

# The primary care provider and the patient living in poverty: Applying the Bridges to Health and Healthcare model to NP practice

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## ABSTRACT

**Background and purpose:** There is a much recent emphasis on the social determinants of health, and poverty is the most influential of these. It is not enough merely to understand the influence of poverty on health—the primary care provider must understand how to effectively treat patients who live in poverty.

**Methods:** This article applies the Bridges to Health and Healthcare model for understanding poverty to primary care practice from an individual provider's perspective. The article walks the reader through the implications of generational poverty for the primary care clinician in a typical office visit from history taking to following up.

**Conclusions:** Most primary care practitioners approach patients from a middle-class perspective. Awareness of the challenges and different perspectives of those in generational poverty can enhance care and outcomes.

**Implications for practice:** The individual provider can use the understanding of driving forces, resources, language and cognition, environment, and relationships provided by the Bridges to Health and Healthcare model to benefit patients in generational poverty.

**Keywords:** Bridges to Health and Healthcare; generational poverty; population health; poverty; primary care; Ruby Payne.

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Social status and income inequality are known to influence a wide array of health outcomes (American Academy of Family Physicians [AAFP], 2015; Glass & McAtee, 2006; Marmot & Wilkinson, 2006). Research suggests that high-quality primary care experiences can help mitigate the adverse health effects of poverty (AAFP, 2015). For patients to benefit from primary care, the provider must be knowledgeable about effectively treating the patient living in poverty.

Ruby Payne is a well-known theorist who applies research about the social norms of economic class to education, and she and her team have more recently applied this information to health care in Bridges to Health and Healthcare: New solutions to improve access and services (Payne, Dreussi-Smith, Shaw, & Young, 2014). This article applies their theories to primary care and the role of the nurse practitioner (NP) in connecting with patients in

generational poverty. The premise of this work is that the environments, experiences, and restrictions of generational poverty affect how people approach life, and there are implications for practice in how we interact with those differences. The major elements of the framework incorporated in this article are summarized in Table 1. There are both broad systemic implications and practice management implications, but this article focuses on the individual clinician–patient interaction throughout a patient visit, from history taking to follow-up.

Middle-class expectations permeate primary care. Patients are expected to call ahead for appointments, be on time, fill out pages of paperwork before being seen, know their health history and be able to provide it concisely, understand and track their diagnoses and treatments, ask pertinent yet succinct questions about issues that are unclear, have prescriptions filled, take medications consistently and correctly, communicate about side effects, keep appointments for tests and procedures and referrals (which may involve traveling miles away), go to therapy weekly or more often if recommended, get their blood work done after fasting, change their diet, exercise, quit smoking, lose weight, and produce copays and deductibles upfront. Health

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**Table 1. Economic class environments and the hidden rules of health care**

	Poverty Environments	Middle Class Environments
Driving forces	Relationships, survival	Achievement, stability
Effect of environments on prevention and treatment	"It's a problem when it's a problem." Poverty requires a lot of survival activity; go to a provider only when there is a problem, to meet an immediate need. However, a trusting relationship with the provider can motivate prevention and healthy choices	Go to provider regularly as an investment in good health. Relationship with provider is, in general, a professional transaction in which the achievement and experience of the provider provides credibility and influences trust
Destiny and self-efficacy	Poverty does not allow people many choices. More likely to believe in fate, to doubt that personal choices are going to improve their future. Death is an unavoidable and often sudden part of life	Strong belief in personal choice; good choices now can improve the future. Death can be postponed a long time with proper care and planning, and is planned ahead for
Time	Present-time orientation—poverty focuses on the problem at hand, therefore prevention becomes more abstract	Future-time orientation—all about planning ahead. The stable resources allow the patient to focus on avoiding problems
Language	400–800 word vocabulary commonly used in poverty environments in all settings ("speak plain English"). Depends heavily on nonverbal communication. Contributes to low health-literacy. The practitioner must be skilled in bridging the patient to meaningful communication and trust	Both casual communication and medical terminology are usually somewhat understood and accepted. There tends to be less reliance on nonverbal communication, although health-literacy principles are still important
Discourse	Poverty does not require communication to be sequential, and may start with the most exciting or dramatic event. Value is on the listener hearing the story and understanding. Feeling heard is critical to a trusting relationship	Linear, logical, concise story structure. Value is accurate communication. Communication is expected to be short and concise
Environmental stability	Unpredictable, chaotic. A stable environment is a dream, not something to count on. Need to cultivate skills to survive in unstable setting	Every effort is made to control environment; a stable environment is an expectation, the basis for all other planning
Food/nutrition	Satisfying hunger is primary concern	Nutritional value and taste are primary concerns

*Adapted from Payne (1998), Payne et al. (2014), Payne et al. (2001).*

care providers expect patients to be future driven, have expertise in planning and projecting cause and effect, and prioritize health—in other words, to have middle-class priorities, skills, and values. For those living in poverty, life is often unstable, with one crisis after another, which undermines both the ability and the desire to accomplish these factors (Payne et al., 2014). Effective strategies for mitigating this divide begin with the provider understanding the priorities and

expectations of those in generational poverty and how to enhance clinician–patient interactions.

### History taking

Once the patient is checked in and ready to be seen, there are economic class differences in history taking. Social position influences communication style and values, which, in turn, influence medical history taking. Those in the middle class usually trust a person with the correct

credentials because credentials are a result of achievement and achievement is the currency of the middle class. Providers typically do not need to earn middle-class patients' trust—their credentials earn it for them. In poverty, trust, which is key, is tied to relationships, not credentials (Payne, DeVol, & Druessi-Smith, 2001). For underresourced patients, the provider earns trust by listening and recognizing the patient as a person (Payne et al., 2014). Time invested in building the relationship during the new patient appointment will yield fruit later. If patients do not feel the provider is viewing them as a person, a tug-of-war can happen. The providers try to obtain the information that they need to accomplish certain goals as quickly as possible, and patients try to get them to know them as a person. Patients may even withhold key information about their medical complaints until they feel acknowledged (Payne et al., 2014). For established patients, instead of starting each visit with the History of Present Illness, the practitioner might consider starting by updating the social history in a conversational way. If there is only time for one question, asking “How is your mother (grandmother, daughter, etc.)?” buys a lot of relationship points.

In the middle class, patients come to see their health care provider with the conscious intent to obtain information. A relationship with the provider is appreciated, but not required, to benefit from his or her expertise. The goal of the visit, for both the patient and provider, is to achieve the desired health outcome. The provider's primary purpose in the encounter is to support the patient's achievement of that goal. Underresourced patients do not always expect that wellness will be achieved. Life in generational poverty often involves unstable and uncontrolled life circumstances, leading to a much more tenuous sense that personal actions control or even influence outcomes (Payne et al., 2014). The goal of the visit for the patient in poverty may simply be acknowledgment and treatment of symptoms, not necessarily long-term disease management.

Research tells us that in relationships, nonverbal communication is actually more important than verbal communication (Burgoon, Guerrero, & Floyd, 2016). Patients who communicate primarily in the casual register, as patients in generational poverty tend to do, are experts in body language. If providers do not sit down at eye level to talk with them, they know that the providers are not going to hear them out. If the NPs roll their chair back as soon as they have decided what is wrong with the patient and what their plan is, the patient knows they have stopped listening. A provider who stands over the seated patients to listen to their heart and lungs through their clothes instead of having them get on the examination table is communicating that he or she is just going through the motions. Middle-class patients may notice these nonverbal messages but are more likely to accept

that this merely means that the provider is busy, not that he or she does not care.

Storytelling is an important element of communication in generational poverty. A history is a story, and storytelling is not always linear or concise. Storytelling is an art, an important form of entertainment in many cultures (Payne et al., 2001). Patients want to share their story with the provider as a gift of themselves and their storytelling talent. Time- and productivity-constrained providers can become quite frustrated with patients who give their history of present illness in a nonlinear manner, and patients who feel their story is a gift can feel devalued by the provider who does not want to hear the details. It can be acceptable to interrupt a person telling a story, but the interruption must respect the story. The provider can interrupt for clarification, but an interruption to bypass the story can lead to a tug-of-war as described above.

### Diagnostic reasoning

It is critical to consider social and environmental factors in the differential. Admittedly, the expert clinician considers these factors for middle-class and upper-class patients, but the effects of poverty on living conditions can dramatically influence care. A patient who has lost his or her job and is at risk of losing his or her home often has anxiety-related exacerbations of his or her chronic conditions. The same is true for an asthmatic child's exposure to cockroaches, any child's exposure to lead paint, poor nutrition, and lack of sleep due to environmental issues, and a child no longer exercising because of moving to an unsafe neighborhood, to name a few. Nurse practitioners are aware that these experiences can cause and exacerbate poor health conditions, but if social and environmental factors are in the providers' mental differential, they are more likely to ask relevant questions and put the big picture together.

### Presenting information

Vocabulary is smaller and communication is more informal for patients in poverty, who mostly communicate in a casual register. In middle-class and professional settings, it is the formal register that prevails (Payne et al., 2001). Patients in poverty may know the individual words the provider is using, but the information still may not make sense to them if it is presented entirely in the formal register. To a patient in poverty, “professional speak” may sound like Shakespearian English—somewhat understandable, if presented slowly. When the provider translates the information into a casual register, it improves both understanding and relationship with the patient. Effective providers generally translate medical concepts into lay language as they speak with patients. With patients in poverty, a second translation from the formal register to a casual register is needed. Abstract concepts are more readily communicated in a casual

register using analogies. To improve communication, the provider can use analogies for diabetes, hypertension, hyperlipidemia, etc. Models, drawings, and timelines are also useful (Payne et al., 2014).

If people in generational poverty speak and understand verbal language in a casual register, the effect is magnified in written communication (Joos, 1967). Much excellent research has examined the effects of low health-literacy levels (Agency for Healthcare Research & Quality, 2011). For most patients in generational poverty, the medical literature is written in a foreign language. Imagine having to read every piece of written health care communication in a language you studied in high school but have not spoken since. Medical consent forms and releases are all written in the formal register, as are most instruction sheets. It can be challenging to find good patient education materials that are written at a low health-literacy level. However, most educational materials from the Centers for Disease Control and Prevention and the National Institutes of Health are available at a low health-literacy level—Vaccine Information Sheets are a good example. Instructions for tests and procedures are best written in short, concrete steps, preferably accompanied by pictures. This is not to suggest omitting written information if the information cannot be provided at the appropriate health-literacy level. If the provider does not have information sheets written at a low health-literacy level, reviewing the information verbally while highlighting or underlining the most important information on the instruction sheet significantly improves comprehension (Sheridan et al., 2011).

### Building on strengths

Patients living in poverty are creative problem solvers. For example, I took care of a 16-year-old mom whose own mother died. She had no stable family to rely on and no money to pay for the funeral. She took her baby and went around to the bars where her mother used to drink, and raised the money for her mother's funeral by passing the hat. People in poverty often do more for relatives and neighbors than those living in more stable environments—*independence and self-sufficiency are not as highly prized or as possible in poverty*. When financial resources are low for long periods of time, philanthropy is not measured by amounts of money and time given to charities, but by resources and time devoted to raising grandchildren, nieces, nephews, and others whose parents have died or are in prison. Neighbors take in neighbors, and families take in extended-family members who have lost their jobs and their homes, give money to those who have a funeral to pay for and no savings, give rides to those whose car is not running...today, tomorrow, the next day, and the next. The provider may hear, "What goes around comes around." It comes back to relationships. The person may receive

a little bit of much-needed cash from someone they once helped, enough so that the recipient of the help does not feel like a charity case. No one has ever measured the billions of dollars a year that government and charities do not spend as a result of such informal giving. Taking in a homeless family for three months is arguably a much greater sacrifice than volunteering at a free clinic one evening a week, but no one puts it on their resume. Even in terms of formal giving, that which is deducted from income taxes, people with lower incomes donated an equal or higher percentage of their income than did those in the middle class and in wealth (Daniels, Naranyanswamy, Myers, & Panepento, 2014). People with few resources may not—often cannot—solve their problems the same way as someone with a different time focus, set of relationships, and set of resources. Problem solving has to make sense with what is available.

To develop a treatment plan with a patient in poverty, the provider needs to tap into the patient's creativity and relationships, not just recommend agency-provided resources that are familiar to the provider. When patients state that they cannot do something for whatever reason, the provider can ask whether there is a family member or neighbor who would be willing to help, or can ask whether there is someone they have helped in the past who might be able to help them in return. Often, with a little encouragement and feedback, the patient is able to think of a practical, effective solution.

### Lifestyle changes

Because of present-time orientation in poverty environments, an emphasis on immediate improvement, rather than preventing the risk of an event 10 or 15 years in the future, is more effective in promoting lifestyle changes. What might happen to a child 20 years from now as a result of poor nutrition or lack of dental care today is just not real to many parents in poverty. This combines with an often-fatalistic perspective and lack of self-efficacy to dilute or negate many health-promotion and disease-prevention messages. One counter to this is to focus on what is important—relationships. In discussing risks for the future, the provider may use the patients' family history to point out the likelihood that they will end up in the same situation as their grandma, for example, or will be unable to care for their children. Some providers use timeline models in which drawing the past, present, and future with the patient is part of treatment planning (Payne et al., 2014).

Once patients have agreed that they want to make lifestyle changes, there are still differences in approach. A present-time orientation means it is unhelpful to set goals that will not be met for a year, such as losing 50 pounds. Even if that is the overall goal, it needs to be broken down into smaller goals that can be attained in shorter periods of time. A goal may be to reduce soda

intake by one can per day, to walk around the block three times a week, or to keep one appointment. Setting smaller goals is also a best practice for middle-class patients, but patients in poverty are even less likely to be able to take the large goal and turn it into action.

If patients say that they want to make lifestyle changes and improve diabetic control, and then miss their next two appointments, what might be going on? To understand why patients make the decisions that they make, thinking about relationships is foundational. The patients may not have made the lifestyle changes that they said they would and may avoid the provider because of fear of disappointing the provider or being shamed by the provider. Middle-class patients may reschedule their appointment (instead of simply failing to show up) until they can demonstrate progress in achieving their goal, but they are primarily concerned with disappointing themselves, not their health care provider. Their shame is about failing to achieve rather than about damaging the relationship with their provider. They will likely return before they run out of medication because ultimately, they see themselves as the consumer. Patients in poverty are less likely to see themselves as the consumer.

Health care providers who treat adolescents from poverty face unique challenges. In general, adolescents are not future-oriented. Most providers who care for adolescents know that talking to them about the health consequences of smoking 30 years from now rarely influences their behavior today. This effect is magnified for adolescents in generational poverty. For example, I worked in a health center in an alternative high school. Many of our boys had attention-deficit hyperactivity disorder (ADHD) and were failing all their classes, but did not want to take medications for ADHD. They would say, "I'm not myself when I take the medication," but they could not elaborate. One boy clarified, "When I take the medication, I sit quietly in my seat during class, do my work, am respectful to my teachers, and get good grades." He paused. "And the downside of that?" I finally asked. He said, "If I act that way, I won't have any friends."

Personal strength, the ability to fight, and being funny are the social skills valued in poverty, not good grades and extracurricular achievement outside sports (Payne et al., 2001). Telling adolescents that if they do well in school for the next four to six years, they may be able to get a better job when they are an adult is usually not compelling. When adolescents have the present-time orientation of generational poverty, the cost of losing their social capital among their peers will trump any possible future benefits of doing well in school.

### **Modifying the plan based on available resources**

By definition, poverty involves a lack of financial resources. In the middle class, people have insurance to protect against the consequences of accidents, illnesses, house

fires, and deaths. Homeowner's insurance, long-term disability, savings accounts, pension plans, and credit, along with planning skills, knowledge about and access to systems and information, and bridging social capital, provide cushions against many of life's crises (Payne et al., 2014). Poverty provides very few cushions. If the family car breaks down, there is no money to fix it. This often means that there is no way to get to work, which results in loss of a job, which can result in the loss of housing, leading potentially to homelessness, which may even result in removal of the children from the care of the parent(s). In contrast, if a car breaks down in a middle-class household, it is inconvenient and costly, but is unlikely to lead to the children being placed in foster care. A lack of resources means that patients may stay in situations that are clearly not good because they do not see better options (Payne et al., 2014).

Providers can get frustrated with patients who seem to have endless crises and few resources to address them. Patients do not always want to talk about the situation because, through learned experience, it is clear that some health care providers do not want to hear about their patients' social situations and how they got there. It is a practical reality that experienced providers control the interview—they do not allow the patient to control it. Providers learn how to cut off the flow of information that they consider irrelevant. The provider's time is a limited resource, and efficiency in obtaining needed information is important. However, the entire visit is a waste of time if the patient does not do any of the tasks needed to get better because he or she does not have the resources to do so, and if the provider fails to modify the plan to take available resources into account.

In making a plan together with the patient, it is vital to determine whether the resources will be available to execute the plan. If the patient has Medicaid, being able to afford laboratory tests or X-rays is not an issue, but if there is no insurance or a very high deductible, it is a different story. Hospitals charge more for tests and procedures overall than do freestanding facilities, but they do have Hospital Care Assurance Programs (HCAP) that drastically reduce the cost to a low-income patient; however, the hospital laboratory may or may not apply HCAP to laboratory tests. For a practice that serves many low-income patients, most large laboratories work out agreements, based on volume, to charge significantly less for uninsured patients. Providers may ask whether the patient has access to transportation to get the prescription filled and enough money to afford the copay or the cost of the prescription. If transportation is an issue, providers can consider a pharmacy that delivers. An acute awareness of the cost of medications and less expensive alternatives is critical for underinsured and uninsured patients. For working poor patients who have health care through work or from an Affordable Care Act plan, the

cumulative cost of their copays is still an important consideration. For the uninsured patient, a way to use patient assistance programs is vital. A hospital social worker or discharge planner generally knows about community resources and will happily meet with practitioners who admit to or refer to their facility to share information.

### **Making referrals**

Although health care policy changes have reduced the percentage of uninsured patients, there are still many individuals in the United States who lack health insurance. Research has repeatedly demonstrated that uninsured patients are less likely to fill their prescriptions and obtain other recommended services (Kaiser Family Foundation, 2016). The NP who works with poor and medically underserved populations needs to be highly aware of community resources. Fortunately, some NPs have a social worker at their facility, but that is not always the case.

When making referrals to specialists, the provider needs to ask the patients whether they will be able to get to the appointment with the specialist and whether they can afford the copay. The NP who works with uninsured patients needs to become connected with specialists who operate on a sliding fee scale. The NP should know that Medicaid and its managed-care systems generally pay for transportation to office visits, specialists, tests, and procedures—patients are often unaware of this benefit. Sometimes, however, patients are picked up by a van along with many others, so a one-hour appointment can become an all-day affair. If the patient works or has to bring along small children because child care is unavailable, this may be a significant barrier.

For agencies that operate on a sliding scale based on income, particularly mental health and social service agencies, there may be nonfinancial barriers to keeping the appointment. For a patient in poverty, mistrust of “agencies” is common. Certain organizations in a community are more trusted than others. Patients are typically the best source of information about how “poverty-friendly” local resources are. Some agencies with limited resources deliberately use patient persistence as a criterion for admission. For example, consider a community mental health crisis agency that requires those seeking help to show up at 6 a.m. on Monday and wait until they can be seen, often waiting many hours. The justification is that it eliminates those who do not really “want help.” They assume those who are not willing to show up at 6 a.m. and spend all day waiting do not have the determination to be successful in treatment. Such a policy certainly eliminates those who have a job and those who are too mentally ill to keep track of the day and time, own an alarm clock, catch the correct bus, etc. When this type of agency is suggested as a referral or resource,

patients who have dealt with them before may get a sour look and roll their eyes. However, if given an explanation as to what to expect, the patient will more often do what is needed to get the help instead of getting angry because of feeling disrespected by that agency in the past.

The best communication always includes the what, why, and how (Feuerstein & Rand, 1974). The Reuven Feuerstein theory, supported by subsequent research, suggests that this three-step pattern of communication builds cognition and understanding. The “what” identifies the stimulus/issue, the “why” assigns meaning, and the “how” is the process to address the issue effectively. For example, the “what”: “This is the procedure at this mental health agency”; the “why”: “Even though this is a difficult policy, it’s there because they get so many no-shows—the therapists and the psychiatrists are good”; the “how”: “Bite the bullet and jump through these hoops to get what you and your family need.” Even when the targeted agency is not poverty-friendly, if the provider explains how the system works and why adhering to the system is worth it, then the patient is much more likely to go along with it. Ruby Payne strongly advocates teaching the hidden rules of the educational system to children in poverty (Payne, 1998). The primary care provider needs to teach the hidden rules of the health care system to patients in poverty.

An interprofessional team is critical in managing a high-risk, high-need patient. Facilitating referrals of all kinds is beneficial, but sometimes more attention is needed than the primary care provider can give. Home visitation and care coordination have been demonstrated to be effective in addressing the needs of high-need, low-resource patients (Beck et al., 2016). However, for a family in poverty to open the door for a strange woman who shows up on their doorstep depends on trust; it makes a difference when someone the family trusts (their primary care provider, for example) vouches for the person who will be visiting. Patients need to be told what to expect from home health and case management services, as with any other referral.

### **Work and school absences**

Low-income jobs are more likely to have no vacation or sick time, and missing a day or being late because a health care appointment took longer than anticipated may get the employee fired (Acs & Nichols, 2007). Patients are much more likely to need a work excuse to miss a day. They may stay home because of vomiting, and then may stay home the next day to be seen by their provider to obtain a work excuse for the day before.

### **Access to advice after they leave**

Friends and family members often ask NPs for medical advice or simply for an interpretation of what a patient’s provider told him or her or what the patient information

that came with the medication means; they are the family medical expert. People in poverty lack bridging social capital—key relationships—with more-educated people. A person in poverty rarely has access to a family member who is a physician, NP, physician's assistant, or registered nurse. A nursing assistant may be the family medical expert. The quality of advice given by that family "medical expert" is likely to be less helpful. If a practice has an advice nurse, providers should encourage patients to use them. Most Medicaid managed-care providers have advice nurses; however, the rule in poverty is, "Don't trust someone you don't know." The NP can create a secondary trust relationship through a recommendation, but the provider who recommends a service that does not do a good job will lose trust. The local pharmacist is an available health care resource who is widely available, but patients living in poverty rarely think to ask a pharmacist questions about their prescription medications, let alone about over-the-counter medications. If the NP explains that this is an option, patients are more likely to use that resource. A school nurse can also be a resource. Such measures can help to supplement the sparser human capital resources in families and neighborhoods in poverty.

### Follow-up visits

It is critical to reinforce the patient-provider relationship at follow-up visits. The provider congratulates the patient on any small progress made. An unmet goal is approached from a problem-solving perspective, and blame is avoided. If, by contrast, the provider lectures the patients about how their behaviors are killing them slowly and that they need to quit smoking, lose 60 pounds, start exercising, take their pills twice every day as prescribed, etc., there are likely to be cancellations and no-shows in that patients' future. That does not mean that there is no place for a serious talk about consequences in a patient-provider relationship, but it must be carefully framed as the provider caring about the patients and wanting what is best for them. Liberal application of "you can do this" should accompany the discussion. These are principles that apply to any patient lifestyle intervention, but the emphasis on relationship-building is critical for patients in poverty (Payne et al., 2001).

### Conclusion

Economic class differences are a major area where population health intersects with clinical practice. Recognizing the effects of poverty as a social determinant of health is not enough—it is necessary for the clinician to practice in a way that helps to mitigate those effects. When working with patients from underresourced environments who are driven by relationships, survival, and a short-term orientation to time, there is no amount of

access, availability, outcome measures, or cost-reducing supply-chain strategies that will ever take the place of the trust building, social capital bridging, and mutual respect established between the provider and the patient. When the provider understands and responds to what is important to the patient in long-term poverty, and when the practice understands and accommodates the strengths, limitations, and hidden rules of poverty, patients receive better care and have better outcomes.

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