustrate that social support is a cornerstone of healthcare access for seniors. Whether provided by family, friends, or professional aides, such support helps older adults attend appointments, manage their care, and feel emotionally secure throughout the process. This theme suggests that strengthening social networks and caregiving infrastructure is essential for promoting equitable and consistent healthcare engagement among aging populations.

Theme 12: Employment and Healthcare Accessibility

This theme examines how seniors' employment status—whether full-time, part-time, or retired—affects their ability to access healthcare services, including telehealth. The data revealed that employment influences not only income and insurance coverage but also time availability, stress levels, and flexibility in managing health appointments. Participants described how work-related constraints, lack of paid sick leave, and limited insurance benefits created significant barriers to care. Participant 4d shared the financial strain of working while managing health needs:

> My job offers health insurance, but it is insufficient to cover everything… Even with the coverage, I have to pay a lot out-of-pocket for medications and

> treatments, which is a strain on my budget. She also noted the difficulty of taking time off due to workplace pressure, which further complicated her ability to seek regular medical care.

Participant 5e, who works in retail, emphasized the impact of unpredictable hours and the absence of paid sick leave:

> I lose wages if I am sick or need to go to the doctor… Sometimes, I wait until I cannot handle it anymore, which is not ideal. Her experience illustrates how employment can force seniors to delay care, even when it is urgently needed.

Participant 6f described the scheduling challenges of full-time work, stating,

> My work schedule does not allow me to take time off to see a doctor… I feel trapped by my work schedule and the lack of flexibility. Despite efforts to book appointments during breaks or after hours, she found that healthcare providers were often unable to accommodate her availability.

Together, these reflections highlight the complex interplay between employment and healthcare access for older adults. Work-related constraints—whether financial, temporal, or structural, can delay treatment, increase stress, and reduce the likelihood of consistent care. This theme suggests that improving healthcare accessibility for working seniors requires attention to workplace policies, insurance adequacy, and flexible scheduling options that support timely and affordable care.

Theme 13: Community Resources and Healthcare Infrastructure

This theme captures how the availability—or lack—of community resources and healthcare infrastructure directly influences seniors’ ability to access timely, quality care.

Participants described how local clinics, transportation services, outreach programs, and digital infrastructure shaped their healthcare experiences, particularly in relation to telehealth. Their reflections reveal that limited access to essential services often results in delayed care, increased reliance on emergency services, and heightened frustration. Participant 5e shared her struggle with overbooked clinics and underfunded local programs:

> The nearest clinic is always overbooked, and sometimes, I cannot get an appointment for weeks… I end up missing appointments or having to go to emergency rooms because of the delays. She emphasized that local policies and lack of funding for transportation assistance further compounded these challenges, making healthcare feel increasingly inaccessible.

Participant 6f echoed these concerns from a rural perspective, stating,

> I live in a small town… the local clinic is underfunded and does not always have the equipment or staff to provide the care I need. She also described difficulties obtaining timely medication refills and the burden of traveling over an hour to see a specialist, noting, Transportation is a huge issue. There is not enough support for seniors who do not have transportation.

Participant 7g added that even when clinics are available, their limited hours and unreliable transportation options create barriers:

> None are open after regular hours… I often rely on family members or a local volunteer driver service, which is not always available. She expressed concern that local healthcare policies fail to support seniors who require frequent care,

stating, More must be done to improve access to services in our community.

Together, these reflections highlight the critical role of community infrastructure in shaping healthcare access for older adults. Inadequate clinic availability, poor transportation networks, and limited outreach programs contribute to delayed treatment and increased reliance on emergency care. This theme suggests that strengthening community-based support—through expanded clinic hours, reliable transportation, and hybrid service models—is essential to ensuring equitable healthcare access for seniors, particularly in underserved or rural areas.

Theme 14: Other Structural or Personal Barriers to Care

This theme captures the less visible but deeply impactful barriers that seniors in Sumter, South Carolina, face when accessing healthcare. Beyond infrastructure and policy, participants described emotional hesitations, cognitive limitations, physical impairments, and systemic inefficiencies that complicate their ability to engage with both in-person and virtual care. These personal and structural challenges often intersect, creating compounded obstacles to timely and effective healthcare. Participant 3c highlighted the role of digital literacy and technological access in shaping her experience with telehealth:

> I do not know how to navigate telehealth platforms, and my internet connection is not great. I feel like I am missing out on many healthcare options because I cannot figure out how to use those online systems. Her hesitation to try new services reflects a broader concern among seniors who feel excluded from digital healthcare due to limited technical skills or unreliable connectivity.

Physical limitations also emerged as a significant barrier. Participant 4d shared,

> I have much trouble getting around due to my arthritis. Even getting to the pharmacy can be difficult. She explained that while she tries to schedule appointments close to home, that is not always possible, and her mobility challenges often force her to cancel or postpone care. Transportation was another recurring issue.

Participant 5e noted,

> I used to drive, but my vision is not what it used to be… I have had to miss doctor's appointments because I cannot get there alone. Her experience underscores how the loss of independence—whether due to aging, disability, or lack of support—can severely limit access to essential services.

Together, these reflections reveal that healthcare access is shaped not only by external systems but also by deep personal realities. Seniors face a complex web of barriers that include technological exclusion, physical impairments, and emotional vulnerability. Addressing these challenges requires more than expanding services—it demands empathetic communication, tailored support, and systems that recognize the cognitive, emotional, and logistical needs of aging populations. Structural and personal barriers are often intertwined, and overcoming them is essential to building equitable, senior-friendly healthcare systems.

Theme 15: Social and Cultural Influences on Telehealth Adoption

This theme explores how seniors' cultural backgrounds, social environments, and generational perspectives influence their attitudes toward telehealth. Participants revealed

that perceptions of legitimacy, privacy, and appropriateness are often influenced by deeply rooted social norms, religious values, and community narratives. These external influences—ranging from family opinions to cultural expectations—play a significant role in either encouraging or discouraging the adoption of virtual care. Participant 5e reflected on the skepticism within her community, stating,

> There is a lot of discussion in my community about telehealth, but it is not all positive. Some people are concerned about privacy and whether their information will be secure. Her hesitation was tied not only to personal concerns but also to the lack of visible support from trusted sources, suggesting that community endorsement is key to building confidence in telehealth.

Participant 6f described how mixed messages from her social circle affected her willingness to engage with virtual care:

> I have heard many positive things about telehealth from my doctor, which reassured me. However, some friends think it is not as reliable as seeing a doctor in person. Despite recognizing its convenience, she remained cautious due to peer concerns about diagnostic accuracy.

Participant 7g emphasized the influence of cultural and religious beliefs on her healthcare decisions:

> Culturally, my family has always valued in-person visits with doctors. My religious beliefs also play a role in how I view healthcare. While she initially resisted telehealth, hearing more positive perspectives from fellow church members began to shift her outlook, illustrating how trusted community voices

can reshape attitudes over time.

Together, these reflections highlight that telehealth adoption among seniors is not solely a matter of access or functionality—it is deeply embedded in social and cultural contexts. Family encouragement, community skepticism, religious values, and generational norms all contribute to how seniors perceive and engage with virtual care. This theme suggests that successful telehealth implementation must go beyond technical solutions, incorporating culturally sensitive outreach, trust-building strategies, and community-based education to foster acceptance among older adults.

Theme 16: Barriers to Telehealth Utilization: Personal and Systemic Challenges

This theme highlights the complex and intersecting challenges that prevent seniors from fully utilizing telehealth services. These barriers are not limited to technology—they span emotional discomfort, cognitive limitations, financial constraints, and infrastructural shortcomings. Participants described how these personal and systemic obstacles often compound one another, making virtual care feel inaccessible or impractical. Participant 2b shared a discouraging experience that shaped her reluctance to use telehealth again: "One time, my video call froze, and I could not hear the doctor. I was so embarrassed and frustrated that I did not want to try it again." Her preference for face-to-face interaction stemmed from a desire for more transparent communication and greater comfort, underscoring how technical failures can erode trust in virtual platforms.

Participant 3c emphasized the infrastructural limitations that made telehealth unfeasible: "I do not have a reliable internet connection at home, and my computer is ancient… The whole process is frustrating, and I end up canceling the appointment and

seeing the doctor in person." Her experience illustrates how outdated technology and poor connectivity can block access to virtual care, even when the intention to use it exists. Participant 4d expressed deeper concerns about privacy and financial viability: "I do not trust telehealth… I do not feel secure with virtual consultations and do not think I would get the same quality of care." She also noted that her insurance coverage was insufficient, making telehealth financially unattractive. Her comments reflect how systemic issues—such as data security fears and inadequate insurance support—can reinforce personal hesitation.

Together, these reflections reveal that a web of interrelated challenges shapes telehealth utilization among seniors. Technological illiteracy, unreliable internet access, financial constraints, and negative past experiences contribute to avoidance or refusal of virtual care. For many, traditional in-person visits remain the preferred option due to their perceived reliability and emotional reassurance. This theme suggests that improving telehealth adoption requires not only technical upgrades and policy reform but also empathetic design and personalized support that address the lived realities of older adults.

Evidence of Trustworthiness

This study employed a range of strategies to strengthen the trustworthiness of its findings by enhancing credibility, transferability, dependability, and confirmability. This section outlines the methods used to establish trustworthiness within the study's context, which explores telehealth, access to care, and perceived lived experiences of seniors 50 and older living in Sumter, South Carolina.

Credibility

In this phenomenological exploration of seniors' lived experiences with telehealth and access to care in Sumter, South Carolina, credibility was foundational to ensuring the trustworthiness and academic integrity of the study. Given the deep personal nature of the participants' reflections, establishing credibility required a rigorous and transparent research process. To begin, I engaged in reflexivity, a continuous process of self-awareness and critical reflection to acknowledge and mitigate potential biases, assumptions, and personal perspectives that could influence data collection and interpretation. As Goldblatt and Band-Winterstein (2016) emphasize, reflexivity in qualitative research is essential for maintaining objectivity and ensuring my influence does not distort the authenticity of participants' voices. I documented my research background, motivations, and methodological choices to promote transparency and allow readers to understand the lens through which the study was conducted (Elo et al., 2014).

The use of semi-structured, open-ended interviews via Zoom allowed participants to share their experiences with telehealth in their own words, fostering rich, nuanced data. Probing questions encouraged deeper reflection and helped uncover the emotional and practical dimensions of accessing care in a rural setting. This approach aligned with the phenomenological aim of capturing the essence of participants' lived experiences. To further enhance credibility, I implemented member checking throughout the data collection and analysis phases. Participants were invited to review their interview transcripts and preliminary thematic summaries to ensure accuracy and offer clarifications or additional insights. This iterative process not only validated the findings

but also empowered participants to shape the interpretation of their narratives, reinforcing the collaborative nature of qualitative inquiry.

Building trust with senior participants was especially critical, given the sensitivity of discussing health-related experiences and potential barriers to care. Trust was cultivated through clear communication, assurances of confidentiality, and empathetic engagement. Before each interview, participants received comprehensive information about the study's purpose, procedures, and the ethical safeguards in place. I maintained a respectful, non-judgmental stance throughout the interviews, acknowledging the emotional weight of their stories and honoring their perspectives. Ethical considerations were integral to maintaining credibility. Informed consent was obtained from all participants, outlining their rights, the voluntary nature of participation, and the measures taken to protect their privacy. The study received Institutional Review Board (IRB) approval, ensuring adherence to ethical standards and reinforcing the integrity of the research process. By weaving reflexivity, transparency, participant collaboration, and ethical rigor into every stage of the study, I upheld the credibility of this qualitative inquiry. I honored the voices of seniors navigating telehealth and access to care in their community.

Transferability

In this phenomenological study exploring seniors' lived experiences with telehealth and access to care in Sumter, South Carolina, transferability was a vital component in ensuring that the insights gained could resonate beyond the immediate research setting. While the study focused on a specific geographic and demographic

population, the goal was to provide rich, contextualized findings that could inform broader discussions on telehealth accessibility and aging populations in similar rural or underserved communities. Transferability was strengthened through detailed descriptions of the research context, including the unique characteristics of Sumter County—its rural infrastructure, healthcare resources, transportation limitations, and socio-cultural dynamics that influence seniors' engagement with telehealth services. These contextual details allow readers to assess the relevance of the findings to other settings with comparable challenges and demographics (Stalmeijer et al., 2024).

Additionally, the study captured diverse participant narratives, reflecting a range of lived experiences shaped by factors such as age, health status, technological literacy, socioeconomic background, and prior access to care. By incorporating direct quotes and personal anecdotes, the findings offer vivid illustrations of how seniors perceive and navigate telehealth, enabling readers to draw parallels with populations in other regions. The methodological transparency included detailed descriptions of the interview process, participant selection criteria, and thematic analysis—further supports transferability. Readers are equipped with sufficient information to determine whether the study's conclusions may apply to their own contexts or inform policy and practice in similar environments. Ultimately, transferability in this study was not about generalizing findings, but about offering contextually rich insights that can inspire reflection, adaptation, and action in other communities facing similar barriers to healthcare access among aging populations.

Dependability

In this phenomenological study, dependability was a key criterion for ensuring the consistency and reliability of the research process as it explored seniors' lived experiences with telehealth and access to care in Sumter, South Carolina. Given the dynamic nature of healthcare delivery and the evolving role of telehealth in rural communities, it was essential to establish a dependable framework that could support the study's methodological integrity. To achieve this, I employed a systematic and transparent approach to data collection and analysis. The research design, interview protocols, and analytical procedures were clearly documented to facilitate replication and demonstrate consistency across all stages of the study. This audit trail included detailed notes on how themes were developed, how decisions were made during coding, and how interpretations were grounded in participant narratives.

I also ensured methodological coherence by aligning the research questions, data collection methods, and analytical strategies with the phenomenological framework. This alignment helped maintain consistency in how participants' experiences were explored and interpreted, reinforcing the dependability of the findings. Moreover, data saturation was used as a benchmark for reliability. Interviews continued until no new themes or insights emerged, confirming that the data set was sufficiently rich and comprehensive to support the study's conclusions. This process ensured that the findings reflected a wide range of experiences and were not shaped by isolated or incomplete accounts. By maintaining a transparent and replicable research process, engaging in reflexive documentation, and reaching saturation, I upheld the dependability of the study. These

strategies ensured that the insights into seniors' perceptions of telehealth and access to care were not only contextually grounded but also methodologically sound, providing a reliable foundation for future research and policy development in similar rural settings.

Confirmability

Confirmability was essential to ensuring the integrity and trustworthiness of this phenomenological study, which sought to understand seniors' lived experiences with telehealth and access to care in Sumter, South Carolina. Because qualitative research centers on participants' subjective narratives, it was critical that the findings reflected their perspectives rather than any personal biases or assumptions I, as the researcher, might hold. To uphold confirmability, I employed rigorous methodological strategies that emphasized transparency and neutrality throughout the research process. This included maintaining a detailed audit trail of decisions made during data collection, coding, and thematic analysis. All interpretations were grounded in direct participant quotes and supported by consistent patterns across interviews, ensuring that conclusions were firmly rooted in the data.

I also engaged in reflexivity, continuously examining my own background, beliefs, and potential biases that could influence the research. By documenting my positionality and reflecting on how my experiences might shape the lens through which I viewed participants' stories, I actively worked to minimize undue influence on the interpretation of findings. This reflexive practice enhanced the objectivity and credibility of the study. Moreover, data saturation was achieved through iterative interviews, continuing until no new themes or insights emerged. This ensured that the findings were

comprehensive and representative of the seniors' diverse experiences with telehealth, rather than selective or anecdotal. Saturation reinforced the depth and reliability of the data, supporting the confirmability of the study's conclusions.

By integrating reflexivity, methodological transparency, and saturation, I ensured that the study's findings were authentically derived from participants' voices and experiences, providing a trustworthy foundation for understanding telehealth access among seniors in Sumter, South Carolina.

Results

This chapter presents the findings from semi-structured interviews conducted with seniors living in Sumter, South Carolina. Using a phenomenological approach, the study explored participants' lived experiences with telehealth and access to care in a rural context. Thematic analysis revealed 16 distinct themes, organized around the three research questions. These themes are supported by direct participant quotes and tied to relevant literature to provide depth and context. The number preceding each theme corresponds to its designation in the thematic analysis, providing a clear reference for how the themes were identified and organized during data interpretation.

RQ1: What Are the Perceived Experiences of Seniors with Telehealth Utilization?

Six themes emerged that reflect seniors' diverse and evolving engagement with telehealth services.

Technological Barriers and Digital Literacy

Many participants struggled with using telehealth platforms due to limited digital skills, outdated devices, or unreliable internet access. One participant shared:

“I do not know how to work those apps. I just wait for my regular appointment.”
This aligns with Kruse et al. (2017), who found that digital literacy is a significant barrier for older adults, especially in rural areas.

Convenience and Reduced Travel Burden

Several seniors appreciated the ability to consult with providers from home, especially when transportation was unavailable: “It saved me a trip to Columbia. I did not have to ask my daughter to take off work.” Lam et al. (2020) emphasized the role of telehealth in reducing travel-related stress for rural populations.

Impersonal Nature of Virtual Care

Participants often described telehealth visits as lacking warmth and human connection: “The doctor was nice, but it felt like talking to a robot. I miss the eye contact.” Shigekawa et al. (2018) noted that virtual care can diminish patient-provider rapport, especially for seniors who value relational continuity.

Skepticism Toward Remote Diagnoses

Some seniors questioned the accuracy of diagnoses made through telehealth: “How can they tell what is wrong without touching me?” This reflects concerns raised by Dorsey & Topol (2020) about the clinical limitations of remote assessments.

Privacy and Confidentiality Concerns

A few participants expressed discomfort sharing sensitive health information online: “I do not like talking about my health on the computer. You never know who is listening.” This theme echoes broader concerns about data security in digital health platforms (Cohen et al., 2022).

Adaptation and Growing Comfort

With support from family or repeated use, some seniors reported increased confidence using telehealth: “My grandson showed me how to use the tablet. Now I can do it myself.” This supports findings that telehealth satisfaction improves with familiarity and assistance (Gale et al., 2019).

RQ 2: What Are the Perceived Experiences of Seniors with Access to Care?

Five themes emerged that highlight systemic and personal barriers to healthcare access in Sumter County.

Transportation Limitations and Geographic Isolation

Participants consistently cited transportation as a significant obstacle: “If I do not have a ride, I just wait it out. Sometimes I get better, sometimes I do not.” Henning-Smith (2020) identified transportation as a critical determinant of rural health outcomes.

Financial Constraints and Insurance Coverage

Several seniors expressed concern about out-of-pocket costs and gaps in Medicare coverage: “I cannot afford all those co-pays. I just skip the appointments unless it is serious.” Ortman et al. (2014) noted that financial insecurity often leads to delayed or forgone care among older adults.

Provider Availability and Appointment Delays

Participants described long wait times and limited provider options: “It takes weeks to get an appointment, and sometimes they cancel at the last minute.” Bolin et al. (2015) documented provider shortages in rural areas and their impact on timely access to care.

Fragmented Continuity of Care

Some seniors experienced inconsistent follow-up and frequent provider turnover: “Every time I go, it is a new doctor. I have to explain everything all over again.” This theme highlights the challenges of maintaining consistent care relationships in rural settings.

Community Support and Informal Networks

Churches, neighbors, and family members often played vital roles in bridging care gaps: “My church helps with rides and checks on me when I am sick. They are a blessing.” Crouch et al. (2019) emphasized the importance of informal networks in rural elder care.

RQ 3: What Factors Influenced Telehealth Use and Access to Care?

Five overarching themes emerged that explain the conditions under which seniors engaged with telehealth and sought care.

Health Status and Urgency of Needs

Participants were more likely to use telehealth for routine checkups than for urgent or complex issues: “I will do telehealth for my diabetes check, but not if I am having chest pain.” Koonin et al. (2020) found that telehealth is most effective for low-acuity care.

Trust in Healthcare Providers and Systems

Trust in providers strongly influenced seniors’ willingness to try telehealth: “I trust my doctor, so I will do whatever she recommends—even video calls.” Gale et al. (2019) emphasized that trust is a key factor in rural health engagement.

Awareness and Education About Telehealth Services

Many participants were unaware of telehealth options or confused about how to access them: “I did not know I could see my doctor online until my daughter told me.” This highlights the need for targeted education and outreach, as noted by the CDC (2021).

Cultural Attitudes Toward Technology and Medicine

Beliefs about aging, independence, and technology shaped engagement: “I am old-fashioned. I like to see my doctor in person.” This theme reflects generational attitudes that influence healthcare choices.

Family Involvement in Healthcare Navigation

Adult children and caregivers often facilitated access and decision-making: “My daughter sets up the appointments and helps me with the video calls.” This supports literature on the role of caregivers in managing elder healthcare (Wolff et al., 2016).

Summary of Findings

The 16 themes identified in Table 4 in this study reveal a complex interplay between technological access, healthcare infrastructure, personal health needs, and community support. Seniors in Sumter, South Carolina, navigate telehealth and access to care through a lens shaped by trust, adaptability, and systemic limitations. These findings contribute to a deeper understanding of how healthcare delivery can be tailored to meet the needs of aging populations in rural settings.

Table 5

Summary of Core Themes by Research Question

Research Question	Theme		Key Insight
RQ1: Telehealth Utilization	1	Technological Barriers and Digital Literacy	Seniors struggled with devices, apps, and internet access
	2	Convenience and Reduced Travel Burden	Telehealth reduced the need for transportation and dependence on others
	3	Impersonal Nature of Virtual Care	Lack of face-to-face interaction diminished emotional connection
	4	Skepticism Toward Remote Diagnoses	Concerns about accuracy without physical exams
	5	Privacy and Confidentiality Concerns	Discomfort sharing sensitive information online
	6	Adaptation and Growing Comfort	Increased confidence with support and repeated use
RQ2: Access to Care	7	Transportation Limitations and Geographic Isolation	Lack of public transit and long distances hindered access
	8	Financial Constraints and Insurance Coverage	Out-of-pocket costs and limited coverage discouraged routine care
	9	Provider Availability and Appointment Delays	Long wait times and few provider options
	10	Fragmented Continuity of Care	Inconsistent follow-up and frequent provider turnover
	11	Community Support and Informal Networks	Churches, neighbors, and family filled care gaps
RQ3: Influencing Factors	12	Health Status and Urgency of Needs	Telehealth is used more for routine than urgent care
	13	Trust in Healthcare Providers and Systems	Provider relationships influenced willingness to engage
	14	Awareness and Education about Telehealth Services	Many seniors lacked knowledge of telehealth options
	15	Cultural Attitudes Toward Technology and Medicine	Beliefs about aging and technology shaped engagement
	16	Family Involvement in Healthcare Navigation	Adult children and caregivers facilitated access and decision-making

Summary

Chapter 4 of this phenomenological study provided in-depth insight into the lived experiences of seniors residing in Sumter, South Carolina, as they navigated telehealth services and broader access to care in a rural setting. Through semi-structured interviews, participants shared personal narratives that illuminated the emotional, logistical, and systemic dimensions of healthcare delivery. Thematic analysis of the data resulted in the identification of 16 distinct themes, distributed across the three guiding research questions.

The first research question asked, “What are the perceived lived experiences of seniors living in Sumter, South Carolina, with telehealth utilization?” Participants expressed a range of experiences, from appreciation of convenience to frustration with technological barriers. Six themes emerged: technological challenges, convenience and reduced travel, impersonal nature of virtual care, skepticism toward remote diagnoses, privacy concerns, and growing comfort over time. While some seniors found telehealth helpful for routine checkups, others struggled with digital literacy, felt disconnected from providers, or questioned the accuracy of virtual assessments. These findings reflect the broader discourse on digital equity and the importance of relational care in virtual environments.

The second research question explored, “What are the perceived lived experiences of seniors with access to care living in Sumter, South Carolina?” This question revealed five themes: transportation limitations, financial constraints, provider availability and delays, fragmented continuity of care, and community support networks. Participants

described experiencing long wait times, limited provider options, and a reliance on informal support systems, such as churches and family members. These experiences highlight the persistent challenges of rural healthcare infrastructure and the crucial role of community-based resources in addressing care gaps.

The third research question asked, “What factors influenced telehealth use and access to care?” Five overarching themes emerged: health status and urgency of needs, trust in healthcare providers, awareness and education about telehealth, cultural attitudes toward technology and medicine, and family involvement in healthcare navigation. Seniors were more likely to use telehealth for low-acuity care and chronic condition management, predominantly when guided by trusted providers or family members. However, lack of awareness and cultural hesitations about technology often limited engagement.

Overall, the findings of this study offer a nuanced understanding of how seniors in Sumter County experience healthcare in a rural context. Their voices reveal both the promise and limitations of telehealth, the systemic barriers to care, and the social dynamics that shape healthcare decisions. These insights contribute to a broader conversation about aging, digital inclusion, and healthcare equity, and provide a foundation for future policy, practice, and research aimed at improving care delivery for older adults in underserved communities like Sumter, South Carolina. The findings of this study reveal a complex interplay between technological access, healthcare infrastructure, personal health needs, and social support. Seniors in Sumter, South Carolina, navigate telehealth and access to care through a lens shaped by trust,

adaptability, and systemic limitations. While telehealth offers convenience and reduced travel burden, its limitations in physical examination, emotional connection, and technological reliability remain significant concerns. Financial constraints, employment status, and community infrastructure further influence access to care. Social and cultural factors, along with family involvement, play a critical role in shaping healthcare decisions.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative phenomenological study was to explore the lived experiences of seniors 50 and older residing in Sumter, South Carolina, with respect to their engagement with telehealth services and perceptions of access to care. As the healthcare landscape continues to evolve—driven by technological innovation and accelerated by public health emergencies such as the COVID-19 pandemic—telehealth has emerged as a critical modality for delivering care to populations that may otherwise face barriers to traditional in-person services. Seniors, particularly those in rural communities, represent a vulnerable and historically underserved demographic. Their experiences navigating telehealth and other healthcare access channels are essential to understanding how digital transformation intersects with healthcare equity.

This study was guided by ABMHSU, which provided a theoretical framework for examining the factors influencing healthcare utilization. The model emphasizes three core components: predisposing factors (e.g., demographics, health beliefs), enabling resources (e.g., income, insurance, access to technology), and perceived need (e.g., self-assessed health status and the urgency of care). Each set of interview questions was intentionally aligned with one of these domains to elicit rich, contextualized narratives that reflect the multidimensional nature of healthcare engagement. This chapter presents a comprehensive interpretation of the study's findings in relation to existing literature, with attention to how participants' experiences reflect or diverge from the constructs within Andersen's model. Key themes and insights are discussed through the lens of predisposing characteristics, enabling conditions, and perceived healthcare needs. The

chapter examines the implications for clinical practice, healthcare policy, and community-based interventions aimed at enhancing access and outcomes for older adults. Limitations of the study are acknowledged to contextualize the scope and transferability of the findings. Finally, recommendations for future research are offered, followed by reflections on the broader societal implications of the study, emphasizing its potential to inform of meaningful and equitable change in healthcare delivery.

Interpretation of the Findings

The findings of this qualitative phenomenological study revealed a nuanced and multifaceted understanding of how seniors 50 and older residing in rural Sumter, South Carolina, experience telehealth and access to care. Participants expressed a spectrum of emotions and attitudes toward telehealth, ranging from appreciation for its convenience and time-saving benefits to frustration with its limitations and concerns about the adequacy of virtual care. While many seniors acknowledged telehealth as a necessary adaptation during the COVID-19 pandemic, it was not widely embraced as a preferred long-term solution. Several interrelated factors shaped participants' experiences, including technological literacy, physical and cognitive health, socioeconomic status, and the quality of provider-patient communication. Trust in virtual platforms emerged as a recurring concern, with some seniors questioning the reliability and personal connection afforded by remote consultations. Access to traditional healthcare services was similarly constrained by geographic isolation, transportation challenges, financial limitations, and systemic barriers within the healthcare infrastructure.

Social support systems, particularly the involvement of family members, played a

critical role in helping seniors navigate both telehealth and in-person care. These findings align with national trends observed among aging populations in underserved areas, yet they also highlight the distinctive cultural and infrastructural realities of rural southern communities. Notably, the study underscores that while telehealth holds promise for enhancing healthcare access, its implementation must be tailored to the unique needs, preferences, and lived experiences of older adults. Collectively, these insights emphasize the imperative for healthcare systems to be inclusive, empathetic, and responsive—ensuring that digital innovations do not inadvertently exacerbate existing disparities but instead serve as tools for equitable and person-centered care.

Research Question 1 Findings and Reviewed Relevant Literature

RQ 1 was “What are the perceived experiences of seniors living in Sumter, South Carolina, with telehealth utilization?” The findings revealed that seniors residing in Sumter, South Carolina experienced telehealth in deeply personal and often ambivalent terms. For many participants, telehealth represented a welcome innovation, particularly during periods of illness, inclement weather, or heightened public health concerns such as the COVID-19 pandemic. The ability to consult with healthcare providers from the comfort of one’s own home was viewed as a significant convenience, reducing the burden of travel and logistical coordination. Telehealth was generally accepted as a valuable modality for addressing routine health concerns.

However, participants also expressed notable reservations. Initial encounters with telehealth were often marked by technological challenges, including difficulties navigating digital platforms and concerns about privacy and data security. These barriers

were compounded by limited digital literacy and age-related sensory or cognitive changes. Several seniors reported feeling disconnected from their providers during virtual visits, citing a lack of warmth, attentiveness, and relational continuity that they associated with in-person care. This perceived impersonality contributed to feelings of isolation and dissatisfaction, particularly when addressing complex or severe health conditions. Over time, some participants demonstrated increased comfort and adaptability with telehealth, especially when supported by family members or caregivers. Nonetheless, the duality between convenience and clinical adequacy remained a recurring theme. While trust in individual providers often persisted, skepticism about the legitimacy and diagnostic accuracy of virtual care lingered.

These findings are consistent with existing literature on telehealth and aging populations. Kruse et al. (2017) identified digital literacy and trust in technology as significant barriers for older adults, while Choi et al. (2020) emphasized the importance of designing telehealth platforms that accommodate age-related changes. Lam et al. (2020) further noted that seniors frequently perceive telehealth as less “real” or legitimate than traditional care, underscoring the tension between technological efficiency and the humanistic aspects of healthcare delivery. Collectively, the findings suggest that while telehealth holds promise for expanding access to care, its implementation must be sensitive to the emotional, psychological, and relational needs of older adults. This includes training providers in empathetic virtual communication, ensuring platform accessibility, and integrating support systems that enhance user confidence and engagement.

Research Question 2 Findings and Reviewed Relevant Literature

RQ 2 was "What are the perceived experiences of seniors with access to care living in Sumter, South Carolina?" Access to care emerged as a central concern among seniors residing in Sumter, South Carolina, who described a range of barriers that impeded their ability to obtain timely and appropriate healthcare. Geographic isolation, limited transportation options, and a shortage of local providers were frequently cited as structural obstacles. Participants reported long wait times for appointments, difficulty coordinating care across multiple providers, and challenges navigating complex insurance and billing systems. These barriers were compounded by socioeconomic factors such as low income, limited education, and financial insecurity, which often led to delayed or forgone care due to high out-of-pocket costs. Employment-related constraints further exacerbated access issues, particularly for individuals not yet eligible for Medicare or those managing chronic conditions without stable income or employer-sponsored coverage. The presence or absence of social support systems, such as assistance from family or friends, was often identified as a key factor in determining whether care was accessible. Participants expressed a desire for more coordinated and community-based healthcare solutions, including mobile clinics, home visits, and localized health programs that could mitigate logistical and financial burdens.

These findings are consistent with existing literature on rural healthcare disparities. Whitacre et al. (2019) noted that rural residents experience higher rates of chronic illness and lower rates of preventive care due to systemic barriers. Anderson and Hussey (2020) emphasized the compounded effects of geographic isolation and resource

scarcity on the healthcare access of older adults. Additionally, Graham (2021) highlighted the critical role of social determinants of health, such as transportation, housing stability, and social support in shaping healthcare utilization among seniors. The experiences of seniors in Sumter reflect broader national trends while also underscoring the unique infrastructural and cultural realities of rural southern communities. These insights reinforce the urgent need for targeted interventions that address both systemic and individual level barriers to care. Moreover, the study affirms the importance of integrating social determinants of health into care planning and delivery to promote equity and improve outcomes for aging populations.

Research Question 3 Findings and Reviewed Relevant Literature

RQ 3 was "What factors influenced telehealth use and access to care?" The study identified a constellation of interrelated factors that influenced telehealth utilization and access to care among seniors residing in Sumter, South Carolina. Technological literacy emerged as a primary determinant, with participants who were comfortable using smartphones, tablets, and computers reporting more positive experiences with telehealth. In contrast, individuals with limited digital skills or cognitive impairments found virtual platforms to be confusing, stressful, and inaccessible. Infrastructure limitations, particularly unreliable internet connectivity in remote areas, further hindered participation in telehealth services. Financial constraints also played a significant role. Some seniors lacked the resources to purchase necessary devices or maintain data plans, which restricted their ability to engage in virtual care. Insurance-related limitations, including coverage gaps and unclear reimbursement policies, compounded these challenges. Trust

in healthcare providers and the broader medical system influenced willingness to adopt telehealth, with several participants expressing skepticism about the quality, accuracy, and privacy of virtual consultations. Cultural attitudes and personal preferences had equal influence. Many seniors expressed a strong preference for face-to-face interactions, viewing in-person care as more legitimate and emotionally satisfying. Social and familial support systems played a critical role in shaping telehealth engagement; participants who received assistance from family members were more likely to continue using telehealth. Conversely, those without such support often resisted adoption due to perceived inadequacies and discomfort with digital modalities.

These findings align with existing literature on the digital divide and healthcare disparities. Lam et al. (2020) identified infrastructure and literacy gaps as significant barriers to telehealth adoption among older adults, while Cimperman et al. (2016) emphasized the importance of perceived usefulness and trust in shaping patient satisfaction. The influence of cultural norms and social cues is consistent with the Health Belief Model, which posits that perceived benefits, perceived barriers, and external influences guide health-related decision-making (Rosenstock, 1974). Velasquez and Mehrotra (2021) further documented the intersection of cultural attitudes and digital health adoption, particularly among minority and underserved populations. Collectively, these findings underscore the need for a holistic and culturally responsive approach to telehealth implementation. Strategies such as digital literacy workshops, peer support networks, and community-based outreach can enhance engagement and reduce disparities. Addressing technological, financial, relational, and cultural factors is essential

to ensuring equitable access and meaningful utilization of telehealth among aging populations in Sumter, South Carolina.

Integration of Theoretical Framework

To interpret the findings of this study, ABMHSU was applied as the guiding theoretical framework. Andersen's Behavioral Model of Health Services Use provides a comprehensive framework for examining healthcare utilization, highlighting how predisposing factors, enabling resources, and perceived need interact to influence individual decisions to seek care (Andersen, 1995; Babitsch et al., 2012). This framework was particularly relevant to the present study because seniors in rural communities encounter multiple overlapping barriers to accessing healthcare—barriers that extend beyond individual choice to structural and systemic constraints. By situating the lived experiences of participants within ABMHSU, the discussion highlights how demographic characteristics, financial and technological resources, and perceptions of health needs collectively influenced telehealth use in Sumter, South Carolina. This theoretical grounding not only strengthens the interpretation of findings but also underscores the broader implications for designing equitable, person-centered telehealth strategies.

Predisposing factors such as age and health beliefs influenced how participants approached telehealth. While some initially expressed skepticism due to generational discomfort with digital technology, others described a willingness to adopt telehealth when its benefits—such as convenience and reduced travel—became evident. These attitudes underscored the role of pre-existing beliefs and demographic characteristics in shaping telehealth acceptance.

Enabling resources emerged as critical determinants of access. Participants repeatedly emphasized the importance of digital literacy, reliable internet connectivity, and health insurance coverage in facilitating or hindering the use of telehealth. For example, those with private insurance or TRICARE/VA coverage reported fewer financial obstacles, while others described cost concerns that limited consistent utilization. Access to technology and social support networks also served as enabling or constraining factors.

The perceived need strongly influenced whether participants chose to use telehealth. Many viewed virtual visits as appropriate for routine check-ins, prescription renewals, and follow-ups. However, they believed that acute conditions or complex health issues required in-person assessment for accurate diagnosis and reassurance. These perceptions influenced decisions about when telehealth was a viable alternative to traditional care.

By aligning the study's findings with ABMHSU, it became clear that telehealth utilization among seniors in rural Sumter was not determined by a single factor but rather by the interaction of predisposing, enabling, and need-related elements. This integration demonstrates the model's continued relevance in analyzing healthcare access within emerging modalities. Moreover, it underscores the importance of interventions that not only enhance enabling resources (e.g., broadband access, digital literacy programs) but also address predisposing beliefs and respond to patient perceptions of need. Together, these insights provide a pathway for designing equitable and person-centered telehealth initiatives for older adults in underserved communities.

In summary, interpreting the findings through ABMHSU demonstrated that telehealth utilization among older adults in rural Sumter was shaped by the interaction of predisposing factors, enabling resources, and perceived need. Demographic characteristics and health beliefs influenced participants' openness to virtual care, while access to technology, digital literacy, insurance coverage, and social support determined whether telehealth was feasible in practice. Equally important, participants' perceptions of when telehealth was sufficient and when in-person care was necessary guided their healthcare decisions. Framing the results within ABMHSU confirmed the model's applicability to the context of emerging health technologies and underscored areas for intervention. Policies and practices that expand enabling resources, address predisposing attitudes, and align services with patients' perceived needs hold promise for reducing inequities in rural healthcare delivery. Grounding the study in ABMHSU therefore provided both theoretical clarity and practical direction, supporting the design of equitable, person-centered telehealth strategies for older adults in underserved communities.

Limitations of the Study

This study presents several limitations that should be considered when interpreting its findings. First, the sample size was relatively small (N = 7). Although data saturation was achieved, the limited number of participants constrains the generalizability of the results beyond the specific context of Sumter, South Carolina. The phenomenological approach emphasizes depth over breadth; however, future studies with larger and more demographically diverse samples could provide a more comprehensive

understanding of seniors' experiences with telehealth and access to care.

Second, the study focused exclusively on seniors residing in a single rural community. Rural regions vary significantly in terms of infrastructure, demographics, and healthcare resources, which can impact telehealth engagement and access in different ways. As such, the findings may not be representative of older adults in other geographic or cultural settings. Additionally, all participants identified as Black or African American. While this offers valuable insight into the experiences of a specific demographic group, it limits the ability to compare findings across broader racial and ethnic populations.

Third, the study relied on self-reported data collected through qualitative interviews. This method is inherently subject to recall bias, personal interpretation, and social desirability bias. Participants may have selectively emphasized certain aspects of their experiences or underreported others, which could potentially affect the accuracy and completeness of the data. Moreover, the trustworthiness of qualitative interviewing depends heavily on participants' willingness to share openly and honestly. While efforts were made to foster a respectful and transparent research environment (Creswell et al., 2013; Patton, 2015), the subjective nature of the data remains a limitation.

Fourth, logistical and procedural challenges impacted the research process. Obtaining Institutional Review Board (IRB) approval for participant recruitment posed significant delays, and scheduling interviews at specific times proved challenging due to participants' varying availability and health statuses. In some cases, participants withdrew from the study, which further constrained the sample size and diversity. These recruitment and retention challenges may have introduced selection bias, favoring

individuals who were more available, engaged, or comfortable with the research process.

Fifth, technological limitations during data collection—such as internet connectivity issues may have affected the depth and clarity of participant responses. The study may have inadvertently excluded individuals who lacked access to technology or were less comfortable participating in virtual interviews, thereby skewing the sample toward more digitally literate or tech-savvy individuals.

Additionally, the study was conducted primarily in English, which may have limited participation from seniors who communicate in languages other than English or come from diverse cultural backgrounds. This linguistic constraint may have partially obscured the experiences of non-English-speaking seniors in the region.

Finally, the study was conducted within a defined time frame, which may not fully capture the evolving nature of telehealth utilization and healthcare access. Changes in policy, technology, and public health conditions particularly in the aftermath of the COVID-19 pandemic could influence seniors' experiences in ways not reflected in the data collected during this period. Taken together, these limitations suggest that the findings should be interpreted with caution. They underscore the need for future research that incorporates broader geographic, demographic, linguistic, and technological contexts. Expanding the scope of inquiry and addressing structural barriers to participation will be essential for developing a more inclusive and representative understanding of telehealth and healthcare access among aging populations.

Recommendations

Based on the findings of this study, several recommendations are proposed to

enhance telehealth utilization and healthcare access among older adults, particularly in rural communities such as Sumter, South Carolina. These recommendations are categorized into three domains: practice, policy, and future research.

Recommendations for Practice

- Enhance Digital Literacy Training: Implement targeted digital literacy programs for older adults in rural areas to improve their comfort, confidence, and competence in using telehealth platforms. Training should be accessible, culturally sensitive, and tailored to varying levels of technological proficiency.
- Develop Hybrid Care Models: Establish integrated care models that combine telehealth with periodic in-person visits, particularly for managing chronic diseases. This approach can preserve relational continuity and ensure comprehensive care delivery.
- Train Providers in Empathetic Virtual Communication: Equip healthcare providers with skills in empathetic and patient-centered virtual communication to foster trust, reduce perceived impersonality, and improve patient satisfaction during telehealth encounters.
- Design Accessible Telehealth Platforms: Advocate for the development of telehealth technologies that accommodate age-related sensory and cognitive changes. Features such as larger text, simplified navigation, and voice-assisted interfaces can enhance usability for older adults.
- Expand Community-Based Health Services: Promote mobile clinics, home visits, and community health programs that complement telehealth and address barriers

to in-person care, particularly for seniors with mobility or transportation challenges.

Recommendations for Policy

- Invest in Broadband Infrastructure: Prioritize the expansion of broadband access in rural communities to eliminate technological barriers and support equitable participation in telehealth services.
- Subsidize Telehealth Devices and Internet Services: Provide financial assistance for telehealth-enabling devices and internet connectivity to low-income seniors, thereby reducing cost-related barriers to virtual care.
- Expand Insurance Coverage for Telehealth Services: Advocate for comprehensive telehealth coverage under Medicare, Medicaid, and private insurance plans to minimize out-of-pocket expenses and encourage sustained utilization.
- Support Transportation Services for In-Person Care: Fund and expand transportation programs for seniors in rural areas to facilitate access to traditional healthcare services when telehealth is not appropriate or feasible.

Recommendations for Future Research

- Conduct Comparative Geographic Studies: Examine differences in telehealth adoption and healthcare access between rural and urban populations to identify context-specific barriers and facilitators.
- Explore Intergenerational Influences on Health Decision-Making: Investigate how family dynamics and intergenerational relationships shape older adults' engagement with telehealth and healthcare services.

- Assess Longitudinal Health Outcomes: Conduct longitudinal studies to evaluate the impact of sustained telehealth use on health outcomes, care continuity, and quality of life in underserved communities.
- Examine Racial and Ethnic Variability in Telehealth Experiences: Explore telehealth perceptions and utilization across diverse racial and ethnic groups to inform culturally responsive interventions.
- Include Caregiver Perspectives: Study the role of caregivers in facilitating telehealth access for seniors, particularly those with cognitive impairments or limited technological proficiency.

These recommendations aim to inform the development of inclusive, effective, and sustainable telehealth ecosystems that address the unique needs of aging populations in rural settings. By integrating practice innovations, policy reforms, and targeted research, stakeholders can work collaboratively to reduce disparities and promote equitable access to care for older adults.

Implications

The findings of this study carry significant implications for healthcare practice, policy development, and future research, particularly in the context of telehealth utilization among older adults in rural communities. By centering the lived experiences of seniors in Sumter, South Carolina, the study reinforces the understanding that telehealth is not a universally applicable solution. While it offers tangible benefits such as convenience, reduced travel burden, and expanded access to care its effectiveness is contingent upon thoughtful implementation that takes into account individual, cultural,

and systemic factors. Healthcare providers and policymakers must recognize that seniors' engagement with telehealth is mediated by a complex interplay of technological competence, emotional readiness, cultural values, and trust in the healthcare system. These variables influence not only the adoption of telehealth but also the quality of the care experience and the perceived legitimacy of virtual interactions. Interventions that fail to address these dimensions risk exacerbating existing disparities and alienating vulnerable populations. Moreover, the study underscores the importance of designing healthcare systems that are responsive to the diverse realities of aging populations. Older adults bring unique perspectives, preferences, and needs to the telehealth experience, which must be honored in the development of virtual care models. This includes ensuring that platforms are accessible to individuals with sensory or cognitive impairments, training providers in empathetic virtual communication, and offering hybrid care models that preserve relational continuity.

The study also highlights the broader social determinants of health, such as income, education, geography, and social support that influence access to care and shape health outcomes. These determinants are particularly salient in rural communities, where infrastructural limitations and resource scarcity compound barriers to both telehealth and traditional healthcare services. Addressing these challenges requires a holistic and interdisciplinary approach that integrates healthcare delivery with technological innovation, community engagement, and social services. In sum, the implications of this study advocate for a more inclusive, equitable, and person-centered approach to telehealth. By aligning technological solutions with the lived experiences of older adults,

stakeholders can foster meaningful engagement, improve health outcomes, and advance the goal of healthcare equity in underserved populations.

Implications for Positive Social Change

This study makes a meaningful contribution to the discourse on health equity and digital inclusion by amplifying the voices of Black seniors residing in a rural southern community. This population is often marginalized and underrepresented in healthcare research. By documenting their lived experiences with telehealth and access to care, the study contributes to a more comprehensive understanding of the structural and interpersonal factors that influence healthcare engagement among older adults in underserved regions. The findings underscore the urgent need to bridge the digital divide through community-based initiatives that promote access to technology, literacy, and trust. Seniors in rural communities face compounded barriers—including geographic isolation, limited infrastructure, and socioeconomic constraints—that hinder their ability to benefit from emerging healthcare technologies. Addressing these barriers through culturally sensitive telehealth solutions and targeted infrastructure improvements can significantly enhance the quality of life for older adults, support aging-in-place strategies, and foster trust in virtual care modalities. Moreover, the study advocates for a human-centered approach to healthcare innovation. It encourages policymakers, healthcare providers, and technologists to consider the emotional, cultural, and relational dimensions of telehealth when designing and implementing digital health systems. Compassionate and accessible platforms that reflect the realities of aging populations are more likely to empower users and promote sustained engagement.

The research also highlights the value of participatory, and community engaged methodologies in shaping healthcare solutions. Involving seniors directly in the development, evaluation, and refinement of telehealth services ensures that interventions are responsive to their needs and preferences. This participatory approach not only enhances the relevance and effectiveness of healthcare delivery but also promotes social inclusion and civic empowerment among older adults. In sum, the implications for positive social change extend beyond technological adaptation. They call for systemic transformation rooted in equity, empathy, and collaboration ensuring that all seniors, regardless of race, geography, or income, have the opportunity to access high-quality, dignified, and person-centered care.

Conclusions

This qualitative phenomenological study examined the lived experiences of seniors 50 and older residing in Sumter, South Carolina, regarding their engagement with telehealth services and perceptions of healthcare access. The findings revealed that older adults navigate telehealth and broader healthcare systems through a lens shaped by personal, technological, cultural, and systemic factors. While telehealth presents considerable promise, particularly in enhancing convenience and reducing logistical barriers, its success is contingent upon thoughtful, inclusive, and context-sensitive implementation. Participants' narratives illuminated both the benefits and limitations of virtual care. Many seniors appreciated the ability to access healthcare from the comfort of their own homes, especially during periods of illness or inclement weather. However, challenges related to digital literacy, infrastructure, trust, and relational continuity

underscored the complexity of telehealth adoption in rural aging populations.

These findings affirm that telehealth is not a one-size-fits-all solution; instead, it must be tailored to accommodate the diverse needs, preferences, and capabilities of older adults. The study also highlighted the critical role of empathy, infrastructure, and policy in shaping equitable healthcare experiences. Addressing barriers such as unreliable internet access, limited technological proficiency, and financial constraints is essential for fostering digital inclusion and healthcare equity. Moreover, culturally aligned care models that honor the values and lived realities of seniors can enhance engagement and satisfaction with both virtual and in-person services.

By centering the voices of seniors in a rural southern community particularly those from historically marginalized backgrounds this research contributes to a more nuanced understanding of healthcare access and digital transformation. It calls on healthcare providers, policymakers, and technologists to listen actively, respond compassionately, and design systems that reflect the human dimensions of care. In doing so, stakeholders can build more responsive, effective, and dignified healthcare delivery models that promote aging in place and reduce disparities in underserved communities. Ultimately, this study underscores the need for ongoing efforts to bridge the care gaps for rural seniors. Through interdisciplinary collaboration, community engagement, and policy innovation, the healthcare system can evolve to meet the needs of older adults in ways that are equitable, sustainable, and transformative.

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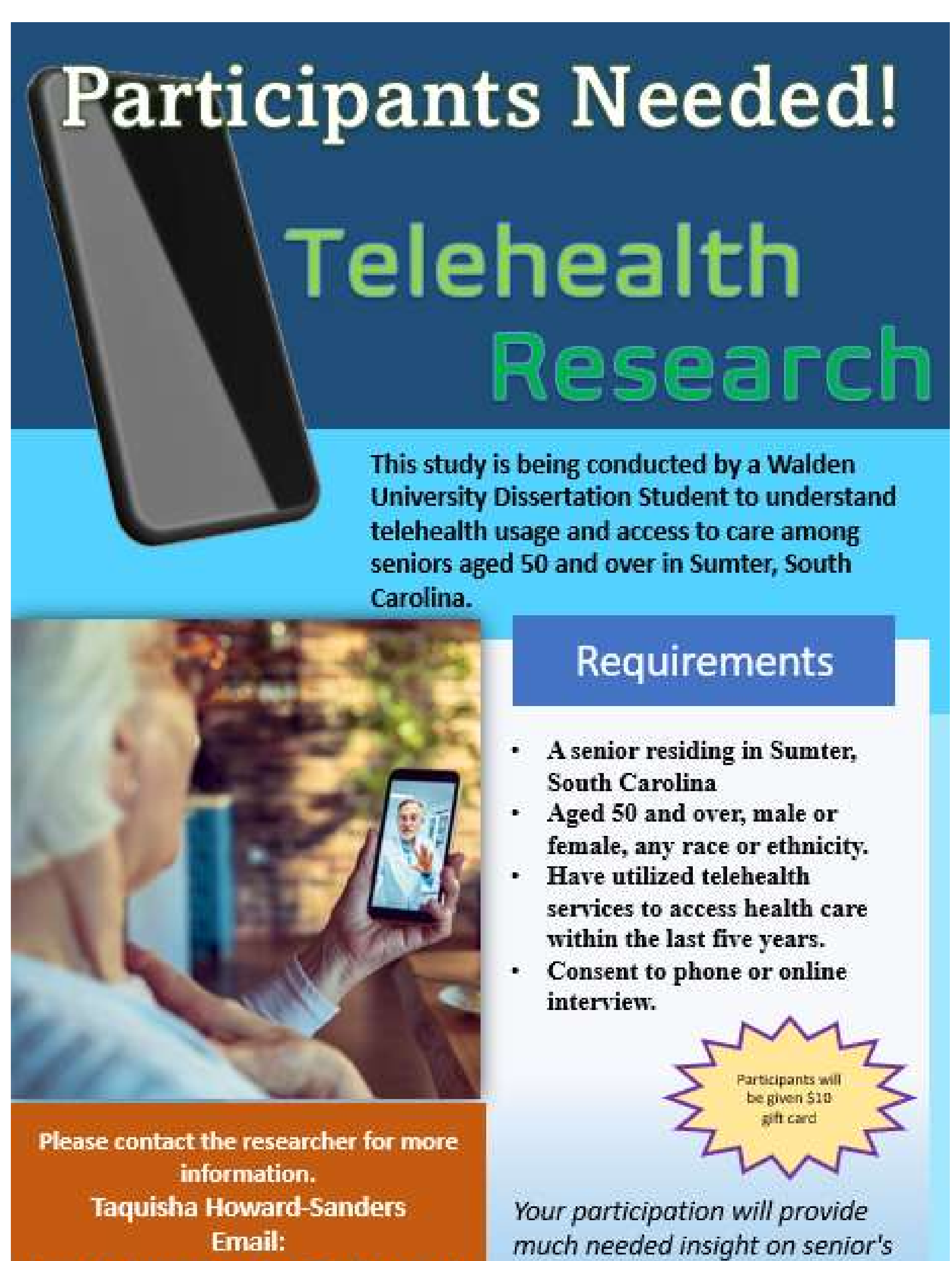
Appendix A: Participant Recruitment Flyer



Appendix B: Demographic Survey Questions

1. How old are you?

    - 50 – 59
    - 60 – 69
    - 70 – 79
    - 80 – 89
    - 90 – 99
    - 100 and over

2. Which of these groups would you say best represents your race? Please select all that apply.

    - Black
    - White
    - Asian
    - American Indian or Alaska Native
    - Native Hawaiian or other Pacific Islander
    - Other [box for text entry]

3. Are you Hispanic or Latino?

    - Yes
    - No
    - Do Not Know.

4. What is your gender?

    - Male
    - Female
    - Non-binary
    - Other [box for text entry]

5. What is the highest level of education you have completed?

    - Some high school
    - High school diploma or GED
    - Some college education
    - Associate’s degree
    - Bachelor’s Degree
    - Graduate or Professional Degree

6. What is your current relationship status?

- Married
- Divorced
- Widowed
- Separated
- Never Married
- Member of an unmarried couple
- Single
- Other [box for text entry]

7. What was the total combined income of those living in your house during the past 12 months? This includes money you and your partner make, alimony, child support, and housing allowances.

   - under $10,000
   - $10,000-$29,999
   - $30,000-$49,999
   - $50,000-$69,999
   - $70,000-$89,999
   - $90,000 or more

8. Which of the following best describes your work status?

   - Employed full-time.
   - Employed part-time.
   - Retired
   - Taking care of the house or family
   - Unable to work for health reasons.
   - On Layoff
   - Disabled
   - Volunteer Worker
   - Looking for work
   - Other [box for text entry]

9. Are you covered by health insurance or some other kind of health plan?

   - Yes
   - No
   - Do Not Know

10. What type of healthcare coverage do you have?

- o Private health insurance
- o Medicare
- o Medicaid
- o Military Healthcare (TRICARE/VA/CHAMP-VA)
- o Other government program
- o No coverage

11. In the last 12 months, was there any time when you did not have any health insurance coverage?

    - o Yes
    - o No
    - o Do Not Know.

12. In the last 12 months, have there been any times when you have used telehealth services to see a doctor?

    - o Yes
    - o No
    - o Do Not Know.

13. Do you have access to technology and/or the internet?

    - o Yes
    - o No
    - o Do Not Know.

Appendix C: Interview Questions

1. What are your personal experiences with telehealth services and access to care?
2. What is your understanding of telehealth services and access to care?
3. What are your general thoughts and perspectives about telehealth services and access to care?
4. Do you have any unique concerns about telehealth services as opposed to other in-person services when accessing care? If so, explain.
5. Do you have trustworthy issues surrounding telehealth services?
6. Who do you trust most or least about telehealth services?
7. Are there any contributing factors, such as other people's opinions, religious beliefs, or the media, which have played a role in your decision not to use telehealth services?
8. What are your views on promoting telehealth services to access care?
9. Will you use telehealth services if friends and family use telehealth services to access care?
10. Did a lack of confidence in the effectiveness of telehealth services influence your decision to refuse to use it? Please elaborate.
11. Tell me what significant issue(s) prompted your decision to refuse telehealth services to access care.
12. When I say access to healthcare, I mean your ability to see a doctor for regular care or in an emergency.

    a. Do your finances affect your access to healthcare? If so, how?

    b. Do your friends and family affect your access to healthcare? If so, how?

    c. Does your work affect how you access healthcare? If so, how?

d. Does your local community affect how you access healthcare? If so, how?

e. Does anything else affect your ability to see a doctor when needed? If so, what?