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Increasing Uninsured Patients' Compliance with Return Primary Care Visits

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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MS, Walden University, 2016

Project Submitted in Partial Fulfillment
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Abstract

Patients who are unable to comply with their health care regimen are almost 3 times more likely to have an adverse health outcome and are more likely to suffer irreversible progression of a chronic disease process. Increasing patient return clinic visits is essential, not only to curtail rapidly rising costs of health care but also to improve patient outcomes. This project focused on an uninsured patient population of a clinic in a rural community in the southeastern United States. The purpose of the project was to conduct a systematic review of the literature and identify the barriers and motivating factors for chronic care return primary care visits among uninsured patients. The theoretical models supporting the project were the health belief model and the chronic care model. A search of scholarly databases resulted in 366 articles meeting the inclusion criteria of peer-reviewed English-language literature published since 2014 that focused on outpatient care among uninsured populations. All identified articles were reviewed, and several interventions emerged as options to increase patient return rates: care transition and coordination services, patient education, patient follow up, pharmacy assistance programs, food assistance programs, and integration of computer-based literacy interventions. The clinic administrators determined that the best option for the site would be implementation of an on-site food program. The findings of this project have potential to create social change in clinics for uninsured in the community by addressing food insecurity and providing patients an incentive to return for care every 6 months.

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Dedication

I would like to take this opportunity to dedicate this DNP Project to my parents, the Rev. Rex M. and Marjorie Gray Carleton. Any success I have had in my life is entirely due to them.

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Section 1: Nature of the Project

Introduction

As of 2012, 117 million individuals, accounting for half the United States adult population, were diagnosed with at least one chronic health condition (Centers for Disease Control and Prevention [CDC], 2017). Half of those individuals were diagnosed with two or more chronic health conditions (CDC, 2017). The United States spends 71% of its annual $2.7 trillion annual health care expenditures caring for Americans diagnosed with more than one chronic condition (CDC, 2017). Additionally, persons diagnosed with multiple chronic health conditions must contend with significantly higher out-of-pocket costs to treat their conditions (CDC, 2017). Patients who adhere to their prescribed treatment regimen are almost three times more likely to have a favorable health outcome than those who do not (Jones, Smith, & Llewellyn, 2014). However, an estimated 50% to 60% of all patients fail to adhere to their medications as prescribed (Lam & Fresco, 2015). An estimated 30% of all hospital admissions caused by medication-related issues are the result of nonadherence (Lam & Fresco, 2015).

Failure to return for follow-up care for chronic conditions may be a central factor in the irreversible progression of the disease process (Davis, Baldwin, Hingorani, Dwyer, & Flanagan, 2017). Complications resulting from missed appointments cost the United States healthcare system over $150 billion annually (Odonkor & Cohen, 2017). Not only do missed appointments adversely affect a clinic's efficiency, but they also result in increased healthcare costs and wasted resources (Shrestha, Hu, & Taleban, 2017). However, the individual burdens and expenses associated with appointment noncompliance are not well understood limiting the ability to address this issue effectively (Mallow, Theeke, Barnes, Whetsel, & Mallow, 2014). Therefore, research into obstacles preventing patient compliance with return visits is warranted to understand this problem better and design an effective approach to addressing the problem. This clinical practice problem was particularly suited for a systematic review of the literature.

Problem Statement

In the clinic setting, patients are seen for an exacerbation in their chronic disease but do not return for scheduled follow-up visits. The clinical practice problem that required addressing, therefore, was the lack of follow-up visits among the patient population with chronic diseases. This failure in the continuity of care too often results in patients using emergency departments (EDs) as a resource for their primary health care needs, placing a further burden on already overcrowded EDs and increasing the financial strain on the treating facility. Expecting hospital EDs to provide primary medical care to uninsured patients with chronic health conditions is unrealistic in the face of continually rising healthcare costs. Identifying evidence-based approaches to increasing attendance at follow-up appointments for medical care is essential to improve the overall health of patients. The findings of this project are significant for the field of nursing practice as nurse practitioners (NPs) who serve as primary care practitioners are unable to provide proactive care for their patient population. It was imperative that this project identified factors that may increase patient appointment compliance in the primary care setting so that recommendations for improving clinic processes and practices can be presented to the area's free primary care clinic.

Project Purpose

The purpose of this doctoral project was to uncover evidence-based methods to address the gap-in-practice presented by patient nonadherence to follow-up care. The practice-focused questions that I used to guide this doctoral project were:

1. In uninsured patients located in a community with a free primary care clinic, why do the patients fail to return as scheduled for follow-up of their chronic health conditions?
2. What would motivate uninsured patients to return consistently as scheduled to ensure continuity with the care of their chronic health conditions?

This doctoral project has the potential to address the gap-in-practice created by indigent patients failing to return as scheduled by identifying factors behind missed follow-up clinic visits and recommendations for how to correct this pattern of noncompliance. Appropriately structured, the measures that I identified in this doctoral project could be implemented in other outpatient settings, thereby improving continuity of care in other clinics that would also result in improved patient outcomes.

Nature of the Doctoral Project

This project was a systematic review of the scholarly literature related to noncompliance with clinic follow-up visits. A substantial body of evidence exists supporting the importance of continuity of care. DuGoff, Bandeen-Roche, and Anderson (2016) demonstrated the relationship between consistent follow-up with a known provider and decreased adverse outcomes in a study involving 1,600 older adults diagnosed with diabetes and at least one other chronic condition. The relationship between continuity of care and health care costs was further demonstrated in a retrospective cohort study in patients with chronic obstructive pulmonary disease, type 2 diabetes, and congestive heart failure (Hussey et al., 2014). Maarsingh, Henry, van de Ven, and Deeg (2016) demonstrated the association between decreased continuity of care and increased mortality risk in a longitudinal aging study involving 1,712 individuals over a 17-year period. In a study involving 47,433 patients treated for hypertension, hypercholesterolemia, diabetes, or their associated complications, consistency with medical care was inversely related to all-cause health care costs, cardiovascular events, and cardiovascular mortality (Shin et al., 2014). While these data supported the connection between lack of continuity of care and less favorable patient outcomes, none of these studies involved uninsured patients in an indigent care setting.

As a result of this project, I have developed recommendations for an indigent primary clinic to improve continuity of care among their uninsured patients. I conducted a targeted review of the scholarly literature to evaluate the research relevant to the practice setting and the specific patient population. After a critical appraisal of the scholarly articles, selected methods that had shown to be effective in improving patient compliance with follow-up care were incorporated into an evidence-based recommendation for interventions to be developed and implemented at the indigent care clinic. In this doctoral project, I addressed the gap-in-practice that exists between the current state of patient noncompliance with follow-up care and optimal adherence and its associated improved patient outcomes.

Significance

There are a number of stakeholders who will be impacted by addressing this local problem. First and foremost are the indigent patients whose disease processes will be brought under better control and whose risks for long-term complications will be significantly reduced. The patients' caregivers and family members are also included as stakeholders as they are the ones whose lives are negatively impacted as a result of the patients' disease exacerbations and deteriorating health status. Other stakeholders of this problem include the clinic staff of indigent care clinics who must spend extra time and resources to treat a patient population whose chronic diseases are poorly controlled. The NPs providing care for this patient population are also stakeholders as they are being prevented from providing optimal disease management for this patient population focusing instead on treating exacerbations and complications caused by inconsistent patient follow-up. The support staff of these clinics are also stakeholders in this issue as these patients take longer to process and require a higher level of care. The funding organizations are significant stakeholders for this problem as they are responsible for meeting the operational costs of the clinic. Addressing the problem of inconsistent patient follow-up will ensure the donors' contributions to the clinic are used most effectively in providing free primary medical care to uninsured members of the community.

The practice of NPs working in outpatient primary care settings will benefit from this doctoral project through the identification of methods determined to be effective in increasing patient compliance with scheduled return visits. Improving patient follow-up will allow NPs to provide optimal disease management care and ensure patients maintain an optimal level of health free of chronic disease exacerbations and complications from lack of care continuity. It is likely that measures determined to be effective in increasing overall patient compliance with care may be relevant for improving compliance with follow-up visits.

Potential implications for positive social change include introducing healthy behavior patterns to the clinics' patient population. Additionally, as the patients learn effective health management skills, it is hoped that their family members and caregivers will learn from their experiences and also adopt a healthier pattern of chronic disease management.

Summary

The numbers of patients diagnosed with chronic health conditions and the costs associated with providing medical care for these individuals is increasing exponentially. Identifying the motivating factors behind patient noncompliance with follow-up visits is essential for this problem to be addressed. Through appropriate interventions, I project that patient health outcomes will be improved, while the burden of care faced by their caregivers will be reduced. Additionally, the practice of NPs will benefit by having a patient population adherent to their scheduled return clinic visits, thereby allowing for the provision of optimal chronic disease management. The potential implications of this doctoral project include the ability to incorporate the interventions in other outpatient primary care settings providing a significant positive social change.

Section 2: Background and Context

Introduction

The practice problem for this DNP project was the lack of adherence to follow-up appointments in the indigent setting. The practice-focused questions that I used to guide this doctoral project were:

1. In uninsured patients located in a community with a free primary care clinic, why do the patients fail to return as scheduled for follow-up of their chronic health conditions?
2. What would motivate uninsured patients to return consistently as scheduled to ensure continuity with the care of their chronic health conditions?

Focusing on these questions, the purpose of this project was to conduct a systematic review of the scholarly literature. The data I retrieved from the systematic review was used to identify methods to increase patient return to the clinic.

To support the process of evaluating this issue and recommending effective interventions, I selected a model best suited to identifying the motivating factors behind patient health behavior. The health belief model (HBM) was created in the 1950s by social psychologists in the United States Public Health Service to anticipate patient health-promoting behaviors and has been applied to a variety of diseases and settings (Skinner, Tiro, & Champion, 2015). I determined that the HBM was an effective tool to support this doctoral project. Patient adherence to their chronic care clinic visits directly impacts nursing practice as NPs must practice reactive care, rather than proactive care. Correcting this pattern of noncompliance will improve the level of care NPs provide to their patients, creating a positive impact on nursing practice and improving patients' health. In my role as a DNP student, I am strategically situated as an observer in the project setting, a position that allows me to consider the clinic operations through the trained eyes of an NP while maintaining the impartiality of an observer.

The Health Belief Model and the Chronic Care Model

The HBM has been used for over 50 years as a tool to determine which health behaviors people are most likely to complete (Skinner, Tiro, & Champion, 2015). The HBM purports that people are more likely to engage in health behaviors if they believe they are at risk of a developing a condition, that the disease or condition could have serious consequences, that a particular behavior could reduce their risk or the severity of the disease, that they will reap benefits from engaging in a health behavior, and if they perceive the benefits of action outweigh the risks of inaction (Skinner et al., 2015). Additionally, the HBM applies to individuals who are genetically predisposed or whose health and lifestyle risk factors increase the likelihood that they will develop a condition (Skinner et al., 2015). Clinician's use the HBM model to assess the patient's perceived susceptibility of risk for developing a condition (Skinner et al., 2015). Perceived severity represents the individual's belief regarding the seriousness of developing a disease or choosing not to seek treatment and any social consequences that will occur, inability to work or participate in activities, feeling stigmatized or ostracized because of their condition, or damaging their relationships with others (Skinner et al., 2015). The perceived threat is the relationship between susceptibility and severity; if the person does not perceive susceptibility or severity, then a threat that is present may not be recognized (Skinner et al., 2015). However, if susceptibility and severity are both determined to be elevated, then perceived threat is similarly increased (Skinner et al., 2015). Perceived benefits describe the belief that an advantage or positive result will occur if a recommended action is taken to reduce the threat or decrease risk factors (Skinner et al., 2015). While some health-related benefits are tangible, such as money saved by not smoking or reducing the number of prescriptions required to control their condition, others are social, such as feeling less stigmatized by maintaining a healthy weight and a more acceptable physical appearance or not smoking and being relegated to designated smoking areas (Skinner et al., 2015). Perceived barriers are those obstacles the individual believes will result in negative consequences for engaging in the health behavior (Skinner et al., 2015). Perceived barriers may include the costs of purchasing their prescription medications, the time required to prepare meals at home as opposed to the convenience of fast food, or the fear of being teased by their friends who continue to engage in unhealthy behaviors (Skinner et al., 2015). Finally, cues to action are internal or external motivators that prompt the patient to engage in a behavior Skinner et al., 2015). For example, an individual may be internally motivated by a symptom or externally motivated after hearing of a disease in the popular press (Skinner et al., 2015). Using the patient's perceptions as the basis of the HBM lends credence and strength to the structure provided by this model.

The validity of the HBM has been demonstrated through the universality of its application, making it an ideal model for this doctoral project. In a systematic review by Jones, Smith, and Llewellyn (2014), 78% of the 18 studies, reported significant improvements in patient adherence with 39% showing moderate to substantial effects when health behavior interventions were based on the HBM. A cross-sectional study of hypertensive patients revealed a direct correlation between higher perceptions of susceptibility, severity, and benefit and increased rates of adherence when compared to those with lower rates of perceptions (Kamran, Ahari, Biria, Malepour, & Heydari, 2014). The HBM was used to demonstrate the ability to correlate injury prevention behavior in high school students located in Shanghai, China (Cao, Chen, & Wang, 2014). After following the students for 1 calendar year, the participants' perceptions of benefits and seriousness were determined to significantly impact health behavior with perceived susceptibility and cues to action being the second and the third most important elements (Cao et al., 2014). The HBM was also used in a study involving 1,101 participants to demonstrate a correlation between the preventive health behavior of colorectal cancer screening with the participants' perceptions (Sohler, Jerant, & Franks, 2015).

Vaccination compliance is increasingly becoming a significant public health concern with herd immunity no longer a guarantee (Lewis et al., 2015). In a recent sampling of United States Air Force basic training recruits, seroprevalences for measles, rubella, and mumps were insufficient to ensure herd immunity (Lewis et al., 2015). However, recent studies involving the HBM have shed light on the relationship between vaccination rates and the perceptions of adults and the caregivers of infants and young children (Wagner et al., 2017). In a study involving 619 caregivers of children between the ages of 8 months and 7 years of age, perceived safety and vaccine necessity was significantly associated with pneumococcal vaccination rates (Wagner et al., 2017). In a second study involving 2,007 students, increased perceptions of barriers with decreased perceptions of general or specific benefits were more likely to not receive the human papillomavirus vaccination (Donadiki et al., 2014). Finally, in a study involving 1,377 adult patients exposed to an 8-month influenza vaccine campaign, the HBM demonstrated that addressing the participants perceived benefits and barriers improved vaccination behavior (Jones et al., 2015).

The HBM has also shown effectiveness at determining health behaviors of underage children (Walker, & Jackson, 2015). In a study involving eight focus groups composed of 42 children from second to fifth grade, perceptions of benefitting from improved esthetic appearance along with the perception of barriers and access to toothbrushes were determining factors in oral hygiene compliance (Walker, & Jackson, 2015).

Finally, the HBM has demonstrated the likelihood of patients adhering to their prescribed medications in a cross-sectional study of hypertensive patients from China revealing that increased levels of perceived susceptibility, self-efficacy, and cues to action accompanied with a decreased level of perceived barriers were significantly related to improved adherence with their antihypertensive medications (Yue, Li, Weilin, & Bin, 2015).

A second model that was well-suited to this doctoral project was the chronic care model (CCM), which was developed by Wagner and researchers at the MacColl Institute for Healthcare Innovation (Marcelli et al., 2017). The CCM was designed based on the literature that identified successful system change and practices that improved the care of patients with chronic health conditions and from the feedback and consensus of experts in their field (Sendall, McCosker, Crossley, & Bonner, 2017). The CCM transforms daily care measures for patients with chronic health conditions from reactive and acute measures to planned, proactive, and population-based care (Sendall et al., 2017).

By incorporating patient self-management support, community resources, health care organization support, clinical information systems, decision support, and the organization of the team, the CCM ensures effective care of the chronic patient (Marcelli et al., 2017). The first two of these components, community resources, and patient self-management support, focus on the patient and strive to empower patients to independently manage their health care needs and optimize their access to healthcare (Sendall et al., 2017). The final four, healthcare organization support, clinical information systems, decision support, and organization of the team, are strategies that aim to restructure the care and interdisciplinary teams, not only to better meet the individual patients needs but to improve the practice culture as it affects chronic disease management (Sendall et al., 2017).

The CCM was used in a retrospective study lasting 2 years involving 2,354 primarily uninsured, Hispanic hypertensive patients (Turner et al., 2018). Incorporating each of the six elements of the CCM, the intervention included a revision of the electronic medical record, establishing a registry of patients with diabetes mellitus, the creation of hypertension treatment protocols, education of the team, performance feedback, and case management (Turner et al., 2018). While the patients in the study demonstrated significantly improved control of their systolic blood pressure readings, the improvement took three to four years to realize indicating the financial rewards for this particular intervention may not be immediately apparent (Turner et al., 2018).

The CCM was also used in a quality improvement project designed to improve glycemic control by supporting diabetes self-management in a free clinic in the southeastern United States (Russell, Vess, Durham, & Johnson, 2017). Following an intervention incorporating each of the six elements of the CCM, mean fasting blood glucose readings decreased from 8.8% to 14.3% in comparison to the pre-intervention months (Russell et al., 2017). Both the HBM and the CCM were essential theoretical support for my work on this doctoral project.

Specific terms were used in this doctoral program and require clarification.

Patient: The uninsured individuals that seek medical care at the primary care outpatient clinic of this setting inclusive of patients ranging in age from 30 to 64 years and excludes patients age 65 years and older insured by Medicare.

Faith-based organization: The organization that provides the funding that allows the project primary care clinic to provide free medical care based on a motivation driven by their beliefs to create a positive social change in their community.

Compliance and adherence: The terms used interchangeably to indicate the patient is following the treatment plan as established by the NP.

Follow-up treatment: The behavior or action prescribed by the NP for the patient that includes returning for appointments or laboratory tests, maintaining blood glucose, blood pressure, or weight logs and bringing them to clinic appointments, taking their medications as prescribed, or any other health care behavior as directed by the NP.

Appointment: Initial appointment will be used to identify the patient’s first appointment at the clinic. And finally, follow-up appointment will be used to describe any appointment following the initial office visit at a time interval specified by the NP.

Relevance to Nursing Practice

Despite the evidence supporting improved patient outcomes resulting from patient adherence to their prescribed treatment plans, less than half of all patients comply with their prescribed health care plan (Lam & Fresco, 2015). Almost half of all deaths from asthma occur as the result of nonadherence to the treatment regimen (Andersson, Garfield, Eliasson, Jackson, & Raynor, 2014). Nearly one-third of all medication-related hospitalizations occur because of patient noncompliance (Lam & Fresco, 2015). Additionally, nonadherence increases the risk of death in diabetes by 80% and results in a 3.8-fold increase in the risk of death the first year following a heart attack (Andersson et al., 2014). However, patients whose conditions cause noticeable symptoms are more adherent than their asymptomatic counterparts (Andersson et al., 2014). This type of health behavior was also demonstrated in a population-based cohort study lasting 2 years using the medical records of 176,516 children between the ages of 5 and 18 years who were diagnosed with asthma (Engelkes, Janssens, Jongste, Sturkenboom, & Verhamme, 2016). A direct correlation was shown between the severity of the asthma and adherence with treatment and follow-up (Engelkes et al., 2016). Adherence to recommended health behaviors is shown to vary among recommendations with dietary and lifestyle recommendations more frequently disregarded than prescription medication instructions (Andersson et al., 2014). Such disregard for prescribed treatment regimens results in an adverse impact on the practice of NPs, preventing them from providing optimal patient care aimed at controlling their patients' chronic health conditions.

Patients who miss more than one follow-up clinic visit in 1 year are more likely to have higher hemoglobin A1c (HgbA1c) and lipid levels, increased body weight, increased blood pressure readings, higher depression scores, and take more medications (Mallow, Theeke, Barnes, Whetsel, & Mallow, 2014). While patient noncompliance may be an elective behavior, the failure to return for follow-up care results in health disparities further increasing the incidence of health status exacerbations and complications in different patient groups (Mallow et al., 2014). Patient populations located in geographically remote locations are more likely to be underinsured or uninsured and defer health care behaviors due to the costs involved (Mallow et al., 2014). Additionally, rural populations are less likely to participate in preventive health screenings (Mallow et al., 2014). Early follow-up visits are associated with increased patient adherence (Davis, Lin, Yu, Balkrishnan, & Feldman, 2014). Therefore, identifying and implementing measures effective at motivating this patient population to adhere to their prescribed treatment regimen is essential.

Previous research has shown decreased follow-up rates in poorly educated, low-income minority patients (Rosati, Ables, & Warren, 2017). Indigent patients have been identified to face obstacles to follow-up care that is unique to their socioeconomic status (van Zyl et al., 2015). Even when the management approach is identical, and the medical care for indigent patients is provided at no cost, indigent patient populations demonstrate nearly double the rate of noncompliance with their treatment regimen when compared to their insured counterparts (Thomas et al., 2017).

The doctoral project presented here addressed the nursing practice issue of patient noncompliance, and the subpar patient outcomes that result from skipped or missed follow-up visits among indigent patients. Identifying a method to motivate patients to attend free medical appointments was the first step in controlling these patients' chronic health conditions and curtailing the burden their noncompliance places on the community's resources. Research was conducted to identify the motivating factors behind the behavior pattern that allowed corrective measures to be developed and implemented.

Local Background and Context

The rates of uninsured and un- or underemployed individuals and households below the poverty level in the community of the DNP project are significantly higher than the rest of the United States, making this a medically underserved region. Adding further stress to the health care resources in this area is the precarious status of the two area hospitals. Both hospitals were forced to close several years ago and have only recently reopened. Despite the availability of a free primary care clinic located in the community, uninsured patients often fail to use the clinic for their primary care needs presenting instead to the hospitals' EDs. This inappropriate use of medical resources is increasing the financial strain on these medical facilities and jeopardizing their continued fiscal viability. Therefore, addressing the gap-in-practice was essential, not only to enable the uninsured patients in this community to receive primary care in the appropriate setting and at the appropriate intervals, but also to decrease complications due to inadequate chronic care management.

Role of the DNP Student

I first became aware of the community's indigent clinic while performing clinical rotations for my Master of Science in Nursing, Family Nurse Practitioner degree. Even after completing the clinical hours required for my degree, I continued to volunteer my services as an RN as I feel this clinic fills a critical gap in the healthcare network of this community. After completing my degree and becoming certified as an NP, I continued to volunteer as an NP to support this clinic and its patient population. My involvement with this community predates the primary care clinic as I was previously employed as an RN in the ED by both of the community's hospitals.

As an RN, I have spent the past 30 years working in EDs located in inner-city, rural, county, and private facilities. Through that experience, I quickly came to realize that certain individuals perceive the ED as their primary care site. However, I also realized that these same individuals routinely ran out of their prescription medications, did not have the benefit of preventive health care measures, were treated by a different practitioner at each visit, and had a much higher rate of complications and exacerbations requiring aggressive treatment and resulting in a more rapid deterioration of their health than their counterparts. When considering the commonalities among these patient populations, however, a common denominator was identified; a generational approach to healthcare. Certain individuals have been taught at an early age to address their health care concerns in the outpatient setting with one primary care practitioner while other persons experience healthcare interventions as a reaction to adverse symptoms with care provided in an ED. Therefore, an evidence-based approach must be designed to positively impact the behavior of this patient population.

Summary

Evidence from the scholarly literature was presented to support the need for the doctoral project and the theoretical approach to be used in the project. The local context of the project was described, and specific practice-focused questions were formulated to focus the systematic review of the literature and address the gap-in-practice identified by this doctoral project. Section 3 describes the methodology to be employed in the conduct of this project.

Section 3: Collection and Analysis of Evidence

Introduction

The purpose of this project was to identify measures designed to improve follow-up adherence in the indigent patient at a privately funded primary care clinic. The practice-focused questions for this project were designed to determine how to promote the return of patients for their medical care as scheduled. While logic would suggest that patients with chronic health conditions would comply with a treatment regimen designed to ensure their disease processes are optimally controlled, and exacerbations and complications are prevented, the data reveal a much different reality. Therefore, it was essential to identify answers to these practice-focused questions.

I used scholarly literature as the source of information into the issue of patient noncompliance. Specifically, I conducted a review of the scholarly literature to identify research that has been performed on underinsured or uninsured patients and measures taken to address noncompliance with their return primary care visits. However, less than 9% of individuals in the United States were without continuous insurance for the calendar year 2016 (United States Census Bureau, 2017), resulting in much of the research conducted in the United States being focused on the health behavior of insured individuals. Therefore, I included articles on research conducted in regions of the world that do not have high rates of insured individuals. While the behavior of individuals from other countries may be affected by cultural influences not found in the United States, the inability to afford medical care creates disparity in health care regardless of the setting.

Practice-Focused Questions

Patient adherence to the prescribed return visits bears a direct relationship to patient outcomes. However, research has demonstrated that even when care is available, uninsured patients are nearly twice as likely to be noncompliant with their visits (Thomas et al., 2017). This lack of compliance results in exacerbations in the patients' chronic diseases and increases the burden on the patients and their caregivers. The practice-focused questions that I used to guide this doctoral project were:

1. In uninsured patients located in a community with a free primary care clinic, why do the patients fail to return as scheduled for follow-up of their chronic health conditions?
2. What would motivate uninsured patients to return consistently as scheduled to ensure continuity with the care of their chronic health conditions?

My focus for this DNP project was to create evidence-based recommendations to improve patient compliance with their scheduled follow-up clinic visits.

Sources of Evidence

Sources of evidence for this DNP included material from the scholarly literature, specifically, literature regarding follow-up care with uninsured patient populations. While a significant amount of research was available, much of it focused on insured patients of a more stable socioeconomic class. Although the issue of follow-up adherence transcends all socioeconomic levels, priorities are different among individuals who lack an income able to cover their cost of living, healthy meal choices, safe housing, and reliable transportation. This class disparity renders motivators that work with one set of individuals being ineffective in the other group. Researchers explored various motivators for attending return visits such as charging the patient a percentage of the overall cost of a missed appointment or requiring a nonrefundable, fixed deposit that is either applied to the charge for the appointment or forfeited if the patient fails to attend (Aggarwal, Davies, & Sullivan, 2016). However, conclusive evidence supporting the effectiveness of financial incentives is lacking, and financial penalties disproportionately affect patients with limited incomes (Aggarwal et al., 2016). Therefore, I reviewed the scholarly literature to gain insight into the motivating factors for return clinic visits in this patient population and to identify evidence retrieved from research in similar practice settings or with similar patient populations. While an abundance of research evidence had been published in the current literature on improving patient follow-up in primary care clinics in the United States, the vast majority of the research was conducted in practice settings in which payment was required, either through an insurance company or by the patient out-of-pocket. Therefore, to the extent possible, I focused the literature review on settings in which medical care was provided at no cost to the patient.

The evidence I collected from the scholarly literature bore a direct relationship to the purpose of this doctoral project, to positively impact patient compliance with follow-up visits. Should recommended effective methods to promote primary care return visits be implemented in this practice setting by the administrative board, not only will adherence to the treatment plan be improved, but patient outcomes will improve, the indigent clinics will function more efficiently, and NPs will be able to proactively treat their patients rather than reacting to complications caused by noncompliance with the treatment plan. Therefore, it was essential that I identified evidence to answer the practice-focused questions of this doctoral project.

Published Outcomes and Research

Google Scholar, PubMed, MeSH, Medline, and ProQuest were each accessed for research pertinent to the project question. By searching these databases, I had access to peer-reviewed articles specifically addressing my clinical practice questions. Additionally, I engaged in snowballing, the process of researching the reference lists of the articles I select for inclusion in my DNP project.

Key search terms included: *follow-up care, patient follow-up, compliance, patient compliance, adherence,* and *patient adherence.* Additionally, to identify articles specific to the patient population of this DNP project, I used the terms *indigent, uninsured,* and *underinsured* with and without patient as a descriptor. I limited the data retrieval from the scholarly literature to the previous 5 years to prevent outdated research from being included and to ensure that the settings reflected current standards in primary care practices. While an abundance of material was present in the scholarly literature regarding patient follow-up in the healthcare setting, little of the research had focused exclusively on improving patient follow-up in the indigent patient population. I completed an exhaustive review of the evidence to identify material appropriate for the population addressed by this doctoral project.

Although the United States is a developed country, many of the challenges faced by underinsured or uninsured patients are similar to those faced by persons residing in less developed regions of the world. Therefore, I included research conducted on indigent patient populations in other areas of the globe. By limiting the selection to scholarly publications, the material was that which had been generated by experts in their fields and subjected to the peer-review process before publication in a journal. Before any work began on the project, the project was first approved by Walden University's Institutional Review Board.

Analysis and Synthesis

The evidence I collected for this doctoral project was taken from my review of articles from scholarly literature and the suitability of the evidence to the practice setting, the patient population, and the clinical practice problem. I excluded studies conducted in clinics in which the patient population pays for their services and included studies that focused on primary care of lower-socioeconomic, medically underserved patients and rural geographic areas without public transportation.

As the scholarly literature was available online, data retrieval occurred virtually rather than as a series of print articles. As I identified potential material for inclusion in the literature review, I determined the qualifications of the authors, how and from whom funding was obtained, and the location of the publisher. Additionally, I categorized the studies by design, the significance of the results, the measures of validity, the sample size, and the identification of methodological limitations. Finally, I determined whether or not the material had been cited by others provided insight into how the material had been used by others as well as identified other material potentially beneficial to this search. I then organized the literature to indicate the level of evidence as well as the quality of that evidence. Appendix C provides a review of the studies in this DNP project. Using Melnyk and Fineout's seven levels of evidence hierarchy, the articles were ranked from Level 1, the highest level of evidence to Level 7, the lowest level of evidence based on expert opinion (Melnyk & Fineout cited in Mick, 2016). Accordingly, the articles in this DNP Project included one Level 2 article, one Level 3 article, two Level 4 articles, and one Level 7 article. Relying on the Melnyk levels of evidence criteria provided the ability to differentiate between critically appraised evidence and background information not supported by scientific research. Evaluation of the literature based on the Melnyk levels of evidence criteria provided the ability to differentiate between critically-appraised evidence and background information not supported by scientific research.

As with any topic, I expected that gaps in the current literature would exist as well as strengths and limitations of the identified material. Identification of these issues not only served to support the inclusion of data in my DNP project but to highlight the need for ongoing research into the topic as well. Finally, following the identification and analysis of the studies relevant to my topic, I provided a list of recommendations that would address the gap in practice of patients failing to adhere to their treatment regimen.

Summary

The purpose of this project was to identify methods that would improve patient compliance with their prescribed follow-up care to improve patient outcomes. I designed practice-focused questions for this project to determine what could be done by the clinic to encourage and support the uninsured patients to return for chronic care visits. Additionally, by relying on material retrieved from studies published in the scholarly literature, the resulting product included evidence-based recommendations for the clinic to consider for addressing the problem. Following the approval of this doctoral project by Walden University's IRB (approval number 10-18-18-0474060) evidence collection and analysis began with the ultimate goal of positively impacting patient outcomes in this chronically underserved patient population.

Section 4: Findings and Recommendations

Introduction

Patients who fail to return for follow-up care are at an increased risk of adverse health outcomes. However, uninsured patients are almost twice as likely to be noncompliant with their medical appointments, even when care is available (Thomas et al., 2017). As a result of this noncompliance, providers for this patient population are unable to treat their patient population proactively. The practice-focused questions that I used to guide this doctoral project were:

1. In uninsured patients located in a community with a free primary care clinic, why do the patients fail to return as scheduled for follow-up of their chronic health conditions?
2. What would motivate uninsured patients to return consistently as scheduled to ensure continuity with the care of their chronic health conditions?

Guided by these questions, the focus of this doctoral project was to conduct a systematic review of the scholarly literature. Evidence for this DNP project included material taken from the scholarly literature that focused on improving compliance in the uninsured patient population. Data retrieval occurred virtually through scholarly internet sources using a PRISMA Flow Diagram to organize the relevant material as detailed in Appendix A. After restricting the information to material published since 2014 that focused on outpatient settings serving uninsured and underserved patients, I identified a total of 366 articles. Appendix C provides a detailed breakdown of the review of the 366 studies with six determined to be pertinent to this DNP Project, 24 identifying interventions not financially feasible in the indigent care setting, 36 identifying barriers to follow-up but failing to provide a solution, 17 focusing on patients with insurance, and 284 articles otherwise not pertinent to the topic at hand.

Findings and Implications

When I restricted data retrieval to articles that focused on appointment compliance for uninsured patients in the outpatient setting, a common theme of food insecurity as an impediment to patient follow-up was identified. Forty-eight million people in the United States live in food-insecure households (Katz, 2016). Food insecurity exists when the individual or household does not have reliable access to an adequate supply of nutritious food (Wetherill, McIntosh, Beachy, & Shadid, 2018). Disease management is negatively impacted by food insecurity resulting in poorer patient outcomes (Wetherill et al., 2018). The association between food insecurity and patient adherence to the treatment plan was relevant this doctoral project.

Vancouver Infectious Diseases Centre chose to address the issues of hepatitis C virus infection and food insecurity by issuing food coupons to redeem at community pop-up clinics (Alimohammadi et al., 2018). Of the patients who presented for hepatitis C virus testing, 100% redeemed their voucher for a free meal indicating that food incentivization may be an effective method of improving clinic appointment attendance (Alimohammadi et al., 2018).

Boston Medical Center emergency department staff and providers screen all patients for hunger (Katz, 2016). Patients determined to be in need of food support are provided a prescription from the provider that allows them to receive food from the Preventive Food

Pantry (Katz, 2016). Boston Medical Center opted to use a provider’s prescription as the mechanism to initiate patient inclusion in the food bank as the provider's order removes the stigma associated with being hungry and poor (Katz, 2016). Additionally, the Preventive Food Pantry and primary care providers are housed in the same facility allowing for concurrent patient follow-up and food supplementation (Katz, 2016).

The University of Oklahoma also created a food pharmacy to address the issue of food insecurity adversely impacting patients’ health status (Wetherill et al., 2018). Similar to the Boston Medical Center’s program, providers introduced patients to the OU Food Pharmacy through a prescription (Wetherill et al., 2018). However, the OU Food Pharmacy takes their program one step further by creating medically-tailored food packages designed by a dietician that also include curriculum addressing nutritional information and recipe cards (Wetherill et al., 2018). In the pilot study, all of the OU Food Pharmacy patients were given a diabetes, prediabetes, hypertension, and/or hyperlipidemia food package(s) (Wetherill et al., 2016). Additionally, the majority of the participants reported being food insecure and having to choose between medications and food at least once during the preceding year (Wetherill et al., 2018). While mean food insecurity did not change, among those patients diagnosed with hypertension who had used the food pharmacy at least four times, diastolic blood pressure was significantly improved (Wetherill et al., 2018). While diastolic blood pressure is only one of many health measurements, hypertension is a significant risk factor for many adverse cardiovascular events (Rapsomaniki et al., 2014).

Food insecurity has also been associated with an increase in missed appointments and noncompliance among HIV patients receiving free antiretroviral therapy (ART), resulting in an increase in adverse health outcomes (Whittle et al., 2016). Africa, in particular, struggles with widespread food insecurity and high rates of HIV infection (Maluccio, Palermo, Kadiyala, & Rawat, 2015). In a study involving 640 ART-naive HIV/AIDS patients living in Uganda, over a 12-month period, food assistance substantially decreased the number of self- and health care provider-reported HIV-related symptoms as well as increased overall physical health scores (Maluccio et al., 2015). In a second study focusing on HIV patients in Honduras who had demonstrated suboptimal adherence to their treatment regimen, monthly household food baskets with nutritional education decreased the number of missed clinic appointments and self-reported missed doses of ART (Martinez et al., 2014). Additionally, on-time prescription refills increased by 19.6% within the first 6 months of the intervention (Martinez et al., 2014).

Despite the commonalities found between food insecurity and lacking health insurance, relatively little research was available addressing these two interconnected issues. While the research on these topics did indicate that addressing food insecurity also addressed patient adherence to the treatment plan, each of the five studies in this doctoral project were conducted in a specific locale using resources unique to that area (Alimohammadi et al., 2018; Katz, 2016; Maluccio et al., 2015; Martinez et al., 2014; Whittle et al., 2016). This limitation raises the concern that the success of these programs may not apply to other settings. Additionally, the interventions in Boston and Oklahoma were funded by large organizations while the interventions in Africa were government-funded projects.

The implications of addressing food insecurity as a means to improve patient compliance have implications beyond improving the individual patient's overall health. Food insecurity is a concern of the household, not just the patient with the chronic health condition. By providing nutritious food supplementation, the other members of the home will reap the benefits of decreased food insecurity and improved nutrition. Additionally, by incorporating nutritional foods into the household members' diets, a pattern of healthful food choices will be supported that will serve to create a healthier populace.

Recommendations

Based on the material identified through the literature review, food assistance interventions are effective at improving patient follow-up. Therefore, I designed a food assistance program for use in the outpatient clinic setting providing primary care to uninsured patients. Following the conclusion of this DNP Project, I am recommending that The Food Box Rx program be implemented in the indigent care clinic that served as the clinical site for the project.

Strengths and Limitations of the Project

A strength of this doctoral project is the success of similar food assistance programs in the United States as well as in Uganda and Honduras. Each of these interventions identified that the provision of food positively impacted patient follow-up with their treatment plan. A limitation of the project is that following a thorough search of the scholarly literature, I only found six articles in which food interventions were used to address patient follow-up. However, I found no studies in which food interventions were unsuccessful in addressing patient adherence to the treatment plan, it is possible that the dearth of information reflects the small amount of research conducted on this topic, rather than the inability of this intervention to improve patient follow-up.

Section 5: Dissemination Plan

Dissemination Plan

As a result of the dissemination of my findings, I expect that the organization will implement the Food Box Rx Program plan I designed for the free outpatient primary care clinic. In addition to the free medical care, the funding organization for the clinic also supports a community service center that provides assistance with employment opportunities, living expenses, showers, new clothing, and a food pantry. However, at present, the primary care clinic does not coordinate their services with the other services provided by the funding organization. While food donated to the food pantry includes day-old bakery items, the food pantry also receives a steady supply of canned fruits and vegetables. Additionally, each summer and fall, the food pantry receives donations of fresh produce from area gardeners as well as sporadic donations from overstocked grocers throughout the year. While the food pantry does not typically receive donated proteins, providing food boxes of fresh and canned fruits and vegetables as well as the healthier bakery items would enhance the nutritional content of the patient's meals as well as, at least partially, alleviate the food insecurity experienced by the patient and their household. Therefore, the Food Box Rx intervention will be implemented to coordinate the efforts of the primary care clinic and the food pantry and enhance the nutritional status of patients' diets, which may also improve patient follow-up in this patient population.

For all patients presenting to the clinic, household food insecurity will be assessed by a nurse practitioner using the United States Household Food Security Survey Module: Six-Item Short Form (United States Department of Agriculture, 2017). Appendix B contains the

Six-Item Short Form developed by researchers at the National Center for Health Statistics in conjunction with Abt Associates Inc. to identify households where food insecurity exists (United States Department of Agriculture, 2017). Background information on the Six-Item Short Form, the U.S. Household Food Security Survey Module: Six-Item Food Security Module with instructions, and instructions on Coding Responses and Assessing Households' Food Security Status are provided in Appendix B. The nurse practitioners will use this information to determine whether or not the patient is in a food-insecure household and eligible for the Food Box Rx intervention. Each patient identified to be food insecure will receive a food box at the conclusion of their clinic appointment as well as a prescription from the nurse practitioner enabling them to receive monthly food boxes for their households. The prescription from the nurse practitioner will be signed and dated by the provider and will include the patient's name, date of birth, and the number of members in the patient's household. As with prescriptions for medications, the food box prescription will expire at the end of 6 months, thereby motivating the patient to return to the clinic for their follow-up medical care as well as a reevaluation of their household's food insecurity. Food boxes will contain the following items: four cans of vegetables per week for each member of the home, four cans of fruits per week for each member of the home, and one loaf of bread per week for every two members of the household. If the home has an odd number of members, the number of household members will be rounded up. Food boxes will be prefilled by the food pantry volunteers and stored in the primary care clinic's storeroom to allow for the first food box to be provided during the patient's clinic appointment. When the patient presents to the food bank for their monthly food box, they will receive a portion of fresh produce for each member of the household. The portion size of the fresh produce will be determined by the item, i.e., a head of lettuce, a stalk of celery, a bundle of leafy greens. For individual items such as apples, pears, or potatoes, they will be issued in five-pound portions. Due to the perishable nature of fresh produce and bakery items, these items will continue to be stored at the food pantry to prolong their shelf-life.

Orientation for the food box prescription program will be provided by the organization's manager and lead nurse practitioner at the clinic and by the organization's manager at the food bank. As the food boxes will contain non-perishable food items, 20 boxes will be maintained at the clinic. The manager will be responsible for inventorying the food boxes at the end of each day at the clinic and informing the food pantry how many replacement boxes are required. Delivery of the food boxes to the clinic will be made by the organization's driver as part of his daily responsibilities.

Analysis of Self

As a healthcare professional who has spent the majority of the past 30 years working in county and inner-city emergency departments, I have a deep appreciation for the obstacles encountered by persons with chronic health conditions who lack health insurance. Additionally, as a family nurse practitioner, the majority of my experience has been in settings that serve uninsured and indigent patients. These experiences were the motivating factors for my DNP project. The focus of this project has not been just to ask why the patient does not return for follow-up care, but also to determine what can increase the likelihood that the patient will return as requested. Combining the knowledge and skills I have gained as a health care professional as well as those acquired as a student-scholar, I have sought to design an evidence-based intervention best suited to the patient population of this project. Before the implementation of the Affordable Care Act, approximately 16% of the nonelderly population was uninsured (Kaiser Family Foundation, 2018). While the Affordable Care Act increased access to health insurance, as of 2016, 10.3% of nonelderly individuals remained uninsured in the United States (Kaiser Family Foundation, 2018). Additionally, as long as Congress remains at odds on how to address the ongoing issue of access to health care for the uninsured, this uninsured patient population will continue to present unique challenges to the health care industry. As a family nurse practitioner whose focus is the care of the uninsured patient, I am uniquely situated to both implement and evaluate evidence-based interventions created for this patient population.

A unique barrier faced during the completion of this doctoral project was the challenges presented by the uninsured patient population. When the patient must choose between prescription medications and groceries, food wins out. Therefore, an intervention designed to encourage the patient to return for care while supporting their basic needs was essential. Additionally, as with any intervention designed to impact a patient population, culture had to be considered. All too often, culture is used as a synonym for non-white racial identity (Fisher-Borne, Cain, & Martin, 2015). However, while race and ethnicity are integral components of a person's cultural identity, other influences such as gender, disability, socioeconomic status, and sexual orientation cannot be discounted (Fischer-Borne, Cain, & Martin, 2015). Similarly, the presence, or lack, of health insurance shapes a patient's cultural identity. Therefore, by approaching this unique patient population through a position of cultural humility, mutual empowerment and respect can be achieved thereby creating the opportunity for optimal care and lifelong learning for both the clinician a well as the patient (Foronda, Baptiste, Reinholdt, & Ousman, 2016).

Summary

Patient adherence to follow-up care is essential if optimal patient outcomes are to be achieved. However, when patients are forced to choose between health care appointments and meeting their daily needs, health care often comes in second. If we are to successfully meet the health care needs of those on the fringes of society, we must first design evidence-based interventions that not only address their health care needs, but also the most basic needs for their survival. Therefore, in this DNP project, I identified and initiated an intervention capable of improving patient follow-up in an indigent care setting, while addressing basic food insecurity. Appropriately implemented interventions based on the findings of this DNP project will not only alleviate the food insecurity experienced by this patient population but has potential to improve overall health status by facilitating the continuity of their health care. The findings of this project have potential to create social change in clinics for uninsured in the community by addressing food insecurity and providing patients an incentive to return for care every 6 months.

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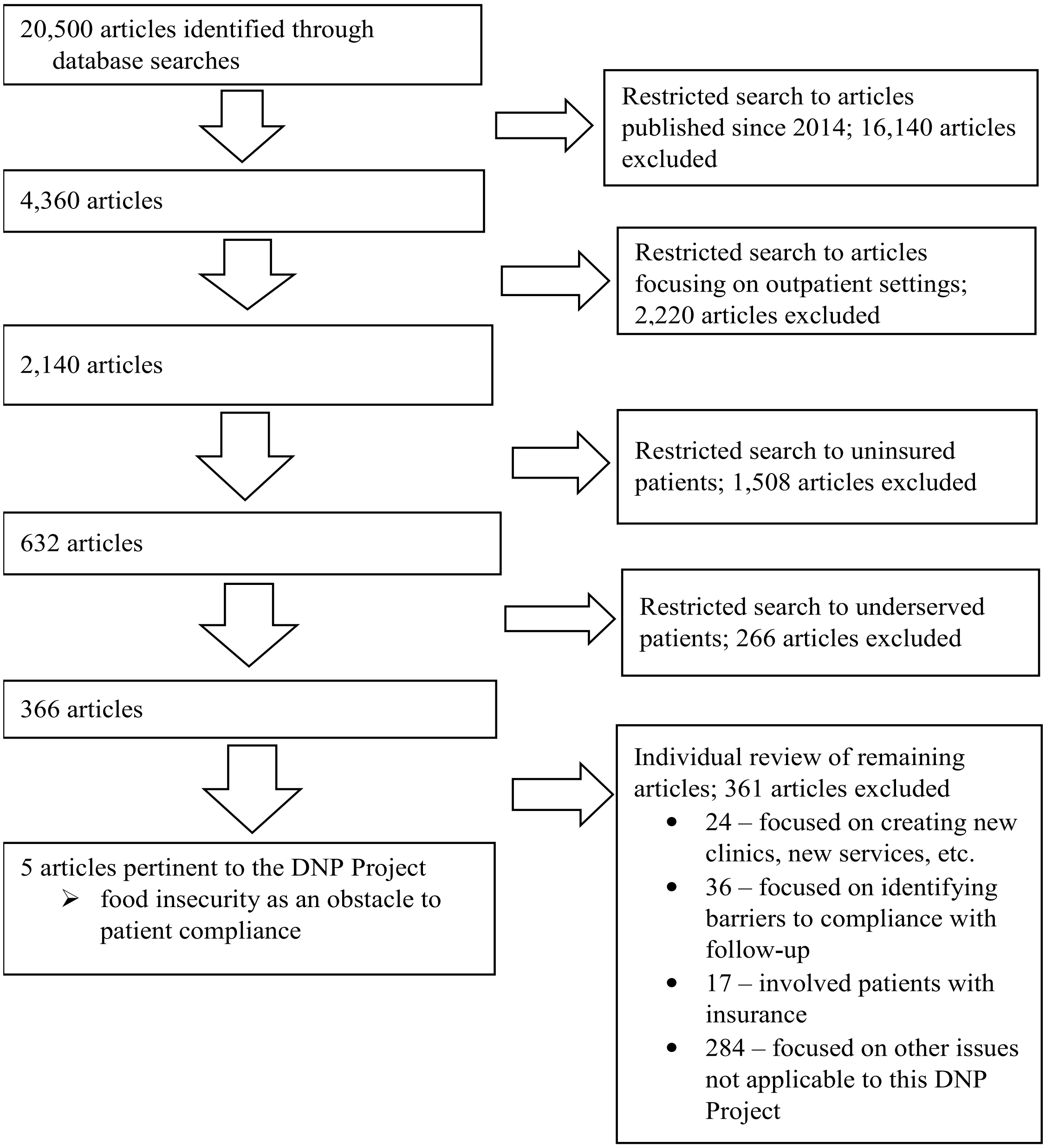
Appendix A: Prisma Flow Diagram



Appendix B: Food Insecurity Questions and Scoring

U.S. Household Food Security Survey Module: Six-Item Short Form
Economic Research Service, USDA
September 2012

Revision Notes: The food security questions in the 6-item module are essentially unchanged from those in the original module first implemented in 1995 and described previously in this document.

September 2012:
Added coding specification for "How many days" for 30-day version of AD1a.

July 2008:
Wording of resource constraint in AD2 was corrected to, "…because there wasn't enough money for food" to be consistent with the intention of the September 2006 revision.

January 2008:
Corrected user notes for coding AD1a.

September 2006:

- Minor changes were introduced to standardize wording of the resource constraint in most questions to read, "…because there wasn't enough money for food."
- Question numbers were changed to be consistent with those in the revised Household Food Security Survey Module.
- User notes following the questionnaire were revised to be consistent with current practice and with new labels for ranges of food security and food insecurity introduced by USDA in 2006.

Overview: The six-item short form of the survey module and the associated Six-Item Food Security Scale were developed by researchers at the National Center for Health Statistics.

Background: The six-item short form of the survey module and the associated Six-Item Food Security Scale were developed by researchers at the National Center for Health Statistics in collaboration with Abt Associates Inc. and documented in "The effectiveness of a short form of the household food security scale," by S.J. Blumberg, K. Bialostosky, W.L. Hamilton, and R.R. Briefel (published by the *American Journal of Public Health*, vol. 89, pp. 1231-34, 1999). ERS conducted additional assessment of classification sensitivity, specificity, and bias relative to the 18-item scale.
If respondent burden permits, use of the 18-item U.S. Household Food Security Survey Module or the 10-item U.S. Adult Food Security Survey Module is recommended. However, in surveys that cannot implement one of those measures, the six-item module may provide an acceptable substitute. It has been shown to identify food-insecure households and households with very low food security with reasonably high specificity and sensitivity and minimal bias compared with the 18-item measure. It does not, however, directly ask about children's food security, and does not measure the most severe range of adult food insecurity, in which children's food intake is likely to be reduced.
These next questions are about the food eaten in your household in the last 12 months, since (current month) of last year and whether you were able to afford the food you need.

NOTE: If the placement of these items in the survey makes the transition/introductory sentence unnecessary, add the word "Now" to the beginning of question HH3: "Now I'm going to read you...."

FILL INSTRUCTIONS: Select the appropriate fill from parenthetical choices depending on the number of persons and number of adults in the household.

HH3**.** I'm going to read you several statements that people have made about their food situation. For these statements, please tell me whether the statement was often true, sometimes true, or never true for (you/your household) in the last 12 months—that is, since last (name of current month).

The first statement is, "The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more. Was that often, sometimes, or never true for (you/your household) in the last 12 months?"

[ ] Often true
[ ] Sometimes true
[ ] Never true
[ ] DK or Refused

HH4. "(I/we) couldn't afford to eat balanced meals." Was that often, sometimes, or never true for (you/your household) in the last 12 months?

[ ] Often true
[ ] Sometimes true
[ ] Never true
[ ] DK or Refused

AD1. In the last 12 months, since last (name of current month), did (you/you or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?

[ ] Yes
[ ] No (Skip AD1a)
[ ] DK (Skip AD1a)

AD1a. [IF YES ABOVE, ASK] How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?

[ ] Almost every month
[ ] Some months but not every month
[ ] Only 1 or 2 months
[ ] DK

AD2. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

[ ] Yes
[ ] No
[ ] DK

AD3. In the last 12 months, were you every hungry but didn't eat because there wasn't enough money for food?

[ ] Yes
[ ] No
[ ] DK

User Notes

(1) Coding Responses and Assessing Households' Food Security Status:
Responses of "often" or "sometimes" on questions HH3 and HH4, and "yes" on AD1, AD2, and AD3 are coded as affirmative (yes). Responses of "almost every month" and "some months but not every month" on AD1a are coded as affirmative (yes). The sum of affirmative responses to the six questions in the module is the household's raw score on the scale.

Food security status is assigned as follows:

Raw score 0-1—High or marginal food security (raw score 1 may be considered marginal food security, but a large proportion of households that would be measured as having marginal food security using the household or adult scale will have raw score zero on the six-item scale)
Raw score 2-4—Low food security
Raw score 5-6—Very low food security

For some reporting purposes, the food security status of households with raw score 0-1 is described as food secure and the two categories "low food security" and "very low food security" in combination are referred to as food insecure.

For statistical procedures that require an interval-level measure, the following scale scores, based on the Rasch measurement model may be used:

Number of affirmatives	Scale score
0	NA
1	2.86
2	4.19
3	5.27
4	6.30
5	7.54
6 (evaluated at 5.5)	8.48

However, no interval-level score is defined for households that affirm no items. (They are food secure, but the extent to which their food security differs from households that affirm one item is not known.)

(2) Response Options: For interviewer-administered surveys, DK ("don't know") and "Refused" are blind responses—that is, they are not presented as response options but marked if volunteered. For self-administered surveys, "don't know" is presented as a response option.

(3) Screening: If it is important to minimize respondent burden, respondents may be screened after question AD1. Households that have responded "never" to HH3 and HH4 and "no" to AD1 may skip over the remaining questions and be assigned raw score zero. In pilot surveys intended to validate the module in a new cultural, linguistic, or survey context, however, screening should be avoided if possible and all questions should be administered to all respondents.

(4) 30-Day Reference Period: The questionnaire items may be modified to a 30-day reference period by changing the "last 12-month" references to "last 30 days." In this case, item AD1a must be changed to read as follows:

AD1a. [IF YES ABOVE, ASK] In the last 30 days, how many days did this happen?

______ days

[ ] DK

Responses of 3 days or more are coded as “affirmative” responses.

(5) Self Administration: The six-item module has been used successfully in mail-out, take-home, and on-site self-administered surveys. For self-administration, question AD1a may be presented in one of two ways:

Indent AD1a below AD1 and direct the respondent to AD1a with an arrow from the “Yes” response box of AD1. In a parenthetical following the “No” response box of AD1, instruct the respondent to skip question AD1 and go to question AD2.

Present the following response options to question AD1 and omit question AD1a:

- Yes, almost every month
- Yes, some months but not every month
- Yes, only 1 or 2 months
- No

In this case, either of the first two responses is scored as two affirmative responses, while “Yes, only 1 or 2 months” is scored as a single affirmative response.
The two approaches have been found to yield nearly equal results. The latter may be preferred because it usually reduces the proportion of respondents with missing information on how often this behavior occurred.

Appendix C: Literature Included

Citation	Purpose	Population/ Sample Size(N)/ Setting	Design	Variables/ Instruments	Intervention	Results	Nursing Implications	Intervention Effectiveness	Type/ Level of Evidence
Alimohammadi, A., Holeksa, J., Parsons, R., Yung, R., Amiri, N., Truong, D., & Conway, B. (2018). Diagnosis and treatment of hepatitis C virus infection: A tool for engagement with people who inject drugs in Vancouver's Downtown Eastside. *Canadian Liver Journal, 1*(2), 14-33. doi:10.3138/canlivj.1.2.002	"This study evaluates a new model of engagement with people who inject drugs in the Downtown Eastside."	Over a 12-month period, 1,283 OraQuick tests performed at 44 community pop-up clinic	Multidisciplinary, community-based approach to diagnose inner-city people infected with the hepatitis C virus providing on-site testing, immediate medical consultation, and meal vouchers as an incentive to adhere to clinic appointments.	Demographic variables including homelessness, unemployment, injection drug use, and indigenous origins. Z-test was used to evaluate specific variables Z- test was used to compare the study cohort to the national value	Community pop-up clinics were strategically placed in Vancouver's Downtown Eastside to evaluate up to 30 adults in a three-hour period for the hepatitis C virus using the OraQuick test.	21% tested positive for the hepatitis C 68% who tested positive were people who injected drugs 50% began care in the clinic 61% who received interferon-free directly acting antiviral hepatitis C virus therapy attained 100% cure rate Individuals choosing no care more likely to be homeless	The multidisciplinary team included members from nursing, medical, and logistics support. So structured, nursing was an active participant in providing addiction-related, medical, psychiatric, and social support.	Effective	Level 4
Katz, A. (2016). News: Food counts as medicine at Boston Hospital. Emergency Medicine *Emergency Medicine News, 38*(3A), 1.doi:10.1097/01.eem.0000481857.54281.85	"Physicians at Boston Medical Center (BMC) are writing patients prescriptions for its on-site Preventive Food Pantry to combat hunger."	N/A	N/A	N/A	Providers screen for food insecurity provide Prescriptions for Boston Medical Center Preventive Food Pantry.	The Boston Medical Center Emergency Department has not seen an increase in health patients presenting for hunger.	Nurse Practitioners as well as nurses can be active partners in screening patients for food insecurity.	Effective	Level 7

Maluccio, J. A., Palermo, T., Kadiyala, S., & Rawat, R. (2015). Improving health-related quality of life among people living with HIV: Results from an impact evaluation of a food assistance program in Uganda. *PLOS ONE, 10*(8), e0135879. doi:10.1371/journal.pone.0135879	"To conduct a prospective impact evaluation of a monthly household food basket on the physical and mental dimensions of health-related quality of life."	640 participants from two districts, 318 in the intervention district and 322 in the nonparticipation district	Controlled trial without randomization	Individual background, individual measured health status, individual self-reported health status and diet, household background, distance from household to clinic and market, and survey interview characteristics.	Food assistance intervention	Over a 12-month period food assistance significantly improved physical health scored and substantially decreased the number of provider- and self-reported HIV-related symptoms	Nurse Practitioners as well as nurses can be instrumental in screening for food insecurity	Effective	Level 3
Martinez, H., Palar, K., Linnemayr, S., Smith, A., Derose, K. P., Ramírez, B., … Wagner, G. (2014). Tailored nutrition education and food assistance improve adherence to HIV antiretroviral therapy: Evidence from Honduras. *AIDS and Behavior, 18*(S5), 566-577. doi:10.1007/s10461-014-0786-z	"We implemented a pilot intervention with people receiving ART in Honduras to test the effects of provision of a household food basket plus nutritional education sessions on ART adherence compared to nutritional education alone."	400 HIV patients at four clinics in Honduras	A 12-month prospective clinical trial to study the effects of nutritional education alone versus nutritional education with a food basket on antiretroviral therapy adherence in Honduras	Food insecurity, anthropometric measurements, and dietary intake	Nutritional education alone versus nutritional education with a food basket.	On-time prescription refills increased with the food basket and nutritional education group by 19.6% after six months with no further increase at 12 months.	N/A The randomization of the study participants was conducted at the top removing nursing from actively participating in this study.	Effective	Level 2

Wetherill, M. S., Chancellor McIntosh, H., Beachy, C., & Shadid, O. (2018). Design and implementation of a clinic-based food pharmacy for food insecure, uninsured patients to support chronic disease self-management. *Journal of Nutrition Education and Behavior, 50*(9), 947-949. doi:10.1016/j.jneb.2018.05.014	"The University of Oklahoma (OU) Food Pharmacy was designed to accomplish 3 outcomes: (1) improve patient knowledge and intake of affordable, medically appropriate foods, (2) reduce household food insecurity, and (3) reduce nutrition-related clinical risk factors for cardiometabolic disease."	Any patient accessing using one of the two test clinics that were identified by a medical student, social work student, or were self-enrolled in the program.	A clinic-based food pharmacy designed to support chronic disease self-management for uninsured patients identified to be food insecure	N/A	Monthly food packages, educational booklets, and recipe cards.	Significant improvement in daily dietary fiber intake. Nonsignificant increase in daily vegetable and fruit intake. No change in mean food insecurity. Significantly improved mean diastolic blood pressure among participants with hypertension that used the food program at least four times.	Although nursing was not an active participant in this study, nurses are trained to identify patients who are food-insecure	Effective	Level 4

Appendix D: Literature Reviewed

	5 Pertinent to the DNP Project	24 New Clinics, New Services, etc.	36 Identifying Barriers	17 Insured Patients	284 Otherwise Not Pertinent to the DNP Project
1	Alimohammadi, A., Holeksa, J., Parsons, R., Yung, R., Amiri, N., Truong, D., & Conway, B. (2018). Diagnosis and treatment of hepatitis C virus infection: A tool for engagement with people who inject drugs in Vancouver's Downtown Eastside. *Canadian Liver Journal,* 1(2), 14-33. doi:10.3138/canlivj.1.2.002	Seggelke, S. A., Hawkins, R. M., Gibbs, J., Rasouli, N., Wang, C., & Draznin, B. (2014). Transitional care clinic for uninsured and Medicaid-covered patients with diabetes mellitus discharged from the hospital: A pilot quality improvement study. *Hospital Practice, 42*(1), 46-51. doi:10.3810/hp.2014.02.1091	Virapongse, A., & Misky, G. J. (2018). Self-identified social determinants of health during transitions of care in the medically underserved: A narrative review. *Journal of General Internal Medicine, 33*(11), 1959-1967. doi:10.1007/s11606-018-4615-3	Medford-Davis, L. N., Lin, F., Greenstein, A., & Rhodes, K. V. (2017). "I broke my ankle": Access to orthopedic follow-up care by insurance status. *Academic Emergency Medicine, 24*(1), 98-105. doi:10.1111/acem.13058	Rubin, D. J. (2018). Correction to: Hospital readmission of patients with diabetes. *Current Diabetes Reports, 18(*4). doi:10.1007/s11892-018-0989-1
2	Milne, W. K. (2013). News: Food counts as medicine at Boston Hospital. *Emergency Medicine News, 35*, 1. doi:10.1097/01.eem.0000430463.97133.02	Shubhakaran, K. (2016). The feasibility of establishing a free clinic for uninsured patients with neurologic disorders. *Neurology: Clinical Practice, 6*(1), 8.1-8. doi:10.1212/01.cpj.0000481031.10070.56	"Harkey, K., Kaiser, N., Inman, M., & Reinke, C. E. (2018). "Are we there yet?"- Factors affecting postoperative follow-up after general surgery procedures. *The American Journal of Surgery, 216*(6), 1046-1051. doi:10.1016/j.amjsurg.2018.09.016	Capp, R., Misky, G. J., Lindrooth, R. C., Honigman, B., Logan, H., Hardy, R., … Wiler, J. L. (2017). Coordination program reduced acute care use and increased primary care visits among frequent emergency care users. *Health Affairs, 36*(10), 1705-1711. doi:10.1377/hlthaff.2017.0612	Rubin, D. J. (2015). Hospital readmission of patients with diabetes. *Current Diabetes Reports, 15*(4). doi:10.1007/s11892-015-0584-7
3	Maluccio, J. A., Palermo, T., Kadiyala, S., & Rawat, R. (2015). Improving health-related quality of life among people living with HIV: Results from	Feinglass, J., Wein, S., Teter, C., Schaeffer, C., & Rogers, A. (2018). A qualitative study of urban hospital transitional care. *Qualitative Research in*	Patel, N., Yopp, A. C., & Singal, A. G. (2015). Diagnostic delays are common among patients with hepatocellular carcinoma. *Journal of the National Comprehensive*	Suh, H. S., Kang, H., Kim, J., & Shin, E. (2014). Effect of health insurance type on health care utilization in	Yek, C., De la Flor, C., Marshall, J., Zoellner, C., Thompson, G., Quirk, L., … Jain, M. K. (2017). Effectiveness of direct-acting antiviral therapy for hepatitis C in difficult-to-treat patients in a safety-net health system: A retrospective

	an impact evaluation of a food assistance program in Uganda. *PLOS ONE, 10*(8), e0135879. doi:10.1371/journal.pone.0135879	*Medicine & Healthcare, 2*(2). doi:10.4081/qrmh.2018.7216	*Cancer Network, 13*(5), 543-549. doi:10.6004/jnccn.2015.0074	patients with hypertension: A national health insurance database study in Korea. *BMC Health Services Research, 14*(1). doi:10.1186/s12913-014-0570-9	cohort study. *BMC Medicine, 15*(1). doi:10.1186/s12916-017-0969-3
4	Martinez, H., Palar, K., Linnemayr, S., Smith, A., Derose, K. P., Ramírez, B., … Wagner, G. (2014). Tailored nutrition education and food assistance improve adherence to HIV antiretroviral therapy: Evidence from Honduras. *AIDS and Behavior, 18*(S5), 566-577. doi:10.1007/s10461-014-0786-z	Conklin, J. R., Togami, J. C., Burnett, A., Dodd, M. A., & Ray, G. M. (2014). Care transitions service: A pharmacy-driven program for medication reconciliation through the continuum of care. *American Journal of Health-System Pharmacy, 71*(10), 802-810. doi:10.2146/ajhp130589	Fiorillo, C. E., Hughes, A. L., I-Chen, C., Westgate, P. M., Gal, T. J., Bush, M. L., & Comer, B. T. (2017). Factors associated with patient no-show rates in an academic otolaryngology practice. *The Laryngoscope, 128*(3), 626-631. doi:10.1002/lary.26816	Hoadley, J. H., & Summer, L. S. (2014). The role of Medicaid managed care in delivery system innovation. doi:10.15868/socialsector.25072	Sonmez, H., Kambo, V., Taha, R., & Poretsky, L. (2016). Reducing hospital re-admissions in patients with diabetes: Developing better strategies. *Endocrine Practice, 22*(9), 1134-1136. doi:10.4158/ep161315.co
5	Wetherill, M. S., Chancellor McIntosh, H., Beachy, C., & Shadid, O. (2018). Design and implementation of a clinic-based food pharmacy for food insecure, uninsured patients to support chronic disease self-management. *Journal of Nutrition Education and Behavior, 50*(9), 947-949. doi:10.1016/j.jneb.2018.05.014	Gao, L., Joseph, J., Santoro-Levy, M., Multz, A. S., & Gotlieb, V. K. (2016). Utilization of pharmaceutical patient and prescription assistance programs via a pharmacy department patient assistance program for indigent cancer patients. *Hospital Pharmacy, 51*(7), 572-576. doi:10.1310/hpj5107-572	Graham, J. L., Shahani, L., Grimes, R. M., Hartman, C., & Giordano, T. P. (2015). The influence of trust in physicians and trust in the healthcare system on linkage, retention, and adherence to HIV care. *AIDS Patient Care and STDs, 29*(12), 661-667. doi:10.1089/apc.2015.0156	Kessell, E., Pegany, V., Keolanui, B., Fulton, B. D., Scheffler, R. M., & Shortell, S. M. (2015). Review of Medicare, Medicaid, and commercial quality of care measures: Considerations for assessing accountable care organizations. *Journal of Health Politics, Policy and Law, 40*(4), 761-796. doi:10.1215/03616878-3150050	Sudore, R. L., Barnes, D. E., Le, G. M., Ramos, R., Osua, S. J., Richardson, S. A., … Schillinger, D. (2016). Improving advance care planning for English-speaking and Spanish-speaking older adults: Study protocol for the PREPARE randomised controlled trial. *BMJ Open, 6*(7), e011705. doi:10.1136/bmjopen-2016-011705

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9		Roberts, D. L., Velligan, D. I., & Fredrick, M. (2017). The use of access groups for engagement in community mental health post	Sims, R. R., William I. Sauser, J., & Bias, S. K. (2016). Transforming government organizations: Fresh ideas	Bhatia, R., Lala Chinoy, S., Kaushish, B., Puri, J., & Singh Chahar, V. (2017).	Wieder, R., DeLaRosa, N., Bryan, M., Hill, A. M., & Amadio, W. J. (2014). Prescription coverage in indigent patients affects the use of long-acting opioids in the management of cancer pain. *Pain Medicine, 15*(1), 42-51. doi:10.1111/pme.12238

		hospitalization. *Community Mental Health Journal, 54*(5), 533-539. doi:10.1007/s10597-017-0212-x	and examples from the field. Charlotte, NC: IAP.	Examining the evidence on the effectiveness of India's rural employment guarantee act. doi:10.23846/wp0027	
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