ABSTRACT

CHURCHWELL, ATALAYSHA LAQUETTE. The Complexity of Care: A Single Case Study Exploring the Intersectionality of Culture and Chronic Life Stressors on Trust. (Under the direction of Dr. Edwin R. Gerler).

The purpose of this instrumental qualitative case study was to learn about the lived experiences of patients within primary care settings as it relates to trust. The development of trust is central to the therapeutic relationship between providers and patients. The assessment process, which is a crucial first step in ascertaining the needs of patients, is only as accurate as the information that the provider is able to obtain. Knowing the thorough history of the patients’ presenting problems, treatment history, and perspective regarding culture and life stressors can assist the provider with having a more holistic picture of what is happening with the patient and what is important to them. This case study explored the factors of chronic life stressors and culture on trust development within a primary care clinic in Durham, North Carolina. The Primary care clinic is identified as where the patients are assigned and receiving care for at least three months with a chronic health condition and assigned to a Physician within the practice. Patients were identified two ways, which include patients meeting prescreening referred by providers and patient volunteers. Patients were interviewed about their experiences with trust in their providers within the primary care clinic. Recommendations for future research and clinical implications were also discussed.
The Complexity of Care: A Single Case Study Exploring the Development of Trusting Patient-provider Relationships

by
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DEDICATION

This is dedicated to my personal village who has supported me along my journey to find my purpose and to my community whom have allowed me to live it. May the fruition of my work allow others to be heard, be well, and feel supported in their life journey.
Atalaysha Laquette Churchwell was born in Grand Rapids, Michigan and raised in Kentwood, Michigan. She earned a bachelor’s degree in university studies from Middle Tennessee State University. She subsequently graduated with a master’s degree in Counseling Psychology from Tennessee State University. Upon graduating, Atalaysha worked in governmental departments, community behavioral health, and health systems as a counselor, administrator, and behavioral health coordinator in Tennessee and North Carolina for several years before returning to school to pursue her doctoral degree in Counselor Education at North Carolina State University. Atalaysha is a Licensed Professional Counselor and Licensed Clinical Addiction Specialist.
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CHAPTER ONE: INTRODUCTION

In the early twenty-first century, discussions about disparities in health led to a conclusion that health inequalities across race, gender, and other cultural factors are among the nation’s most unyielding concerns (CDC, 2007; Nelson, 2002). The World Health Organization’s Commission on the Social Determinants of Health (2008) concluded that reducing health inequities was a matter of social justice. Social injustices such as historic oppression can be a chronic life stressor, which are constant and can be tied to enduring social structures, causing or exacerbating health concerns (Meyer, 2003). According to the American Psychological Association (APA): “Chronic stress can occur in response to everyday stressors that are ignored or poorly managed, as well as exposure to a traumatic event” (How Stress Harms section, para 3, 2013). Chronic stress can exacerbate risk of chronic health conditions such as heart disease, obesity, depression, gastrointestinal problems, and asthma. The Center for Disease Control (CDC; 2007) named chronic disease a public health challenge of the 21st century with nearly half the population being affected by 2030. With the rising concerns of health disparities and the challenges of chronic disease, it becomes increasingly relevant to identify and resolve barriers to engaging patients in effective care.

Disease management is best accomplished through trusting relationships between patients and providers (LaVista et al., 2009). The United States has historically had difficulty with embracing people of color, and this has led to the lack of preparation for the social dynamic that a multiracial democracy yields (Comas-Diaz, 2000). People of color and other marginalized populations have historically not received an equitable distribution of the American dream. Specifically, populations that include people of lower socioeconomic status experience limited resources that can include housing, transportation, and chronic physical and behavioral health
concerns. Often times these disparities are the foundations of other more direct challenges that
derail treatment progress. These challenges highlight the importance of having further research
regarding the multiple factors that can affect health outcomes and what providers can do to
address those concerns in an effort to promote enhanced health outcomes.

Of particular interest, is the literature regarding social cultural factors such as
communication, expectations, difference in race and gender, mistrust and underutilization of
preventative care (DesJesus, Vickers, Howell, & Stroebel, 2012; Johnson-Lawrence, Griffith, &
These developments in the exploration of some of the factors that affect health outcomes are
promising. However, research exploring the intersection of chronic life stressors and culture on
patient-provider trust within marginalized populations, given that mistrust negatively affects the
therapeutic relationship and the health outcomes, was missing from the discussion. Adults within
marginalized populations receiving care within Primary Care clinics experience disruptions in
health outcomes when there is a perception of mistrust within the patient-provider relationship.
Gaining insight into perceptions of trust among marginalized populations regarding the patient-
provider relationship could lead to the development of improved provider interventions, better
engagement, and improved patient health outcomes.

As the integration of health care and the use of Patient-Centered Medical Home model
(PCMH) models have evolved there is potential for providers of care in clinic settings to expand
and better address the needs of the identified population. Additionally, the collaborative
approach outlined within the PCMH model encourages and invites the provider within the clinic
to be expanded to include nurse practitioners, social workers, counselors, physician assistants,
and the primary care provider. A core objective of the PCMH model is to, “address the rising
costs stemming from the escalation of chronic diseases. Primary care thus shoulders the double burden of preventing and managing rising chronic disease while also being responsible for lowering health care costs” (Howard, Malouin, & Callow-Rucker, 2016, pg. 10). The PCMH model also called Primary Care Medical Home model encourages patients to be managers of their own illness (Howard, Malouin & Callow-Rucker, 2016). The model identifies strategies to address health outcomes and challenges the health care providers to explore the lives of patients and engage with community resources to promote health education, lifestyle, and environmental changes.

The professional counselor in an integrated PCMH, as other healthcare providers can be an important member of the team to help empower the patient, identify variables that affect patient engagement in their health, and improve their health outcomes. Counselors and other behavioral health professionals can address emotional and behavioral barriers to engagement to care and provide the necessary resources to patients that may prevent patient follow-through. Being able to better understand the totality of the patient’s needs is beneficial towards the identification of a person-centered plan of care. The purpose of the current study was to learn about how the patient experiences patient-provider trust development within a primary care clinic. The study was qualitative in nature and attempted to outline qualitatively the shared experiences of patients within a Durham County primary care clinic dealing with trust development. The current researcher focused on exploring the experiences of patients regarding trust within the patient-provider relationship. The researcher also examined how chronic life stressors and culture may affect the perceptions of trust. Additionally, the researcher explored patient perceptions of provider engagement in PCMH.
Primary Care and Current Modeling

Primary care is a core component within any health system. Kilo and Wasson (2010) identify that “primary care was defined as an entity in 1961. Medicare and Medicaid programs were signed into law July 1965” (pg. 10). The World Health Organization (WHO) at the international conference in 1978 defined primary care in the Alma-Alta declaration. The WHO defined primary care as:

Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO, 1978).

Although, it was thought that appropriate health could be achieved for all by the year 2000, at this time in the United States there still isn’t universal healthcare for individuals and families. However, there have been advances that have been made to identify and improve care in community clinic settings. When individuals have access to primary care it can reduce the use of crisis services and provide opportunity to engage in preventative care. It is the intention of primary care to be effective and safe for the patient population and community they serve. The World Health Organization updated part of the definition to primary health care (2008) to include:

Person-centeredness, comprehensiveness and integration, and continuity of care, with a regular point of entry into the health system, so that it becomes possible to build an enduring relationship of trust between people and their health-care providers (pg. 42).
The patient is intended to be the center of care. The consistent engagement of care with primary care clinics is intended to support a trusting relationship between the patient and the provider. Additionally, the primary care relationship is intended to be just that, the primary health relationship that a patient has and not the acute settings of the emergency department.

**Patient-Centered Medical Home**

The Patient-Centered Medical Home model are examples of primary care clinics intended to follow guidelines identified by the National Center for Quality Assurance (NCQA). In 2007 the American College of Physicians adopted the principles of PCMH. Phillips and Bazemore (2010) identified the core of the PCMH’s to include the redesign of primary care, reimbursement reform, relationship focused, and comprehensive care. PCMH’s should address rising cost of healthcare by expanding the team of providers to better coordinate care within the clinic and empowering the patient to address chronic conditions. Providers can include physicians, nurse practitioners, nurses, physician assistants, social workers, counselors, pharmacist, and nutritionist. PCMH’s encourages whole person care for the patient, utilizing team coordination to overcome some barriers of multiple system engagement. Transitions out of crisis services such as inpatient hospital visits back to the community are crucial opportunities to coordinate care and ensure patients are supported and connected within their community and with their primary care clinics for continued care.

**Five key functions.** The Agency for Healthcare Research and Quality (AHRQ) identifies five key functions and attributes of a PCMH. This entity is within the U.S. Department of Health and Human Services. The key functions that support the PCMH model are (a) comprehensive care, (b) patient-centered, (c) coordinated care, (d) accessible services, and (e) quality and safety.
Ensuring patient-centered comprehensive care requires the provider to invest in understanding the culture, motives, and specific needs of the patient to improve health outcomes.

**Population health.** Addresses the concerns of the wellness of the community in addition to the individual patient. Exploring health on a larger population scale with the availability to evaluate data to guide appropriate interventions. To appropriately address population health it includes preventive care, cross system collaboration, early intervention, and investment from the patient to manage chronic conditions.

**Patient engagement.** The patient’s role within the PCMH model is to collaborate with the provider and take the lead in care planning that is relevant to them. This is a shift from provider driven care; the patient is the true expert of their needs. With the patient invested in the direction of their care, interventions identified should empower the patient to the action of change. Keeley, West, Tutt, and Nutting (2014) state, “The patient experience has been described as a multidimensional, complex phenomena that is influenced by individual and environmental phenomena” (pg. 2). To improve patient engagement it requires the attention of both the patient and provider in the way they interact. Kilo and Wasson (2010) found there is, “still much to learn about truly meeting patients' needs and engaging patients meaningfully in their care” (pg. 776).

**Need and Rationale for the Study**

Expectations for PCMH’s to meet accreditation requirements consistently address safety concerns. Often in attempts to engage the patient in their care, practices provide patient satisfaction surveys or review patient safety reports. Satisfaction doesn’t equate to trust with the provider, but that one may be satisfied with the service and the immediate need is met. There has been research exploring some social cultural factors such as communication. Improved
communication can encourage trusting relationships, but may not be an exclusive variable to trusting relationships.

Additionally, explorations of race and gender in relationship to trust have been examined. O’Malley, Sheppard, Schwartz, and Mandelblatt (2004) explored higher trust in the physician by African American woman increase their participation in preventative care. Benkert, Peters, Clark, and Keves-Foster (2006) found that trust dilemmas affect African American’s willingness to seek care and follow treatment recommendations. Additionally, Benkert et al. (2006) identified racism as a chronic life stressor. O’Malley et al. (2004) encouraged exploring global trust, as it is difficult to separate institutional trust versus interpersonal trust with provider. Trust is central to an effective patient-provider relationship. There were limitations in the research regarding a lack of direct observation of patient care and engagement with providers.

Behnia (2008) explores interpersonal trust and how three typical approaches to trust development only speak to initial trust and that the client-provider relationship benefits from a deeper level of trust development. Trust and the belief of future trustworthy actions encourages cooperation and can reduce the complexity of life (Behnia, 2008). Hupcey and Miller (2006) found the patient perception of trust aren’t well understood. Additionally, with PCMH the definition of the provider has expanded and much of the current research explores the patient-provider relationship regarding the physician. There is a wealth of research that is disease specific regarding belief of trust. Murray and McCrone (2014) identified that much of the qualitative research completed has been grounded theory or cross-sectional quantitatively with tools that are patient-physician specific. The research has explored ethnically diverse populations, but are often evaluating White and African American populations from metropolitan areas.
In review of the literature, an identified gap is exploring cultural influences that aren’t connected to ethnicity specifically, unevaluated variables that influence trust, patients living in smaller communities, including a wider definition of provider, exploration of additional populations that are identified as marginalized populations. Finally, research that explores alternative qualitative methodologies could provide an additional perspective regarding understanding what trust development means and looks like for the patient.

Specifically, this research explored the identified gap in the literature regarding understanding the intersectionality of culture and chronic life stressors on trust development. The problem explored was: Understanding adults within marginalized populations receiving care within a Primary Care clinic and their experiences of trust development within the patient-provider relationship. The purpose of this case study was to explore and describe how culture and chronic life stressors factor on trust development between the provider and patients at a local integrated primary care clinic, and summarize some assertions that may be used by the patient and/or the provider to address those factors to improve health outcomes. The current study adopted a single instrumental case study (Stake, 1995) with the issue of Trust Development being illustrated at a Durham County primary care clinic. It was the intention of the researcher to gain insight into the issue of trust development with individuals within a specific primary care clinic in a smaller urban city in North Carolina and how providers can promote health outcomes.

The research was grounded in multiple in-depth interviews with patients, informal field observation within clinic of the immediate environment and service flow, and review of archival records regarding the clinic to include statistical data made available for public use. The bounded time of the case was with patients who had been assigned to the PCMH for at least three months at time of the first interview, no more than two years. Initial interviews with participants were
completed within two-week timeframe. Based on this single case study, the aim of the research was to a) Identify and organize overarching themes/issues; b) Synthesize and summarize the study findings to help inform future development of effective ways to develop trust taking cultural and chronic life stressors of patients into consideration.

**Significance of the Study**

Two of the three components of the *Triple Aim* of healthcare are quality care and improved health of the population (Institute for Healthcare Improvement, 2014). Currently, focusing on client satisfaction does not address trust development. Trust can affect adherence and follow-through with healthcare needs. With limited time during encounters and the complexity of concerns that patients can have, addressing patient-provider trust can improve the quality and health of the population. Translating some of the constructs of the aforementioned theories into practice combined with a better understanding of trust development within primary care clinics, could be useful in accomplishing improved interactions, authentic relationships, and identifying patterns that hinder trust thus becoming a barrier to care. Obtaining an extensive understanding of trust development within the practice between patients and providers in primary care settings was the objective of this study.

Providers within primary care practices engage with clients often at the onset or exacerbation of chronic life stressors, which can include chronic health conditions and historic oppression. The multitude of stressors, the rate at which they occur, and their intersectionality with culture factors for marginalized populations can make it difficult to identify the source of client concerns. An analysis of socio-economic, historical, psychological, and environmental factors as they relate to ethnic and cultural truths broadens the scope to a collectivist perspective rather than an individual one (Comas-Diaz, 2000). A change in provider perspective to
embracing their client’s non-linear experiences that are complex could promote a more accurate awareness of the client experience. This in turn increases the ability of individuals to relate to others more authentically and empathetically (Comstock et al., 2008).

Healing has the potential to occur in the context of mutually empathic and growth fostering relationships (Comstock et al., 2008). Patient-provider trust is promoted when clients feel understood, respected, and heard; leading to their believing the provider has their best interest in mind (Levin et al., 2006). With secured patient-provider trust, client health responses can improve, thus improving health adherence, outcomes, and overall quality of care. Trusting relationships could position providers to facilitate the reorganization and adaptive functioning necessary to develop new client patterns within the dynamic human system (Livneh & Parker, 2005). Helping individuals develop relationships that promote growth can be beneficial to relational connections. Lastly, this new framework encourages providers to help clients with exploring the root of their concerns instead of the presenting symptoms.

Changing client perceptions of provider’s awareness of their needs and enlightening providers to consider alternative perspectives that can still assist them with accomplishing their overall goal of improved health for patients; will be a system shift (Perna, 1997). The shift in perspective towards a more social justice holistic health approach that fosters trust development will require psychosocial education and advocacy to encourage stakeholders to make the change. This is a unique opportunity for the counseling profession to take a leadership role in advancing integrative models that support and advocate for marginalized populations’ healthcare needs. It is hoped that the information from this study would be used in future research to increase provider awareness on foundational ways to engage the patient and develop trust in a more lasting way.
Additionally, to encourage counselors to explore possible interventions within PCMH’s that support trust development.

**Research Questions**

This study explored the lived experiences of patients within the PCMH as it related to issue of patient-provider trust development. The purpose of this exploratory qualitative design was to learn from the direct accounts of patients what their experience are with issues of patient-provider trust development. The research questions that were explored were: *How does trust development begin within a primary care clinic? How do patients perceive provider trust? What are ways trust development is established or hindered?*

**Key Terms Defined**

There are several key terms used throughout the literature that are important to be aware of. Some terms have been used interchangeably, therefore, it is important to define the key terms of this study. Failure to define key terms could result in confusion. The following key terms are mentioned in this study:

1. **Patient** – The individual receiving services. Can also be referred to as client, consumer, beneficiary, or enrollee.
2. **PCMH** – Primary Care Medical Home. May also be referred to as Patient-Centered Medical Home. Phillips and Bazemore (2010) identified the core of the PCMH’s to include the redesign of primary care, reimbursement reform, relationship focused, and comprehensive care.
3. **EMR** – Electronic Medical Record. May also be referred to as an Electronic Health Record. This record includes patient specific information that can include diagnosis, treatment plans, and medication.
4. Marginalized Populations – Historically underserved or unserved communities. Groups of people that have been pushed to the margins of society economically, culturally, politically, and socially. Individuals that may identify with a history of oppression, poverty, geographic isolation, socioeconomic status, mental health diagnosis.

5. Provider – Individuals that are a part of the care team providing services. This can include Physician, Specialist, Nurse, Nurse Practitioner, Physician Assistant, Social Worker, Counselor, Dietician, Pharmacist, and Health Education staff.

6. Lived experience(s) – The first-hand accounts, interpretation, and impressions of an individual. In the case of this study, it would be the lived experiences of patients.

Summary

This dissertation consists of five chapters. Chapter One provided an overview of the subject matter, detailed Primary Care, PCMH, explained the need and rationale of this study. It explains the significance of the study, states the research question, and defines key terms that will be used throughout the dissertation. Chapter Two is a literature review on trust, perceptions, and chronic stress as it relates to the patient-provider relationship. Various theories that can relate to variables that affect trust are examined. Chapter Three provides an outline of the research design, methodology, participants, data collection, and data analysis. Chapter Four reports on the results and findings of this study. Chapter Five is a summary of this research. The limitations of this study and implications for future research are reported.
CHAPTER TWO: LITERATURE REVIEW

The formulation of a therapeutic perspective can evolve over years of experience for a provider. Developmental stages and the acquisition of appropriate skills at each level are essential to the clinical process when creating effective treatment planning. Developing treatment pathways within a team is a central focus with the Primary Care Medical Home Model (Thom et al., 2014) which has been successful in lowering costs, improving quality care, and enhancing patient satisfaction. The Institute for Healthcare Improvement (IHI; 2014) presents the Triple Aim of healthcare as a focus on excellent quality care, lowering total cost, and improving the health of their populations. With a focus of lowering cost while improving quality care and health, many providers have limited time with clients, challenged to address complex care needs appropriately, and may find it difficult to juggle the requirements of the healthcare system. Finding ways to help providers address the multitude of system concerns while meeting the needs of their patients can only benefit both the providers and the patients, thus accomplishing the Triple Aim of healthcare.

Improving the health of the population has to include the patient identified within the population. Satisfaction with the services provided within the health system are multilayered. Additionally, the patient and their experiences are complex. Within any given clinic, both individual and systematic cultures collide; each affecting the potential health outcomes of the patient uniquely (Oelke, Thurston, & Arthur, 2013; Simonds et al., 2013). The literature supports that a collaborative approach to care is helpful with not only obtaining, but also sustaining treatment outcomes for patient (DeJesus et al., 2012; Dobbins, Thomas, Melton, & Lee, 2016). However, the collaboration has to functionally include not only the expansion of the identity of the provider within the clinic working together, but also the patient engaging in a meaningful
way with the team to improve their health outcomes (Okorgo & Odedina, 2016). Phillips and Bazemore (2010) explored the lack of understanding of the most beneficial way that the primary care practices can function in health reform.

For the purpose of this study, the focus is on the patient-provider relationship. The literature contains a number of articles that discuss multiple variables affecting that relationship including systems and organizations as a whole (Blomqvist & Stahle, 2004; Lanham et al., 2016). The patient-provider relationship is complex, but at the core of understanding the relationship, is trust (Behnia, 2008; Dawson-Rose et al., 2016). This study focuses on issues of trust development within the patient-provider relationship. This literature review explores trust and concepts that were found in the review to be effected by or interfere with trust development within the patient-provider relationship. The subject being discussed and mentioned in the literature review are seen as similar and related to the current study and the research question.

**Trust and Trust Development**

Trust is defined by Levin, Whitener, and Cross (2006) as, “a person’s willingness to be vulnerable to another because he or she expects that the other person has his or her interest at heart, cares for him or her, and feels goodwill toward them” (p. 1164). The patient-provider relationship essentially begins with the patient presenting in a vulnerable state with health concerns. There are multiple definitions of Trust within the literature. For the purpose of this study, Levin, Whitener, and Cross (2006) definition and the dependence of meeting patient expectations for care to establish and/or maintain trust as described by Hupcey et al. (2006) is the combined definition of trust and trust development used. Satisfaction is different from trust and ensuring expectations of patients and providers are understood is important to accomplishing both. Rowe, Kellam, and Stott (2014) stated: “Patients and providers bring completely different
expectations to clinical encounters. When these expectations differ due to cultural reasons, beliefs, or values, communication is necessary to ensure each participant is satisfied with the result of the encounter” (p. 34). Furthermore, Thom, Hall, and Pawlson (2004) pointed out that:

Satisfaction looks backward, based on past experience, while trust looks forward, and expectation of future behavior. Although satisfaction refers to the patient’s opinions of the physician’s actions, trust refers to the relationship between the physician and patient based largely on perceptions about the physician’s motivations. Trust also has a strong emotional component not present in satisfaction (p. 127).

Individuals who trust have positive expectations of another’s intentions, competence, and believe they wouldn’t be exploited for reasons such as power, profit, or pleasure (Behnia, 2008). Studies show that physician trust is more important than treatment satisfaction in predicting adherence to prescribed therapy and overall satisfaction with care (Piette, Heisler, & Krein, 2005). Physician trust correlates positively with acceptance of new medications, intention to follow physician instructions, perceived effectiveness of care, and improvements in self-reported health status (Haskard-Zolnierek & DiMatteo, 2009). Some individuals will have trust within the health system and individual professionals within that system just because the respect that comes with the profession (Platt, Jacobson, & Kardia, 2018).

As the expansion of the definition of provider has occurred supporting a more collaborative approach, there are identifiable gaps in the literature regarding trust development with additional team members. Much of the literature explores the patient-provider trust relationship in comparison to the physician or nurse within the Primary Care Clinic and separately the counselor or social worker within the therapeutic relationship (Behnia, 2004; Thom, 2004). Smythe et al. (2017) in a phenomenological study within the nursing profession
explored through interviews with mental health workers how it appeared they had a stronger bond of trust versus nursing. When there are limits given to trust, it will be limits to receiving it. Smythe et al. (2017) found through provider interviews that offering relational space to patients, having open thinking, and acknowledging mutual trust is a continual process; trust appeared stronger from the participant perspective. There is potential with additional information from the patient that the integrative nature of a PCMH can improve trust development. With the integrative care component in PCMH clinics, there is an opportunity to gain understanding from the patient’s perspective of trust.

Collaboration in care plan development when attempting to address chronic health concerns is helpful. Van Dongen et al. (2016) explored through a qualitative focus group mapped influences of collaborations from healthcare professionals that found provider motivation, identified leadership within a team, understanding the culture of the clinic, and patient-provider related factors as key to successful teams. Limitations identified were that participants focused on theory and not an expression of their personal experiences. Additionally, a noted limitation and suggested further research were the need to explore patient experiences and perceptions, as they are a vital member of the team needed to have successful collaboration and improved outcomes (Van Dongen et al., 2016).

**Importance of Trust in PCMH**

As the primary care team has adjusted to meet the needs of the population and to meet the Triple Aim of health care, the PCMH in many identified practices includes multiple licensed professional involved to assist the patient with improved quality of care. These new teams improve shared decision-making, coordination of services, care plans with clear goals, and clear communication (Dobbins et al., 2016). To accomplish improved outcomes with the patient in
shared decision-making, trust becomes essential to accomplish the goal at hand. Being transparent regarding cost of procedures and other health concerns goes along way for patients establishing trust with their providers (Liao, Emanuel, & Navathe, 2016).

Conversations about care becomes more individualized. Additional members of the team, it becomes increasingly important for the providers to improve communication with the team and with the patient to reduce confusion and treatment direction (Liao, Emanuel, & Navathe, 2016). The organization that is thoughtful in their designation of PCMH incorporates training, structure, and person-centered communication to develop trust within the treatment process. Lantham et al. (2016) did a cross-sectional study surveying clinicians at U.S. family medicine clinics and found that trust and reflection together become a strong indicator of a strong relationship. However, the focus of this study was discussing the importance of trust within the PCMH team and effectively expanding the team to improve care. Improved trust and reflection increased diversity of thought, shared decision-making, and mindfulness. Lantham et al. (2016) limitations involved the study was by self-report without direct observation of clinic interactions with members of the team and with the patient. Lastly, some of the characteristics identified for trust within the PCMH include the patient too and there is benefit in exploring their perspective to understand the patient’s perception of the strengthening of the relationship.

Patient engagement improvement is vital to the Triple Aim. One response to the changing healthcare landscape is to look at the expansion of provider definitions and to explore the best way these teams address complex needs of the patient population. Fleming et al. (2017) research discussed Complex Care Management (CCM) with patients with high frequency of crisis care and unstable social determinants of health. Fleming et al. (2017) completed an ethnography for 16 months interviewing and observing providers of CCM. This resulted in a better understanding
of the provider’s perception on what was necessary to improve patient engagement and what prevented engagement. Often patients have a crisis or multiple crises due to their unmanaged health concerns. Providers within Fleming et al. (2017) study identified that, “the more marginalized the patients, the higher unpredictability of engagement” (p. 15).

**Perceptions**

Rowe et al. (2014) highlighted a challenge related to the manner in which medical doctors are trained that is, medical school is about learning technical words and approaches to problem solving with differential diagnoses. From the provider perspective, Molina and Simon (2014) pointed out that sometimes-subtle unfair treatment, or a belief in inferior treatment, has negatively affected the perceptions of some marginalized groups. In this vein, LaVista et al. (2009) reported about the role that mistrust has on care and that a trust scale for physicians was not applicable to the uninsured because there is limited research on the effect of trust on health. Perceived connectedness in social relationships as an effort to improve health outcomes produced seven attributes by Phillips-Salimi, Haase, and Kookan (2012): intimacy, sense of belonging, caring, empathy, respect, trust, and reciprocity (p. 242).

Benbenishty and Hannink (2015) identified the importance of both verbal and non-verbal communication in developing trust. In addition, communicating expectations and not assuming others are aware of actual thoughts is important to developing trust between patients and providers (Rowe et al., 2014). In establishing effective communication, demonstrating empathy supports the development of trust and gains connectedness within the patient-provider relationship (Derksen et al., 2016; Mallidi & Duvernoy, 2017). However, Onguti, Mathew, & Todd (2018) from the perspective only of physicians seemed to look specifically of patient scenarios that appeared to present barriers or conflicts to address. The perception of patient
conflict can prevent the patient from trusting the provider and being authentic. As Treiman et al. (2018) found patient-centered communication is beneficial with newly diagnosed cancer patients in North Carolina and improved patient-provider relationships. Patient-focused communication assist the patient with processing new information on chronic health conditions and how to navigate ways to address quality of life concerns.

Patients with Medicaid or uninsured seem to have additional issues to interfere with their care including social instability. Misky et al. (2018) found that patients with Medicaid or uninsured experienced health system failure, lack of consistent care and issues with the relationship with provider post discharge from hospital. There were several articles in the literature that explored misperceptions and the effect on communication, health needs, utilization of services, and medication in relationship to trust (Benbenishty & Hannink, 2015; Haskard-Zolnierek & DiMatteo, 2009; LaVeist, Issaac, & Williams, 2009; O’Malley et al., 2004; Polinski et al., 2014). In all, clearly understanding the perceptions of the patient and how trust is encouraged or hindered would be beneficial to the patient-provider relationship and patient’s engagement in treatment recommendations.

**Social Determinants of Health**

The World Health Organization (2008) described Social Determinants of Health (SDOH) as circumstances in the environment that affect a wide range of health functions and the quality of life, identifying those social gaps that need to be addressed. Some examples of SDOH address accessibility and availability to social and economic conditions that can improve health. Inaccessibility and unavailability to a need can be a source of stress both acutely and chronically (Piazza et al., 2013). Scheid and Smith (2016) explored patient trust controlling for social economic status and gender. The research included North Carolina Medicaid patients and found
additional factors should be explored regarding rust including social status, culture and expanding race and gender (Scheid & Smith, 2016). The vulnerability of the patient population makes unstable social determinants alter health engagement and outcomes more unsure (Junewicz et al., 2017; Padela, Pruitt, & Mallick, 2017).

**Psychosocial Factors of Health Outcomes**

Racial health disparities have been observed in addition to disparities between gender and social economic class (CDC, 2007; Johnson-Lawrence et al., 2013; Nelson, 2002). Medical mistrust within minority populations deters medication adherence with individuals with diagnosis of HIV, but this is true with other chronic health issues (Kalichman, Eaton, Kalichman, & Cherry, 2017). Social inequality can deprive people of a sense of self and increase stress related to those feelings (Meyer et al., 2011). Forms of discrimination can act as chronic stressors that have long-term effects of health outcomes (Molina & Simon, 2014). For example, Senteio and Veinot (2014) stated: “African American patients, who are more likely to live in low-income neighborhoods and to have multiple chronic conditions, are even less likely to follow medical recommendations” (p. 1745).

Life stressors can irritate illness-related symptoms of chronic health conditions (Piazza, Charles, Sliwinski, Mogle & Almeida, 2013). Furthermore, Tucker, Arthur, Roncoroni, Wall, and Sanchez (2013) emphasized that: “Patient-centered healthcare has been found to enhance patient-provider communication and improve treatment adherence, which in turn positively affects the health outcomes of patients” (p. 64). As opposed to the medical pathology focus on the cause and effect of disease and disease management, IHI (2014) believes the future in healthcare is addressing the reduction of health inequities and finding new approaches.
There were several studies within the literature that explored race, ethnicity, discrimination, and sexism in relationship to health outcomes (Hirschfield, 1996; IOM, 2002; Johnson-Lawrence et al., 2013; Meyer, 2003; Molina, 2014; Nelson, 2002). Health inequities were identified within marginalized populations that negatively affect health outcomes related to adherence to care, engagement to care, and trust of care. Culture as defined by Sue and Sue (1990) are, the thoughts, beliefs, practices and behaviors of a person(s) in the areas of history, religion, social organization, economic organization, political organization, and collective production. As providers, it becomes necessary to be not only culturally competent of the patient population served, but also be aware of one’s own cultural identity and the influences both have on the bi-directionality of care within the patient-provider relationship. Much of the research within the literature explored culture in relationship to race and ethnicity, competence of the provider, and individual cultural identity and potential effects on patient trust (Hirschfield, 1996; Oelke et al., 2013; Simonds et al., 2013).

Individuals and communities at large remain underprepared to change the culture to that of one of positive health. Barriers continue to be access to healthcare, cost of healthcare, health literacy, distrust, and a strong ability to navigate complex healthcare (Gage-Bouchard, 2017; Talmage, Figueroa, & Wolfersteig, 2018). Culture is identified as a SDOH and with the multi-layered cultural structures that both the provider and patient are a member of, it becomes imperative that each invest time to understand. Although there were several articles in the literature about individual SDOH in relationship to health inequities for marginalized populations, there was not a study that looked at the intersectionality of trust, culture, and chronic life stressors. In addition, the previous research was specific to the population identified for the study.
Pilot Study

The purpose of the pilot study was to explore and describe how culture and chronic life stressors factor into the development of trust with providers and health outcomes. The pilot study adopted a single instrumental case study (Stake, 1995) with one Behavioral Health Consultant provider as the ‘case’, Margaret (pseudonym); working within the environment of the identified local clinic using an embedded analysis unit of two individual patients experiences ‘context’ Bryan and Reed (pseudonyms). It was the intention of the researcher to gain insight into the issue of trust development with individuals who previously mistrusted providers. Additionally, how Margaret addressed those concerns with two patients to promote health outcomes. The research was grounded in in-depth interviews with Margaret, observation with Reed, and review of electronic medical records of both patients. The bounded time of the case was patients having had access to six months of interventions by Margaret from February 2016 through July 2016 with researcher exploring trust development at the halfway point of treatment interventions. As an exploratory inquiry the objective of the pilot study was to seek answers to the following research questions: How do cultural and chronic life stressors factor into the development of trust with providers and health outcomes? What interventions and how are they selected to develop trust and promote health outcomes?

The pilot was small scale and the findings supported that the provider, Margaret, developed trust by bearing witness, reestablishing rapport, collaborating with the patient, continually assessing motivation of patient, and providing training for the provider. The findings were from the perspective of what the provider found to work for a couple of patients she specifically worked with. What was identified within the pilot was that further exploration of the
patient’s perception needed to be explored. Additionally, research questions needed adjustment to get to the core of the patient experience, and interview questions needed to explore patient experiences. Lastly, additional coders would increase dependability of results, and if there was to be any transferability; the clinic as a whole including multiple providers and patient experiences should be explored.

As the primary researcher, it became clear that the patient experiences needed exploration and were the gap in previous research. Additionally, the researcher was drawn to further explore the collective stories of patients within the PCMH in Durham County. Through patient exploration, more detail on how trust developed would be gathered. As a result of the pilot, alterations to the study design and research process were made and the primary researcher’s passion in the subject matter intensified.

**Patient-Provider Trust**

There is an opportunity with the PCMH, which the culture of the organization and the culture of the patients with life stressors have a unique experience of the phenomenon of trust development that should be better understood. Studies completed specifically directed at patients identified as HIV/AIDS patients explored patient-provider relationships (Okoro & Odedina, 2016). Limitations identified in this study was volunteer basis only of participants and it was one identified chronic illness with patients with similar demographics. Lastly, Okoro and Odedina (2016) found that it is imperative to discuss other aspects of patient’s life other than the illness including SDOH concerns. Much of the research within the literature that was qualitative in nature used grounded theory and phenomenological methods. The research that was quantitative in nature focused on the different trust scales or surveys. This study hopes to gain a deeper understanding of patient’s experience of trust within the identified PCMH. Exploring the
participants experience with questions that are open ended in nature. This study hopes to gather responses that are greater in detail and value to the patient-provider relationship.

**Theories and Models**

Although there are many theories and models that have constructs relevant to health promotion, relationship development, and systems; it was the intention of this study to explore the unknown of the patient experience and gain understanding of their perceptions of the patient-provider relationship related to trust development. The study explored the patients lived experiences and within the instrumental case study the primary researchers lens had the ability to change. The research did not attempt to prove or disprove a theory. However, there are four theories that each have a component that speak to method and/or research question regarding the population of participants. Therefore, it is important to detail those theoretical models that may give providers and participants a different way of approaching the same phenomena.

**Relational Cultural Theory**

Relational Cultural Theory (RCT) was developed by Jean Baker Miller in 1976. Comstock et al. (2008) stated RCT focuses on “exploring how issues related to sex role socialization, power, dominance, marginalization, and subordination affect the mental health and relational development of all people” (pg. 279). Healing for individuals has the potential to occur in the context of mutually empathic and growth fostering relationships (Comstock et al., 2008).

RCT complements the multicultural and social justice movement by contextualizing how sociocultural challenges can interfere with growth-fostering relationship and exploring the complexities of human interactions (Comstock et al., 2008). Disconnections can occur at social, cultural, and systemic levels (Frey, 2013). The theory is based in a constructivist approach,
focusing on the experiences of others and no set reality. Additionally, it has collectivist and humanistic principles. RCT was found to be at the core of strong therapeutic relationships (Headly, 2014). The principles of RCT align with the micro skills necessary to develop a strong therapeutic relationship. It takes into account the cultural backgrounds of the patient and provider, and promotes growth and development within the therapeutic relationship. Additionally, growth in the relationship can result for both participants in feelings of empowerment, connection, self-reflection, and hope. There are seven core tenets of relational development as described by Jordan (2000), but a few speak to reasons for research questions and method of study to understand the patient’s experience of trust development: people grow through and toward relationships throughout the lifespan and in growth-fostering relationships, all people contribute and grow or benefit; development is not a one-way street.

With the awareness that people connect and grow in relationship with each other and that development isn’t one-sided, there is a benefit to understanding how patient’s perceive provider trust and what could establish or hinder the development of trust. Connectedness and the desire to connect to others is a benefit of RCT. That positive connection to others promotes a healthy relationship that encourages trust. However, in the limited interactions of a patient-provider relationship mutual empathy can be difficult to obtain. Additionally, providing training for providers to appropriately use the skills of RCT within a primary care clinic haven’t been previously demonstrated within the literature or in practice. Exploring connections and how disconnects through the development of growth-fostering relationships can be strengthened, identified, and addressed would bring depth to the patient-provider relationship. Although, there isn’t a previous demonstration of using RCT within patient-provider trust development the
promotion of growth-fostering relationships is worth exploring if those skills would be of benefit.

**Ethnopolitical Theory**

Ethnopolitical is an identified theory to assist with addressing the compartmentalization, demonization, and intentional disregard of experiences of people of color that affect the pursuit of happiness. In the manifestation of the theory, Comas-Diaz (2000) assumes that ethnopsychological perspective with a liberation paradigm equals the ethnopolitical theory. Comas-Diaz (2000) defines the theory to, “study the effects of oppression, racism, and political repression on individuals, groups, and societies” (p. 1319).

It is innate to compartmentalize and categorize people by visually identified constructs as early as three years old in an effort to detect allies and enemies (Hirschfeld, 1996). It is much easier to identify differences instead of embracing similarities. Human rights are for all humans, but this fact has traditionally been compromised in the United States. The awareness of that is what potential patients or inappropriately identified patients bring to the therapeutic relationship. The analysis of socio-economic, historical, psychological, and environmental factors as it relates to ethnic and cultural truths broadens the scope to a collective one instead of individual (Comas-Diaz, 2000).

The assumption is that the model appropriately used can assist people who have suffered racism or oppression to gain racial equality and social justice (Comas-Diaz, 2000). By studying the historical significance of oppression, one can gain a better understanding of how the experiences of marginalized populations could negatively affect their trust of individuals within the system; which includes healthcare providers. Ethnopolitical theory can give some potential
insight into promoting self-awareness and developing understanding for what may hinder trust development.

The theory is newer and doesn’t have specific tenets or components that make it similar in structural organization and as user-friendly to train others in relationship to Relational Cultural Theory. However, there is a base understanding to the effect of oppression and the willingness to bear witness, and comprehend how that systemic oppression affects trust in the patient-provider relationship. Empowering both participants to name the terror and establish what healthy communication and partnership need to look like for the relationship to be successful. There is additional benefit in ensuring that as a provider, patient experiences can be heard in their authentic truth and valued in an effort to overcome what may have previously hindered trust.

**Chaos and Complexity Theory**

Abductive reasoning is a central component of Chaos Theory of Career (CTC; Bright & Pryor, 2005), dealing with patterns, relationships, and is lateral not linear. Knowledge is open to doubt and change while looking at interpretations from different viewpoints. Chaos theory posits the idea that change is always possible. Reestablishing the belief in change or new possibilities could be helpful in changing the perceptions of both the providers and patients in the therapeutic relationships. Additionally, being open to observing the possible patterns of the past and learning from them could help with improving health outcomes. CTC promotes exploration of emergent patterns of behavior with the examination of how one’s life story can provide ideas for the future (Bright & Pryor, 2005). Similar to removing the limits a career counselor could have on a discussion using CTC, health care providers would attempt to listen to the smallest details that may have a significant impact on understanding a patient’s behavior (Bright & Pryor, 2005).
In general, Chaos Complexity Theory (CCT) promotes understanding systems that are nonlinear, dynamic, self-organizing, and self-similar (Livneh & Parker, 2005). Providers who have developed trust with patients will be able to guide them towards behaviors and cognitions that are new and adapted patterns that reorganize patients towards future health goals (Livneh & Parker, 2005). This theory addresses the necessity of understanding systems and the complexity that is involved in trusting relationships. Both RCT and Ethnopolitical theory have in common with CCT that there is the ability of change, connection, and growth for individuals, which all speak to the potential for relationships to be different. Additionally, both RCT and Ethnopolitical theory explore some of the complexities to relationships and human understanding. Disconnections and historic oppression can be the cause of emergent previous patterns of patients and helping providers recognize that and empower the patient to create new patterns that appreciate the complexity of care could be beneficial to overall health outcomes.

**Social Ecology Model for Health Promotion**

Social Ecology models explain the person-environment interaction and behavior has multiple levels of influence. Sallis, Owens, and Fisher (2008) found that if individuals are provided with motivation and skills to change behavior and if environments and policies are created that nurture the change behavior, healthy choices become attractive. Stokols identified four assumptions that are central to health promotion as (cited in Sallis, Owens, & Fisher, 2008, p. 469):

- Health behavior is influenced by physical environment, social environment, and personal attributes.
- Environments are multidimensional, such as social, physical, actual, or perceived.
- Human environment interactions occur at varying levels (individual, family, cultural, whole populations).

- People influence their settings, change settings then influence health behaviors

  This model may provide some insight into the potential for future interventions that promote behavior change. Additionally, the view of person-environment interaction may give insight into the environment of the clinic and the influences of health behavior. The multiple layers of environment types and how patients interact can immediately affect patient interaction. Health promotion can occur at a clinic level, community, and internally.

  Overall, these theories aren’t all inclusive or offered to explain the phenomena. However, each on some level speaks to reasons for the chosen method of research or research question. Once engaged with the participants my lens may change with a deeper understanding of patients experiences of trust development within a PCMH. It is the intention of the researcher to access theoretical understanding that may encourage and support the ability for the researcher to better understand what may encourage or hinder trust development within the patient-provider relationship.

  **Gaps in the Literature**

  The gap in the research is the effect of both cultural and chronic life stressors and if they simultaneously influence trust development. Content related to understanding patient perceptions and recommending provider interventions to address potential factors of mistrust were not found in the literature review. Additionally, missing was direct observations of patient-provider encounters, offering a detailed way to witness the human event of trust developed in the interaction. The majority of the literature, although helpful, would not explain the experience of patients within a PCMH and how trust is developed. The study by Vu et al. (2017) explored a
fictional case with psychosocial adversities and with interviews of the team of providers identified provider and system changes for the patient, without the patient involved in the study. Although, it was helpful to discuss the provider’s belief that system changes and communication styles are at the core of addressing chronic life stressors with patients, interviews with the patients will be the vantage point that this researcher will address. The biggest gap in the literature is the topic needs to be researched in greater depth.

The theories and model reviewed relate foundationally and thinking of future interventions based on potential participant response. Connection, growth towards relationships, and understanding marginalized populations could potentially be ways that trust is established or hindered in the patient-provider relationship. Those components are explored in RCT and Ethnopolitical theory. In understanding the complexity of potential chronic health concerns and other chronic life stressors, Chaos and Complexity Theory can be helpful. Understanding patient experiences of trust and how that has hindered or established, with the long-term objective of improved health; the Social Ecology Model can provide some insight for future interventions. Additionally, the literature provides information on a great deal of surveys, questionnaires, and treatment models to look at provider trust, patient satisfaction, and even vulnerability. However, understanding patient perceptions and provider interventions to address potential factors of mistrust were not found in the literature. A case study presents a unique possibility to hear individual’s perspective in their voice and to explore how the issues can be addressed potentially in the future. The identified PCMH will be a clinic that has a multidisciplinary team to explore fully patient-provider trust development. It is the intent that the current study will be beneficial not only for improving awareness about the topic, but also that it may lead to future research in the areas of trust development.
CHAPTER THREE: METHOD

This chapter includes the purpose of the study, the research questions, and a description of the research design, participants, procedure, data collection, and data analysis. In addition, it also discusses construction of the questionnaire including pilot study feedback and adjustments to the original focus and questions.

Purpose of the Study

The main goal of this case study was to explore and describe how culture and chronic life stressors factor on trust development between the provider and patients at a local integrated primary care clinic, and summarize assertions that may be used by the patient and/or the provider to address those factors to improve health outcomes. The current study adopted a single instrumental case study (Stake, 1995) with the issue of Trust Development being illustrated at a primary care clinic. It was the intention of the researcher to gain insight into the issue of trust development with individuals who may mistrust providers within the primary care clinic in a smaller urban city in North Carolina and how providers can promote health outcomes.

Most research conducted has been with a variety of patient populations, different disease states, and varied levels of trust explored. Although this research is important, this study focused on the experiences of trust development with patients at a PCMH regarding the patient-provider relationship. This study was qualitative, using a case study approach in order to explore a real life case (the identified clinic) to better understand the issue of trust development. A case study allows understanding rather than explanation of the issue.

Case Study

A case study is appropriate when there is reasonable access to multiple sources of data regarding an identified case and explores a contemporary phenomena (Goodman-Scott, Hays, &
Cholewa, 2018; Yin, 2018). A case study can be informative about experiences of the average person within the care clinic. Multiple sources will be accessible for this study including interview of patients within the PCMH, review of public records about the population and health outcomes of the PCMH, and observations in the field to better understand the environment of the clinic. A case study is a bounded system or case and allows examination of a case without manipulation of behavior (Yin, 2018). It is the intent that as Yin (2018) stated, “Within a common case lessons might provide information about social processes related to interest” (p. 50). Participants may express insight into social and institutional structural perspective regarding the case and their effect on trust. In addition, the case study approach allows for a more detailed description and exploration of particulars regarding the identified phenomenon.

Interviewing multiple participants within the single identified case gives opportunity to explore multiple perspectives and expand the understanding of patient experiences in a particular setting. Creswell (2013) described the use of a single case as a method to gain insight into a particular phenomenon, and learning has the potential to generalize or develop theory. Stake (1995) described triangulation as using the multiple data points to verify or establish meaning. A single instrumental case study administered in the research completed by Goodman-Scott, Hays, and Cholewa (2018) identified the case as a middle school, provided rich description of the case, and explored themes. Improved understanding of the identified community PCMH and the patient experience of trust development within that PCMH made a single instrumental case study most appropriate for this study.

**Identified PCMH**

The PCMH is located in a smaller urban community of Durham, North Carolina. The PCMH services approximately 33543 unique patients annually through multiple locations
throughout the community. At this time, approximately 43% of the population within the clinic identify as uninsured or self-pay and 27% identify with North Carolina Medicaid as their health insurance coverage type. The clinic provides a wide range of services to patients including dental, behavioral health, pediatric, adult, and family medicine since 1971. The clinic houses multiple services at multiple sites, to ensure preventative quality care for underserved patients. Per the Health Resources Services Administration (HRSA, 2017) report, at least 92% of the population at the clinic identifies as a racial/ethnic minority. In addition, approximately 72% of the clinic population identified as at or below 200% of poverty (HRSA, 2017).

The PCMH has multiple providers engaging in patient care that includes physicians, nurses, nurse practitioners, dentists, social workers, counselors, physician assistants, dietitians, and non-clinical; working in a collaborative effort to support the patient populations multitude of needs. The PCMH strives to have accessible, affordable, high quality health care services to the medically underserved in Durham county with over 40 providers serving adults (HRSA, 2017). Documentation of all services are in a primary electronic medical record that are accessible across a local health system and has the ability to be viewed by providers within participating health systems to access records to support the continuum of care. The clinic was identified as the case for this research because of the desire to explore the phenomenon of trust development within a bounded timeframe and environment with the intent to delve more in-depth into the specific clinic patient population. Trust development within the clinic is explored through the semi-structured interviews of patients assigned to the clinic with the intent that the findings may provide an understanding of the phenomena within the clinic.
Research Design

Trust development within the PCMH is the issue explored. The researcher identified a primary care clinic recognized to be following the patient-centered medical home model as the case unit. Exploring the concern through a case study allows the researcher to explore the lived experiences of patients within the PCMH at the identified bounded time. The issue is trust development and it is explored within-site of the PCMH serving adults patients. The clinic identified is a PCMH. Additionally, the PCMH described gave accessibility to the population, varied perspectives on trust development, and the opportunity to explore patient’s perception of engagement. Sampling of patients within the clinic happened through random purposefulness, maximum variation, and chain sampling. Lastly, the clinic identified provided for accessibility to patients across multiple marginalized factors. The researcher was able to gain rich descriptions of trust development within the clinic through the interviews with participants. Although, each participant had their own experience within the clinic, all of the interviews and additional supporting data helped to better understand the experiences within the clinic and helped to give in-depth understanding of experiences within the clinic. An instrumental case study as defined by Stake (1995) was selected because the research focused on an issue within a bounded case, within specified time and with multiple data sources.

Data Collection

Interview questions were developed by the researcher based on a review of the literature regarding marginalized individuals, cultural, chronic life stressors, and perceptions of trust with providers in the health system regarding health outcomes. An initial conceptual framework was developed and can be reviewed (See Appendix A). Additionally, the interview questions were informed by the clinical experience of the researcher with dually diagnosed marginalized
individuals in healthcare services and peer reviewed for appropriateness. Lastly, the questions were informed by feedback from patients and the provider in the pilot study. Necessary questions were adjusted, omitted, or added to better explore trust development within the clinic. There were two semi-structured, open-ended question interviews with patients, scheduled at least a week a part with at least one being face-to-face. The interview protocol included structured and unstructured follow-up questions. The second interview was completed telephonically and the researcher completed field observation within the clinic to observe environment, flow, and general interactions within the clinic. Patients were asked about their relationship with their provider, how they perceive trust, and ways trust could be established with provider (See Appendix B and C). The procedures for data analysis followed the recommendations for case study research as outlined by Stake (1995) and Merriam (1998). The researcher analyzed data by consolidating, reducing, grouping complex data into categories, interpreting what patients have said, what the researcher has observed, and searched for meaning in the data collected.

**Participants.** The participants for this study were identified as patients at the identified PCMH. It was the intention of the researcher to gain insight into the issue of trust development with individuals who are patients at the clinic for at least three months prior to the interview. The PCMH and patients reside in Durham, North Carolina. Durham County is considered an urban community with a population of 294,618 per Dataworks NC 2016 data. Dataworks NC identified the community demographics to be 2.6 Other, 4.7% Asian, 13.3% Hispanic, 37.2% Black, and 42% White. Statistics from Dataworks NC described race/ethnicity diversity in the county to have a median of .56 on the Simpson Index of Diversity scale, with a score of 1 to describe extreme community diversity and 0 describing none. The community is 52.2% women.
It was the intent of the researcher to have participants in the study have a similar demographic distribution of the county data. There were initially fourteen patients that were assigned to the PCMH that identified and completed study prescreening. Three individuals didn’t meet minimal prescreening criteria and weren’t eligible to participate in the study. Additionally, two qualified participants didn’t show for all aspects of the study and hence didn’t complete the study. Therefore, there were nine participants that completed all aspects of the study. Each of the nine participants had attended the PCMH for at least three months and hadn’t been engaged at the clinic for more than two years at the time of the study. All of the participants identified as cisgender and one participant identified with the LGBTQIA community. Six of the participants identified as female and three identified as male. Of the participants that completed the study, 56% of the participants self-identified as Black, 22% identified as other race/ethnicity including at least two additional ethnicities, 11% of the participants were Latino and 11% were white. They vary in age from late-thirties to early-sixties. The demographics of the nine participants, as displayed in Table 1, reflect the overall demographics of patients at the PCMH.
Table 1

Demographic Information of Participants

<table>
<thead>
<tr>
<th>Pseudonym Chosen by Participant</th>
<th>Length of Clinic Assignment (Months)</th>
<th>Age</th>
<th>Gender</th>
<th>Race/Ethnicity</th>
<th>Health Knowledge</th>
<th>Group Membership</th>
<th>Chronic Life Stressor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latoya</td>
<td>24</td>
<td>44</td>
<td>F</td>
<td>Other, Native American/Black</td>
<td>5</td>
<td>Women, SES, Unemployed</td>
<td>Financial Stress, Work related, Health of Self, Loss of Loved one</td>
</tr>
<tr>
<td>Monica</td>
<td>22</td>
<td>57</td>
<td>F</td>
<td>Black</td>
<td>5</td>
<td>Women, Physical Disability</td>
<td>Financial Stress, Trauma, Health of Self, Loss of Loved one</td>
</tr>
<tr>
<td>Nivea</td>
<td>13</td>
<td>42</td>
<td>F</td>
<td>Black</td>
<td>5</td>
<td>Ethnicity, Women, SES</td>
<td>Financial Stress, Trauma, Caregiver, Health of Self, Loss of Loved one</td>
</tr>
<tr>
<td>Ebony</td>
<td>18</td>
<td>63</td>
<td>F</td>
<td>Black</td>
<td>3</td>
<td>Women, Physical Disability</td>
<td>Health of Self, Retirement</td>
</tr>
<tr>
<td>Will</td>
<td>23</td>
<td>58</td>
<td>M</td>
<td>Black</td>
<td>4</td>
<td>Physical Disability</td>
<td>Financial Stress, Health of Self</td>
</tr>
</tbody>
</table>

Table 1 Continued
<table>
<thead>
<tr>
<th>Pseudonym Chosen by Participant</th>
<th>Length of Clinic Assignment (Months)</th>
<th>Age</th>
<th>Gender</th>
<th>Race/Ethnicity</th>
<th>Health Knowledge</th>
<th>Group Membership</th>
<th>Chronic Life Stressor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marco</td>
<td>18</td>
<td>38</td>
<td>M</td>
<td>Latino</td>
<td>3</td>
<td>Country of Origin, Immigrant</td>
<td>Work Related, Health of Self</td>
</tr>
<tr>
<td>Jason</td>
<td>8</td>
<td>39</td>
<td>M</td>
<td>Black</td>
<td>4</td>
<td>Country of Origin, Unemployed</td>
<td>Financial Stress, Health of Self/Other</td>
</tr>
<tr>
<td>Sabrina</td>
<td>23</td>
<td>38</td>
<td>F</td>
<td>Other, Latina/Black</td>
<td>3</td>
<td>Women, Unemployed</td>
<td>Financial Stress, Divorced, Work Related, Caregiver, Health of Self/Other, Loss of Loved one</td>
</tr>
<tr>
<td>Nancy</td>
<td>18</td>
<td>43</td>
<td>F</td>
<td>White</td>
<td>5</td>
<td>Women, Physical/Mental Disability, SES, LGBTQIA</td>
<td>Financial Stress, Health of Self, Housing Instability</td>
</tr>
</tbody>
</table>
The study was submitted and approved by the Institutional Review Board at North Carolina State University prior to commencing. The participants were recruited using a mixture of three purposeful sampling strategies. Baker and Edwards (2012) described identifying enough participants that there is no additional insight gathered with more participants. The description of saturation and the awareness that qualitative research does not identify sample size in the same manner as quantitative research, allows the researcher to explore in-depth interviews and open discussions with the participants. Additional data points identified assisted with gaining insight to the clinic and advance understanding of trust development. Saturation occurred with the nine participants within the case study. Baker and Edwards (2012) stated saturation in a single case study occurs with at least four to twelve participants.

**Procedure.** This study followed all requirements of the Internal Review Board at North Carolina State University. The researcher used the snowball strategy by requesting from providers in the PCMH, that the study information be shared with patients that have similar characteristics of the predetermined criteria. Additionally, patients were recruited using the maximum variation technique by reaching out to patients at the clinic while on-site to seek as much diversity as possible. Lastly, the researcher accepted patient volunteers that met criterion-i described by Palinkas et al. (2015) as patients that are identified and selected meeting the predetermined criterion of importance.

The predetermined criteria for patients were individuals that had: (a) assigned provider at clinic, (b) insurance payer identified as Medicaid or uninsured, (c) at least twenty-one years old, (d) assigned to the clinic at least three months before interview and no more than two years, (e) identify with at least one marginalized population, (f) identify with at least one chronic life stressor (See Appendix D).
Participants were recruited through the identified sampling strategies. Providers received emails and in-person invitations to share study marketing information with patients with similar characteristics of predetermined criteria (See Appendix E). Patients identified, participated in a telephonic formal invite to the study (See Appendix F). Furthermore, patients self-identified from study marketing flyer dispersed throughout clinic-contacted researcher via phone and if confirmed to meet predetermined criteria were invited to participate. The intention with the use of multiple recruitment strategies was to engage a diverse group of information rich patients. The participants received a formal recruitment letter with instructions about the in-person interview process, the second interview process, a copy of the informed consent form for preview, and the expectations of the participants during the study (See Appendix G). Potential participants were invited to participate in the study via phone or in-person when they met the predetermined criteria. The participants who expressed interest were screened for inclusion and exclusion criteria. Those participants that were still eligible to participate in the study, an in-person interview was scheduled with the primary researcher. Those interviews were scheduled in a confidential and convenient location for the participants. Participants received a reminder of the scheduled interview via their identified preferred way of communication.

Data was collected from in-person interviews individually with each participant and field observation of the clinic flow (See Appendix H). Each participant was able to withdraw from the study at any time for whatever reason. Patients that participated in the study in its entirety received a $25 gift card to a local merchant.

The primary investigator transcribed all of the in-person interview transcripts verbatim. The transcripts were sent (via mail or in-person) to each participant so they could do a member check. Additionally, all field observation notes were documented. Following the completion of
the member checks, the interview verbatim transcripts were sent to the three person coding team for initial coding and auditing. The coding team was made up of the primary investigator, one professional that identifies with at least one of the occupations included in the definition of provider, and a graduate of the Counseling and Counselor Education doctoral program at North Carolina State University. Each team member has completed qualitative coursework and had been trained to analyze data using thematic coding methods and descriptive statistical analysis of demographic information.

**Informed consent.** Each participant was informed about the purpose of the study, received a formal study letter, and a copy of the informed consent (Appendix G) prior to the interview. Participants also received a hard copy of the interview questions (Appendix B and C) prior to the interview to support transparency of the interview and to assist with member checking of transcript, and two randomly selected participants completed member checking of identified themes and assertions at the conclusion of the study. The informed consent included information regarding the purpose of the study, what to expect as a participant of the study, potential risks and benefits, confidentiality protection, and information regarding the IRB office. Participants chose their own pseudonyms for the purposes of confidentiality in the study. Informed consent was reviewed verbally at the in-person interview and all signed forms were scanned and stored on a secure encrypted computer accessible to primary researcher only.

**Forms of data collected.** The primary researcher collected three forms of data for this study, which included individual interviews of participants, observations in the clinic, and documents and records. The initial interviews lasted no more than 60 minutes each and were in-person. Follow-up interviews occurred telephonically. Both were audio-recorded. Multiple complete observations occurred at the PCMH to observe environment and flow. Researcher
observed lighting, traffic flow within the clinic, sign-in, and general behavior of staff and patients during different times of the day. Documents and records included review of existing public records regarding clinic demographics and health outcomes for the past fiscal year. The multiple forms of data were used in an effort to triangulate the data and increase credibility and validity in results as recommended by Creswell (2013). Data including audio and written transcript were stored on an encrypted computer with additional multifaceted identification for entry.

**Instrumentation.** Interview questions were developed by the researcher based on a review of the literature regarding marginalized individuals, cultural, chronic life stressors, and perceptions of trust with providers in the health system regarding health outcomes. An initial conceptual framework was developed and can be reviewed (See Appendix A). Additionally, the interview questions were informed by the clinical experience of the researcher with dually diagnosed marginalized individuals in healthcare services and peer reviewed for appropriateness. Furthermore, current research on interview design, field experience, and the feedback received from the pilot study were considered to create and edit the interview questions. The interview protocol included structured and unstructured follow-up questions. The second interviews were completed telephonically. The follow-up interview included questions to clarify from initial interview, insight after field observations, and check-ins regarding interactions with providers since initial interview. Included in Table 2 are the connections between the research questions and the interview questions. This demonstrates that there is content validity within the study for interview protocol questions.
Table 2

*Research Questions in Alignment with Interview Questions*

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Corresponding Interview Question Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does trust development begin within a primary care clinic</td>
<td>B1, B2, B6, B7, B8, B9, B10</td>
</tr>
<tr>
<td>How do patients perceive provider trust</td>
<td>B1, B2, B12, B13, C1, C4</td>
</tr>
<tr>
<td>What are ways trust development is established or hindered</td>
<td>B1, B2, B3, B4, B5, B10, B11, C2, C3</td>
</tr>
</tbody>
</table>

Patients were asked about their relationship with their provider, how they perceive trust, and ways trust could be established with the provider. Demographic questions were aimed to understand the participants’ age, gender, ethnicity, knowledge of health, time at the PCMH, identified marginalized population, and identified chronic life stressor (See Appendix I).

The questions used in this study, were being used for the first time by the primary researcher. The questions used were proposed after the primary researcher conducted an initial pilot study. After field observations were completed within the pilot and patients began to share their words, feelings, and experiences regarding trust in the primary care clinic; they were so relevant and engaging that the vantage point was altered for this study. The pilot gave credence that further exploration of patient’s experiences of trust development within the PCMH would gather a richer understanding. The interview questions now allow the stories of patients to be explored from within rather than interpreted (See Appendix J) for the pilot study questions. Lastly, the demographic questions were removed from the same interview question document to improve confidentiality efforts.

The interview questions were formed to encourage participants to recall their experiences that would share insight with the primary researcher into the language and feelings relevant to
the participant regarding trust development with their provider. The questions were primarily open-ended with some closed that included follow-up questions gathering participant perceptions. Follow-up questions were based on what the participant shared in an effort to gain further clarity and understanding. Turner (2010), states open-ended interviews allow the participant to fully discuss their views and experiences. Language that promoted comprehension of the participants was used in the interview structure. Additionally, the interview structure allowed the interviewer to listen to participants more as they shared their experiences in their language, which increased validity (Creswell, 2013). The refocus of the research questions and the restructure of the interview questions improved the connection to the purpose of the study. Each of the interview questions related to one or more of the research questions, accomplishing content validity; seeking understanding of what it was intended to explore. In addition, respondent validation occurred when randomly identified participants reviewed identified themes and findings continued to be relevant to participant experiences.

**Data Analysis**

All interviews were transcribed verbatim and reviewed for accuracy by the primary researcher. The verbatim transcripts were sent to the participants via mail or in-person delivery. Participants were asked to voluntarily serve as “member checkers” for their transcribed interviews. After review occurred, participants were asked to contact primary researcher to discuss any changes and any noted changes were made to the final transcribed interview. Next, the primary researcher who is also identified as the primary investigator provided the verbatim transcripts to the other two coding team members. The primary researcher completed memos while collecting data to capture thoughts and connections that materialized through the process. Data analysis and data collection occurred simultaneously as described by Creswell (2013).
The transcripts of the interviews were coded with Saldana (2016) infrastructure of first cycle coding methods including in-vivo open coding, attribute coding, and descriptive coding. First cycle coding occurred between two coders discussing, expanding, and collapsing codes as appropriate. During this process and second cycle coding, eclectic coding occurred with reevaluation of the “process and a demonstration of how to proceed” (Saldana, 2016, p. 213). From there, axial coding where items were categorized and relationships were identified, finally selective coding based on patterns exploring phenomena. In qualitative data analysis, codes are defined as “most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data” (Saldana, 2016, p. 4). The identified themes with brief description were given to a few randomly selected participants for final member checking to ensure accuracy of the patient’s experience. There is a Data collection matrix, which can be found (See Appendix K). Lastly, there are outreach to participants to member check and triangulate the data (See Appendix L-O). The following illustration provides the steps to the data analysis process.
Figure 1. Data Analysis Procedure

Research Team

Although the primary researcher completed the data collection for this study, a coding team was a part of the research team. The research team consisted of three individuals. The primary investigator is currently enrolled in a Counselor Education Doctoral program. The second participant was a graduate from the same Counselor Education Doctoral program, at a large research one university in North Carolina. This individual functioned as an external auditor and was able to provide confirmability to the findings ensuring there wasn’t any inappropriate biases that influenced the data analysis and that the findings were trustworthy. The third member of the research team was a professional in the health system that identified as a licensed professional counselor.
Positionality of Researcher

In an effort to identify, address, and clarify potential research bias, I engaged in self-reflection and acknowledgement in this positionality or reflexivity statement. Creswell (2013) indicated that one must be aware of their biases, values, and history that may shape interpretation of data. In that effort I acknowledge that, I have worked with co-morbid patients with chronic health and behavioral health concerns in general for over fourteen years, but more specifically the past nine years. The researcher’s interpretive framework aligns with a transformative/postmodern critical race theory. More specifically as Creswell (2013) discussed, I am very interested in changing the way people think, developing an understanding of the complexities that race relations play on the inequity within society and how that continued oppression impairs marginalized groups from progression. Due to my years of experience working with marginalized individuals and being of a race that has great historical oppression in society, I recognize I have some assumptions about my research before it begins. I assume that patients may not specifically define how historical oppression affects their health engagement, but can reveal some consistent themes that may develop new definitions. I may have some personal bias and beliefs that are contraindicated to the participants and I will need to ensure that their attitudes are expressed and not mine personally.

In an effort to evoke change within the system and empower patients I could still be viewed as an insider to the health system and an outsider to the population, that trust for myself as the researcher could be negatively affected. My class, race/ethnicity, health, and spirituality feed a great deal, into whom I am as a person and how I see the world. I have had personal experiences that have shaped my view on oppression of marginalized individuals. It feeds my passion to eradicate the power differential, but it is also a bias that I must be ever cognizant of.
Validation Strategies

When examining validation and evaluation within the study a few different methods were used. Since the research was completed using a case study, it affected how validation was addressed. Stake (1995) states participants should, “play a major role directing as well as acting in a case study” (p. 115). Member checking with a few randomly selected participants to ensure the identified themes and assertions of the research are relevant and accurate to them helped address construct validation and demonstrated some credibility. Additionally, for some external dependability interview and research questions were reviewed by peers for feedback to ensure items evaluated what they were sought to evaluate. Triangulation was addressed by using multiple data sources of interviews, observations, and document/record review to establish credibility of the case study. In addition to data triangulation, investigator triangulation occurred with multiple coders and an auditor reviewing differing views of participants (Denzin, 1978). By adjusting the coding team from the initial pilot from one coder to a team of three, it helped to reduce any potential biases and allowed the team to identify potential blind spots. The goal of the team was to have a fuller comprehension of the patient experience when completing data analysis and thematic coding process. An identified mentor study addressed validation with triangulation of multiple data source reviews.

Completing a case study with a bounded time and multiple data sources lend positively towards validation, as a great deal of information on the case are verifiable facts in health system data. During the evaluation of the research, it was the intention that whenever possible; direct quotes of the participants that connected with the themes identified were highlighted to demonstrate the importance of the research and potential identify areas for future research.
Summary

In this chapter, a rationale for the use of qualitative case study design was provided, researcher’s positionality explored, information on the study’s framework offered, and the study’s research questions listed in relationship to interview questions. Data analysis was also discussed demonstrating efforts taken to enhance trustworthiness and the validity of the findings. Finally, necessary improvements and lessons learned from the pilot study that improved content validity was described in detail.
CHAPTER FOUR: FINDINGS

This chapter includes a review of the purpose of the research study, a profile of each participant, a profile of the PCMH that participants are assigned to, and the study’s findings. The purpose of this study was to explore the experiences and describe how culture and chronic life stressors factor on trust development between the provider and patients at a local integrated primary care clinic. A single instrumental case study design that was exploratory in nature was used to investigate the phenomena of trust development within the bounded case of a primary care medical home (PCMH) in Durham, NC. There were three primary research questions that guided the study: How does trust development begin within a primary care clinic? How do patients perceive provider trust? What are ways trust development is established or hindered? Findings include themes and subthemes that were identified through the triangulation of data related to the PCMH.

Participant Profiles

A profile of each participant precedes the description of the findings. Participants were asked to select their own pseudonym. How participants came to identify their pseudonym also is a part of their profile. Effort was taken to ensure that enough information was provided to accurately portray the participants, their experiences in relationship to the case, and the PCMH in general without giving away specific details that could be identifying.

Latoya

Latoya identifies as a woman in her mid-forties. Lives with her sister and is currently unemployed. She identifies as multi-race of Native American and Black. Latoya has been a patient at the clinic right at two years at the time of the study. Latoya has experienced a great deal of loss within her life, has severe health concerns, and financial stress. Additionally, Latoya
has been diagnosed with depression and has a counselor and psychiatrist that she includes in her experiences of patient-provider relationship. Latoya identified her pseudonym from a recollection of a great night out and it was the name she used. Every time we communicated and the pseudonym was used, it brought a smile to her face. Latoya was recruited by a provider and initiated contact with primary investigator.

**Monica**

Monica identifies as a woman in her late-fifties. Shares unstable housing with her daughter and has limited disability income. She identifies as Black. Monica has been a patient at the clinic for twenty-two months at the time of the study. Monica has experienced consistent financial stress including during the study, unstable health, loss of loved ones, and past trauma. With numerous health concerns, Monica has multiple providers participating in her care. Monica identified her pseudonym as she stated it, “Sounds like a stable, carefree, solid name.” Monica initiated participation through marketing material within the clinic.

**Nivea**

Nivea identifies as a woman in her early-forties. She lives with her husband. She identifies as Black. Nivea has been a patient at the clinic for thirteen months at the time of the study. Nivea has experienced financial stress that makes medication cost a large concern, past sexual trauma, loss of loved ones, and health concerns that require specialty visits that are a financial strain. Nivea identified her pseudonym from a container of lotion that she had in her purse and stated that, “It reminded her that she has to be smooth.” The statement made both of us laugh. Nivea was recruited during on-site marketing at the clinic by primary investigator.
Ebony

Ebony identifies as a woman in her early-sixties. She is recently retired and lives with her daughter. She identifies as Black. Ebony has been a patient at the clinic for eighteen months at the time of the study. Ebony has a newer physical disability that remains unstable. Ebony identified her pseudonym as a nod to her “beautiful skin”. Ebony was recruited during on-site marketing at the clinic by primary investigator.

Will

Will identifies as a man in his late-fifties. Lives independently and had previous homelessness. He identifies as Black. Will has been a patient at the clinic almost two years at the time of the study. Will has financial stress, physical disability, and severe health concerns that have him connected to multiple providers and medications. Will identified his pseudonym from the first thing he saw in my office. He stated, “It describes my will to live.” Will had a very thankful attitude from a near-death experience that he had and it was a strong motivation for him. Will was recruited by a provider and initiated contact with primary investigator.

Marco

Marco identifies as a man in his late-thirties. He is married with two children. Marco identifies as Latino. He has been a patient at the clinic for eighteen months at the time of the study. Marco identifies as an immigrant, has health concerns, and has work-related issues. He identified his pseudonym from someone he use to know. Marco was recruited during on-site marketing at the clinic by primary investigator.

Jason

Jason identifies as a man in his late-thirties. He is married and had previous unemployment. Jason identifies as Black. He has been a patient at the clinic for eight months at the time of the
study. Due to previous unemployment, he works multiple jobs now and continues to have financial stress. Jason has his own health concerns and has a great deal of concern regarding his wife’s health. He identified his pseudonym randomly and couldn’t recall what made him choose it. He initiated participation through marketing material within the clinic.

**Sabrina**

Sabrina identifies as a woman in her late-thirties. Lives with her boyfriend and is currently unemployed with adult children. She identifies as multi-race of Latina and Black. Sabrina has been a patient at the clinic almost two years at the time of the study. Sabrina has experienced health concerns for herself and others, divorce, loss in her life, caregiver stress, and financial instability. She experienced a health crisis that she felt was provider error. Sabrina identified her pseudonym from thinking of a television show she use to watch. Sabrina stated, “I might be a witch, but at least I’m a good one.” Sabrina initiated participation through marketing material within the clinic.

**Nancy**

Nancy identifies as a woman in her early-forties. Lives by herself and doesn’t have any children. She identifies as White and a member of the LGBTQIA community. Nancy has been a patient at the clinic eighteen months at the time of the study. Nancy has financial stress, housing instability, physical and mental disability, and health concerns. Nancy identified her pseudonym as a “name of convenience” and provided no additional background information. Nancy was recruited during on-site marketing at the clinic by primary investigator.

**PCMH Experience**

The identified local PCMH is located in Durham, NC with a large primary site and ten satellite sites throughout the community. Patients can receive preventative, behavioral health,
dental, and primary health care from pediatric to geriatric. The clinic provides extended hours beyond traditional primary care clinics including hours of operation until 8 PM and Saturday hours. The PCMH provides transportation to the clinic for patients to increase accessibility to the services located within the clinic, but also to reduce no show rates of patients throughout the clinic. At the time of the study, the clinic was looking for additional drivers to support this service and there were extended wait times for patients due to this gap in care.

At the primary location, the facility is organized regarding services. Upon entrance into the clinic there are uniformed security, however it is not required to check-in with them to receive services. In the front lobby are chairs and check-in for individuals that need to enroll or reenroll in the clinic. Throughout the clinic, there are signs visible to which clinic type, pharmacy, lab, or other service areas that may be needed. Additionally, there are colorful art representing the community and the populations served at the PCMH. On the first floor of the clinic are conference rooms for classes that are offered on disease management and self-care in addition to financial services.

There are staff at each of the multiple check-in desk that are bilingual or readily provide accessibility to bilingual staff to support the diverse population of the clinic. Additionally, the clinic set up supports mobility and accessibility to patients who use durable medical equipment to support mobility. Throughout the field observations, the primary investigator recorded the above notes (See Appendix H). At different times of the day, the patient and provider traffic throughout the clinic was consistently heavy, with a great deal of individuals going in and out of the clinic. Front desk staff were overheard talking about their day and responsibilities. Front desk were helpful, but didn’t appear to initiate interactions. Patients were observed to be a mix of patiently and impatiently waiting to be seen and have their needs met.
PCMH Data Findings

Beyond the field observations and participant interviews, records and documents related to the PCMH were reviewed in support of this case study. HRSA (2017) reported that approximately 72% of the patients within the age of 15-64 years old identify as women. In addition, primary health concerns include hypertension, diabetes, and asthma. Quality care measures include adult tobacco use/cessation interventions, colorectal cancer screenings, and screenings for clinical depression and follow-up (HRSA, 2017). Of note, the depression screening completion percentage of 75% don’t include patients whose motivation to improve may influence results (HRSA, 2017). The local clinic is accredited and certified by the Joint Commission as a Primary Care Medical Home (PCMH) with references to core values of courtesy, respect, quality, accessibility, teamwork, and continuous improvement (LCHC, 2016). The clinic was established with a desire to treat low income, underserved populations in the community where they live (LCHC, 2016).

Findings

The findings are presented in a narrative format and organized by research question with identified themes and subthemes. Table 3 provides identified themes and subthemes among participants by research question.
Table 3

*Identified Themes and Subthemes by Research Question*

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Identified Theme</th>
<th>Subtheme 1</th>
<th>Subtheme 2</th>
<th>Subtheme 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does trust development begin within a primary care clinic?</td>
<td>Communication, Collaboration, Safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionalism</td>
<td>No Show, Time, Demonstrated difference between providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of Provider</td>
<td>Power and Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How do patients perceive provider trust?</td>
<td>Communication, Collaboration, Safety</td>
<td></td>
<td></td>
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<tr>
<td>Quality of Provider</td>
<td>Power and Control</td>
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<tr>
<td>Responses to Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support with Resources/Resourcesfulness concerns</td>
<td>Access, Alternatives to Care, Survival</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionalism</td>
<td>No Show, Time, Demonstrated difference between providers</td>
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Table 3 Continued

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Identified Theme</th>
<th>Subtheme 1</th>
<th>Subtheme 2</th>
<th>Subtheme 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are ways trust development is established or hindered?</td>
<td>Communication</td>
<td>Collaboration</td>
<td>Safety</td>
<td></td>
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<tr>
<td>------------------------------------------------------------</td>
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<tr>
<td>Quality of Provider</td>
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<tr>
<td>Support with Resources/Resourcefulness concerns</td>
<td>Access</td>
<td>Alternative s to Care</td>
<td>Survival</td>
<td></td>
</tr>
<tr>
<td>Professionalism</td>
<td>No Show</td>
<td>Time</td>
<td>Demonstrated difference between providers</td>
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</table>
Research Question 1: How does trust development begin within a primary care clinic?

The following themes are identified for research question 1: communication, professionalism, and quality of provider. Definitions and examples of themes can be found in the descriptions that follow. In the subtheme of collaboration, it was of conceptual interest regarding skills identified within motivational interviewing being desired by patients to address trust development. This will be further explored in Chapter.

Communication. This theme represents the exchange of information. The Why conversations. Listening to patients both verbally and non-verbally. Sub-themes include safety and collaboration. Safety explored comfortability in difficult conversations and cultural awareness in communication. Collaboration explored person-centered communication and setting the agenda of the interactions/communication together. For Latoya, communication is about explaining “why” taking medications and how they will help:

Don’t just throw another medication at me, communicate with me about the benefits.

Help me understanding what is going on and why it’s happening. Listening and understanding that I am somebody and encourage me. Let me come in the room.

Sabrina saw communication for herself to be a core truth:

Providers being open and honest and helping me through the process. That allows me to feel free to what and how I share with you. Pay attention to me and don’t let what’s going on with me fall through the cracks because you didn’t work with me.

Jason saw communication as essential to trust stating, “Just tell me the truth, no matter how bad it is or how bad it is going to be. As long as you tell me the truth, we can talk it out and make this.” Ebony expressed concerns regarding safety regarding communication of cultural beliefs on health. Ebony states, “Be non-judgmental regarding my weight and background.
Provide a safe zone at all time for communication.” Nivea desired, communication regarding if she could afford medication, disease, and to feel as though the provider is listening. Nivea states, “Rapport depends on if provider comes into the appointment actually listening or rushing me.”

**Professionalism.** This theme represents, How you address me begins at the front desk. If I call you, call me back. Having a demonstration that you care for me. Respect my knowledge about myself and my capabilities. Sub-themes include *time, demonstrated difference between providers,* and *no show.* Time explored setting appointments, wait times, getting all needs met in short time, quickly. Demonstrated difference between providers explored participants that saw multiple providers being able to see difference in care. Additionally, service delivery expectations with increased patient knowledge of health and advocacy for self. No show refers to the patient perception versus provider on double booking and waiting in the lobby. This was seen as disrespectful of time, unprofessional with little concern to patient’s employer, and family. Sabrina found a lack of professionalism to be an alternate explanation for “why people leave, not compliance with care”. Sabrina felt enraged by no shows:

> Does it make sense? It's backwards, its backwards, I can understand a little bit just in in knowing that people no show for appointments. And so you rather have a couple of people there with the chance that one person is going to not show up so that you're not sitting there twiddling your thumbs, but five to 10? Do you know what the likelihood is that five people are not going to show up in that appointment time? It's highly unlikely, right? Which is, which is why a lot of times you're not seen exactly on time, right. And they'll actually come in early, you know, because of that. So, you know, a good day is when somebody calls out, then more than likely you'll be seeing on time, you know, like, oh, what happened, you know, or you're the first on that eight o'clock, whatever your
appointment time is. You're the first to sign in, you know, so, but if your appointments at 830 and you come in there and 810 I mean, yeah, you come in there two minutes early. And somebody else came in there 15 minutes early and checked in for that eight o'clock appointment, then they're going to be seen before you. Yeah. So yeah, you know, that is an interesting way.

Nivea identified the demonstrated difference between providers when:

I was first diagnosed the doctor I had didn't do a really good job explaining to me what diabetes meant. I heard that actually and I didn’t think it was a big deal. I know a lot of people with sugar. I felt like okay, well I’m extra sweet, big deal you know. He pulled out I don’t remember, but he pulled out like a whiteboard or paper I don't know. He was drawing, I guess he was trying to draw some cells and trying to explain the pancreas and all this other stuff and I was at the time I don't know I just wanted to kind of follow him. Which I did because I'm not stupid so I followed what he was saying, but it didn't like sink in the gravity of what was happening to me, which is a huge thing. However, with my current provider I looked for someone else that looks like, looked for someone like me so I found a woman that I felt like they'd be more sympathetic or maybe you know, more willing to help. I'm not sure how she found me, but I do remember her listening and paying attention. She didn’t blame you, yes I get it, my blood sugar's were high or whatever. I guess the same content but different approach yes made me want to do better or like trying to figure out you know how I can do better.

Will found that for him professionalism was inclusive of time stating, “Just do a good job. Let me know if I have to wait and make it about me when I see you.”
**Quality of provider.** This theme represents the Competence of the provider. The provider being the light at the end of the tunnel. Belief that the provider can change life when gives a little extra and when passionate. Additionally, the desire that patients don’t want to see providers be overwhelmed as this makes them feel like a burden. Expectation that a quality provider will be honest, open, be real, and sincere. Sub-theme is *power and control.* Power and control explored the control over explanation of medication and diagnosis, the power to know important information. Patient needed the power deferential in a quality provider to allow them to be more than a report or record. For Marco, he believed in the quality of the provider based on “the knowledge of what I need to work on and you know, what I might need to take care of this.” Nancy desired the ability of the provider to be straightforward. Nancy found the quality of the provider to be demonstrated in:

I mean the biggest thing for me is like, keep it real. I will keep it real with you, so I ask you to keep it real with me. Don't lie and don't do all those fluffy words. Like just what is it, you know, and all of that? Well, you need to follow a low sodium diet or you listen, if you go find a different way to help make this disability check that I got add up to something different than what it adds up to. Then you can tell me about all of that. If you not help me figure out how I can make work what I got.

Monica felt the power dynamic of some providers affected the quality of the provider, describing a situation where she received charity care:

My back doctor wanted me to go back to get some more visits and this particular therapists, she says to me. I don't know why you coming back here. I don't know why your using charity here. She said, well, you just using them and I'm like, okay, and my doctors referring me back over here and you don’t have nothing to do with that, you
know, so what are you trying to say that I shouldn't get any kind of health care because I
don't have any insurance, what is it to you, you know, nobody else is complaining you’re
the only one complaining. It was a big deal, but I never got a call back from her
supervisor never and they had stated I would get a call from the supervisor, I never did
get a call back from the supervisor.

Sabrina states within the clinic the:

Doctor is really in control. It’s really not the patient, it’s the doctor. The doctor can
misdiagnose you, cannot see something, not give you information that can ultimately
save your life. I’m powerless over there in that arena.

**Research Question 2: How do patients perceive provider trust?**

The following themes are identified for research question 2: *responses to health, support
with resources/resourcefulness, professionalism, communication, and quality of provider.*
Definitions and examples of themes can be found in the descriptions that follow. Specifically,
definitions and examples of themes not previously explored in research question 1. In the theme,
support with resources/resourcefulness it was a surprise code regarding the expectation that
PCP’s would be a patients first thought for resources. This could be related to the integrated
nature of the clinic including counselors and social workers with a great deal of knowledge of
resources and are heavily involved. This will be further explored in Chapter Five.

**Responses to health.** This theme represents the impact of mental and physical health.
Additionally, outside factors and natural supports and how they may effect health. How life
stressors affect health on a day-to-day basis. For Ebony, an immediate response to her health
currently is:
Just emotionally, draining and it makes me not want to go on the day of his visit. I get this whole anxiety thing because, you know, you still probably are weighing the same thing you know. So, I don’t look forward to seeing him. You know, there's different cultures and they have different things that are inclusive to their culture. And I think that needs to be more a part of the whole overall understanding of patient-physician relationship and the person owns some of that, you gotta change, be willing to change too. You can't keep coming in with the same thing expecting different results.

Sabrina found that life stressors affected her responses to health because, “I don’t know if you’re more sensitive to what you become numb too.” Sabrina spoke to feeling stressors reduce her tough exterior and just feeling exposed. Latoya expressed responses to her health that negatively affect her wellness:

I have an illness called Tako-tsubo cardiomyopathy. What it is, is stress related. So, if anything real stressful happens to me it will make my heart fail. Additionally, because everything is always related back to those life stresses and it could be and you know I could feel good on the outside like what happened was my grandmother had past and nobody told me cuz I'm originally from D.C., but I was abandoned and bought to North Carolina to live with my dad's family. So when I found out that my grandma that was taking care of me in D.C. had past and nobody told me you know on the outside I was upset, but you know I was like okay she was Old, so you know, but it still ended up attacking my heart so like I can’t control it.

Nivea discussed that recent societal concerns and media had been a trigger for her and having external trigger.
**Support with resources/resourcefulness.** This theme represents provider’s ability to assist with other needs that may affect patient interactions with health including social determinants/drivers of health. SDOH may include meal alternatives, transportation, medication cost, utilities, housing, and medication samples. Providers being resourceful and knowing resources. Understanding the affordability of needs. Sub-themes include *access, alternatives to care, and survival.* Access explored the accessibility to the clinic, bus line, walking distance, knowledge, and lack of income. Additionally, there were concerns on if lack of insurance removes options to access the best quality of care. Alternatives to care explored providers not just pill pushing or weight loss focused, but providing an understanding of nutrition and other ideas about health and medication. Lastly, survival which addressed feelings of not wanting to die and that they superseded emotions about provider. Healthiness and sustaining life being at core motivation, going to provider because health requires it.

Monica looked to her provider to gain assistance with paying some bills. Monica states, “I needed a letter on describing my condition, what it is, you know, why I need heat you know. So, he like did it right away and so that was nice.” Nancy appreciated support and wanted to ensure providers understood her needs:

I’m just trying to figure this all out. Identification of resources is helpful. My provider gave me some resources to try and help with my housing instability and finding somewhere safe to live. I am hoping something comes through. I don’t want to die. Nivea identified that once she found the right provider they:

Found medication samples and gave suggestions on alternatives to medication. Overall, she gives me hope that I can get better and I find it can be fixed like a lot. I’m not just waiting to pretty much die. They can suggest some very simple things that I can do. I
need to believe you, if I’m believing in you, I want to do better, I want to improve my chances.

Sabrina found that current providers focus on immediate concerns and miss out on affecting long term results. Sabrina believes that providing information to patients can change their lives. Sabrina states:

Doctors that really have passion for what they are doing go the extra mile and give you something extra because it cost them nothing. Those extra resources can change someone’s life. Access is another like, if I know, but I don’t have access to different right then that’s another thing so the same classes that they’re giving for this starchy food, cut back on this, do half of that, helps.

**Research Question 3: What are ways trust development is established or hindered?**

The following themes are identified for research question 3: responses to health, support with resources/resourcefulness, professionalism, communication, and quality of provider. Definitions and examples of themes have been described within research question one and two and there aren’t any additional themes or subthemes that haven’t been described.

Although the experiences were unique to each participant, many themes and subthemes were relevant to multiple patients. Participants shared to their comfort level and many shared additional experiences when the audio recording ended. Some patients expressed genuine concern for their providers being overwhelmed and some were just trying to get their basic needs met. Overall, all of the unique experiences were relevant, important, and authentic to the nine participants in this study.
Chapter Summary

In this chapter, a profile of each participant was provided, the PCMH experience was provided, and the findings of the study, as organized by research question, were offered. The purpose of the study and the research design were also reviewed. The next chapter will include a discussion of the findings, implications, and final conclusions.
CHAPTER FIVE: DISCUSSION

In Chapter Four, the findings of the study, including profiles of the participants, the PCMH experience, and a presentation of the themes were offered. In an effort to provide a rich, thick description of the data as supported for case study (Creswell, 2013); participant experiences were honored with direct quotes and no interpretation of their experiences in Chapter Four. In this chapter, a discussion of the findings, study limitations, implications for Counseling and Healthcare administration are offered.

In summary, the purpose of the study was to learn about how the patient experiences patient-provider trust development within a primary care clinic. The study was qualitative in nature and attempted to outline qualitatively the shared experiences of patients within a Durham County primary care clinic dealing with trust development. A single instrumental case study design that was exploratory in nature was used to investigate the phenomena of trust development within the bounded case of a primary care medical home (PCMH) in Durham, NC. In this chapter, the findings are discussed and conclusions are drawn from each research question. The implications of the findings for health care administration, researchers, counselors, and clinic providers are offered. Finally, conclusions are discussed.

Theoretical Connections

Within the literature the primary methodologies explored regarding trust were related to grounded theory or quantitative in nature. It was believed that exploring alternative qualitative methodologies would provide an additional perspective regarding understanding what trust development means and looks like for the patient. Although, there weren’t any identified studies that used the Ethnopolitical theory, Chaos and Complexity Theory (CCT), or RCT in relationship to the patient-provider trust development relationship, there was some support in the findings of
the benefit. Finding ways to help providers address the multitude of system concerns while meeting the needs of their patients can only benefit both the providers and the patients, thus accomplishing the Triple Aim of healthcare. There was insufficient information provided in the findings to confirm benefit of the social ecological model for health promotion. Sallis, Owens, and Fisher (2008) found that if individuals are provided with motivation and skills to change behavior and if environments and policies are created that nurture the change behavior, healthy choices become attractive. However, all of the participants in the study identified as a higher knowledge of their health. Additionally, participation in their health didn’t seem to be a factor as many of the participants desired their providers have more investment in their health than an avoidance of change behavior. When further exploration of trust development, this may be a factor in the future with a larger sample and expansion beyond the local PCMH.

Chaos and Complexity theory (CCT) support findings within the study surrounding the non-linear components on life and how it can affect your interactions with providers, peers, and natural supports. Additionally, the complexity of multiple life stress can negatively impact your internal and/or external stability. While Monica was a participant in the study she lost heat in her home again. She didn’t have any formal support that she hadn’t used previously to attempt to regain heat. Having to stay with friends 25 miles from her home made it difficult to engage in her healthcare, additionally it was a stressor towards her daily survival. Latoya was in a car accident between her first and second interview and had to cancel multiple appointments with her providers. Missing appointments that would help her process the experience were made worse by the mounting financial responsibilities that occurred as she didn’t have a license for the car. Providers who have developed trust with patients will be able to guide them towards
behaviors and cognitions that are new and adapted patterns that reorganize patients towards future health goals (Livneh & Parker, 2005).

During the study the researcher did not take the stance to point out patterns for participants, but allowed the participants to share the fullness of their experiences without evaluation in the moment. However, the ability to change and encouragement to process through the complexity of life was modeled by the researcher during and since the study. There is an opportunity to empower providers to understand the many factors that influence patient interactions and can encourage or hinder trust development. The participants who found providers and extended members of their treatment team that could not only understand the complexity of their needs, but help them process through them were identified by the participants to be providers that they fully trusted.

Two primary tenets of Ethnopolitical theory that were beneficial in the collection of patient experiences and would be essential in trust development in the clinic moving forward are, bearing witness and naming the terror. As explained by Nivea:

Past trauma is a chronic stressor for me, it doesn’t always affect how I interact with the doctor, but it is an obvious byproduct regarding some of the things that’s going on in the media right now.

As Ebony was having a physical response as she described her feelings going to see her provider and knowing that he would bring up her weight, the researcher was able to bear witness to her feelings and concerns. Many of the patients spoke of needing to know they were being heard and that they were a part of the discussion, not just being informed.
**Bearing Witness**

To act as a witness, to listen to the recounted experiences of others helping to reformulate identity and promote political and internal change are ways to define this intervention (Brahnam, 2012; Comez-Dias, 2000). Gentile (2013) stated, “Theories about witnessing have gained therapeutic traction for those analysts attempting to engage patients within these collapsed spaces of meaning making” (pg. 457). If PCP’s are concerned with time needed to engage in this intervention, working within teams could allow other providers within the team to each take some responsibility to offer the space needed to effectively bear witness for patients.

At the completion of the study, the researcher has received outreach back from several participants that spoke to the feeling of being heard. Additionally, participants expressed the hope that sharing their experiences would be helpful to the PCMH as a whole. Although, it was the intention of the study to better understand the experiences of patients within the identified PCMH and potentially share some assertions regarding the study, the researcher was able to reveal some of the gaps that patients experienced in interactions. The study had positive unexpected findings.

**Growth-Fostering Relationship**

Two primary factors conceptualized prior to the study and were supported within the findings was the importance of growth-fostering relationships and that disconnections prevent growth and engagement. RCT identifies that people grow through and toward relationships throughout the lifespan and in growth-fostering relationships, all people contribute and grow or benefit; development is not a one-way street (Comstock et al., 2008). Disconnections can occur at social, cultural, and systemic levels (Frey, 2013). Healing for individuals has the potential to
occur in the context of mutually empathic and growth fostering relationships (Comstock et al., 2008). Nivea shared the difference in providers when she described:

My current provider I trust, I will wait to see her when our schedules line up. I make it a point to see her because I trust her. I feel like she actually listens to me. She problem solves with me. Let’s figure this out together. She took the time to explain what was happening when medication changed. We look to see if there are generics or a patient assistance program. She cares and is a really good provider. I am really glad to have found her, it’s been a lot of work over a lot of years.

Latoya spoke to the difference in accountability and relatability with her counselor versus her primary provider. Growth-fostering relationships that ensure space for the complexities of life and allow individuals to share their truth, promote health. Ebony’s disconnect with her provider regarding cultural norms and expectations of their relationship was a source of frustration and mistrust with her provider that left her not feeling safe to be her authentic self within their interactions. Nancy identified that there was no other way for her to be, but to live in her truth about what she is able to do. Nancy identified that it was important for her to:

Find a good combo. My provider now listens to what I have to say even if they don’t like what I’m saying. The long waits at the clinic are disrespectful to our time, but when I finally get into my provider it helps to talk. We are progressing.

Both Jason and Marco were indifferent to feeling of a growth-fostering relationship with their provider. Both saw the providers professionalism, communication, quality of provider as sufficient to support trust development and the relationship they had. A growth-fostering relationship is as unique as each of the participants and more awareness from the provider on the patient’s relationship need supports progress.
Understanding Complexity

As stated, Chaos Complexity Theory (CCT) promotes understanding systems that are nonlinear, dynamic, self-organizing, and self-similar (Livneh & Parker, 2005). Acknowledging the complexity of the multitude of factors that effected the participants on a daily basis was crucial to establishing trust. Each of the participants spoke to a desire for their providers to believe they have the ability to change health behavior and to “do better” on health goals in the future. Additionally, patients needed to believe they could change and the chaos of their life and health weren’t the end of their potential. Will understood the complexity of his care and had a strong internal motivation to take care of his health stating:

I know how the situation goes now. I don’t think the way I used to. It’s different times.
You know before I felt like that’s not gonna happen to me. And then you like, what, I gotta do something different, your not going to take me out. I got it. You got to make sure that your’re lucky. You don’t go through what I’ve been through and not change.

Sabrina described the complexity of her health and her providers support, “Don’t just delay my death that isn’t education. If you put out my fire, but I’m in hell you just got me to a steady burn.” Nivea described the ultimate experience with her provider:

I felt like I was confident that whatever they were telling me like they were confident in me or the process that it will work. I’ve noticed that I have done better with people who actually believe that I can change. That, you can get better so that will definitely change the dynamic.

Figure 2, is a visual of the patient trust cycle and the potential factors that can disconnect participants. Monica felt supported and that her provider was an advocate for her in addressing external influences that were increasing chaos in her interactions. Nancy was empowered to be
honest with her provider regarding, “doing what I can” at this time and that her provider would understand and meet her where she was. The patient trust cycle connects the conceptual framework as the potential disconnections that interfere with the participant’s experience within the PCMH as explored through the case study.

Research Questions #1: How does trust development begin within a primary care clinic?

All of the participants were able to identify if they were in a trusting relationship with their provider. Trust was inclusive of safety, collaboration, communication, knowledge, and being listened to about participant needs and their person. The overall expectation from participants related to trust development, was understanding how the provider demonstrated their intention on helping the patient. A lack of appreciation, validation, and respect of the patient influenced the ability of the patient to have positive trust development.
**Communication.** Positive communication was demonstrated through a collaborative spirit. Allowing participants to feel safe to be authentic and not receive judgement by the provider or instruction without discussion. Participants were also able to discuss willingness for communication to be reciprocal and identified that as a goal. Nivea stated:

Customize to me, meet me where I am. Have a conversation with me outside of what you read in the chart because the chart will give you some awareness, but I’m apart of this. Connect with me.

**Professionalism.** The concept of professionalism starts at the front door. From the warm smile of the security guard, to the acknowledgement given by front desk staff. Everyone in the PCMH is a part of the team and patients discussed professionalism inclusive of all staff not just their providers. Reciprocity related to time was a consistent concern by all the participants. In addition, communicating expectations and not assuming others are aware of actual thoughts is important to developing trust between patients and providers (Rowe et al., 2014). Currently, patients receive a satisfaction survey randomly based on clinic visits. Patients can be satisfied with service at appointment, but not have established trust with provider. The satisfaction survey could be improved with adding to the patient experience questions related to trust and what it looks like for the patient. Furthermore, the current appointment reminder calls could be extended to include a general check-in on the patient and how they are doing in other areas of their life, being proactive to potential disconnections. Both the Social Determinant of Health and the Health Literacy questionnaires within the electronic medical record if required for all patients could improve provider knowledge of external and internal factors affecting patients and logic on ways to assist. William Jefferson Clinton stated, “We cannot build our own future without helping others to build theirs.”
The topic of no shows at the clinic was of great concern from at least three participants, in relationship to respect to time and professionalism. As a provider within the health system, the researcher is aware of the justification of overbooking to address no show rates. However, Sabrina’s explanation on the perception that she feels related to waiting past a scheduled appointment gave new perspective to a common clinic concern. Exploring alternatives to addressing no show rates would improve trust development within the PCMH.

**Quality of provider.** Two of the participants discussed specifically related to imbalance of power and control with their current providers. Ebony was currently feeling a loss of control on the ability to collaborate with a quality provider and it was disconnecting her from the treatment relationship and her response to health. The PCMH proudly provides access to quality care to the community. There are multiple levels of care provided at the clinic in an effort to make accessible to patients sincere care that doesn’t leave historically marginalized populations behind. Both the participants and the PCMH exemplified that the belief and demonstration of the ability to connect, grow, and change where necessary as a partnership between the community and the PCMH conveyed quality.

**Research Question #2: How do patients perceive provider trust?**

**Research Question #3: What are ways trust development is established or hindered?**

Both Research Question #2 and #3 identified the same themes within the findings. Perception is reality. Changing patient perceptions of provider’s awareness of their needs and enlightening providers to consider alternative perspectives that can still assist them with accomplishing their overall goal of improved health for patients, will be a system shift (Perna, 1997). If there isn’t a positive perception of trust within the patient-provider relationship any
further development of trust is hindered. Communication may also be damaged and both patient’s and providers don’t communicate in a way that supports growth and connection.

**Support with resources/resourcefulness concerns.** Working with formal and informal supports in a collaborative manner to help address health concerns of patients is important. Informal supports include family and friends that are important to the patient and can help with treatment goals. Within a PCMH, individual team members advocating on the behalf of patients to ensure their voices are heard and their concerns are expressed empower patients. When supporting populations that resources are limited, the providers knowledge of available resources becomes essential to trust and the patient belief that the provider is there to help them. When there are financial stressors, it becomes necessary for the provider to not just have knowledge of medications and disease management, but awareness of the affordability of medications and resources that may meet that gap. The patients have a need for the provider to not only bear witness, but to identify assistance to close the gap of care.

**Responses to health.** Participants discussed multiple factors that effected how engaged they were and how they experienced trust with their provider. As found in the literature, chronic life stressors can have a negative effect on health. Patients that felt misunderstood had a perception of mistrust. The female participants to the study had a multitude of physical and emotional responses to their experiences of trust. Latoya and Ebony expressed strong responses to health that negatively affected trust development. Marco and Jason based their explored outside factors that affected their response to health, but in general felt comfortable to share health concerns and believed they would receive the support they need within the PCMH. Okoro and Odedina (2016) found that it is imperative to discuss other aspects of patient’s life other than the illness including SDOH concerns. Improving consistency across the health system of all
patients receiving necessary screenings for depression, anxiety, trauma, and resiliency would add to knowledge on how to best support patients.

In summary, there were five primary themes related to trust development in the patient-provider relationship within a PCMH. Providers having a foundational understanding of CCT, RCT, and Ethnopolitical theory will help with improving the establishment of trust and changing patient perceptions. Clarifications to the patient satisfaction surveys, adaption of patient outreach between appointments, and consistency with use of questionnaires and screenings available within the EMR can help PCMH staff understand and address patient experiences of trust. Each of the participants were willing to engage in their care outcomes and were invested to continue to receive care from the PCMH.

**Limitations**

Some limitations were identified within the pilot study and were addressed within this study. An additional coder was added to ensure no issues or themes were missed and to improve dependability. An auditor was also included to ensure biases weren’t represented within the findings and to support or disprove any of the identified codes through the first and second cycle coding. Transferability may be limited because the study occurred at one setting within a bounded time. Exploring cases throughout multiple clinical sites and with multiple identified providers would lend positively to transferability. As the study included the culture of the clinic and participant membership into marginalized populations within a smaller community, this could affect generalizability. Patients assigned to the clinic that met all of the prescreening criteria, but had multiple no-shows for appointments; their experiences of trust development could have been beneficial to the in-depth exploration and may have identified some additional similarities or differences. The topic would benefit from further empirical future research.
Implications for Counseling

Not every primary care clinic is actively promoting additional training for providers that will promote engagement of patients that have experienced factors of chronic life stressors and identify with a marginalized population. Nor is trust development evaluated the same across health systems and the helping profession. Providers are encouraged to have good patient satisfaction scores and as the literature supports that doesn’t necessary equate to provider trust. Ebony shared what may be most beneficial for counselors and how our presence as part of the treatment team can improve trust. Ebony stated:

I didn’t know. I wasn’t aware or didn’t realize how much trust was important to me or was a part of the overall experience. I didn’t have words for it. All I knew was I wasn’t happy. I didn’t realize trust was what I was missing until you allowed me to talk it out.

The local PCMH within this case study actually has had a few integration projects with entities outside of the clinic and with social work and counselors within their behavioral health services, they have the ability to expand in a profound way. Many of the themes that were identified by the participants are core skills within motivational interviewing training.

Motivational interviewing skills include having a collaborative conversation with patients about change, where the clinician assist with strengthening motivation to change, removes the implied authority of the provider, draws out the authentic need of the patients while empathizing with their experiences (Miller & Rollnick, 2002). Skills such as agenda setting with patients, ensuring the patient takes the lead in their care and the change they seek are valuable skills that counselors have experience in and can support other PCMH providers with strengthening that skill. Motivational interviewing is encouraged throughout the health system, but isn’t required throughout.
It is the hope of this study to further interest in this topic and for future research to implore providers to make these concerns a priority in improving patient health outcomes. Additionally, that multicultural awareness classes are more in-depth and required for providers for continuing education. According to Ratts et al. (2016), multicultural counseling must evolve with society if “the counseling profession is to continue to address the needs of culturally diverse clients and the social justice concerns that both shape and contextualize mental health and overall well-being” (p. 29). As counselors and counselor educators, we have the additional duty to take the lead with other professionals and ensure that patient well-being is addressed including those factors that occur outside of the PCMH and sometimes because of what occurs within the PCMH. Other implications within this study are realistic action interventions easily assessable for all team members within primary clinics to use. Finally, this study offered patients the ability to share their experiences within the PCMH with a description of what trust and help looks like for the participants. Participants were willing to share how to best connect in a trusting healthcare relationship, as providers we just need to make the time to listen, effectively communicate, and join their collaborative team.

**Practice and Future Research**

As a current Licensed Professional Counselor (LPC) working within a health system, I am very aware of the conundrum that counselors within a health system find themselves in. Patients within a PCMH need services and don’t present within the limitations of insurance types. Many PCMH’s that have behavioral health staff employ social workers to avoid limitations with insurance coverage. However, as the need continues to increase there continues to be availability to expand provider types within integrated health care teams to be more inclusive of LPC’s. There are additional collaborative care codes for Medicaid and Medicare that
will allow for the practice of LPC’s to expand throughout integrated teams. In each of the participant experiences within this study, those individuals that were connected with multiple providers with at least one including behavioral health staff, were more equipped to address responses to health and it expanded their resources to address life stressors. More counselors as part of the team on-site at the PCMH’s and counselor educators to prepare future clinic staff can help support meeting all components of the Triple Aim.

Future research includes conducting a quantitative study that could determine if there is a correlation between trust development and use of RCT core tenets. Additionally, a multi-site study to further explore generalizability throughout PCMH’s. Lastly, further exploration on multiple groups within the PCMH to explore if themes of trust development change with longer engagement at the clinic.

**Conclusion**

Exploring trust development within the PCMH, being aware of the perceptions of the patients, their experiences within the clinic through a case study has allowed a more in-depth narrative. The patients were able to verbalize what help looked like for them and from that potential interventions that are more person-centered can be developed. Minimally, the patients were able to give some direction for trust development and sustainability within the local PCMH. Two of the three components of the Triple Aim of healthcare are quality care and improved health of the population (Institute for Healthcare Improvement, 2014). Previous focus on patient satisfaction hasn’t addressed trust development. Trust can affect adherence and follow-through with healthcare needs. Taking the time to resolve disconnects and factors that influence trust development as explored in Figure 2, will help the patient experience trust development within the PCMH. Improved understanding of patient’s experiences within the clinic regarding trust
could promote the providers to self-reflect on their practice, the tools of engagement they use, and encourage the team to reevaluate what patient engagement or patient satisfaction means. Feedback from the provider and patient in the pilot study were used to refocus this study.

The instrumental case study allows issues to be “explored with a political, social, historical, and personal context” (Stake, 1995, pg. 17). Culture and Chronic health concerns can become barriers to developing trust and improving health outcomes. Continual exploration of the complexity of factors for marginalized individuals within the clinic that can disconnect them from care is essential. It is important as providers that we are actively engaged with the patient in growth-foster relationships, advocating for them, bearing witness to their issues, building rapport with appropriate communication that is collaborative, constantly assessing motivation and responses to health, and providing training when it is appropriate to overcome those obstacles improving provider availability to accomplish those interventions and use of tools within the EMR. Providing a safe space for patients to reformulate their health identities, to promote health outcomes will help develop trust. Lastly, strong health identities and trust will help secure the therapeutic relationship and provide the support patients need to accomplish their goals.
REFERENCES


Retrieved from http://go.galegroup.com/ps/i.do?p=EAIM&sw=w&u=duke_perkins&v=2.1&it=r&id=GALE%7CA180861154&sid=summon&asid=d49b58a83e85e8717e61663bc6353953


http://dx.doi.org.proxy.lib.duke.edu/10.1037/a0032056


doi: 10.1111/jan.12502


https://www.census.gov/quickfacts/table/PST045215/37063

https://www.census.gov/quickfacts/table/PST045215/37145,37063


doi:10.1016/j.acap.2017.01.014


http://www.who.int/social_determinants/tools/multimedia/alma_ata/en/

Appendix A

Conceptual Framework

Patient-Centered Medical Home Clinic

- Patients Perceived Trust
- Cultural/Chronic Life Stressors
- Health Outcomes
- Time
- External Influences
- Internal Influences

Trust Development
Appendix B

In-Person Interview Questions

Participant De-identified Name ______________ D ATE: _____ Time:___ Location:____

“We will now be audio recording. You may ask to stop at any time.”

B. Patient Specific Questions

B1 Describe how your identified life stressors affect your engagement in treatment?
    Follow-up: Have you discussed this with your provider?
    If yes, what ways do you feel your provider has addressed them?
    If no, what has prevented you from doing so?

B2 Describe how your identified life stressors do not affect your engagement in treatment?

B3 What encourages you to engage with your provider(s)?
    Follow-up: What do you identify as assets to engagement? Describe

B4 What prevents you from engaging with your provider(s)?
    Follow-up: What do you identify as barriers to engagement? Describe

B5 Describe the ultimate experience with your provider(s) that would encourage you to return to the clinic?

B6 What are your general beliefs about establishing a trusting relationship?

B7 What behaviors do you expect to demonstrate a trusting relationship?

B8 What behaviors do you perform in a trusting relationship?

B9 What do you feel is most important to develop trust in the patient-provider relationship?
    Follow-up: Describe what that looks or looked like for you?

B10 How does trust influence your relationship with your provider(s)?
    Follow-up: Describe when you began to trust or distrust your providers?

B11 Describe what has hindered trust development?

B12 Do you feel your provider(s) trusts you?
Follow-up: Describe what that feels like?

B13 What other information would you like to share related to trust in the patient-provider relationship?

That concludes interview one.
Appendix C

Second Interview Questions

Participant De-identified Name ______________ DATE: _______ Time:____Location:____

“We will now continue audio recording. You may ask to stop at any time.”

C. Second Interview Questions
C1 What clarifications do you have from interview one? Probing questions

C2 Describe any interactions with your provider(s) have you had since our first interview?

C3 Describe how any life stressors have affected your engagement in treatment since our first interview?

Follow-up: Have you discussed this with your provider(s)?

If yes, what ways do you feel your provider has addressed them?

If no, what has prevented you from doing so?

C4 What other information would you like to share related to trust in the patient-provider relationship?

*Upon completion of this study, the researcher may follow-up with participant to ensure description is accurate and/or any identified themes/constructs are consistent with participant experience.*
Appendix D

Prescreen Checklist

Participant ID Name ______________ DATE: ______ Time:____Location:____

_______Assigned to a provider at clinic
_______Insurance payer identified as ( ) Medicaid ( ) Uninsured
_______At least twenty-one years old
_______Clinic assigned at least three months before interview and no more than two years current
_______Identify with at least one marginalized population
_______Identify with at least one chronic life stressor.

If Yes to all the above
Question:
Is potential participant a provider at clinic? ( )Yes ( )No *must be no to continue
Does potential participant agree to schedule an in-person interview? ( ) Yes ( ) No
Interview Date:___________ Interview Time:____________ Location:_______
Appendix E

Provider request for Participant Recruitment E-mail

Email subject heading: Seeking Patients for a Study on Patient-Provider Trust Development

Dear Colleague:

I am currently pursuing my doctoral degree in Counselor Education at North Carolina State University and completing research for my degree requirements. The purpose of this email is to request a referral of patients that you identify as potential participants in a study to complete my requirements for my dissertation research titled *The Complexity of Care: A Single Case Study Exploring the Intersectionality of Culture and Chronic Life Stressors on Trust*, under the advisement of Dr. Edwin Gerler. The referral process is, share study information using attached provider script and flyer with potential patients and provide them my contact information to learn more details regarding the study if they are interested. My research interest is in trust development. I am interested in learning more about the development of trust within the patient-provider relationship in primary care clinics.

Participants will partake in two interviews with at least the first interview being in-person. Patients are required to meet the predetermined criteria: (a) assigned provider at clinic, (b) insurance payer identified as Medicaid or uninsured, (c) at least twenty-one years old, (d) assigned to the clinic at least three months before interview and no more than two years, (e) identify with at least one marginalized population, (f) identify with at least one chronic life stressor. Participants will complete an initial in-person interview with the primary researcher. The first interview will take no more than 60 minutes of their time. The second interview no more than 30 minutes. A date, time, and location of the interview will be arranged that is most convenient for the patient. During the interview, participants will be asked to sign an informed consent, complete a brief demographic questionnaire, and respond to a semi-structured set of interview questions about trust development. The interview will be audio-recorded and transcribed. To protect the patient’s identity they will be asked to create a pseudonym that will be used to identify their responses to the interview. As an incentive, each participant that completes all steps of the study will receive a $25 Gift Card as compensation for their time and participation.

Participation in this study is voluntary. Since the nature of this study has to do with personal material involving trust relationships, there is a small risk of increased emotions and feelings after completing this interview. Participants are encouraged to seek help and speak with someone if necessary. There are no other anticipated risks to participants, and participants are able to withdraw at any time from this study. Questions about the Institutional Review Board approval of this study can be directed to Jennie Ofstein, Regulatory Compliance Administrator, Institutional Review Board, NC State University at Box 7514, NCSU (919.515.8754).

If you have patients that would be eligible to participate, please share with them my contact information. Potential participants can contact me at Atalaysha Churchwell, alchurc3@ncsu.edu.
Additionally, they can contact me at 919.812.9633. If you do not have patients eligible to participate, but you know of a provider within the clinic that may, please share this email with them. Thank you for your consideration of this request.
Sincerely,

Atalaysha L. Churchwell, MS, LPC, LCAS
Appendix F

Telephonic Script for Potential Participants

Researcher: Thank you for contacting me to learn more information about this study. I would like to share a little information about me. I am currently pursuing my doctoral degree in Counselor Education at North Carolina State University and completing research for my degree requirements. I would like a few moments of your time to discuss your potential participation in a study to complete my requirements for my dissertation research titled *The Complexity of Care: A Single Case Study Exploring the Intersectionality of Culture and Chronic Life Stressors on Trust*, under the advisement of Dr. Edwin Gerler. My research interest is in trust development. I am interested in learning more about the development of trust within the patient-provider relationship in primary care clinics. Will you allow me up to 10 minutes to review the expectations of the study and to complete a pre-screen if one has not been done to confirm your eligibility to participate? (Y) (N)

Researcher: Eligible participants will partake in two interviews with at least the first interview being in-person. Participants will complete an initial in-person interview with the primary researcher. The first interview will take no more than 60 minutes of your time. The second interview no more than 30 minutes. A date, time, and location of the interview will be arranged that is most convenient for you. During the interview, participants will be asked to sign an informed consent, complete a brief demographic questionnaire, and respond to a semi-structured set of interview questions about trust development. The interview will be audio-recorded and transcribed. To protect your identity you will be asked to create a pseudonym that will be used to identify your responses to the interview.

Researcher: Does this sound like something that would interest you? (Y) (N)

Researcher: Can we review the Prescreen Checklist to confirm we can schedule an interview for you? (Y) (N) *If Yes, review checklist and schedule appointment. If No, thank them for their time and encourage them to stay engaged in their health

Researcher: Inform confirmed eligible patient that as an incentive, each participant that completes all steps of the study will receive a $25 Gift Card as compensation for their time and participation. Participation in this study is voluntary. The next steps are I will send you an Informed Consent form for you to review and identify any questions you may have before our scheduled interview. We will go over the form in detail when we meet with each other. You will receive this information via email unless you identify an alternate method to deliver the information. Since the nature of this study has to do with personal material involving trust relationships, there is a small risk of increased emotions and feelings after completing this interview. Participants are encouraged to seek help and speak with someone if necessary.

Researcher: Confirm scheduled appointment time and location. Thank you so much for your time and I look forward to speaking with you in more detail on (appointment date). If you have questions prior to our scheduled appointment, you can contact me at Atalaysha Churchwell at alchurc3@ncsu.edu or 919.812.9633. Thank you again.
Title of Study: The Complexity of Care: A Single Case Study Exploring the Development of Trusting Patient-Provider Relationships (eIRB#14367)
Principal Investigator: Atalaysha L Churchwell
Faculty Sponsor: Dr. Edwin Gerler

What are some general things you should know about research studies?
You are being asked to take part in a research study. Your participation in this study is voluntary. You have the right to be a part of this study, to choose not to participate or to stop participating at any time without penalty. The purpose of this research study is to gain a better understanding of participant’s experiences of trust within the patient-provider relationship.

You are not guaranteed any personal benefits from being in a study. Research studies also may pose risks to those who participate. In this consent form, you will find specific details about the research in which you are being asked to participate. If you do not understand something in this form, it is your right to ask the research for clarification or information. A copy of this consent form will be provided to you. If at any time you have questions about your participation, do not hesitate to contact the researcher(s) named above or the NC State IRB office as noted below.

The purpose of this study
The purpose of this case study is to explore and describe how culture and chronic life stressors factor on trust development between the patients and providers from the patients perspective at a local integrated primary care clinic, and summarize some assertions that may be useful to address those factors to improve health outcomes.

Am I eligible to be a participant in this study?
In order to be a participant in this study you must: Meet the predetermined criteria of: (a) assigned provider at clinic, (b) insurance payer identified as Medicaid or uninsured, (c) at least twenty-one years old, (d) assigned to the clinic at least three months before interview and no more than two years, (e) identify with at least one marginalized population, (f) identify with at least one chronic life stressor. Results of this study may help patients and providers better understand patient experiences of trust in the patient-provider relationship. Your participation in this study will help the primary investigator with the completion of her doctoral degree requirements by completing this step of the dissertation process. The research collected during this study will greatly help the primary investigator better inform her future professional research. You cannot participate in this study if: You do not meet the predetermined criteria above.

What will happen if you take part in the study?
If you agree to participate in this study, you will be asked to partake in two interviews with at least the first interview being in-person. The in-person interview will occur at the office of the PI
at the date and time agreed upon with you. If the location is not convenient for you, an alternative location may be confirmed with you and the PI. The interviews will be audio-recorded and de-identified. The second interview is a follow-up interview and will be scheduled after the first. It can take place via phone unless you request an in-person interview. You will complete an initial in-person interview with the primary researcher. The first interview will take no more than 60 minutes of their time. The second interview will last no more than 30 minutes. A date, time, and location of the interview will be arranged that is most convenient for you. During the interview, you will be asked broad questions about trust development, engagement, and your relationship with your provider(s). The interviews will be audio-recorded on a digital audio recorder. Before the interview begins, you will be asked to complete demographic information. This demographic information will not be used to identify you in any way. The information will only be used to provide group demographic information (demographic information will only be presented in aggregates). After the first interview is completed, the primary researcher will transcribe the interview from the digital recorder. After the transcription is completed, the primary researcher will provide you, the transcription in-person or a hard copy mailed to you depending on your preference. You will then be asked to check the transcription for accuracy and will be allowed to add any additional comments at that time. Your participation should require no more than four hours total of your time including review of transcript for accuracy. You will be asked to sign this informed consent at the end of this document.

Risk and Benefits
There are minimal risk associated with participation in this research. The researcher anticipates no foreseeable risk regarding questions asked to obtain information regarding personal experiences of trust and the patient-provider relationship. However, you should be aware that thinking about chronic life stressors as it relates to trust development might bring up personal issues related to those stressors. The primary investigator strongly encourages you to seek the proper level of care you need if this becomes necessary. The confidential Alliance Access & Information line is available at (800) 510-9132 if you deem necessary. Other than this slight possibility, the researcher anticipates no significant stress, anxiety, threat, due to the content of the in-person interview the participants will complete.

The direct benefits to your participation in the research include helping expand counseling research in the area of trust development, patient-provider relationships, and chronic life stressors. Additionally, your participation may help bring more attention to the area of patient engagement for professional counselors. The indirect benefits to your participation in the research are that you may benefit from contributing to advancing research for Patient-Centered Medical Home clinics and, as a participant, increase knowledge of your health beliefs, which may influence positively your self-awareness, attitudes, and health outcomes.

Confidentiality
The information in the study will be kept confidential to the full extent allowed by law. Data will be stored securely on an encrypted computer with a firewall and Virtual Private Network (VPN) login with multifactor identification and password accessible to PI only. Data regarding your contact information to complete the steps in the study will be stored no longer than eight months past collection of information or until your transcript has been verified by you and your participation in the study is complete. This information will be kept separate and accessible to
the PI only on a password-protected spreadsheet. No reference will be made in oral or written reports that could link you to the study. Individual data with individually identifiable details removed may be made available to the public as required by some journal and funding agency data sharing policies. Prior to the first interview beginning, participants will choose a pseudonym to be used in the transcribed interview. The interviews will be audio recorded and you will receive an electronic copy of it to be reviewed for accuracy and any additional information you would like to add. Use of the pseudonym will help insure that your responses are confidential. A data analysis team of two to three other coders will be reviewing the transcripts to develop themes. None of your demographic information or identifying information will be shared with members of the coding team to ensure confidentiality. Great care will be taken that any quotations included in the qualitative write-up will not be identifiable to a specific person.

There are exceptions to your right to confidentiality and the PI is obligated to report in the following situations: You are in danger to yourself or others; child or elder abuse is suspected in your case, a medical emergency arises in which you are unable to provide appropriate information. If any of the situations above arise, I am bound by law as a mandatory reporter to release related information regarding those situations.

**Compensation**
For participating in this study and completing all steps to the study, you will receive a $25 gift card to a local merchant. If you are unable to complete all steps to the study, which includes both interviews, you will not be eligible for the gift card.

**Emergency Medical Treatment**
If you are hurt or injured during the study session(s), the researcher will contact 911 for emergency medical services. There is no provision for free medical care for you if you are injured as a result of this study.

**What if you are a NCSU or Duke student?**
Participation in this study is not a course requirement and your participation or lack thereof, will not affect your class standing or grades at NC State University or Duke University.

**What if you are a NCSU or Duke employee?**
Participation in this study is not a requirement of your employment at NCSU or Duke University Health System, and your participation or lack thereof, will not affect your job.

**What if you have questions about this study?**
If you have questions about the study itself or the procedures implemented in this study, you may contact the researcher, Atalaysha Churchwell at alchurc3@ncsu.edu or 919.812.9633.

**What if you have questions about your rights as a research participant?**
If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact the NC State IRB Office via email at irb-director@ncsu.edu or via phone at 1.919.515.4514. You can also find out more information about research, why you would or would not want to be in research, questions to ask as a research participant, and more information about your rights by
going to this website: https://go.ncsu.edu/research-participant

**Consent to participate**
I have read and understand the above information. I have received a copy of this form. I agree to participate in all aspects of this study including interviews, with the understanding that I may choose not to participate or to stop participating at any time without penalty or loss of benefits to which I am otherwise entitled.

Participant’s signature: ___________________________ Date: _________

Investigator’s signature: ___________________________ Date: _________
Appendix H

Observational Protocol

Length of Activity: ____
Date of Activity:
Field Notes of PCMH general Observation

<table>
<thead>
<tr>
<th>Descriptive Notes</th>
<th>Reflective Notes</th>
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Appendix I

Demographics Questionnaire

Participant ID # ______________ DATE: ________ Time: ____ Location:____

A. DEMOGRAPHIC INFORMATION (NOT AUDIO RECORDED)
A1 How long have you been assigned to the PCMH clinic?  
_____Years ___Months

A2 What is your age? ______
[ ] PREFER NOT TO ANSWER

A3 What is your gender?
[ ] MALE [ ] FEMALE [ ] Other

A4 What is your race/ethnicity?

○ African American/Black  
○ Asian  
○ White American  
○ Latino/Latina  
○ Middle Eastern  
○ Pacific Islander  
○ Other (please specify)  

A5 On a scale from 1-5, with 5 being very high. What is your level of knowledge of your personal health? Mark X in the appropriate box

<table>
<thead>
<tr>
<th>1-Very Low</th>
<th>2-Below Average</th>
<th>3-Average</th>
<th>4-Above Average</th>
<th>5-Very High</th>
</tr>
</thead>
</table>

A6 Please select the groups to which you belong.

○ Individuals of a particular ethnicity/country of origin
○ Women
○ Individuals with physical/mental disabilities
○ Individuals of lower socioeconomic status
☐ Elderly
☐ Unemployed
☐ Individual released from incarceration
☐ Immigrants, Refugees, and migrants
☐ Individuals that identify as LGBTQIA

A7 What chronic life stressor(s) do you individually identify with?
☐ Financial stress
☐ Divorce
☐ Work-Related
☐ Marital problems
☐ Care Giving
☐ Repeated Exposure to Trauma
☐ Health of self/others
☐ Loss of a loved one
☐ Housing instability
☐ Retirement
☐ Imprisonment
☐ Other (please specify)
Appendix J

Pilot Study Interview Questions

Pilot Case Study for ED 730
Bearing witness to the effects of health outcomes: A single case study exploring the intersectionality of culture and chronic life stressors on trust.
Participant ID #/De-identified Name ______________ DATE: ______
Time:_____ Location:____

A. DEMOGRAPHIC INFORMATION (NOT AUDIO RECORDED)
A1 What is your current position?
Year of Licensure?
Number of years in practice?
A2 What is your age?
______ YEARS
[ ] PREFER NOT TO ANSWER
A3 What is your gender? [ ] MALE
[ ] FEMALE [ ] Other
A4 What ethnicity do you identify with? ____
A5 What is your clinical FTE?
½ day per week = 0.1, or 10% FTE
______% (5-100%)
[ ] UNSURE
A6 Of the patients that you see what percentage _____ %
would you estimate are Medicare or Medicaid?
[ ] Don’t Know
A7 How would you describe the setting in which you
most often practice?
[ ] PRIVATE PRACTICE
[ ] COMMUNITY-BASED,
PUBLIC
[ ] ACADEMIC MEDICAL CTR
[ ] OTHER:
A8 How do you receive patient referrals in your setting?

QUALITATIVE SEMI-STRUCTURED INTERVIEW.
“We will now being audio recording. You may ask to stop at any time.”

B. General regarding patients served
B1 How do you access motivation for treatment within your patients?
B2 What are some of chronic life stressors that your patients present with?
B3  What cultural influences do you see presently with your patients?

B4  How do you begin engagement with patients?
   Follow-up:  What is your level of prioritization with health concerns and what is covered during a session?
   Explain: Why you prioritize something over another?

B5  In what way(s) do you begin to develop trust within the therapeutic relationship?

Pilot Case Study for ED 730

Bearing witness to the effects of health outcomes: A single case study exploring the intersectionality of culture and chronic life stressors on trust.

Participant ID #/De-identified Name ______________ DATE: ______
Time:_____ Location:____

Follow-up: Barriers to that development?
Clinical tools used to address barriers?

B6  What is the length of interventions you provide for patients?
   [ ] Per session
   [ ] Entirety of treatment

B7  What do you believe should be involved in a treatment plan for patients with trust concerns?

B8  What does bearing witness mean to you as a provider?
   Follow-up: How do you demonstrate this?

C. Specific to identified case

C1  Please describe facts of identified patient as you know it including: [medical history, previous treatment engagement, personal history (i.e. cultural and life stressors), items that affected trust (i.e. perceived and confirmed)]

C2  What is the current length of treatment intervention for patient?

C3  Please describe what you believe has and hasn’t worked in current and previous treatment for patient?
   Follow-up: Why?
      Specifics in patient treatment plan?

C4  How was trust developed with identified patient?
   Follow-up: Barriers? Strengths? Motivation level?

C5  What are your take-a-ways from interactions with the patient regarding how you provide treatment?
   Follow-up: What would you Change and/or repeat?

C6  Any other items specific to this case you feel are important to share?

That concludes this interview.
*Upon completion of this pilot study, the researcher may follow-up with participant to ensure description is accurate and any identified themes/constructs are consistent with participant experience.*
## Appendix K

### Data Collection Matrix

<table>
<thead>
<tr>
<th>Participant Interview</th>
<th>Clinic Observation</th>
<th>Document/Record review</th>
<th>Theme review by Participant</th>
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Email subject heading titled: For Review

Hello,

I hope this email finds you well. You have been identified to participate in a review of the identified themes of the study. I would like to give you an opportunity to consider whether any of the experiences or perceptions of other participants apply to you. If you are willing to participate in this participant validation process, please respond to this email by (insert date). If you confirm yes to participating in the review of themes identified within the data that information will be sent to you in the response email or can be shared via phone if that is your preference. As noted in your signed informed consent, all data used to identify themes has had all identifiable information removed to ensure all participant confidentiality is intact. This activity should take no more than 10 minutes. I am asking that you complete this review no later than (insert date) and contact me. Thank you in advance as I appreciate your continued engagement in this process.

Atalaysha Churchwell, MS, LPC, LCAS
(919) 812-9633
Email subject heading titled: For Review

Hello,

I hope this email finds you well. Attached is the Informed Consent for your review. We will review and discuss this document in detail at our interview on (insert date). Additionally, I have attached the interview questions to support transparency of the interview and to reduce any concerns you may have of what the questions will entail. Please note that the interview is semi-structured meaning that it is open and allows us to explore your responses further in an effort to better understand your experiences, therefore additional follow-up questions may be asked not previously identified. Thank you in advance and I appreciate your engagement in this process.

Atalaysha Churchwell, MS, LPC, LCAS
(919) 812-9633
Appendix N

Formal Recruitment Letter

(insert date)

Pseudonym name of participant
Durham, NC

RE: The complexity of care: A single case study exploring the intersectionality of culture and chronic life stressors on trust by Atalaysha Churchwell

Dear (insert pseudonym name of participant):

I am writing to inform you of more detail information regarding the instructions to our in-person interview scheduled (insert date). In addition, to share the expectations of you as the participant during the study from the primary researcher. A copy of the informed consent and the interview questions will be sent in a separate email. You are receiving this letter because you self-identified as a potential participant, met the prescreen criteria, and confirmed an in-person interview with me. I am currently pursuing my doctoral degree in Counselor Education at North Carolina State University and completing research for my degree requirements. Participation in this study will assist me in completing my requirements for my dissertation research titled The Complexity of Care: A Single Case Study Exploring the Intersectionality of Culture and Chronic Life Stressors on Trust, under the advisement of Dr. Edwin Gerler.

You will receive an email that contains a copy of the informed consent and the interview questions. I ask that you review that information prior to our scheduled interview. Your interview location is (insert address) and if you have any concerns finding the location or need to reschedule, please contact me at 919-812-9633 as soon as you can. You will receive an appointment reminder phone call prior to your appointment. There will be portions of your interview that are audio recorded and that is identified on your copy of your interview questions. The interview will be transcribed and will be delivered to you in-person or a hard copy mailed to you depending on your preference for your review for accuracy after our interview is complete. Your self-identified pseudonym will be used throughout the interview. If you have not already identified a date for your second interview, please be prepared to do so at the time of our first interview.

During our interview, time prior to the audio-recorded portion of the interview begins, you will be asked to complete demographic information. This demographic information will not be used to identify you in any way. The information will only be used to provide group demographic information (demographic information will only be presented in aggregates). Your participation
should require no more than four hours total of your time including review of transcript for accuracy. To receive the $25 gift card to a local merchant, it is expected that you will complete all steps to the study (initial interview and follow-up interview). At any time, that you wish to discontinue participation or receiving communication from me, you may opt out by contacting me and requesting no further contact be made.

I am available to you to answer any questions that may arise or to reschedule any appointments you deem necessary. Thank you again for considering this research opportunity and please feel free to contact me at the contact information below.

Thank you in advance,

Atalaysha Churchwell, MS, LPC, LCAS
Alchurc3@ncsu.edu
(919) 812-9633
Appendix O

Participant Study Transcript Review Letter

(insert date)

Pseudonym name of participant
Durham, NC

RE: The complexity of care: A single case study exploring the intersectionality of culture and chronic life stressors on trust by Atalaysha Churchwell

Dear (insert pseudonym name of participant):

I am writing to provide you a hard copy of your first interview transcript that was completed on (insert date). As detailed in your informed consent, it is requested that you review the transcript and provide any feedback to me verbally or in writing by (insert date). If no additional feedback is submitted by (insert date), transcript will be coded as transcribed.

This activity should take no more than 30 minutes. I am asking that you complete this review no later than (insert date) and contact me. See attached transcript. Thank you in advance as I appreciate your continued engagement in this process.

Atalaysha Churchwell, MS, LPC, LCAS
(919) 812-9633