ABSTRACT

THE LIVED EXPERIENCE OF ACCESSING HEALTH SERVICES AS AN ELDERLY RURAL INDIVIDUAL

By Dan S. Skeen

Rural communities are identified as health disparity areas due to a significant discrepancy in the overall rate of disease incidence, prevalence, morbidity, mortality, and survival rates in the rural population, as compared to the health status of the general population (National Public Health Week, 2004). This disparity is attributed to decreased access to health services experienced by rural residents, exemplified by decreased availability of health professionals (Wielandt & Taylor, 2010), limited proximity to primary care and specialty services (Baldwin et al., 2008; Wong & Regan, 2009), and challenges in receiving cancer screening and mental health services (Bettencourt, Schlegel, Talley, & Molix, 2007). Health disparities have an even greater impact on the elderly population due to a reduced physiologic reserve and increased susceptibility to illness and disability (Hinck, 2004). Much research has been done to identify these disparities with methods to rectify them, but little research has been conducted with the aim of understanding how the rural elderly view their experiences accessing health services.

The purpose of this descriptive phenomenological study was to gain understanding of the experiences of rural elderly individuals in accessing health services. Information gained clarified their needs regarding access to health services with the ultimate goal of helping to rectify health disparities for the rural elderly.

The study was conducted via in-depth, personal interviews. Nine participants over the age of 65 living in rural Wisconsin, and accessing rural health services for at least 10 years, were recruited through purposive sampling. With the researcher as the instrument, participants were asked open-ended questions in an attempt to capture their lived experience of accessing rural health services. Probe questions were used to further explore individual experiences when necessary. Colaizzi’s method was used to analyze the data, categorizing common statements and developing themes to connect the data. Sampling ended once data saturation was reached.

Three themes emerged during data analysis: (a) 50 first dates, (b) on the road again, and (c) making the most of what you have. The theme 50 first dates signified struggles faced by rural elders in maintaining continuity with their healthcare providers due to the short tenure and rapid turnover of healthcare providers in rural settings. On the road again exemplified the limited proximity of specialty services and the long commutes necessary to achieve access to such services. Making the most of what you have demonstrated the overwhelming sense of appreciation expressed by rural elders for the health services available to them, demonstrating resilience and a general feeling that access to health services is by no means limited by where they reside.
The lived experience of accessing health services by the rural elders in this study illustrates a strong sense of resolve and contentment with their level of access. Despite the overwhelming positive attitude of the participants, two distinct challenges to improving access in rural areas were repeatedly mentioned: (a) difficulty attracting healthcare providers to practice in rural settings for long periods of time, and (b) limited proximity of specialty services in rural areas, resulting in hundreds of miles of travel to achieve access. Further research in these two specific areas may very well help to alleviate these issues and improve access in rural communities. Also, further research is recommended with larger samples in different geographical locations to more completely understand the lived experience of accessing health services as a rural elder.
THE LIVED EXPERIENCE OF ACCESSING HEALTH SERVICES AS AN ELDERLY RURAL INDIVIDUAL

by

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This clinical project is dedicated to the wonderful men and women of Park Falls, WI. By conversing with individuals from this beautiful town, I was given the gift of visualizing true resilience and contentment personified. What some people may see as challenges, the people of Park Falls see as opportunities. Not only making the most of what you have, but truly being proud of what is yours, became a lesson that really hit home with me. I am exceedingly thankful for having had the opportunity to meet and learn from you all.
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Chapter I

Introduction

Background

Health disparities are unavoidable differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups. Health disparities affect population groups based on many characteristics, including ethnicity, gender, socioeconomic status, lifestyle preferences, health status, nationality, and geographic location. Health disparities based on geographic location, specifically based on rurality, are the focus of this study. Rural communities are identified as health disparity populations when there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population (National Public Health Week, 2004). Higher rates of heart disease, cancer, and diabetes in rural areas when compared to urban areas are well documented in the literature (Colleran, Richards, & Shafer, 2007; Dabney & Gosschalk, 2009; Sabesan & Piliouras, 2009). People living in rural areas are also less likely to use preventive screening services, exercise regularly, or wear safety belts (National Public Health Week, 2004).

The above mentioned disparities experienced by rural residents are attributed to decreased access to health services in these areas, along with a higher rate of people who are uninsured and have a lower annual income when compared to those living in urban areas (National Public Health Week, 2004). The decreased access to health services is the focus of this study and is exemplified by a decreased availability of health
professionals (Wielandt & Taylor, 2010), limited proximity to primary care and specialty services (Baldwin et al., 2008; Wong & Regan, 2009), challenges in receiving cancer screening and mental health services (Bettencourt, Schlegel, Talley, & Molix, 2007), and difficulty in acquiring home care and long-term care (Coburn & Bolda, 2001).

Disparities in health are experienced by all rural residents, but there is an even greater impact on the elderly population due to a reduced physiologic reserve, greater amount of co-morbidities, and an increased susceptibility to illness and disability (Hinck, 2004). Furthermore, rural residents tend to be older than urban residents, primarily “as a result of the migration of young adults to urban areas, and to a lesser extent, of return migration of older adults from urban areas back to rural homes” (Kinsella & Wan, 2008, p. 29). In this century, the rate of growth of the elderly population has greatly exceeded the growth rate of the population of the world as a whole. “The world’s older population of 506 million people in 2008 represented an increase of 10.4 million since 2007. The world’s older population grew by an average of 870,000 people each month during the year” (Kinsella & Wan, 2008, p. 7). Under the Census Bureau’s middle series projection for the United States, the number of persons 65 years of age and over would more than double by the middle of the next century to 80 million. About one in eight Americans were elderly in 1994, but about one in five will be elderly by the year 2030 (U.S. Census Bureau, 2010). For these reasons, and the health disparities in rural areas noted previously, rural elderly were the population under investigation in this study.

**Literature Gap**

As mentioned above, much research has been done to identify the health disparities suffered by rural residents. This research has increased awareness of these
disparities and led to increased access to health services in many rural areas (Racher, 2003). Yet significant health disparities continue to exist. An extensive literature review revealed a void in qualitative research on this subject. Qualitative studies exist from a rural healthcare provider perspective (Allan, Ball, & Alston, 2008; Baernholdt, Jennings, Merwin, & Thornlow, 2010; Nelson, 2010), as well as from a patient perspective with regards to coping with chronic diseases as rural residents (George & Thomas, 2010). One qualitative dissertation was done on the topic of accessing health services as a rural elderly couple (Racher, 2003), but no qualitative research has been done addressing the experience of rural elderly individuals in accessing health services. Considering that the experts with the greatest ability to inform us about their experiences are the elderly individuals themselves, this significant primary source of knowledge ought to be investigated to better understand their experiences. Knowledge gained could help identify ways to improve their access to health services.

**Significance for Nursing**

Whether practicing within a clinical, administrative, or educational role, nurses contribute to the well being of individuals, families, groups, and communities. Nurses act as caregivers, advocate for patients, provide information and assistance to patients as they seek and receive health services, plan health programs, and contribute to the development of health policy. This study generates knowledge about the experiences of rural elderly individuals in accessing health services. The results of this study also add to the body of nursing knowledge regarding how the elderly access and use health services in rural areas and factors that influence their decision-making processes. With this understanding, nurses will be better able to provide effective and appropriate care to
elderly individuals, as well as to contribute in health service program planning and healthy public policy development (Racher, 2003).

Statement of the Problem

Disparities in rural health and health services exist, and there is a greater number of elderly living in rural communities as compared to urban areas. Little qualitative research has been conducted with the aim of understanding how elders living in rural areas view their experiences accessing health services.

Study Purpose

The purpose of this study is to gain an understanding of the experiences of rural elderly individuals in accessing health services.

Research Question

What are the experiences of rural elderly individuals in accessing health services?

Definition of Terms

Conceptual definitions.

_Elderly_: Most commonly defined as individuals 65 years of age or older (Hinck, 2004; National Public Health Week, 2004; Racher, 2003; U.S. Census Bureau, 2010).

_Rural_: The U.S. Census Bureau (2010) defines urban as comprising all territory, population, and housing units located in urbanized areas and in places of 2,500 or more inhabitants outside of urbanized areas. Territory, population, and housing units that the
Census Bureau does not classify as urban are classified as rural. Simply put, rural is defined as open country and settlements with fewer than 2,500 residents.

Access: The concepts of potential and realized access are considered important in the formation of a definition for access to health services. Potential access involves structural indicators of the health delivery system (e.g. availability of facilities and providers), and process indicators of the population-at-risk (e.g. illness level and socioeconomic status) (Aday & Andersen, 1981). Realized access includes utilization of health services and consumer satisfaction with the care received. Both potential access and realized access must be present for true access to health services to be present. Khan and Bhardwaj (1994) put it best with this quote:

A population’s potential access to health care basically relates to availability of health care resources (facilities and personnel) relative to their needs for services, and realized access relates to actual use of such resources to satisfy these needs. And use is greatly influenced by availability, as well as the inherent characteristics of the service system and those of the potential users, which express themselves as either barriers or facilitators (p. 67).

Another set of important concepts to consider when forming a definition of “access to health services” is that of initiated and continued access. While initial contact with the healthcare system indicates a degree of access to services, ongoing access is important for continuity of care and improved health outcomes (Aday & Andersen, 1981). Reinforcing factors, such as a positive care experience, influence the repetition or continued use of a health system. Those who continually use a health system express a greater degree of access than one time users, and these individuals are best suited to
evaluate the accessibility and quality of that system (Racher, 2003). There is no agreed upon time period or frequency of use that constitutes continued access.

Taking into account potential, realized, and continued access, the conceptual definition for this study entails the use of rural health services at least once each year for each of the last 10 years.

*Health services:* Racher (2003) identified all of the following as health services: those services provided by nurses, general physicians, medical specialists; pharmacy services; laboratory and X-ray services; hospitals and home care programs; and optometry, dental, and hearing aid services.

**Operational definitions.**

*Elderly:* Individuals, male and female, age 65 years and older, living in northern Wisconsin.

*Rural:* Open country and settlements with fewer than 2,500 residents in northern Wisconsin

*Access:* Availability, as defined by study participants through oral interviews.

*Health services:* Services that contribute to health or illness care, as defined by study participants through oral interviews.

**Assumptions**

Assumptions are basic principles that are believed to be true without proof or verification (Polit & Beck, 2008). Assumptions underlying this study are consistent with the naturalistic paradigm and postmodernism. Under these assumptions:

1. Reality is not a fixed entity but rather a construction of the individuals participating in the research. Reality consists within a context, and many
constructions are possible. No one reality exists and no process by which one ultimate truth can be determined (Polit & Beck, 2008).

2. Rural elderly individuals can provide a wealth of information and are an appropriate source of data.

3. Participants will be honest in their responses

**Chapter Summary**

Health disparities suffered by rural residents are well documented. This disparity is attributed to decreased access to health services in rural areas. These disparities are felt most severely by the rural elderly, as they are more susceptible to illness and have less physiologic reserve in which to cope with health alterations. Research is lacking in the area of qualitative inquiry into the experience of rural elderly in accessing health services. The purpose of this study was to gain an understanding of the experiences of rural elderly individuals in accessing health services. Gaining an understanding into how rural elders view this experience will better position nurses and other healthcare providers to care for these individuals. This study will also provide first-hand accounts into what constitutes elders’ needs in health service accessibility.

Conceptual and operational definitions were included in this chapter consisting of the following terms: elderly, rural, access, and health services. Assumptions noted prior to this study were also identified.
Chapter II

Philosophical Underpinning and Review of Literature

The purpose of this study was to gain an understanding of the experiences of rural elderly individuals in accessing health services. The research question, “What are the experiences of rural elderly individuals in accessing health services?” was best suited for study under a qualitative research paradigm, specifically that of descriptive phenomenology. Under this research paradigm, phenomena, as they are experienced consciously, are described without theories about causes and as free from unexamined preconceptions and presuppositions as possible (Polit & Beck, 2008). A preconceived theoretical framework was not used, but the philosophical underpinnings of descriptive phenomenology warrant discussion and will take place within this chapter.

Qualitative researchers using a descriptive phenomenological method often do not begin with an extensive literature review. This is to reduce the likelihood of injecting bias into data collection or analysis through development of preconceived notions about the topic under investigation (Speziale & Carpenter, 2007). For the purposes of this study, a cursory review of the literature was done in order to refine the research question and build a case to conduct this study. Details of this literature review are also provided within this chapter.

Descriptive Phenomenology

Descriptive phenomenology is the qualitative research design chosen for this study with Husserl’s ideology as the philosophical underpinning. The purpose of phenomenology is to describe particular phenomena, or the appearance of things as
lived experience (Speziale & Carpenter, 2007). The nature of a phenomenon, or what makes something what it is without which it could not be, is investigated. Phenomena as they are consciously experienced (i.e. hearing, seeing, and feeling) are described in rich detail. An important fundamental assumption of descriptive phenomenology is that for any human experience there are distinct structures that make up that phenomenon no matter who experiences it. These distinct structures can only be discovered by studying the individuals involved in the lived experience (Polit & Beck, 2008).

Husserl’s descriptive phenomenological philosophy involves four general steps: (a) bracketing, (b) intuiting, (c) analyzing, and (d) describing. In order to understand the distinct structures that make up a phenomenon, phenomenological reduction is required, by which researchers attempt to temporarily put aside any presuppositions they may hold about the phenomena under study. This is what Husserl called bracketing, and it is done to prevent the injection of bias into a study and to allow the phenomenon to come directly into view without distortion by preconceptions. Intuiting involves a complete immersion in the phenomenon under study by interviewing those experiencing it. The transcribed data is then analyzed to extrapolate common categories and themes. Finally, the themes are described in detail, both singularly and within relation to one another (Speziale & Carpenter, 2007).

**Literature Review**

A review of the literature on the topic of access to health services in rural areas revealed a plethora of studies. Both quantitative and qualitative studies have been done that examined different aspects of rural access. Several studies were performed to examine factors that affect access to health services in rural areas, as well as the health
effects of the limited access suffered by those living in these rural areas. However, there was a gap in the literature with regards to how rural residents themselves viewed their experiences accessing health services. Considering that the experts with the greatest ability to inform us about their experiences are those living in rural areas themselves, this significant primary source of knowledge ought to be more thoroughly investigated and demonstrated the need for further research in this area. This literature review is divided into three sections: (a) factors that affect access to health services in rural areas, (b) results of limited access to health services in rural areas, and (c) rural residents’ experiences with healthcare access.

**Factors that affect access to health services in rural areas.**

Merwin, Snyder, and Katz (2006) studied the influence of the community and individual provider characteristics on the availability of healthcare resources in rural areas. A correlation design using all of the counties in the U.S. was conducted by the researchers with use of the Area Resources File, 2004 dataset. Overall, 3,114 records were used in the analysis. The county was the unit of analysis, thus results represent information about counties versus information about individuals residing in the counties. The analysis was done to determine differences in community characteristics, provider availability, and the presence of publicly funded community health and mental health centers (CHCs & CMHCSs) between counties located in metropolitan and nonmetropolitan areas. The impact of community characteristics, including regional location, classification of rurality, rates of availability of different types of practitioners, and the presence of one or more CHC and/or CMHCS in a county, was also evaluated in this study.
The analysis revealed several statistically significant differences in community characteristics between metropolitan and nonmetropolitan counties. Nonmetropolitan areas were much smaller, had an older population, had a lower percentage of non-White individuals, had $5,000 lower per capita income on average, and had a 3.7% higher percentage of the population living in poverty in comparison with metropolitan areas. A large factor affecting access to healthcare included that there were consistently fewer providers in nonmetropolitan areas, exemplified by the fact that there were almost twice as many physicians per capita in metropolitan areas. Even greater disparity was found in specialty areas, with more than twice as many surgeons and psychiatrists practicing in metropolitan areas versus nonmetropolitan areas (Merwin et al., 2006)

The authors of this study also recognized CHCs and CMHCs as two types of publicly funded organizations developed as a solution to meet healthcare needs of populations throughout the country and chose to analyze the areas benefitting from their existence. What was found was that the more severe the definition of rural, the lower likelihood of the county having a CHC or CMHC. Specifically, the rural areas with a population fewer than 2,500 and not located adjacent to a metropolitan area had the lowest likelihood of having a CHC or CMHC, demonstrating further decreased access to health services (Merwin et al., 2006).

Wielandt and Taylor (2010) performed a study to identify the nature of rural practice and whether recent occupational therapy graduates had been adequately prepared for the diversity of rural work. At the study’s outset, reduced access to health services in rural areas was acknowledged to be partly due to a shortage of health professionals choosing work in rural and remote areas. The researchers wanted to identify reasons for this shortage in order to find ways to increase retention. A
quantitative approach, using self-administered surveys with closed and open-ended questions, was used with a sample of 59 occupational therapists working in rural communities. Data from the surveys were entered into SPSS v14 for frequency data and percentages.

Results of Weinlandt’s and Taylor’s (2010) study revealed that the average length of time in their current position was 5 years, and that most participants identified the rewards of rural practice versus the challenges. Perceived rewards included team work, autonomy, diversity, flexible work schedules, increased client contact, job satisfaction, experiences gained, and the rural lifestyle. Perceived challenges included staff shortages, the generalist nature of rural occupational therapy practice, excess time spent travelling, coping with inappropriate referrals, and the need for more professional support. Also, the majority of the participants believed their training prepared them adequately for rural practice, with some recommending an actual hands-on experience in a rural setting during their coursework and an increase in management and organizational skills content in the curriculum, as these were considered essential skills for effective rural practice (Wielandt & Taylor, 2010).

Baldwin et al. (2008) studied the travel patterns and distances of rural and urban colorectal cancer patients receiving three types of specialty cancer care: surgery, medical oncology consultation, and radiation consultation. A descriptive cross-sectional study used the Surveillance, Epidemiology, and End Results (SEER) cancer registry and Medicare claims data for 27,143 individuals aged 66 years and older diagnosed with stages I through III colorectal cancer between 1992 and 1996. The authors found that over 90% of rural colorectal cancer patients lived within 30 miles of a surgical hospital, but less than 50% lived within 30 miles of a medical or radiation oncologist. Many rural
patients had to travel long distances for specialty care, with the median distance traveled being 47.8 miles. The authors highlighted long distance travel, burdens of time, increased cost, and discomfort as factors negatively affecting the rural elderly patients’ access to specialty healthcare services in this study.

MacDowell, Glasser, Fitts, Nielsen, and Hunsaker (2010) aimed to further investigate claims from previous studies citing shortages of physicians and other healthcare professionals practicing in rural areas. The purpose of the study was to determine whether rural hospital chief executive officers (CEOs) in the U.S. report shortages of health professionals. A nationwide survey was conducted of 1,031 rural hospital CEOs, containing questions about whether or not physician shortages were present in the community and asking about physician needs by specialty. The survey also contained questions about whether or not other health professionals were needed in their town or within a 30 mile radius. There was a 34.4% response rate, yielding 335 respondents.

Physician shortages were reported by 75.4% of the CEOs, with 70.3% indicating shortages of two or more primary care specialties. Family medicine was the most frequently reported shortage (58.3%), followed by internal medicine (53.2%). Frequently reported specialty shortages included psychiatry (46.6%), general surgery (39.9%), neurology (36.4%), pediatrics (36.2%), cardiology (35%), and obstetrics-gynecology (34.4%). The most commonly reported shortages in allied health professions were among registered nurses (73.5%), physical therapists (61.2%), and pharmacists (51%). There was no statistically significant regional variation in shortages (MacDowell et al., 2010).
Results of limited access to health services in rural areas.

Sankaranarayanan et al. (2010) conducted a retrospective study to test the hypotheses that older patients with colorectal cancer and rural patients were less likely to undergo surgery, radiation, and chemotherapy. Using the Nebraska Cancer Registry, 6,561 patients with colorectal cancer were identified between January 1998 and December 2003. Multivariate logistic regression analyses were used to study the association of age and place of residence with each of the three colorectal cancer treatment options. Results were adjusted for patient demographics, insurance payer, ratio of providers to population, and cancer stage. Findings included that patients living in rural areas were less likely to receive chemotherapy than those living in urban areas (P < .001), and patients over the age of 75 were less likely to undergo surgery (P < .05) and receive radiation and chemotherapy (P < .001). Patient outcomes were not studied, but the authors, nonetheless, concluded that advanced age and rural residence need to be considered by decision makers when deciding on treatment options for colorectal cancer.

Sanborn, Manuel, Ciechanska, and Lee (2005) conducted a retrospective chart review to examine the plan of care of all 34 patients hospitalized with congestive heart failure from 2000 to 2001 in a small rural hospital in Canada. The investigation was done in order to assess the need for improved congestive heart failure management in rural settings, where access to specialty services is limited. Results yielded a median age of the hospitalized patients to be 78 years, and most patients had many co-morbid cardiovascular risks. With regards to recommended management, only 23% of the patients were prescribed proper doses of ACE inhibitors, use of beta-blockers was well below recommended rates, and echocardiography was only obtained 38% of the time.
These results represent a need for improved management of congestive heart failure in rural settings.

Harris, Aboueissa, and Hartley (2008) constructed a geographic information system for towns in Maine in order to determine predictors of heart failure (HF) and myocardial infarction (MI) hospitalization throughout the state. Age-corrected MI and HF hospitalization rates for 1998 to 2002 were used as dependent variables with the following independent variables: (a) poverty rate, (b) unemployment rate, (c) median income, (d) educational level, (e) rurality, (f) physician density, and (g) distance to the closest hospital. Univariable and multiple linear regression analyses were used to analyze the results.

During the years 1998 to 2002, there were 24,452 hospitalizations in Maine for MI and 23,330 hospitalizations for HF. The multiple linear regression analysis demonstrated that the being unemployed, living in poverty, and living closer to the hospital predicted higher MI hospitalization rate ($p = 0.000, r^2 = 19.1\%$) and being unemployed and living closer to a hospital also predicted higher HF hospitalization rates ($p = 0.000, r^2 = 8.4\%$). Interestingly, a negative relationship was found between the distance to a hospital and hospitalization rates. The authors hold that this statistic likely does not represent better health in people living in remote, rural areas, but rather, it may indicate that individuals living further from hospitals are less likely to seek hospitalization and may not be hospitalized appropriately for serious cardiovascular ailments (Harris et al., 2008).

Celaya et al. (2010) investigated whether geographic access to mammography screening was associated with the stage of breast cancer diagnosis by using the New Hampshire state population-based cancer registry. With use of this registry, all female
residents of New Hampshire aged 40 years or greater who were diagnosed with breast cancer from 1998 to 2004 were identified. Factors associated with early stage (0 to 2) or later stage (3 or 4) breast cancer diagnosis were compared, with emphasis on the distance of residence from the closest mammography screening facility and rural versus urban locations.

Of the 5,966 women diagnosed with cancer during the time period of this study, the mean driving distance to a mammography facility was 5.5 miles, with a range of 0 to 27.5 miles. The majority of women (56%) lived within 5 miles of a mammography facility, representing good access to this service in New Hampshire. Also, there was no statistically significant association between later stage of breast cancer and travel time to the nearest mammography facility. Furthermore, no significant association between rural versus urban residence and stage of diagnosis was found (Celaya et al., 2010).

**Rural residents’ experiences with healthcare access.**

Racher (2003) conducted a study using rural elderly couples as informants into the struggles of accessing rural health services. This unpublished doctoral dissertation helped shape the research question for the current study and is the only study found that examined how the rural elderly experience access. This study used conjoint interviews of six elderly couples with the goal of understanding how they experienced accessing rural health services. The most valuable data from this study was a deeper understanding of how elderly rural couples relate to one another in their daily lives.

The author found that access to services is viewed as very important to elderly couples and surprisingly, they reported general satisfaction with their ability to access health professionals and health services. Being autonomous in managing issues of distance, geography, weather, and sparse population expressed their abilities to
negotiate the healthcare system and adapt. However, deteriorating health and increasing need for health services were burdens experienced by these couples; thus, maintaining access into the future were topics of growing concern (Racher, 2003).

Couples reported accessing a variety of health services, including those provided by nurses, general physicians, and medical specialists, as well as laboratory, X-ray, dental, optometry, and hearing aid services. Couples also reported using hospitals and home care programs. Concerns were more about maintaining the services they had used in the past rather than seeking new or different services. Couples mentioned the difficulties rural communities experienced as they tried to recruit and retain physicians, and they worried about continued access to rural hospitals and the potential closure of some of the smaller local hospitals. None of these concerns were overwhelming, and these couples found ways to adapt, demonstrating their flexibility and adaptability to living in a rural setting. No effort was made to conduct any interviews with each partner separately (Racher, 2003).

Lamarche, Pineault, Haggerty, Hamel, and Gauthier (2010) sought to assess the care experience of primary healthcare users to determine whether users’ assessments of their experience varied according to the geographical context in which the services were obtained. The experience of 3,389 users of primary care throughout rural and urban Quebec was assessed by secondary analysis of data from a previous survey of primary healthcare users of a random sample of 100 medical clinics. Patients were approached by a research assistant to establish eligibility, explain the study, and negotiate informed consent. Of the eligible patients, 76.9% completed the survey. The survey focused on questions, allowing the patients to comment on accessibility, continuity, responsiveness, and reported use of health services. Surprising to the
authors, positive assessments of the care experience were more frequently made by users in remote rural settings. Positive assessments became progressively less frequent in near-urban settings and were found the least often in urban settings. These differences were present in all components of the care experience.

Chapter Summary

In this chapter the descriptive phenomenological research design chosen for this study was described. Phenomenological studies aim to describe particular phenomena as lived experiences. The lived experience of accessing health services as a rural elder is the phenomenon under study, and considering that the experts with the greatest ability to inform us about their experiences are the elderly individuals themselves, this significant primary source of knowledge ought to be investigated. This study used Husserl’s four step philosophy of (a) bracketing, (b) intuiting, (c) analyzing, and (d) describing when investigating this phenomenon.

The literature review summarized findings from studies that examined factors that affect access to health services in rural areas, results of limited access to health services in rural areas, and rural residents’ experiences with healthcare access. The study findings revealed that a relative shortage of healthcare professionals, decreased proximity of specialty services, and lack of public health institutions in rural settings contribute to the diminished access to health services in these areas. Findings also revealed that poor outcomes in the care of colorectal cancer, congestive HF, and MI result from this reduced access. Interestingly, the small amount of studies exploring the experiences of rural residents with healthcare access found that rural residents generally express satisfaction with their level of access. There does remain a gap in knowledge
regarding the experience of the rural elderly in accessing services, as this group is yet to be studied exclusively as individuals. This supports the need for further research to better understand the lived experience of accessing rural health services as an elderly individual.
Chapter III
Methodology

The purpose of this study was to gain an understanding of the experiences of rural elderly individuals in accessing health services. This chapter contains a thorough discussion of the descriptive phenomenological research design chosen to study rural elderly individuals’ experiences with accessing health services. The population, sample, and setting for data collection, along with data collection and analysis procedures, are described. The chapter concludes with an acknowledgment of the limitations of the methodology selected to study this phenomenon.

Descriptive Phenomenological Design

Descriptive phenomenology is a qualitative research design that is a rigorous form of study requiring the researcher to be involved in every step of the process. In general, qualitative research is grounded in the naturalistic paradigm of postmodernism, with the assumption that reality is not a fixed entity but rather a construction of the individuals participating in the research. Reality consists within a context, and many constructions are possible. No one reality exists and no process by which one, ultimate truth can be determined. Under the naturalistic paradigm, knowledge is maximized when the distance between the inquirer and the participants in the study is minimized (Polit & Beck, 2008). The interpretations of those under study are necessary to understand the phenomenon of interest.

The research question, “What are the experiences of elderly rural individuals in accessing health services?” implies the study of a phenomenon as a lived experience.
The phenomenon in this study was rural elderly individuals accessing health services. When aiming to study a phenomenon as a lived experience, the research study is best suited for a descriptive phenomenological design (Speziale & Carpenter, 2007); thus, the research question drives the choice of design.

As mentioned in Chapter II, descriptive phenomenological philosophy involves four general steps: (a) bracketing, (b) intuiting, (c) analyzing, and (d) describing. In order to understand the distinct structures that make up a phenomenon, phenomenological reduction is required, by which researchers attempt to temporarily put aside any presuppositions they may hold about the phenomena under study. This is called bracketing, and it is done to prevent injecting bias into a study and to allow the phenomenon to come directly into view without distortion by preconceptions. Intuiting involves a complete immersion in the phenomenon under study by interviewing those experiencing it. The transcribed data is then analyzed to extrapolate common categories and themes. Finally, the themes are described in detail, both singularly and within relation to one another (Speziale & Carpenter, 2007).

**Population**

The population of interest in this study is all elderly individuals living in rural Wisconsin who continually access health services in a rural setting. The target population is the elderly living in rural areas in northern Wisconsin. Inclusion criteria for the sample includes men and women: (a) 65 years old or greater, (b) living in rural communities with fewer than 2,500 residents, and (c) using rural health services at least once in each of the last 10 years to establish continued access.
Due to the distinct demographics of rural Wisconsin when compared to other geographical locations in North America, results of this study are not transferable to any area other than rural Wisconsin. Consider Table 1 in comparing Wisconsin demographics to the United States as a whole. These data represent 2008 statistics in percentages, along with the 2009 estimated population.

Table 1. *Comparison of Wisconsin to United States Demographics*

<table>
<thead>
<tr>
<th></th>
<th>Wisconsin</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>5,654,774</td>
<td>307,006,550</td>
</tr>
<tr>
<td>&lt; 5 years of age</td>
<td>6.4</td>
<td>6.9</td>
</tr>
<tr>
<td>≥ 65 years of age</td>
<td>13.3</td>
<td>12.8</td>
</tr>
<tr>
<td>Female</td>
<td>50.3</td>
<td>50.7</td>
</tr>
<tr>
<td>White</td>
<td>85.1</td>
<td>65.6</td>
</tr>
<tr>
<td>Black</td>
<td>6.1</td>
<td>12.8</td>
</tr>
<tr>
<td>Asian</td>
<td>2.0</td>
<td>4.5</td>
</tr>
<tr>
<td>Hispanic</td>
<td>5.1</td>
<td>15.4</td>
</tr>
</tbody>
</table>

U.S. Census Bureau (2010)

Wisconsin is more homogenous racially when compared to the rest of the United States; therefore, transferability of the study results would be limited to this state only.

**Sample and Setting**

A purposive sample was obtained from a rural community in northern Wisconsin meeting the definition in Chapter I. This community is 53.1% female, with a median age of 42.3 years. The population is racially homogenous, with 97% of the population being White (U.S. Census Bureau, 2010).
The purposive sample was obtained by advertising the study in a local church bulletin. The advertisement (Appendix A) included the necessary inclusion criteria for participation, including: (a) ≥ 65 years of age, (b) having lived in the community for at least 10 years, and (c) having accessed health services in that community at least once in each of the last 10 years. Contact information of the researcher was listed on the advertisement and further details, including informed consent, were obtained after making contact. This sampling technique, in conjunction with snowball sampling, rendered nine participants who were included in the study.

Data analysis took place simultaneously with data collection. Sampling continued until data saturation was met. Data saturation was determined when themes and categories in the data became repetitive and redundant. Once data saturation is reached, no new information can be gained by further data collection (Polit & Beck, 2008). Data saturation for this study was reached after interviewing nine rural elders.

Demographic information about the sample was collected in order to assist the reader in making a judgment about the transferability of results. Demographic information was limited to what could be easily observed without imposing a demographic questionnaire on the participants. Exact age was not necessary, as all participants were known to be at least 65 years of age. Sex and race were observed. Income and educational level were not inquired. The sample for this study was made up of all White participants over the age of 65.

**Data Collection Procedures**

After receiving approval from UW Oshkosh Institutional Review Board (IRB) Protection of Human Participants Committee (Appendix B) and permission from a local
church, rural elders were recruited via an advertisement in the church bulletin. The advertisement included the necessary inclusion criteria for participation, including: (a) being at least 65 years of age, (b) having lived in the community for at least 10 years, and (c) having accessed health services in that community at least once in each of the last 10 years. Contact information of the researcher was listed on the advertisement, and further details of the study were made after making contact.

The details of data collection included a focused self-report technique using face-to-face interviews of approximately 30-minute duration. Interviews took place in a setting chosen by each participant to improve comfort and ensure privacy. This interview style allowed participants to tell their own stories in a narrative fashion. Staying within the phenomenological approach, a single open-ended question was asked of each participant, with additional probes being used to stimulate further discussion if conversation was not free flowing or the conversation strayed too far from the topic. Each interview began with the question “What is it like for you to access health services?” If needed, the term “get health services” was used if clarification of the term “access” was needed. The use of a limited amount of open-ended questions was used to minimize closed responses and prevent injecting the researchers own biases into data collection. The interviewer was a passive collector of data.

Data were recorded on audiotapes to allow the researcher to feel a sense of involvement and participation. Participants willing to participate in such an interview were provided an informed consent (Appendix C), allowing them to terminate their involvement in the study at any time without penalty. Due to the use of tape recorded face-to-face interviews as the primary data collection technique, anonymity for informants was not an option; thus, all efforts to maintain confidentiality were essential.
Audiotapes were destroyed once the interviews were transcribed and the transcribed interview documents were kept in a locked file cabinet within the researcher’s home office. Transcription was done by a hired transcriptionist committed to maintaining the confidentiality of the data. Transcribed documents were devoid of names and other descriptive identifiers. After data analysis, study results were shared with the participants as a means of closure, as well as to enhance credibility.

Data Analysis Procedures

Colaizzi’s method of data analysis (Speziale & Carpenter, 2007), which consists of nine steps, was used for this study:

1. Describe the phenomenon of interest
2. Collect participants’ descriptions of the phenomenon
3. Read all participants’ descriptions of the phenomenon
4. Return to the original transcripts and extract significant statements
5. Try to spell out the meaning of each significant statement
6. Organize the aggregate formalized meanings into clusters of themes
7. Write an exhaustive description
8. Return to the participants for validation of the description
9. If new data are revealed during the validation, incorporate them into an exhaustive description.

Applying these procedural steps to the topic under study, the researcher first described the phenomenon of accessing rural health services as an elder in his own words. This was done as a way of bracketing, or identifying preconceived beliefs and opinions about rural health services and the elderly held by the researcher (Polit & Beck,
Being aware of any presuppositions about this phenomenon is a critical step that must be taken before data collection and analysis. In order to accomplish this, a reflexive journal was kept prior to data collection and the identified presuppositions were set aside as much as possible. Notable presuppositions originally held by the researcher were: (a) rural elders have a limited access to health services, (b) the quality of health services in rural areas is poor, (c) quality healthcare providers do not stay in rural area for very long, and (d) it is difficult for rural elders to travel long distances for specialty care. Again, the researcher set these presuppositions aside as much as possible while collecting data.

Step 2 of Colaizzi’s method involves the collection of participants’ descriptions of the phenomenon. This step included conducting nine interviews. Data were analyzed as it was collected, and once data saturation was achieved, recruiting and interviewing ceased.

Step 3 through Step 6 involved reading all the interview transcripts, highlighting significant statements, spelling out the meaning of each significant statement, and organizing the meanings into themes. The themes were then analyzed, and an exhaustive description of these themes was provided, which constitutes Step 7. Step 8 and Step 9 involved returning to the participants for validation and incorporating any new data into the exhaustive description of the phenomenon. Step 8 and Step 9 were done via return phone calls to the participants.

Enhancing rigor.

Credibility of the results was enhanced by use of member checking in Step 8 of Colaizzi’s method. The act of returning to the informants to see whether they recognize the findings and feel they are accurate is done to increase the credibility of findings in
qualitative research (Speziale & Carpenter, 2007). The researcher made follow-up phone calls to the nine participants to review study findings, and all participants verified that the identified themes (Chapter IV) accurately identified their experiences accessing health services.

Transferability refers to the extent to which qualitative findings can be transferred to other settings undergoing similar situations, as another aspect of a study’s trustworthiness (Polit & Beck, 2008). Qualitative research does not aim to generalize findings, but rather to provide thick, rich descriptions of data, allowing consumers of the research to apply the findings to other contexts. As mentioned earlier, the unique demographics of rural Wisconsin make this study’s results transferable only to other rural Wisconsin areas, but only after careful consideration and review.

An audit trail was kept as a means of enhancing confirmability of the study findings. Recording the research activities so that another individual can follow the precise steps and understand the evidence and thought processes that led to the final study conclusions increases confirmability and allows for replication of study results (Speziale & Carpenter, 2007). The previously mentioned reflexive journal also enhanced confirmability by assuring that the research decisions were appropriate and the results were not injected with personal bias.

Dependability, or the stability of data over time and over conditions (Polit & Beck, 2008), was assured through an inquiry audit. This process involves an external reviewer to examine the study data for accuracy. Inquiry audit for this study was performed by an expert qualitative nurse researcher who reviewed the interview transcripts and evaluated the generated themes, determining appropriateness.
Limitations

The following are limitations identified for this study:

1. The participants interviewed may not be representative of all elders accessing rural health services.
2. All participants were from one township in one geographical location.
3. The sample was made up of mostly women and all were White. A more heterogeneous sample may have rendered different results.
4. The purposive sampling technique used may only have attracted those with strong opinions about accessing rural health services. Similar to response bias with surveys, certain characteristics can be assumed of those responding to the church bulletin advertisement. Typically, only those who have had a very good or very poor experience with the phenomenon of interest will reply. It is difficult to capture those in the middle.
5. Thorough demographic information was not collected. A characteristic of the participants, such as income level, may have influenced the responses. Not knowing these specifics makes transferability of the research findings limited.

Chapter Summary

The descriptive phenomenological design for this study involved tape recorded, in-depth interviews with rural elders meeting the inclusion criteria described above. Ethical considerations included IRB approval, providing informed consent, and protecting confidentiality of the participants. Colaizzi’s procedural steps were used throughout data collection and analysis, and data collection ceased when data saturation was achieved. Using the counsel of an experienced research mentor, member checking, and providing
an audit trail were done to enhance rigor in this study. Limitations included response bias, geographical limitations, incomplete demographic information, and a homogenous sample.
Chapter IV
Results and Discussion

The purpose of this study was to gain an understanding of the experiences of rural elderly individuals in accessing health services. A purposive sample of nine elderly participants living in rural Wisconsin was interviewed. The interviews were tape-recorded and the data was transcribed verbatim shortly after collection. Data were analyzed and themes emerged describing the lived experience of rural elders in accessing health services. This chapter includes details regarding the interview process, demographic data describing the sample, study results, and discussion of the results as they compare with those of previous studies.

The Interview Process

This study was conducted with a purposive sample of nine rural elders who met the sampling criteria. Participants were initially recruited via a flyer placed in a local church bulletin (Appendix A), which produced the initial participant. The subsequent eight participants were reached in a snowball fashion by receiving the names of individuals meeting inclusion criteria from the initial participant, calling them via telephone, explaining the study, and confirming their acceptance to participate. The nine individuals that agreed to participate were interviewed separately in a setting of their own choosing without the knowledge of previous participants. Informed consent (Appendix C) was signed prior to the interview, the participants were allowed to ask questions at any time during the study, and they could withdraw from the study at any time without penalty.
The interview process included a focused self-report technique using face-to-face interviews of approximately 30-minute duration. Interviews took place in a setting chosen by each participant to assure comfort and ensure privacy. This interview style allowed participants to tell their own stories in a narrative fashion. Staying within the phenomenological approach, a single open-ended question was asked of each participant, with additional probes being used to stimulate further discussion if the conversation was not free flowing or strayed too far from the topic. Each interview began with the question, “What is it like for you to access health services?” If needed, the term "get health services" was used if clarification of the term “access” was needed. Using a limited amount of open-ended questions minimized closed responses and prevented injecting the researcher’s own biases into data collection. The interviewer was a passive data collector.

Interviews were audio-taped to allow the researcher to feel a sense of involvement and participation. Following the interview, the audiotapes were transcribed by a hired transcriptionist committed to maintaining the confidentiality of the data. Transcribed documents were devoid of names and other descriptive identifiers. The documents were read and re-read to provide the researcher with intimate knowledge of the contents. Once data saturation was reached, Colaizzi’s method was used to analyze the data, categorizing common statements and developing themes to connect the data. After data analysis, study results were shared with the participants as a means of closure, as well as an enhancement of credibility.
**Demographic Data**

The sample for this study consisted of nine (N=9) elderly residents of rural Wisconsin. Demographic information about the sample was collected in order to assist the reader to make a judgment about the transferability of results. Demographic information was limited to what could be easily observed without imposing a demographic questionnaire on the participants. Exact age was not necessary, as all participants were known to be at least 65 years of age. Sex and race were observed. Income and educational level were not inquired. The sample for this study was made up of all White participants over the age of 65 years, two of whom were male and the other seven were female.

**Results**

Transcripts of the interviews were reviewed numerous times by the researcher to evaluate true meanings of the data. Following a thorough analysis of the data, three major themes emerged describing the lived experience of accessing health services as an elderly rural individual. The three themes that emerged during data analysis were: (a) 50 first dates, (b) on the road again, and (c) making the most of what you have. Each theme is described below in detail using quotes from the participants to support the themes.

**50 first dates.**

This theme signified struggles faced by rural elders in maintaining continuity with their healthcare providers due to the short tenures and rapid turnover of providers in rural settings. Participants described meeting a new provider, answering basic history questions, acquiring a level of comfort with the provider, and then having to repeat the
process every 2 to 3 years as providers moved on. Participants described frustration with this "revolving door" and clearly valued continuity of care when they could get it.

One participant described the frequent provider turnover this way:

Some of the changing doctors is a pain when you get used to one, and you think you like them, and I think that’s important in healthcare, but the doctors do leave here frequently. There’s a new doctor here that, supposedly, is going to stay, and I chose him just for that reason. But, I heard that a lot of patients are choosing him because he plans on staying here.

When asked what is difficult about frequently changing healthcare providers, one participant described repeated initial awkwardness, similar to a first date:

Just that you go through the same thing and all the questions, and then you have to figure out if you really like that doctor, and is he thorough enough. Well, it’s just like starting out right from the beginning, and you’ve got to tell them everything. And, I just don’t care for that. I like a family doctor that knows my troubles and can take care of me.

After getting over the initial discomfort of meeting a new healthcare provider, participants described a period of satisfaction and comfort lasting about 2 to 3 years. These periods of comfort would end with each provider’s departure, which was described as a period of bewilderment and pain, sort of like a break-up:

Well, usually, their wives don’t want to (stay), actually. A lot of them would stay, but their wives want to live in the city or something. I don’t know why when you’ve got a nice town where you can raise your kids and don’t need to worry and stuff. But, I wish more of the good ones would stay. Yeah, I’m a person, I
don’t like the change. Like I said, my family doctor, so he knows how you’re feeling, he knows about you.

As participants described this “carousel” of providers, frustration was obvious, but all participants remained positive and grateful for the services available, as is described in the third theme. Nonetheless, it was clear that part of the lived experience of accessing health services as an elderly rural individual included coping with frequent provider turnover and struggling to find continuity of care.

**On the road again.**

The second theme that emerged from the data exemplified the limited proximity of specialty services and the long commutes necessary to achieve access to such services. Participants described short commutes to access primary care services, but when a need arose to access specialty care, they were forced to travel up to 240 miles. Loss of time, extra financial expense, difficulty with family visitation, aches and pains from prolonged sitting, feeling like a burden on family, and a loss of independence were all mentioned as difficulties associated with such travels. These long-trips were especially challenging if weather conditions were bad. One participant described having to travel many miles to access oncology care:

> But, then if something crops up where you need to see a specialist or have some special surgery, that makes it a little more difficult. We have to travel further. Our weather isn’t always good in the winter. We face some bad roads sometimes. [City], which is a little bit more than 2 hours, maybe 2 ½ hours away. And then, both of us have had major surgery at the [large regional] Clinic. Well, that must be about 240 (miles) maybe, about that. So, and we were referred there, basically, because of, in my case it was cancer, and we didn’t have...,
was 4 years ago, and we didn’t have access to the doctors that now [City] area has, otherwise, we probably could have stayed in this area more…, or [City].

This same participant further elaborated on the difficulties faced by her family traveling to visit while she was being treated for facial cancer, “[Husband] said he counted and he made 21 trips back and forth to the [large regional] Clinic when I was going through surgery and reconstruction surgery. And that’s a long way to go.”

Another participant described her experience accessing emergent cardiology care for acute coronary syndrome. On several occasions her health necessitated long ambulance and helicopter transfers with short notice. This, coupled with the long distance between home and the cardiology center, made family visitation difficult. In fact, this participant’s family was unable to visit until the time of discharge:

So, that’s what we do. Just go down there. They wheel me in. Once I was flown and the other couple of times by ambulance. I get a stent put in, and a couple days I go back home, because they don’t keep me very long. My family comes to pick me up to bring me home. Because that’s 100 miles, you know. That’s a long way.

Another participant shared this sentiment when hospitalized for cardiovascular surgery at a specialty facility located over 100 miles from home when he said, “My wife, she wouldn’t drive down there. So, my son, he lives out of [City], he come up and got me.” His entire hospital stay was spent without his wife able to be present.

Follow-up visits with specialists were also described as inconvenient, especially when scheduled early in the morning. There seemed to be a disconnect between the specialty care facilities and the rural elders. One participant described this well:
I love when you make appointments in [City] because they don’t have any idea where [I live]. They’ll say be here at 8 in the morning. They don’t know we have to get up at, like, 5:30 to get there (laughs). Once I said to them, do you know where [I live], and that one lady went, no. So, I said, so make the appointment later. So, that part is difficult, especially in the wintertime, to drive down there, and if you’re not feeling well, that’s a pain. But they do have good testing, and if it’s anything major, that’s where you want to go.

Another unique challenge with having to travel long distances for specialty services was the burden it posed on family and friends. Several elders simply could not independently make the trip for appointments and had to rely on younger family and friends to rearrange their schedules in order to get them there. This feeling of being a burden really distressed one participant:

Well, I always have to have one of my daughters. To get them off from work in order for them to drive me down. Because, my husband, he don’t drive so much either. I mean, to [local city], that’s fine, but outside of that, to go any distance, no. So, like, he has to go over to [City] to the VA doctor about every 3 months, so then my daughter has to take off for that, too, because they don’t have nothing closer. Yeah, I hate that to happen, to depend on somebody else. To put them, I mean, to get them away from their jobs, and you know, and then if you have to wait for quite awhile, you don’t like to make somebody else wait for you. I don’t like to, anyway.

Another participant described his need to rely on others to get him to specialty care as a constant reminder of his lack of independence:
Well, I sure miss my car. So I have a little trouble once in a while, there’s 3 or 4 women and they still got their cars. So, if one of them are available, they take me shopping or over to the clinic. So, but outside of that, I sure miss my car, oh boy. I’ve had a car since I’ve been 18 years old. About 2 years I had a close accident up here on the highway. Boy, that was close.

As participants described their trials and tribulations with traveling these long distances for specialty care, frustration was again obvious, but all participants remained resilient and found ways to overcome these challenges. Nonetheless, it was clear that part of the lived experience of accessing health services as an elderly rural individual included a limited proximity of specialty services, resulting in long distance travel to achieve access.

**Making the most of what you have.**

The third theme that emerged from the data demonstrated the overwhelming sense of appreciation expressed by rural elders for the health services available to them, demonstrating resilience and a general feeling that access to health services is by no means limited by where they reside. Participants described the challenges of provider turnover and long travels to access specialty care, but they unanimously saw these as minor inconveniences and found ways to overcome them. All participants had positive things to say about the local healthcare and viewed any challenges in access as small sacrifices for living in rural Wisconsin. There was a great sense of gratitude for what was available, as demonstrated by the following participant’s comments:

Well, I'm very, I'm very satisfied, and I realize that we are very lucky to have the system that we have available to us. Compared to other towns this size, it’s unusually…. To be able to go 4 – 5 blocks and you’re in the local hospital, which
is getting more professional people who are available to us. Some come from [City], some come from the [City] hospital, whatever that is over in [City], connected to the [large regional] Clinic. They come over once or twice a week, are available. We have access to CT scans, X-rays, MRIs. Right here in our own little town of 2,000+ people. And, we have access, we have connections to the hospitals in [City] and in [City], with more of the assets, what few things they don’t have here. I am very satisfied. I’m glad that I’m in a place like this.

Participants described a preference for accessing the local health services versus the remote specialty services when comparing their own smaller hospital to the larger tertiary care facilities:

I think the one-on-one is important because it’s a smaller hospital, and people just say the care is excellent. Rather than a bigger hospital, where you’re, kind of, lost in the system at times. I’ve found that when I was a patient at [City]. It’s just too big. You’re more like a number than a person. Where in a smaller hospital, you’re more one-on-one, much more personal.

Another participant echoed the above statement:

But, I like our hospital. I don’t think they could have a better one in a smaller place, to tell you the truth. I just think it’s great. So now I have, Dr.[Name] is my heart doctor, and he’s in [City], but he belongs to [healthcare system]. And, they gave me very good care, but they’re a big hospital, but I’ll tell you the truth, when I get sick, I’d just as soon stay at this one, unless it’s something major that they can’t handle. This is a very good one. And I don’t think [local city] could ask for a better one.
When faced with the above mentioned challenge of traveling for specialty care, participants made light of the “minor” inconvenience and found ways to cope, demonstrating resilience:

Only about 30 miles from us here, because we’re on [highway]. So, that’s not so bad. And usually, my husband and I make it a date. I try to make our appointments on days when we can both go, and we don’t go that often. We’re pretty fortunate, in that, we’re both pretty healthy. Yeah, we go shopping. My husband and I like to eat out, as you can see (laughs). So, we go out to eat, and usually, for our yearly checkup, I try to schedule his on the same day as mine. He goes over there, too, but he doesn’t see the same doctor. We have different doctors. But, I try to schedule all of our stuff at the same time, you know, the same day. So, we aren’t making too many trips over there. I like it over in [City],

I have to admit.

Even though participants noted challenges associated with healthcare providers coming and going, as noted in the theme 50 first dates, they found a silver lining in having to find a new healthcare provider every 2 to 3 years, describing “fresh eyes” and a chance to meet new people:

If we didn’t have these doctors coming, we wouldn’t have any at all. And we, certainly, wouldn’t have the quality doctors that we’re getting. So, I think that we’re very fortunate being able to have them. You get to meet somebody new every 3 years.

To an outsider, living in rural Wisconsin may seem to limit one’s access to health services, causing dissatisfaction with the experience; however, that does not seem to be the experience of the rural elders themselves. Participants in this study acknowledged
challenges in accessing specialty services and achieving continuity of care, but these challenges were easily overcome with a positive attitude and resilience. The lived experience of accessing health services as a rural elder was clearly one of satisfaction with no personal sense of limitation.

**Discussion**

The lived experience of accessing health services by the rural elders in this study illustrates a strong sense of resolve and contentment with their level of access. Despite the overwhelming positive attitude of the participants, two distinct challenges to improving access in rural areas were repeatedly mentioned: (a) the difficulty attracting healthcare providers to practice in rural settings for long periods of time, and (b) the limited proximity of specialty services in rural areas, resulting in hundreds of miles of travel to achieve access. These findings generated three distinct themes that emerged during data analysis: (a) *50 first dates*, (b) *on the road again*, and (c) *making the most of what you have*.

The theme *50 first dates* signified struggles faced by rural elders in maintaining continuity with their healthcare providers due to the short tenures and rapid turnover of providers in rural settings. *On the road again* exemplified the limited proximity of specialty services and the long commutes necessary to achieve access to such services. *Making the most of what you have* demonstrated the overwhelming sense of appreciation expressed by rural elders for the health services available to them, demonstrating resilience and a general feeling that access to health services is by no means limited by where they reside. These findings were similar to studies previously
reviewed. A comparison of the current study findings to those of previous studies are found below.

Merwin et al. (2006) found that there were consistently fewer providers in nonmetropolitan areas, exemplified by the fact that there were almost twice as many physicians per capita in metropolitan areas. Even greater disparity was found in specialty areas, with more than twice as many surgeons and psychiatrists practicing in metropolitan areas versus nonmetropolitan. This is consistent with the experience of the rural elders in the current study who described a limited proximity of specialty services and long distances traveled to access the care of specialty providers.

Baldwin et al. (2008) noted that over 90% of rural colorectal cancer patients lived within 30 miles of a surgical hospital, but less than 50% lived within 30 miles of a medical or radiation oncologist. Many rural patients had to travel long distances for specialty care, with the median distance traveled being 47.8 miles. The authors highlighted long distance travel, burdens of time, increased cost, and discomfort as factors negatively affecting the rural elderly patients’ access to specialty healthcare services in this study. The long distances traveled to access specialty services is consistent with the lived experience described by the participants in the current study.

MacDowell et al. (2010) found that physician shortages were reported to be most prominent in primary care, with shortages also present in several specialties, including neurology, cardiology, surgery, and pediatrics. The participants in the current study also described a limited amount of specialists within a close proximity. There was no mention of difficulty accessing primary care providers, but continued access posed a problem due to rapid turnover.
The current study supports many findings in Racher’s (2003) work. Both studies found that access to services was viewed as very important to the elderly and surprisingly, reported general satisfaction with their ability to access health professionals and health services. Being autonomous in managing issues of distance, geography, weather, and sparse population expressed their abilities to negotiate the healthcare system and adapt. Couples in Racher’s study mentioned the difficulties rural communities experienced as they tried to recruit and retain physicians, and they worried about continued access to rural hospitals and the potential closure of some of the smaller local hospitals. None of these concerns were overwhelming, and these couples found ways to adapt, demonstrating their flexibility and adaptability to living in a rural setting. This was supported by the findings in the current study.

The current study also supported findings from Lamarche et al. (2010) who found that positive assessments of the care experience were more frequently made by users in remote rural settings. Positive assessments became progressively less frequent in near-urban settings and were found the least often in urban settings. The current study did not compare the unanimous satisfaction expressed by rural elders with their access to that of urban counterparts, but it nonetheless supports this perceived rural-urban paradox.

Studies that reported a diminished quality of care received in rural areas (Harris et al., 2008; Sanborn et al., 2005; Sankaranarayanan et al., 2010) were not supported by the current study. The rural elders participating in this current study expressed great satisfaction with their health services and gratitude for the access they did have. They in no way felt that their health suffered by living in rural Wisconsin. Naturally, the current study can only provide subjective results about health, but it is clear that when you
measure access to health services and quality outcomes by means of patient report, it is found that rural elders are not denied access and quality outcomes are achievable.

**Chapter Summary**

In this chapter, the interview process, demographic data, results, and discussion of the results were provided. The three themes that emerged during data analysis were: (a) *50 first dates*, (b) *on the road again*, and (c) *making the most of what you have*. The theme *50 first dates* signified struggles faced by rural elders in maintaining continuity with their healthcare providers due to the short tenures and rapid turnover of providers in rural settings. *On the road again* exemplified the limited proximity of specialty services and the long commutes necessary to achieve access to such services. *Making the most of what you have* demonstrated the overwhelming sense of appreciation expressed by rural elders for the health services available to them, demonstrating resilience and a general feeling that access to health services is by no means limited by where they reside. These themes provide a description of the experience of elderly rural individuals accessing health services.

This experience illustrates a strong sense of resolve and contentment with rural elders’ level of access. Despite the overwhelming positive attitude of the participants, two distinct challenges to improving access in rural areas were repeatedly mentioned: (a) the difficulty attracting healthcare providers to practice in rural settings for long periods of time, and (b) the limited proximity of specialty services in rural areas, resulting in hundreds of miles of travel to achieve access. These findings were supported by those of previous studies.
Chapter V
Summary, Conclusions, and Recommendations

The purpose of this study was to gain an understanding of the experiences of rural elderly individuals in accessing health services. This chapter contains a summary of the study, discussion of research conclusions, implications for nursing, and recommendations for future research.

Summary of Study Findings

Rural communities are identified as health disparity areas due to a significant discrepancy in the overall rate of disease incidence, prevalence, morbidity, mortality, and survival rates in the rural population as compared to the health status of the general population (National Public Health Week, 2004). This disparity in health is attributed to decreased access to health services experienced by rural residents, exemplified by a decreased availability of health professionals (Wielandt & Taylor, 2010), limited proximity to primary care and specialty services (Baldwin et al., 2008; Wong & Regan, 2009), and challenges in receiving cancer screening and mental health services (Bettencourt et al., 2007). Health disparities have an even greater impact on the elderly population due to a reduced physiologic reserve and increased susceptibility to illness and disability (Hinck, 2004). Much research has been done to identify these disparities with methods to rectify them, but little research has been conducted with the aim of understanding how the rural elderly view their experiences accessing health services.

The purpose of this descriptive phenomenological study was to gain understanding of the experiences of rural elderly individuals in accessing health
services. Information gained clarified their needs regarding access to health services, with the ultimate goal of helping to rectify health disparities for the rural elderly.

The study was conducted via in-depth, personal interviews in a setting chosen by the participants. Nine participants over the age of 65 years living in rural Wisconsin and accessing rural health services for at least 10 years were recruited by means of purposive sampling. With the researcher as the instrument, participants were asked open-ended questions in an attempt to capture their lived experience of accessing rural health services. Probe questions were used to further explore individual experiences when necessary. Once data saturation was reached, Colaizzi’s method was used to analyze the data, categorizing common statements and developing themes to connect the data. Three themes emerged during data analysis: (a) *50 first dates*, (b) *on the road again*, and (c) *making the most of what you have*. These themes described the experience of elderly rural individuals accessing health services.

The theme *50 first dates* signified struggles faced by rural elders in maintaining continuity with their healthcare providers due to the short tenures and rapid turnover of providers in rural settings. Participants described meeting a new provider, answering basic history questions, acquiring a level of comfort with the provider, and then having to repeat the process every 2 to 3 years. Participants described frustration with this “revolving door” and clearly valued continuity of care when they could get it. Participants described the repeated initial awkwardness of having to meet and greet a new provider every 2 to 3 years as if it were a first date. After getting over the initial discomfort of meeting a new healthcare provider, participants described a period of satisfaction and comfort lasting about 2 to 3 years. These periods of comfort would end with each
provider's departure, which was described as a period of bewilderment and pain, much like a relationship break-up.

*On the road again* exemplified the limited proximity of specialty services and the long commutes necessary to achieve access to such services. Participants described short commutes to access primary care services, but when a need arose to access specialty care, participants were forced to travel up to 240 miles. Loss of time, extra expenses, difficulty with family visitation, aches and pains from prolonged sitting, burdening family and friends for transportation, and a loss of independence were all mentioned as difficulties associated with such travels. These long trips were especially challenging if weather conditions were bad, as is common during winter months in Wisconsin.

*Making the most of what you have* demonstrated the overwhelming sense of appreciation expressed by rural elders for the health services available to them, demonstrating resilience and a general feeling that access to health services is by no means limited by where they reside. Participants described the challenges of provider turnover and long travels to access specialty care, but they unanimously saw these as minor inconveniences and found ways to overcome them. All participants had positive things to say about the local healthcare they had available to them and viewed any challenges in access as small sacrifices for living in rural Wisconsin.

**Conclusions**

As a result of the findings of this study, several conclusions can be drawn. First, the lived experience of accessing health services as an elderly rural individual is a phenomenon best described by the rural elder himself/herself. An outsider may
erroneously assume that access to health services in rural areas is limited, thus the satisfaction with these health services must be poor. Results from this study demonstrate that is simply not the case. Despite the challenges of ongoing provider turnover and long travel to obtain specialty care, rural elders consistently describe a high level of satisfaction with not only their healthcare, but also their access. This may seem like a paradox, and certainly this resilience reflects on something unique to those choosing to spend their lives living in rural areas.

Second, the lived experience of accessing health services as an elderly rural individual involves repeatedly acquainting oneself with new providers. Participants in this study described a rapid turnover in rural providers and the discomfort of the initial awkwardness in meeting new ones. This “revolving door” requires that rural elders be skilled in remembering their own health histories in order to repeatedly catch new providers up to speed.

Third, the lived experience of accessing health services as an elderly rural individual requires long travel to access specialty services. The elderly population in general is more likely to suffer from ailments requiring specialty services, and all the participants in this study cited long travel to achieve access to such services. The rural elder must have not only the means, but also the fortitude to travel long distances to see specialists, sometimes as far as 240 miles away.

**Implications for Nursing Practice**

Whether practicing within a clinical, administrative, or educational role, nurses contribute to the well being of individuals, families, groups, and communities. Nurses act as caregivers, advocate for patients, provide information and assistance to patients as
they seek and receive health services, plan health programs, and contribute to the development of health policy. This study generated knowledge about the experiences of rural elderly individuals in accessing health services. The results of this study have also added to the body of nursing knowledge regarding how the elderly access and use health services in rural areas and factors that influence their decision-making processes. With this understanding, nurses are better able to provide effective and appropriate care to elderly individuals, as well as to contribute in health service program planning and healthy public policy development.

**Implications for Nursing Education**

The findings from this study also have implications for nursing education. The elderly rural population is unique in many ways, and nursing students ought to be acquainted with this uniqueness. Despite the overwhelming sense of satisfaction detected in this study, the literature identifies disparities in health among the rural elderly in other areas of the country. These disparities in health are attributed to decreased access to health services experienced by rural residents, exemplified by a decreased availability of health professionals (Wielandt & Taylor, 2010); limited proximity to primary care and specialty services (Baldwin et al., 2008; Wong & Regan, 2009); and challenges in receiving cancer screening and mental health services (Bettencourt et al., 2007). The resilience of the rural constituents in the current study may allow them to overlook these disparities, acting like a coping mechanism or sense of pride. This sense of pride also leads to a decreased use of services, as reported by Harris et al. (2008), who concluded that individuals living further from hospitals are less likely to seek hospitalization and may not be hospitalized appropriately for serious cardiovascular ailments. This sense of
pride may be useful for maintaining a positive attitude about health, but it also may lead to poor health outcomes. Nursing students and nurse educators should be aware of this rural elder characteristic.

Furthermore, this study is one of many reporting the rapid turnover of healthcare providers in rural areas and the difficulty these areas have attracting and keeping staff. Nursing students, especially nurse practitioner students, ought to be exposed to a rural environment as part of their clinical rotation. Many student nurses end up taking jobs in areas in which they have completed clinical rotations. Mandating that students spend time at a rural site could increase the number of new graduates settling in those areas.

**Implications for Nursing Administration**

The results of this study have implications for nursing administrators. Findings have highlighted areas of frustration for rural elderly individuals accessing health services, chiefly in coping with rapid provider turnover and limited proximity of specialty services. Attracting and retaining healthcare providers is a difficult task and one that should be given a closer look by both researchers and administrators. Coming up with unique ideas to attract and retain providers should be explored. Increased compensation, loan reimbursement, and other incentives may be good ways for administrators to combat this shortage. It may not be possible to prevent the rapid turnover in rural areas, but essential elements certainly can be put in place to lessen the burden on the local residents. For one, use of the electronic medical record would be of great assistance is easing the transition of care to a new provider. Participants in this study repeatedly reported annoyance with having to continually regurgitate their health history when meeting new providers. The electronic medical record would contribute to
avoiding this annoyance; however, such a record can pose a rather large financial burden on small rural institutions.

**Recommendations for Future Research**

Based on the findings of this study, the following recommendations were developed as possible approaches to future research:

1. It is evident in the review of the literature that there is a scarcity of studies regarding the experience of rural elders in accessing health services with the individuals themselves as the source of knowledge. More studies with larger samples are recommended to more completely understand the many dimensions of this phenomenon.

2. All the rural elders in this study lived in one rural Wisconsin town and reported a very high level of satisfaction with their access to healthcare services. It would be beneficial to replicate this study in different rural locations to see if similar results emerged during data analysis.

3. A limitation to this study was the fact that more detailed demographic information was not obtained. This information could have proven useful to see if rural elders experienced access differently based on advanced age, socioeconomic status, social support system, religion, number of comorbidities, etc. Obtaining this information in a replicated study could prove beneficial.

4. This study demonstrated patient frustration with rapid provider turnover in a rural setting as a source of reduced access to services. Researching ways to improve retention of healthcare providers in rural areas would be beneficial.
Examining the specific reasons that providers leave is important to rectifying this issue.

5. This study also demonstrated patient frustration with limited proximity of specialty services to rural areas. Researching ways to lessen the burden of travel for rural elders would be beneficial.

Chapter Summary

This chapter provided a summary of the current study that explored the lived experience of the elderly rural individual accessing health services. An overview of the findings was discussed. This chapter also addressed the implications these study findings have for nursing practice, education, and administration. The lived experience of accessing health services by the rural elders in this study illustrates a strong sense of resolve and contentment with their level of access. Despite the overwhelming positive attitude of the participants, two distinct challenges to improving access in rural areas were repeatedly mentioned: (a) the difficulty attracting healthcare providers to practice in rural settings for long periods of time, and (b) the limited proximity of specialty services in rural areas, resulting in hundreds of miles of travel to achieve access. Recommendations for research in these two areas, as well as others, were also provided in this chapter.
APPENDIX A

Flyer from Church Bulletin
Do you use health services in the [ ] Area and are over the age of 65?

Graduate Nursing Student, Dan Skeen, is seeking individuals over the age of 65 that have lived in [ ] and used health services here for at least the past 10 years. Interested individuals will be interviewed as part of a graduate school research project with the goal of understanding how you, the valued elders, perceive your access to health care. There is no obligation and your opinions will be kept confidential. If interested, please call Dan Skeen at [ ] for more details. Thank you in advance!
APPENDIX B

UW Oshkosh IRB Approval Letter
November 15, 2010

Mr. Daniel Skeen
3329 N Casaloma Dr. Apt 30
Appleton, WI 54913

Dear Mr. Skeen:

On behalf of the UW Oshkosh Institutional Review Board for Protection of Human Participants (IRB), I am pleased to inform you that your application has been approved for the following research: The Lived Experience of Accessing Health Services as an Elderly Rural Individual.

Your research has been categorized as NON-EXEMPT, which means it is subject to compliance with federal regulations and University policy regarding the use of human participants as described in the IRB application material. Your protocol is approved for a period of 12 months from the date of this letter. A new application must be submitted to continue this research beyond the period of approval. In addition, you must retain all records relating to this research for at least three years after the project’s completion.

Please note that it is the principal investigator’s responsibility to promptly report to the IRB Committee any changes in the research project, whether these changes occur prior to undertaking, or during the research. In addition, if harm or discomfort to anyone becomes apparent during the research, the principal investigator must contact the IRB Committee Chairperson. Harm or discomfort includes, but is not limited to, adverse reactions to psychology experiments, biologics, radioisotopes, labeled drugs, or to medical or other devices used. Please contact me if you have any questions (PH# 920/424-7172 or e-mail: rauscher@uwosh.edu).

Sincerely,

Dr. Frances Rauscher
IRB Chair

cc: Dr. Mary Ellen Wurzbach
1910

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APPENDIX C

Informed Consent Document
Dear Participant,

I am Dan Skeen, a graduate nurse practitioner student at the University of Wisconsin Oshkosh. I am conducting a study to gain understanding of the experiences of elderly rural individuals in accessing health services with belief that use of this primary knowledge source will clarify their needs regarding access to health services with the ultimate goal of rectifying health disparities.

Should you choose to be involved, you will be asked to participate in two tape recorded interviews. Interviews will be conducted with just you and I present and will take place in a private location of your choosing. The first interview will last approximately one hour in length. The goal of the interview is for you to do most of the talking. I aim to listen to your thoughts and opinions in description of your experience with accessing health services in a rural area. The second interview will take place several months after the first and will be shorter in duration, approximately fifteen minutes. The goal of this second interview is to share results of my study with you and to confirm that I understood and properly expressed your opinions in my report.

It is important to note that participation in this study is completely voluntary and your opinions will be kept confidential. While I will be required to write up the results of our interviews, there will be no personal identifiers attached to your opinions. No one but me and my research professor, Dr. Mary Ellen Wurzbach will have access to the tape recorded interviews and transcribed documents. The documents will be kept locked in a file cabinet in my home office and will be destroyed after three years.

Signing this form indicates your willingness to participate in this study, but you may withdraw participation at any time without penalty. There is no anticipated medical
or social risk of participating, other than the inconvenience of lost time and the potential anxiety of being interviewed. I will do my best to make you comfortable and to make this a pleasurable social engagement in which you get to express yourself to someone exceedingly interested in your opinion. Should you have any complaints about your treatment as a participant in this study, please contact:

Chair, Institutional Review Board
For Protection of Human Participants
c/o Grants Office
University of Wisconsin Oshkosh
Oshkosh, WI 54901
920-424-1415

Before signing below, take a moment to think of any questions or concerns you might have about participation. I would be more than happy to answer. If you have any questions that come up later, here is my contact information:

Dan Skeen
3329 N. Casaloma Dr. Apt. 30
Appleton, WI 54913
(715) 661-0042

You will sign one copy for me to keep on file, and one for you to keep.

I_____________________________voluntarily wish to participate in the following research study: “The Lived Experience of Accessing Health Services as an Elderly Rural Individual.” All my questions and concerns about participation have been addressed and I understand my rights as a participant. My signature indicates my wish to participate.

Signature:_____________________________Date:______________
REFERENCES


