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Understanding Patient Perceptions Towards Direct Primary Care: A Focus Group Study

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Abstract

Direct primary care (DPC) is a growing model of care that is suggested as an alternative to traditional fee-for-service healthcare. Patient-reported experiences of DPC can provide unique insight into the impact of joining the model and inform quality improvement. The purpose of this study was to investigate patient perceptions of DPC. Thirty-one participants were initially recruited for the study and completed a survey assessing patient demographics. Of the 31 participants, 10 went on to complete the focus group interviews. Qualitative analysis of focus group transcripts identified common themes and subthemes. Focus group findings were stratified into 4 themes including quality of care, access to care, affordability, physician qualities, and reasons for choosing DPC. The top positive subthemes were good communication, joining DPC due to poor past healthcare experiences, and physician personability. The most common negative subthemes were difficulty referring to specialists outside the practice, poor communication, and poor access to medications. All findings were presented and discussed with the investigated clinic to facilitate improvements in healthcare delivery.

Keywords

direct primary care, focus group, patient perceptions, patient perspectives, primary care, patient satisfaction

Introduction

Patient-reported experiences of health services are crucial to the quality improvement process in healthcare. Information on patient satisfaction can be used to compare different healthcare delivery systems, evaluate the quality of care, detect services that require improvement, and identify consumers likely to disenroll (1). Several studies have demonstrated that evaluating patient perceptions of care can aid in the identification of unmet patient needs and the strategic development of quality improvement (2). For instance, a study by Barr et al. (3) recruited participants from 13 tertiary hospitals who were interviewed about hospital quality improvement activities and asked about patient satisfaction in 9 domains including nursing care, physician care, treatment results, patient education, comfort, and cleanliness, admitting, other staff courtesy, food services, and patient loyalty (3). According to this study, the tertiary care hospitals introduced a variety of quality improvement initiatives guided by public reports of patient satisfaction. Another study by Rogers and Smith (4) examined successful quality improvement projects in 50 hospitals in Massachusetts in response to a survey that assessed patients' perceptions of their healthcare (4).

Primary care faces several difficult challenges such as inadequate access for many patients, barriers to providing affordable services, and long wait times—all of which may contribute to patient dissatisfaction. Direct primary care (DPC) is an alternative primary care model introduced to mitigate several of these challenges. It contrasts with the traditional fee-for-service (FFS) model of healthcare where primary care clinicians receive payment per patient per visit (5). In DPC, patients and their physicians enter an affordable monthly membership agreement for comprehensive primary care services (6). By eliminating third-party billing, DPC practices can reduce overhead costs by more than 40% and provide healthcare at more affordable rates (7,8). An analysis of 116 DPC practices found that the average monthly membership fee for DPC patients is $77.38 (8) as opposed to the

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average cost of $160 per appointment for new uninsured patients in traditional FFS healthcare (9). Furthermore, enrolling in DPC typically includes expanded access to the physician, discounted laboratory and radiology tests, and more affordable options for medications (6). For instance, the average DPC appointment consists of 30 to 60 min (10) as opposed to the 7 min meetings in the FFS model (11). As a result, DPC may provide the opportunity for high-value care at an affordable price which could benefit underinsured communities.

There is currently a noticeable lack of academic research on the impact of joining DPC from patients' perspectives. Most articles amount to opinion editorials and practice profiles regarding the DPC model which serve to increase awareness of this emerging healthcare system. However, these articles do not present an exhaustive analysis of the effectiveness of DPC in meeting the needs of its patients. To bridge this gap in the current literature, this study aimed to provide unique insight into patient perceptions of DPC to identify areas of needed improvement and disseminate such findings to increase the familiarity of DPC in the medical community while facilitating future quality improvement strategies for this growing model.

Methods

The present study employed a qualitative design based on focus group interviews with patients from an urban DPC clinic and adopted a community-based participatory research (CBPR) approach. Focus group interviews were conducted in person by the research team from July 2019 to September 2019 at the DPC clinic. The data collected in this study was reported using the consolidated criteria for reporting qualitative research (COREQ) guidelines (12).

Setting

The research team partnered with an urban DPC clinic located in South Florida, United States. The practice was established in 2016 by an internal medicine clinician and is recognized as one of the first clinics to offer DPC in the area. At the initiation of the present study, the size of the patient panel in the clinic was 75 patients. The patient panel in the clinic largely composed of patients who spoke Creole or Spanish at the time of the study.

Recruitment

Of the 75 patients in the patient panel from the DPC clinic, 31 participants were recruited for the study. The inclusion criteria included: (1) participants were 18 years or older and (2) demonstrated an affiliation with the practice where (3) a staff member from the clinic identified them as a patient to whom they provide healthcare services. As part of an ethical recruitment strategy, participants were informed that they could opt out anytime during the study and that their willingness to participate would not impact their quality of care.

Flyers were placed in the office to provide information about the study to potential participants. The DPC clinic referred willing participants to the research team who contacted them using a standardized email and phone script. Participation in this study was voluntary and each patient provided written consent. All 31 participants agreed to complete a questionnaire assessing sociodemographic factors. Of the 31 participants, 10 participants consented to be interviewed in the focus groups.

Sociodemographic Factors

The 31 participants were asked to complete a questionnaire that screened for patient sociodemographic and social determinants of health characteristics as part of the COREQ checklist. Participants either completed the questionnaire in person during their office visit or online through a protected software called REDCap (13,14) on a voluntary basis. The questionnaire included questions from the Protocol for Responding to and Addressing Patients' Assets, Risks, and Experiences (PRAPARE) (15) and an additional question assessing the length of clinic membership. The questions from the validated PRAPARE survey examined income, housing situation, housing stability, household size and dependents, education, employment, insurance, social integration and support, transportation, stress, and material security (15). Complete results from the questionnaire were reported and analyzed in another study (16). Relevant sociodemographic data from the questionnaire was reported in this study to provide a broader understanding of the patient sample.

Focus Group Interviews

The 10 patients who expressed interest in the focus groups were placed into 3 different focus groups that were held over a period of 2 months. Participants were not informed of any direct incentives for focus group participation. However, a thank-you gift was provided by the DPC clinic with a gift card of $25 at the conclusion of the focus group session. The focus group sessions were held in the conference room of the DPC clinic where they were mediated by a trained moderator without any staff of the practice present in the room. Since the clinic had a significant Creole and Spanish-speaking population, the research staff was prepared to offer an interpreter if needed, but focus group participants spoke English fluently, so an interpreter was not used. In the focus groups, participants answered questions about their opinions toward DPC, and how their quality and access to healthcare have changed after joining the practice. Each focus group session was audio-recorded, transcribed, de-identified, and stored in a HIPAA-protected cloud-based drive with only the research investigators having access.

Data Analysis

Qualitative content analysis was applied to the transcripts to answer the research question, "What are patient perceptions of the DPC clinic?" as demonstrated in Table 1. The first step in the analysis was importing the transcripts into the NVivo research software (17) where verbatim interview transcripts were read through 3 times by all authors to acquire a thorough understanding of the text. In NVivo, the second and fourth authors individually reviewed the transcripts line-by-line to create condensed meaning units from transcript statements that were relevant to the aim of the study. Using these condensed meaning units, the authors produced codes that were as close to the original transcript as possible.

The next step involved a discussion of each transcript and the collection of codes by all members of the research team to create a consensus of codes. The subsequent codes that were identified by the research team (etic reviewers) were then validated by the staff at the clinic (emic reviewers). Once a consensus was obtained by both etic and emic reviewers, a codebook was produced where codes were organized and grouped into meaningful categories from which subthemes and themes emerged to answer the research question. The results from the categorization of the statements, including frequency and positive/negative statements, were cross-referenced with the sociodemographic data identified from the PRAPARE survey.

Strategic Planning for Quality Improvement

As part of the CBPR approach, all data collected in the study including patient sociodemographic factors and results from the focus groups were presented and discussed with the DPC clinic to facilitate strategic planning for quality improvement.

Results

The study investigated patient perceptions of a DPC clinic through focus group interviews. Sociodemographic data were collected to deliver a more in-depth understanding of the sample and provided context for the focus group findings as summarized in Table 2. A total of 31 participants were recruited with most reporting that they have been members of the DPC clinic for less than a year owing to the recent establishment of the practice at the initiation of this study. Markedly, the sample was composed of a predominantly male and Caucasian population where more than half were uninsured and almost a third were unemployed.

Of the 31 participants recruited for this study, 10 agreed to be interviewed in the focus groups. A qualitative analysis of the transcripts revealed common themes including quality of care, access to care, affordability, physician qualities, and reasons for choosing DPC. The common themes were dissected into several negative and positive sub-themes which were documented with example patient quotations as reported in Tables 3 and 4.

Positive Themes

Analysis of the transcripts revealed a generally positive perception of the clinic with a total of 115 positive references as summarized in Table 3. Positive themes were good communication, good access to medications, affordability of medications, affordability of membership fee, autonomy, personability, unconventional approaches, poor past healthcare experiences, and inability to afford insurance. Of these, good communication was the most referenced subtheme overall. Participants discussed the ease of communication with the clinician to optimize management and emphasize patient-centered care.

Table 1. Examples Illustrating Qualitative Content Analysis of the Transcripts.

Example quotation	Condensed meaning	Code	Categories	Subtheme	Theme
AU102402: "It's amazing. When my blood pressure is a little high, I text a picture of the log and send it in."	I used text message to communicate my high blood pressure.	Quick and easy communication by text message	Positive perception of communication	Good communication	Quality of Care
JU102702: "I was like really upset, like I don't have the money, but I need to see you … In my case, it was bad because I've been unemployed and with health issues, I can't go without a physician. So if the payment is behind, you won't be able to see him. And with that payment, that also includes your medicine."	When I was unemployed, I could not afford the payment to the DPC clinic but needed to be seen for my health issues.	Difficulty affording DPC fee	Negative perception of DPC fee	Inability to afford membership fee	Affordability

Table 2. Sociodemographic Factors of the Surveyed Sample (n = 31).

Category		Response (%)
Gender	Male	71.0%
	Female	22.6%
	No response	6.5%
Ethnicity	Hispanic or Latino	19.4%
	Not Hispanic or Latino	80.6%
Race	Asian	3.2%
	White	48.4%
	Black/African American	35.5%
	American Indian/Alaskan Native	3.2%
	Other	6.5%
	More than one race	3.2%
Language preference	English	83.9%
	Language other than English	16.1%
Education	Less than high school degree	3.2%
	High school diploma or GED	16.1%
	More than high school	77.4%
	No response	3.2%
Employment	Unemployed	16.1%
	Part-time or temporary work	3.2%
	Full-time work	54.8%
	Unemployed but not seeking work	16.1%
	No response	9.7%
Insurance status	None/uninsured	51.6%
	Medicaid	3.2%
	Medicare	6.5%
	Public insurance	3.2%
	Private insurance	29.0%
	No response	6.5%
Length of membership at clinic	Less than 6 months	12.9%
	6-12 months	41.9%
	1-2 years	29.0%
	2-3 years	9.7%
	3-4 years	3.2%
	No response	3.2%

> It's amazing. When my blood pressure is a little high, I text a picture of the log and send it in. (AU102402)

The participants also explored the reasons why they decided to choose DPC. Analysis of the transcripts revealed 27 references of poor past healthcare experiences (18.6%) and 11 references of not being able to afford insurance (7.6%). One patient revealed that it was quicker and easier to schedule an appointment with the DPC physician compared to previous experiences in the traditional FFS healthcare systems.

> With [the DPC clinician] you may get to see him within two or three days. But with a normal doctor, sometimes you can't get in for months. (JU102702)

Affordability was an important consideration in choosing a healthcare model as it was referenced 15 times (10.4%) in the transcripts. Interestingly, the sample demographic revealed that many participants were uninsured (51.6%) and unemployed (32.2%). One participant discussed the importance of affordable healthcare.

> DPC would prevent catastrophic stuff. DPC is for those people that can't—that group of people that fall through the loophole … DPC, I think, would probably help provide healthcare for a lot of people, especially when it's made affordable like it is here … So, otherwise, with the other model, every time you walk in the door, it's $25, $35, $45 in co-pay. At least with DPC, you can get checked out, and hopefully, you don't have to worry about the ER or any catastrophic events, because you're doing your check-ups, which are primarily every month or as many times as you want to. (AU102402)

The patient above keenly noted that preventative care is often discouraged by FFS models that charge co-pays for each visit. Without proper preventative care, more serious and even "catastrophic" health issues may likely arise leading to more ER visits and exorbitant healthcare costs. Incurring high healthcare costs can discourage patients from seeking healthcare and hinder their access to care, especially for patients of low socioeconomic status who are more likely to have a high risk of comorbidities and limited budgets for healthcare. The uninsured and the underinsured—those that "fall through the loophole"—may benefit from joining a DPC practice as stated by this participant.

Negative Themes

Negative subthemes included poor communication, poor access to medications, difficulty referring out to specialists, and inability to afford the DPC membership fee as shown in Table 4. There were 30 negative references in the transcripts with most of them pertaining to difficulty referring out to specialists (7.6%). Participants reported difficulties finding access to specialists often due to out-of-pocket costs if the doctors were outside of the DPC network.

> I had to make an appointment to see a specialist and the cost was just outrageous. So, I found that a bit stressful, having to go outside the model and the pricing was just -astronomical. (JU102702)

Interestingly, poor communication was the next most cited subtheme despite good communication being the most cited subtheme overall. Poor communication between the patients and the office focused on the lack of receiving phone call returns, while good communication focused on text messaging responses.

> I wouldn't get phone calls back. I would have an issue – like either the pharmacy would say the doctor never sent the

Table 3. Positive Themes and Subthemes With Corresponding Participant Quotations and Number of Times Referenced in Focus Group Transcripts (n = 10).

Theme	Subtheme	Example quotation	References (%)
Quality of care	Good communication	AU102402: "It's amazing. When my blood pressure is a little high, I text a picture of the log and send it in."	29 (20.0%)
Access to care	Good access to medications	AU102402: "You don't have to go anywhere else to get your meds; you can get them right here. Nothing could beat the convenience of that."	9 (6.2%)
Affordability	Affordability of medications	JU102704: "When you get your medication, he's like all right, you're good to go…and you're like, "do I have to pay anything?" and nope you're good."	4 (2.8%)
	Affordability of membership fee	AU102402: "From how [the DPC clinician] has it set up, it is affordable – to see your physician as many times as you want to and anytime."	11 (7.6%)
Physician qualities	Autonomy	JU012703: "Physicians making decisions about prescriptions and things as opposed to an insurance company."	1 (0.7%)
	Personability	JU102704: "When he was explaining the DPC model, he seemed very passionate about it. And he cared about his patients. That's everything you want in a doctor. He's smart, charismatic, empathetic."	20 (13.8%)
	Autonomy	JU012703: "Physicians making decisions about prescriptions and things as opposed to an insurance company."	1 (0.7%)
	Unconventional approaches	JU102702: "He's not afraid to talk about the herbal approach; he's not afraid to talk about different approaches that may be outside the medical practice."	3 (2.1%)
Reasons for choosing DPC	Poor past healthcare experiences	JU102702: "With [the DPC clinician] you may get to see him within two or three days. But with a normal doctor, sometimes you can't get in for months."	27 (18.6%)
	Inability to afford insurance	AU102402: "Before [the DPC clinician], I was still on the Obamacare and my insurance went up by 300%. It was crazy."	11 (7.6%)

Table 4. Negative Themes and Subthemes With Corresponding Participant Quotations and Number of Times Referenced in Focus Group Transcripts (n = 10).

Theme	Subtheme	Example quotation	References (%)
Quality of care	Poor communication	JU012703: "I wouldn't get phone calls back. I would have an issue—like either the pharmacy would say the doctor never sent the medication and then they said they would call me back, but I never got called back."	9 (6.2%)
Access to care	Poor access to medications	JU102704: "The range of prescriptions is limited. I have ADHD, so he prescribes me Vyvanse, so if I didn't have health insurance, that prescription would be $375 a month, which he doesn't carry in his practice."	6 (4.1%)
	Difficulty referring out to specialists	JU102702: "I had to make an appointment to see a specialist and the cost was just outrageous. So, I found that a bit stressful, having to go outside the model and the pricing was just astronomical."	11 (7.6%)
Affordability	Inability to afford membership fee	JU102702: "I was like really upset, like I don't have the money, but I need to see you … In my case, it was bad because I've been unemployed and with health issues, I can't go without a physician. So if the payment is behind, you won't be able to see him. And with that payment, that also includes your medicine."	4 (2.8%)

> medication and then they said they would call me back, but I never got called back. (JU012703)

The next most common negative subtheme was the lack of access to medication. Specifically, patients had difficulty obtaining brand name medications with different formulations, or with any medicine that the DPC practice did not carry.

> The range of prescriptions is limited. I have ADHD, so he prescribes me Vyvanse, so if I didn't have health insurance, that prescription would be $375 a month, which he doesn't carry in his practice. (JU102704)

Discussion

The last decade has seen a steep rise in the popularity of DPC among clinicians and patients alike. In 2015, a survey

reported high interest in DPC where 10% of physicians who were surveyed reported that they had already adopted the model or had plans to transition to it (6). The same survey also revealed that 43% of the participants contemplated switching to DPC. Given DPC's increasing popularity, an assessment of the model's advantages and limitations from the patient's perspective may improve its delivery of care. In this regard, the present study examined patient-reported experiences of DPC from a single urban DPC clinic.

Analysis of the transcripts revealed a relatively positive patient perception of the DPC clinic. This is consistent with the data from the 2014 assessment of the Qliance Medical Management group of patients. Specifically, the assessment focused on patient satisfaction utilizing the national Consumer Assessment of Healthcare Providers and Systems-Clinician and Group (CAHPS-CG) survey, which placed Qliance Medical Management's overall patient satisfaction of DPC above the 95th percentile in comparison to the 90th percentile nationally (18). The present study observed several references regarding favorable communication with the office and physician. Beyond the conventional office visit, DPC physicians may offer increased physician accessibility through electronic correspondence with patients and home visits which are not traditionally offered by FFS models (19). DPC also promises more flexible appointment scheduling as demonstrated by a participant who reportedly switched to DPC after experiencing difficulties with scheduling in the FFS model. These advantages can be ascribed to the smaller patient panels observed in DPC (20). Enhanced accessibility, communication, and flexibility may cultivate a stronger therapeutic and longitudinal relationship between the physician and patient.

A DPC practice can also impact its community through savings in health-related costs in populations who may be underinsured. In the study, where many participants were uninsured or covered by Medicaid/Medicare, affordability of medications and membership fees, and choosing DPC due to difficulties affording insurance were frequently cited. In FFS healthcare, underinsured patients may pay exorbitant sums of money for services due to provider filing claims. FFS healthcare involves the complexity and overhead of hiring dedicated administrative staff to maintain relationships with insurers. Third-party involvement in financial and healthcare decisions often results in increased administrative costs, loss of provider autonomy, and delays in patient care. Since DPC models do not rely on an FFS reimbursement, DPC physicians may devote more resources toward previously nonbillable care which may lead to a greater emphasis on preventative care. One participant keenly noted that preventative care is often discouraged by FFS models that charge co-pays for each visit. Without proper preventative care, serious health issues may arise leading to more ER visits and exorbitant healthcare costs. High healthcare costs may discourage patients from seeking healthcare and hinder access to care for patients of low socioeconomic status who are more likely to have a high risk of comorbidities and limited budgets for healthcare.

This study also demonstrated several actionable limitations of the clinic experienced by the participants. First, participants reported difficulty obtaining referrals to specialists. With limited in-network options, DPC patients are often unable to afford specialist costs having to pay the full cost of the visit and the associated care provided. An increase in the networking and contractual agreements between the DPC physicians and specialists could reduce these costs. As more connections between DPC physicians and specialists are established, difficulties obtaining specialist referrals could resolve with the model's growth.

Another limitation is obtaining medications not covered by the clinic's associated pharmacy. While generic medications are often provided free of charge in DPC practices, out-of-care pharmacies are not covered. As such, any medications obtained from such pharmacies are the financial responsibility of the patient. These limitations can be addressed by expanding partnerships with large-scale pharmacy chains and private local pharmacies that can fulfill a wide array of prescriptions.

Third, the participants reported poor communication with the office referencing the lack of callbacks regarding appointments and medications. Interestingly, the participants who reported favorable communication referenced text messages and emails as means of communication with the clinic. The growing trend of DPC practices to incorporate novel forms of communication may potentially de-emphasize traditional methods of office communication such as phone calls which many patients are reliant upon. As a result, DPC clinics should work to promote all forms of communication by assessing and prioritizing individual patient preferences.

Lastly, a few participants described difficulties affording their membership fees. DPC patients who are unable to afford their membership fees are disadvantaged doubly as this hinders their access to the physician and their medications since all primary care services are housed at the DPC office. As a solution to this, DPC clinics could potentially allow a grace period where patients may retain some basic healthcare services while they are unable to afford their monthly fees.

Limitations and Future Research

While this study provided important insight into patient perceptions of the investigated DPC clinic, several methodological strengths and weaknesses need to be considered when interpreting the results. The impact of DPC on patients is a complex question that is best answered by a qualitative approach where the output can be more nuanced and less confined to rigid definable variables seen in quantitative methods like a survey (21,22). A strength of this study was the focus group methodology which increased the likelihood of participants providing candid responses and provided a discussion where they could build on each other's ideas (21).

A limitation of utilizing focus groups is that it relies heavily on an assisted discussion to produce results. Consequently, the quality of the discussion depended on several factors including the skill of the moderator and the personalities of the participants where outspoken individuals could dominate the discussion skewing results (21). Furthermore, the descriptive nature of this study led to a lack of a control arm, statistical analysis, and the generation of strong correlations.

Adequate recruitment of participants is essential for qualitative studies (23). The research team experienced numerous challenges in the recruitment process. One limitation was the lack of participants that spoke Creole or Spanish despite the DPC clinic patient panel being largely composed of Creole or Spanish speaking patients and having an interpreter on the research team. Another limitation was the sample size (n = 31, 41.3% of the total patient panel) which was considerably small as the DPC clinic was newly established with a patient panel of 75. Furthermore, DPC is a relatively new healthcare model having only been around since the turn of the 21st century which led to difficulties in finding other DPC clinics in the region. As the model grows, recruitment of DPC patients for similar studies may improve.

However, there was a notable lack of continued interest to participate in the focus groups after completing the sociodemographic questionnaires. The number of patients that participated in the focus groups were no more than 10 out of the 31 who were initially recruited at the implementation of this project. A possible explanation is a difference in logistical planning that was needed to complete the questionnaire versus what was needed to participate in the focus groups. There was flexibility of being able to complete the questionnaire in the office at the time of recruitment or online at the patients' convenience. In contrast, participation in focus groups appeared considerably more costly and time consuming as it required arranging a suitable time and location to conduct the interviews. As a result, the logistical and organizational issues in planning the focus groups not only hindered participation but limited the recruitment geographically, a challenge commonly seen in qualitative investigations (24–26). A solution to this may involve the planning of asynchronous online focus groups which could allow participation from any location at any time thereby providing greater geographical flexibility in terms of recruitment strategies. This is demonstrated by a study where the researchers employed an asynchronous online focus methodology to examine community participation in the winter among wheelchair users (27). Over the span of 7 days, the participants had access to an online focus group that was open 24 h/day yielding 105 responses throughout the week. The asynchronous aspect of the focus groups allowed for increased time for reflection and thoughtful discussion as well as greater anonymity (27).

While the findings of the present study may not be generalizable to the larger DPC population, it may still have important implications and help inform quality improvement initiatives within the investigated practice. The DPC healthcare model has shown considerable growth over the years where there were 125 practices in 2014 which expanded to 1500 clinics in 2021 (28). With DPC's substantial growth, large-scale investigations into the patient perceptions of DPC with a nationally represented demographic may be possible in the future.

Conclusion

As part of the CBPR approach, all data, conclusions, and recommendations from this study were directly reviewed and delivered to the investigated DPC practice to facilitate improvements and maintain the success of their practice. Based on the focus group findings, the DPC clinic can provide patients direct access to their physician and an alternative method of healthcare for underinsured patients. The results also revealed actionable limitations in the DPC clinic such as difficulty accessing medications and referring out to specialists. With a now clear picture of patient opinions—both praises and grievances regarding DPC, further research can expand upon the recommendations and potential solutions tendered above to improve this healthcare model.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Ethical Approval

This study was approved by the Florida Atlantic University Social, Behavioral and Educational Research IRB (IRBNET ID #: 1395609-2).

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Statement of Human and Animal Rights

The study was conducted according to the guidelines of the Declaration of Helsinki and all procedures in this study were conducted in accordance with the Institutional Review Board of Florida Atlantic University Social, Behavioral and Education Research under "FAU Medicine Direct Primary Care Impact on Diverse Populations" (IRBNET ID #: 1395609-2).

Statement of Informed Consent

Written informed consent was obtained from all participants for their anonymized information to be published in this article. Florida Atlantic University Social, Behavioral and Educational Research IRB issued approval 1395609-2.

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