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The Experiences of African Americans Seeking Health Care Services

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Walden University

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Walden University

College of Psychology and Community Services

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Sandy L. Sullivan

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Walden University
2025

Abstract

The Experiences of African Americans Seeking Health Care Services

by

Sandy L. Sullivan

MA, Walden University, 2021

MS, Capella University, 2011

BS, Austin Peay State University, 2003

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services

Walden University

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Abstract

Health care experiences are shaped by life events and cultural background, making engagement with providers individualized. African Americans have historically reported distrust of health professionals due to targeted mistreatment. The purpose of this generic qualitative study was to explore the experiences of middle-aged African American adults receiving care from non-African American health care providers. Rosenstock's health belief model was the framework for the study. Nine participants were recruited from social media using purposeful sampling. Data were gathered through semistructured interviews held on Zoom. Saldana's four-step qualitative data analysis process was utilized to analyze the data. The results of the data analysis yielded five themes: (a) middle-aged African American adults desire health care services considerate of culture, (b) middle-aged African American adults experience communication challenges with non-African American health care providers, (c) middle-aged African American adults have varied experiences with non-African American health care providers, (d) middle-aged African American adults experience unconscious bias when receiving health care services from non-African American health care providers, and (e) middle-aged African American adults experience systemic limitations when receiving health care services from non-African American health care providers. The focus on middle-aged African American adults' experiences of engagement contributes to raising awareness of the cultural and systemic changes needed to reduce barriers to care, promote societal change, and improve the quality of health care for African Americans.

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Dedication

This dissertation is dedicated to my daughter, who knows that “Anything In the Whole Wide World” is both literal and possible. To my grandmother, whose unconditional love, compassion, and humility continue to guide me. To my parents, a mother who had the courage to dream big, and a father who exemplifies what it means to be a dad. To my siblings, I extend my gratitude for their love and support throughout this journey. To other family and friends, whose encouragement and understanding propelled me, and to those who inspired this work, may these efforts contribute in some way to knowledge and progress that benefits others.

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Chapter 1: Introduction to the Study

Introduction

African Americans may continue to experience medical disparities. Snowden et al. (2022) stated that health care disparity for African American people continues to exist and continues to affect their health care outcomes. Willoughby (2020) stated that African Americans' life expectancy continues to be lower and their health care quality and access unequal. Gilbert (2022) explained that, throughout the history of the United States, African American people have suffered from socioeconomic harm that is inherent, already embedded in the health systems used. Roy et al. (2020) claimed that African American people suffer from premature mortality because of race-based biases. Spector (2018) stated that structural racism is entrenched in U.S. society and is a contributor to African American systematic oppression that promotes unequal health care. Health care disparities are the factors related to health care that may affect access to and use of health care for African Americans. Health care disparities can be physical, or they can be intangible differences that are experienced in related to a person's ability to use health care services.

Chapter 1 begins with an introduction and background information on the research topic. The chapter continues with the purpose statement and a description of the theoretical framework. The research question is listed, and the nature of the study is revealed. The chapter continues with a list of terms and definitions used in the research study, the research assumptions, and the scope and delimitations of the research. The

limitations and significance of the research are next, and the chapter concludes with a summary.

Background

Historically, some African Americans have distrusted medical professionals and the services that they provide. Alsan et al. (2020) stated that experiences in which African Americans are targeted because of their race or ethnicity have the potential to cause adverse health implications for African American people. Rusert (2009) stated that the Tuskegee Normal and Agricultural Institute confined African American students and extended a previous plantation system of health care into the 20th century. According to Vernon (2020), the Tuskegee syphilis study caused African American men who were injected with syphilis to remain ill and go untreated, threatening their lives. Alan and Wanamaker (2018) stated that the Tuskegee study is used as a landmark example for exploitation and mistreatment of African American men by medical professionals. Allen (2019) outlined that African American people have struggled for equity in health care and health care services from slavery through the passing of the Affordable Care Act. The historical recollections of mistreatment of African American people by health care professionals are relayed through generations.

Problem Statement

People's experiences of health care services are an accumulation of layered life events, much more than what is seen. Adults have varied experiences based on their identified cultural background, which can make engagement with health care systems individualized and vastly different for each person (Hernandez & Sparks, 2020). Income

level and discrimination are the genesis for socioeconomic health disparities, which weigh on the social determinants of health within susceptible minority groups (Entress & Anderson, 2020). A health disparity can be defined as a noted repeated event within a specific group that signifies less-than-optimal outcomes for health (Alvidrez et al., 2019). Discriminatory practices of society have importance when considering the hazards to health outcomes for groups outside the majority population (D'Anna et al., 2018). Communities with culturally distinct members have reports of lower incomes, education, and access to resources, which can equal diminished health and unequal health care service provision (Sntislelaar & Carr, 2023). Some African Americans may experience barriers to health care due to racial and socioeconomic factors.

Although research regarding the experiences of African American people seeking health care services illuminates important findings, I have found little research aimed toward exploring how middle-aged African American adults experience engagement with non-African American health care service providers. The topic of health care for minority populations has received attention, but there is a lack of information about patient experiences and the cultural competence of their health care professional (Flynn et al., 2020). Further work may seek to explore experiences of ethnic minorities with nonminority health care professionals.

Purpose of the Study

The purpose of this generic qualitative research study was to explore how middle-aged African American adults experience engagement with non-African American health

care service providers. Qualitative research methods were appropriate for the current research study. I used a generic qualitative research study to align with the methodology.

The target population was African American, middle-aged, and seeking health care services. I conducted semistructured interviews with middle-aged African Americans to understand how they experience engagement with non-African American health care service providers. In-depth understanding of the group's experiences seeking health care services may provide insight for human service personnel who consider health care a component of whole health for African Americans.

Research Question

How do middle-aged African American adults experience engagement with non-African American health care service providers?

Theoretical Framework for the Study

The framework for this qualitative study was the health belief model. Rosenstock (1974) developed the health belief model, which emerged from research problems in public health to explain health behavior and how people utilize health services. Rosenstock's health belief model addresses people's pleas to evade sickness and their belief that their inaction may not lead to the desired outcome. The model's components are perceived susceptibility, perceived severity, perceived benefit, and perceived barriers (Rosenstock, 1974). The health belief model can be used to study perceived health challenges in communities. I chose this model to explore the perceived experiences of African American adults seeking health care services from non-African American health care providers.

Nature of the Study

This study was a generic qualitative research study. Tenny et al. (2022) described qualitative research as a type of research that provides insight that is applicable to everyday life, collecting participants' experiences, perceptions, and behavior to understand the actions that were a precursor to a problem occurring. A generic qualitative research design, as described by Ellis and Hart (2023), is flexible and allows for a descriptive view of data for interpretation. Kostere and Kostere (2022) explained that a generic qualitative study may not adhere to any specific philosophical assumptions. The generic qualitative research design was the best to explore middle-aged African Americans' experiences of engagement of with non-African American health care service providers because this design allowed me to explore the perceived experiences of the participants.

I conducted semistructured interviews. Moser and Korstjens (2018) described semistructured interviews for qualitative data collection as a means to ask participants questions using an in-person meeting, via telephonic device, or using the internet through a meeting platform. The interviewers' goal is to accurately interpret the primary recurring events described by the participants. Thematic analysis was used to analyze data from interviews. Chapter 3 includes more detail on the method and design.

Definitions

The definitions used in human service research are closely related to definitions used in the health care profession. The following terms and definitions are the terms most used in this research study:

Cultural competency: Acceptance and respect for differences, a self-awareness of someone's personal assumptions and learned prejudices, a responsiveness to diverse groups, and understanding of policy and practice (Desai et al., 2020).

Culture: The beliefs, behaviors, and core values of a group, defining their humanity and identity (Brion, 2022).

Diversity: People belonging to different backgrounds or groups having differing ways of being and different experiences, or someone with a unique upbringing (Beaumont et al., 2021).

Ethnicity: A socially derived category; it can be determined by self-identification and has a cultural component (Johnson et al., 2022).

Health care: A human good affecting life; it reduces pain and suffering and reduces loss of life; further, there is a societal obligation to make it available for all human beings (American Medical Association, n.d.).

Minority: A person identified as not White (Richie et al., 2021).

Race: A social construct that includes facets of physical and cultural attributes that affect African American health and biology (O'Donnell & Edgar, 2021).

Racism: A belief of superiority in which one group has inherited social benefit over another (O'Donnell & Edgar, 2021).

Assumptions

I made several assumptions for the research study. Assumptions are claims taken as fact without proof (Brydges et al., 2021). In this study, I assumed that each participant understood the questions being asked. I assumed that members of the age group selected

were deemed mature adults with the ability to understand and follow directions. I assumed that each participant was being truthful regarding their experiences with health care providers. I also assumed that the participants were recounting their personal engagement with no pressure or comparison from others and that each participant accurately represented the length of time since their last health care visit.

Scope and Delimitations

The scope of the study focused on middle-aged African American experiences of engagement with non-African American health care service providers. Akanle et al. (2020) explained that the scope and the delimitations of a study are the boundaries for the study set by the researcher; a statement of delimitations is an attempt to explain the activities the researcher has not undertaken. The study was delimited to middle-aged African Americans who had engaged with non-African American health care providers in the past 6 months. I did not explore other ethnic groups' perceptions on engagement during the visit. I did not explore whether a patient adhered to provider recommendations. Finally, I did not explore patients' satisfaction with their health care services.

There were other theories considered for the research, such as the socioecological and social cognitive theories. The socioecological framework conveys the importance of the hierarchies of information that contribute to the actions individuals choose to make, things that are internal and external, and the rules that govern such behaviors in society (Scarneo et al., 2019). I did not choose this theory because it is too broad and it can be used to encompass a wider range of aspects in health care and human service research.

The social cognitive theory is used to understand health behaviors and the way the individual, the environment, and behavior operate; it involves the belief that a person has the ability and confidence to exhibit a specific behavior to attain intended results (Shamizadeh et al., 2019). The theory was not used because I focused on the experience during engagement that each participant had with their health care provider and not any ability to achieve results.

Limitations

There were several methodological limitations for this study. Qualitative research limitations are anything that may cause research outcomes to change (Ross & Bibler-Zaidi, 2019). Mwita (2022) explained that qualitative research limitations may include its subjectivity, data analysis, the scope, and the researchers' bias. The current research study may not be generally applied to a larger population. The current study may be a window in time that is dependent on the conditions occurring during that time. To minimize concerns regarding potential limitations, the criteria used for recruitment were clearly stated during the recruitment process and in the results of the study. Another limitation may be researcher bias. I have experienced and have been regularly exposed to experiences of engagement between African American adults and non-African American health care service providers. A personal connection with the topic has the ability to influence interviews, questions, and perceptions. Acknowledging the limitation conveys transparency and helps maintain integrity in the research. I created a journal to document any personal bias, experiences, and opinions. I did not allow personal emotion to influence the research. I carefully transcribed interviews and member checked each

interview. The mentioned tools were used to mitigate researcher bias and to deflect any bias that could have been present based on the research topic.

Significance

The study may be used to address the gap in literature. I have found little research aimed toward exploring how middle-aged African Americans experience engagement with non-African American health care service providers. The study may fill the gap in the literature by specifically focusing on middle-aged African American adults' experiences of engagement with non-African American health care service providers.

Human service professionals may use the knowledge gained from the study to educate and prompt requests for culturally appropriate engagement when working with and providing services for African American adults. Human service professionals may consider utilizing information from the study to advocate for the whole person, assuring that African American adults are receiving culturally competent health care services. Human service professionals who are able to understand the perspective of their clients are better able to procure efficient and effective health care services when needed. Human service professionals who seek to improve the perceived engagement experience of African Americans adults may seek to find care and services that are more amiable to the specific demographic.

Information from the results of the study may lead to positive social change when it is considered in the creation of social policies and practices that promote health and reduce disparity for middle-aged African Americans. The social determinants of health; the environments in which people live, work, and worship; and their age and education

level each help to shape individual health. The study may provide information on the influences that the social determinants of health have on the engagement experiences of middle-aged African American adults seeking health care services. The results of this study may contribute to positive social change through policies, education, and procedures for non-African American health care service providers working with middle-aged African American adults.

Summary

Chapter 1 began with an introduction and background information and continued with the purpose statement and a description of the theoretical framework. The research question was listed, and the nature of the study was revealed. The chapter continued with a list of terms and definitions used in the research study, the research assumptions, and the scope and delimitations of the research. The limitations and significance of the research were next, and the chapter concluded with the summary. Chapter 2 focuses on the literature review.

Chapter 2: Literature Review

Introduction

The purpose of this generic qualitative research study was to explore how middle-aged African American adults experience engagement with non-African American health care service providers. The target population included middle-aged African Americans who had received medical services from non-African American health care providers. I conducted semistructured interviews with middle-aged African Americans to understand how they experienced engagement with non-African American health care service providers. In-depth understanding of the group's experiences seeking health care services may provide insight for human service personnel who consider health care a component of whole health for African Americans.

Human service professionals may be efficient partners in a range of helping environments. Individuals who work in human services networks have the ability to promote equity and efficiency in health care (Kanengoni et al., 2020). Health care providers may not always be aware of the patient experiences their health care decisions create (Cookson et al., 2018). The ability of a provider to offer culturally appropriate health care services may be challenging in diversely populated areas without the support of entities and people working in human services networks who promote health care equity (Palma et al., 2020). Health care experiences may lead people to sense or to face negative or discriminatory conditions (Bulgarelli et al., 2021), which may shape the health care experiences of African American people (Ahmed et al., 2021). Human service professionals may be crucial in African American communities; they may help

community members navigate through the layers of rules and regulations required to receive services. Human service professionals may work to mitigate the social determinants of health, which may allow community members to focus on their well-being. Human service professionals may also advocate for culturally appropriate health care services.

Chapter 2 presents the findings of the study that are relevant to the topic. The chapter begins with the literature review strategy and a description of the health belief model that guided the research study. Chapter 2 includes key concepts that are defined and explained. The key concepts are health care services, access to health care, equity in health care, inequity in health care, culture, race, ethnic minority, cultural competency, diversity, public policy, privacy, health care professionals, medical care, dental care, behavioral and mental health, and pharmacy. Chapter 2 concludes with a summary.

Literature Search Strategy

I obtained access to existing literature through Walden University and Google Scholar. A primary source that I used was EBSCOhost, which included SocINDEX, APA PsychArticles, and ScholarWorks. I used the following key words to locate research studies: *health care, health care services, equity, diversity, culture, cultural competence, and race and ethnicity*. I focused on journals specific to health care and human services, such as *The Journal of Health and Human Services Administration*. I also identified relevant articles in journals such as *The Journal of Human Services* and *The Journal of Health Care Quality*. The search parameters were 2018 to present, 2023. Seminal sources

without current research were dated in accordance with the topic. I have perused to date 130 or more articles as sources for research.

Theoretical Foundation

The theoretical framework for this qualitative study was the health belief model. The health belief model, made official by Irwin Rosenstock in 1974, has been the basis for many health behavior models (Rosenstock, 1974a). The health belief model includes beliefs and sociodemographic variables aimed at explaining why some healthy individuals embrace health-protective behaviors when others are unwilling to make any changes to their behavior (Rosenstock, 1974a). The demographic features noted that are significant when engaging for health services are socioeconomic status, gender, ethnicity, and age (Rosenstock, 1974b). Rosenstock (1974b) developed the health belief model to address real-life practical health problems, including patient communication and compliance, which were not at the time deemed public health concerns. Rosenstock (1974a) used the health belief model to demonstrate facts about individual socioeconomic and racial characteristics as well as to convey the need for social policy to be created to address health care disparities. According to Rosenstock (1974a), the health belief model is deemed to have value within the social sciences community, as it has been tested with actual life circumstances and the model has practical uses for understanding, predicting, and changing health behaviors.

Health motivation, or the reason that participants engage in health services, can be derived in various ways. Rosenstock and Kirscht (1974) stated that any health engagement requires cooperation between the patient and service provider, through

which an idea is formed by the service provider regarding how a patient behaves, why the behavior happens, and how the behavior might be changed. Rosenstock and Kirscht noted that the assumptions about health behavior can be implicit or explicit but are essential for meaningful engagement. Rosenstock (1974b) developed the health belief model from a perceiver's perspective and believed that it is the perceiver that determines their actions in the environment. Rosenstock (1974b) described six tenets when developing the early health belief model. The first is perceived susceptibility, the risk involved with any action regarding health behavior; the second is perceived severity or consequence of a health behavior change; the third is perceived benefits, or what will be gained by a health behavior change; the fourth is perceived barriers, or hindrances to health behavior change; the fifth is cues to action, or the motivation to make a health behavior change; and the final is self-efficacy, the assurance to self-motivate and make health behavior changes (Rosenstock, 1974b). Rosenstock (1974a) noted that the ways in which the six tenets are used depend on the researcher and the specific research topic being studied.

The health behavior model was originally created to address preventive health behaviors. Rosenstock (1974a) identified three health behaviors: The first is preventive health behavior, which is any engagement involving a person who is deemed healthy for preventing disease. The next is illness behavior, which is engagement by a person for the purpose of understanding current health conditions potentially a resolution. The final health behavior is sick-role behavior, which is the engagement of someone with an illness seeking to become well. Engagement in health behavior services of all types is more prevalent among young people, the middle aged, females, the more educated, and people

with higher incomes (Rosenstock, 1974a). There is not one single thing, but many different factors that motivate people to engage and take action regarding individual health behaviors.

Health Belief Model Used to Understand Elderly Engagement

The health belief model has been used to explore varying experiences of engagement with health care services. Mukerjee (2019) discussed elderly people from diverse backgrounds, their cultural attitudes and beliefs, and the influence each has on the desire to maintain their health. Mukerjee concluded that there may be a decrease in health care engagement due to many factors that impact how elderly people may be looking for appropriate health care; economic status, severity of illness, cost of treatment, and the location of medical facilities are a few. Mukerjee used the health belief model to examine how the elderly population perceived health care and health-care-seeking behavior. Zhang et al. (2021) explored health care motivation in the 60-and-over population, attempting to understand the influences on their intention to receive periodic health examinations. Social support was deemed to be a factor in motivation when members of the 60-and-older population engage in health-related behaviors (Zhang et al., 2021). The health belief model was used to convey that individual perceptions of the elderly may have influence on the desire to seek or engage in health care.

Health Belief Model and African Americans With Sickle Cell Disease

The health belief model was used to understand the behaviors of African Americans with sickle cell disease. Smith and Mercado-Sierra (2021) asserted that African American health beliefs regarding sickle cell disease influence their ability to

engage in appropriate preventive measures. Smith and Mercado-Sierra saw the health belief model as a way of predicting how health-promoting conduct could be used to develop strategies to reduce negative behaviors and improve patients' positive health behaviors and patients' health. The study focused on patient screening behaviors and concluded that individuals must perceive sickle cell disease to be severe to seek screening and possible treatment (Smith & Mercado-Sierra, 2021). Pormehr-Yabandeh (2023) examined the pregnancy of women with sickle cell disease, seeking to uncover whether social marketing interventions might improve their outcomes. The study focused on women during their reproductive years, and the health belief model was used to assess their level of engagement (Pormehr-Yabandeh, 2023). The study revealed that social marketing-based intervention was successful in improving their level of health care engagement (Pormehr-Yabandeh, 2023). Social marketing was found to be a beneficial tool for delivering useful information, information that seemingly motivated the women to engage and become invested in their health care.

Health Belief Model to Examine African American Women's Breast Cancer

The health belief model was used to explore the behaviors of African American women regarding breast cancer. Ștefănuț and Vintila (2022) discussed African American women and their breast health, exploring motivating influences that compel women to seek breast exams. Ștefănuț and Vintila concluded that education and constant contact improved the likelihood of self-exams and improved perceptions regarding disease. Ștefănuț and Vintila focused on the effectiveness of a health belief model-based intervention in increasing knowledge and changing beliefs about breast cancer along with

encouraging breast self-examination behaviors. The results obtained were arguments for health-belief-based interventions to be implemented by health care providers who want to promote self-examination as a method of early detection of breast cancer (Ștefănuț & Ventila, 2022). Davis (2021) discussed African American women's high mortality rates due to breast cancer and the benefits of early detection. The health belief model was used to consider how women's health beliefs may be a consideration in their desire to take actions to detect breast cancer (Davis, 2021). Women may be influenced to engage with their primary care provider and receive mammograms if they have a friend or family member who has been diagnosed with or treated for breast cancer (Davis, 2021). Women may intellectually understand the seriousness of breast health or breast cancer, but the illness and information are abstract and do not seem real. When women are directly exposed to illness, it becomes personal; now, there is a face to connect to a diagnosis. Women are then more likely to engage with a health care provider for services.

Eating Disorders and the Health Belief Model

The behaviors exhibited with eating disorders are examined using the health belief model. Tipton et al. (2021) sought to understand treatment-seeking behaviors of females with eating disorders. The females exhibited cues of distress that were evident for mental health professionals as the women sought treatment for their disorder (Tipton, 2021). Women with eating disorders understand the severity of their illness and know how it manifested, although family intervention is required for treatment (Tipton, 2021). The health belief model was used to understand influences on health seeking and treatment (Tipton, 2021). De Leon (2023) examined strategies that would reduce harm

with alcohol use disorders and contribute to a reduction in alcohol-related concerns. The health belief model was used to examine whether the perceived increase in protective behavioral strategies led to a reduction in alcohol usage (De Leon, 2023). The study concluded that perceived effectiveness of behavioral strategies influenced the usage of such strategies, decreased alcohol usage, and lessened the presence of alcohol disorders (De Leon, 2023). The more real-life examples that are available to provide proof that a strategy works, the more motivated participants may be to engage in using the strategy for behavioral changes.

Health Belief Model and Young Adult Behaviors

Young adult behaviors' variation based on sociodemographic characteristics may be examined using the health belief model. Cepa and Furstenberg (2021) explored young adult behaviors across gender and social status spectrums using the health belief model. Cepa and Furstenberg found that young adults of lower income status have fewer positive reports of changed behaviors. Despite different structural barriers to reaching adult milestones, Americans define adulthood in the same way and hold similar views about the importance of adult milestones regardless of age differences (Cepa & Furstenberg, 2021). Malik (2023) examined contributors to the likelihood of young adult health information seeking and sharing on social media platforms. The health belief model was used to explore individual health beliefs' influence on health information sharing and health information seeking by young adults on social media (Malik, 2023). The study concluded that social media health information seeking and sharing positively influence eHealth literacy (Malik, 2023). There are varying points at which adulthood is

determined, points that can be determined by sociodemographics. The ability to successfully navigate the internet and understand social media to review health information seemingly makes the same health information and knowledge available for all young adults.

COVID-19 Pandemic and the Health Belief Model

Preventive health behavior during the COVID-19 pandemic was examined using the health belief model. Can et al. (2022) studied preventive health behaviors of men and women against the COVID-19 outbreak. Can et al. concluded that the health behavior model was able to provide a general framework for the health behavior of interest without having a standard measurement covering all health behaviors. The findings from the study supported Rosenstock's health belief model and showed that, if there is a risk of disease, according to the health belief model, people will seek health care (Can et al., 2022). Sarwar (2023) explored the psychological capital of health appraisals, understanding the benefits, barriers, threat, seriousness, and susceptibility of COVID and the voluntary use of preventive behaviors. The health belief model was used to examine the connection between health, psychological capital, and preventive health behavior (Sarwar, 2023). The study concluded that the most significant influence on health behaviors is understanding of the perceived benefits and perceived threats (Sarwar, 2023). New health behavior may be undesirable or unwanted when the benefits or risks are not understood. In the instance of COVID 19, a person may die because of a failure to understand the risk of a disease or illness, or a person lives because of an ability to understand the risk and benefit and be willing to change behaviors.

Male Teacher Quality of Life and the Health Belief Model

Male teacher quality of life and the behaviors that accompany male teacher quality of life may be explored using the health belief model. Dadvar et al. (2019) used the health belief model to study social capital and quality of life for male teachers. Dadvar et al. concluded that significant social capital had a positive influence on a teacher's quality of life and well-being. People with higher education and income do not necessarily have better well-being than others (Dadvar et al., 2019). While scholars have identified several theories and models in health communication, only a handful of them are commonly used in studies focusing on behavior change. Nganda and Mwithia (2023) asserted that the health belief model is widely applied to change behavior and predicts how people may respond to existing health problems. The health belief model is utilized across disciplines in attempts to understand the influence intellect may have on well-being. An educated male is not likely to have better health, or well-being, but may benefit from a well-rounded social circle.

Why the Health Belief Model Was Chosen for This Study

The health belief model was appropriate for the current study, as the model can be used to explain health motivation, or the reasons individuals may or may not act related to their health care needs. The ability to interview participants and collect information allowed for understanding their health care motivation based on the dimensions of the health belief model. Data that allow for identification and understanding of the reason a participant seeks health care services have the potential to reveal details related to their

perceptions regarding their experiences of engagement with non-African American health care service providers.

Literature Review Related to Key Variables and/or Concepts

Defining Health Care Services and Providers

Health care services and health care providers may be defined in various ways. To receive health care services is to receive medical-related services that are underpinned with health in mind. Health care services may provide care and support for any aspect of a person's life. Health care services can allow for functional health care delivery (Anderson et al., 2020). Borkowski and Meese (2021) explained that the health care service industry is the largest industry in the United States, and it includes physicians, nurses, and other professionals. Health care services are inclusive of many components of health care required for a person's health and well-being.

Health care services are an important piece to overall health. The Department of Health and Human Services (2022) explained that health care services are important in disease prevention and management, reducing disability, preventing mortality, decreasing health disparity, and promoting health equity. Health care services include medical, dental, and prescription services. Cornell Law School (2019) described health care services as any services provided by a health care professional, or by any individual working under the supervision of a health care professional, that may provide diagnosis, prevention, treatment, or assessment of disease or impairment. Health care services are vital to health care. An engagement with health care services may come at any point while accessing care.

A health care provider of any type makes decisions about the health care services that the patient will receive. A health care provider maintains, studies, diagnoses, treats, and prevents human illness and injury of both physical and mental impairments (Organization, 2023). The U.S. Department of Health and Human Services (2024) described a health care provider as a licensed person who provides health care services, such as doctors, nurses, therapists, pharmacists, lab technician, or other health care professional. Health care providers are an integral part of any health care service, from the front desk to the emergency room. Any aspect of engagement with a single health care provider has the ability to affect the health care services provided.

Health Care Access for African Americans

Access to health care for African Americans can be challenging. Access to health care for African Americans is complicated due to competing priorities. The systems that should allow health care for everyone are in place. In place also are the invisible impediments that make access challenging for African Americans. Braveman et al. (2022) explained that the systems, laws, and policies that make access to health care services challenging are the same systems, laws, and policies that have the ability make health care access equal. Jiang et al. (2022) stated that access to health care is the ability to use health care and the ability to afford health care, both of which many African American Americans do not have. Access to health care services for African Americans may be affected through consultation delays, lack of adequate communication, denials in treatment, and harassment (Bulgarelli et al., 2021). African American health care access may be hindered due to prior trauma experiences while attempting to access health care

services (Li, 2021). Lack of access to health care services often renders available health care services unavailable for African Americans (Gaitán-Duarte & Estrada-Orozco, 2021). African Americans have the legal right to access health care services in the United States. However, the legal right of African Americans to access health care services does not guarantee access to health care services from any provider.

African Americans socioeconomic conditions may also contribute to their access to health care service challenges. Access to health care services may be affected by where a person lives and how much money a person makes. Access to health care services may depend on the type of health insurance one has and the options that the insurance offers for care. Many African Americans do not have access to health care services, and they do not have access to primary health care providers, medications, or specialty care because they lack insurance (Department of Health and Human Services, 2022). Maness et al. (2023) described access to health care services as a social determinant of health which disproportionately affects African Americans. The National Center for Chronic Disease Prevention and Health Promotion (2023) listed *five indicators related to health care access* that influence access to and use of health care services for African Americans: ZIP code, county, congressional district, city, and state. Primary health care providers are the route of access for most preventive health care services for African Americans. Many African Americans live in areas that dictate their access to health care; these areas are commensurate with lower incomes. The socioeconomic status of African Americans may influence their ability to access health care services.

Health Care Equity and Health Care Equity for African Americans

Health care equity means the same quality of health care services for everyone. Equity in the context of health care services refers to the ability to provide services that are appropriate for the circumstance using equitable processes that have the capability to result in equal outcomes (Servaes et al., 2022). According to Creary (2021), equity involves many factors, and it is a multidimensional concept. Equity is intertwined with fairness, equality, social justice, social inclusion, solidarity, and altruism. In health care services, equity refers to equal treatment for equal need (Paul et al., 2019). Health equity is defined as a process focused on addressing the distribution of social and economic resources among disadvantaged populations (Henson et al., 2019). Health care equity is the fair, just, and equitable management and distribution of services and application of public policy (Tarlton et al., 2020). Equity in health care services for African Americans is seemingly inclusive of a degree of altruism, which is the ability to think for the good of someone else. Equity in health care services is not providing the exact same services to all; it is providing the same quality of health care services to African Americans.

Equity in health care services for African Americans means that the health care services provided to the African American population are of equal quality to those in the rest of the population. Equity for health care services for the African American community means there is more focused attention on the health needs of African Americans (Ortega & Roby, 2021). Gu et al. (2022) explained that equity in health care services for African Americans may be achieved when culturally appropriate health care services are provided to African American patients along with an equalization in the

availability of health care services, the quality of health care services, and the cost of health care services (Gue et al., 2023). The same health care services provided for everyone across the board may be deemed equal. Equity in health care services for African Americans means that the quality of the services is equal.

There are contributing factors to health care service equity for African Americans. Shahidullah and Petts (2023) explained that African Americans are less likely to receive seamless health care services that contribute to health equity. Rudiger (2020) described universal health care as a potential means to provide everyone with the same rights to state-funded health care services, if the funds were distributed equitably. Smalley et al. (2021) explained that health care equity for African Americans in the United States is a privilege, and it requires the right socioeconomic status and the right sociodemographic status. The Research Triangle Institute International (2024) stated that health equity is achieved when social identities, residence in marginalized communities, and a communities' experiences with oppressive systems do not determine the quality of the health care services received. The quality of health care services a person receives may be based on their income and where their home is located. African Americans are more likely to receive poor quality health care services because of their income level and the location of their home.

Inequity in African American Health Care Services

There is inequity in health care services received by some African Americans. Inequity in health care services involves inconsistent access to care and differences in the quality of informal and formal care (Flynn et al., 2020). Health inequities are specific

areas related to socioeconomic status that continually produce known unfair outcomes in health. Health inequities are mixed in with disparities of health such as race/ethnicity, culture, education, and social advantage (Paul et al., 2019). Health care inequities are derived from unaddressed health disparity (Henson et al., 2019). The inequity in health care services for African Americans is entrenched as a part of the systems that should be available to resolve the inequities in health care services for African Americans.

Inequity in health care services for African Americans may be subtle. Inequity in health care services for African Americans may be expressed by the refusal of treatment, discourteous staff, harassment, or negligence (Bulgarelli et al., 2021). The inequity of health care services for African Americans may be physically and mentally detrimental affecting the patients' behavior, whether they further engage or disengage in health care services (Flynn et al., 2020). Unequitable health care services may range from the quality of annual exams to treatment received for a life-threatening illness (Services, 2023). Inequity in health care services for African Americans may be the result of health care policy that shapes health care services in the United States (Paredes, 2022). African Americans must navigate the invisible barriers to receive health care services. Inequity may be the cause of African Americans not seeking or receiving needed the health care services.

There is inequity in health care services for African Americans. In the United States, health care services were derived from social disadvantages and inequities, many of which affect the African communities that might have benefited from the use of appropriate health care services (Nolan, 2021). Smalley et al. (2021) explained that

inequality and inequity in health care services for African Americans are not defined the same. Inequality is to not provide the same services to every patient and inequity is concerned with not providing appropriate services, and it is related to social justice component. African Americans benefit from health care services that consider socioeconomic and sociodemographic factors. Equitable health care is health care made equal for African Americans.

African American Culture in Health Care Services

African American culture has a significant role in health care services. Culture is a system of people, places, and practices used to enact, justify, or resist while focusing on the differences and similarities between groups and their unique experiences (Causadias et al., 2023). African American culture influences health-related values, norms, beliefs, and behaviors people may have regarding their social and physical environments (Elay et al., 2019). African Americans have historical views related to health care services stemming from events such as the Tuskegee syphilis experiments, and more recent events such as lead poisoning in the water systems of Flint, MI (Gibbons, 2019). African Americans engagement with health care services is contextual, potentially through a lens that is culture specific. African Americans' values, norms, beliefs, and behaviors regarding health care services are culturally bound.

Many African Americans prefer a health care provider with the same or similar cultural background. African Americans have reported that culture is a factor in their perceived lower-quality health care services and dissatisfaction with provider encounters (Elay et al., 2019). An environment that is sensitive of culture may improve African

American patients' health care experiences (Cuevas & Obrien 2019). Schiaffino et al. (2020) stated that African Americans' distrust in the health care system may be reduced by the presence of other African Americans, and messages on health care-related services may be more readily received when communicated by members of the African American community in a manner that respects culture. Moss and Crewe (2020) stated that establishing a cultural lens from which African Americans receive health care services may be beneficial when providing health care services to African American people (Moss & Crewe, 2020). African American are more apt to engage in health care services when they feel that their culture, the norms, beliefs, and values are considered when health care services are rendered. African Americans may feel more comfortable when other African Americans are present.

African American culture matters in health care services. Lee et al. (2021) explained that African American culture is grounded in the belief that caring for the ill is a valued task that to be embraced with dignity and respect. Pruski (2019) explained that, in African American culture, religion, family lifestyle, and communication are areas where culture is most evident and most important for health care services. Omenka (2020) expressed that religion and spirituality are intertwined factors that may contribute to health care service engagement in the African American culture. Comprehension of African American culture is crucial for engaging in health care services to African Americans. African American culture is nuanced, unspoken, and deeply rooted in health care engagement with African Americans.

African American Health Care Services and Race

Race is defined in African American Health Care Services. Race is defined as a social construct that includes physical and cultural attributes of African American peoples' health and biology (O'Donnell & Edgar, 2021). According to the U.S. Census Bureau (n.d.), the determination of race is based on self-identification. According to Bonham (2024), race produces categories to place people in separated groups, to minimize people. Race separates people because of how they look, where they live, how much money they make or what their country of origin is. African Americans do not benefit from placement into a group that is stereotypically deemed unequal or unworthy of quality health care services. Race is an arbitrary way to identify and place African Americans in a group.

Race has a role in African American health care services. Elmada et al. (2022) explained that race has a significant influence on health care service quality for African Americans and on the perceptions and the expectations for health care services. Bassett and Galea (2020) explained that, since the founding of the United States, African American people have suffered more illness and death than European American individuals, including dying an average of 4 years earlier than their European American counterparts (Bassett & Galea, 2020). African American people also have higher rates of psychological and psychosocial stress because they face unfair treatment simply for characteristics of their identity such as race, ethnicity, or culture (McClendon et al., 2021). African Americans are likely to receive a lesser quality of health care services

because of race. Race matters when European Americans have fewer instances of negative experiences for the same health care services rendered to African Americans.

Race is a factor in health care services in the African American community. Wijeyesinghe (2021) explained that race classifies people on the random basis of their skin color and how they physically appear; societies have used the outward appearance of people to harness its dominance and remain disconnected. The African American race is connected to a history filled with acts of discrimination and injustice, which may taint their views on health care services (Odhiambo et al., 2019). In the African American community, there is an awareness of race related to health care services (Almomani, 2021). Race and health care services in the African American community are understood based on the characteristic deemed most identifiable, or the color of the skin.

Ethnic Minority as Identified for Health Care Services for African Americans

African Americans in the United States are ethnic minorities. African American people are described as nonimmigrant ethnic minorities who have a historical lineage to slavery (Adams, 2020). Giaquinto et al. (2022) described African Americans as Black Americans who can identify ancestors that were brought to the United States involuntarily as slaves. The identification of African Americans as ethnic minorities could lead to better efficiency in the health care services. Khanijahani et al. (2021) explained that ethnic minority groups are vulnerable populations and are more susceptible to health-care-related disparities, which when understood and addressed, could lead to more efficient health care services. Byer (2020) reported that African Americans as ethnic minorities experience barriers to health care services that are

socioeconomic, geographic, structural, and institutional. Gbadamosi et al. (2022) explained that improving the quality of health care services and decreasing disparity for African American people may be accomplished by taking into consideration their ethnic minority standing and background. African Americans understand that they are Americans and are aware of the distinction as an ethnic minority group in society. Understanding this distinction may result in improved efficiency in the health care services of African Americans.

African American as an ethnic group have existed in health care services. There is a dominant system based on ethnic group membership in the United States; the system is used to justify inequity in health care services for African Americans (George, 2021). Sharad (2023) explained that ethnicity-based health care service inequalities are widespread within the United States and around the world. Li et al. (2021) explained that African Americans as an ethnic group lack trust for health care services. Ethnic group membership should not dictate the quality of the health care services African Americans receive.

Provider Cultural Competency With African American Health Care Services

Provider cultural competency is defined as having a basic level of knowledge regarding culture when providing health care services. Stubbe (2020) explained that cultural competency stresses that health care service providers be informed, attentive and respectful of the significance in the differences in each patients' background. Providers should respect family cultural traditions and language (Stubbe, 2020). Cultural competency involves health care services being provided with consideration for the

cultural background of the receiver (Nair & Adetayo, 2019). Health care providers' beliefs, attitudes, knowledge, and skills serve as the basis for guidelines adopted by the American Psychological Association for culturally competent care (Flynn et al., 2020). Cultural competence in health care may reduce disparity and provide culturally appropriate care regardless of an individual's cultural background (Abualhaija, 2021). Culturally competent health care service providers understand that preconceived opinions regarding African Americans may influence their decisions regarding health care services. Health care service providers should have basic cultural competence to engage African Americans for health care services.

A health care provider who understands the population in which they work is crucial to cultural competency in health care services for African Americans. Cultural competency should be a requirement for health care providers as the demand for culturally competent health care services increases (Langley et al., 2020). The lack of culturally competent health care service providers may lead to inadequately trained health care service providers (Kolapo, 2018). The cultural competency of health care providers reduces stigma, improves continuity of care, and may improve health outcomes for African Americans (Agency for Healthcare Research and Quality, 2021). It is a benefit for African Americans to receive health care services from a culturally competent health care provider.

Provider cultural competency is a skill for health care services provided to African Americans. Healthstream (2021) explained that culturally competent health care providers pay attention to the way culture may influence the health care service

experiences of African Americans; they pay attention to the cultural details that are the foundation for providing high-quality health care services for African Americans. According to Armstrong-Mensah et al. (2022), African Americans may be reluctant to utilize health care services and they may distrust non-African American health care service providers who they may deem as not culturally competent. Boyle (2023) reported that a health care provider of the same race can improve communication and trust for African Americans seeking culturally competent health care services. At a minimum, a health care provider should be aware of the difference that culture brings when providing health care services. African Americans tend to engage or disengage in health care services based on the degree to which they feel comfort in the quality of the health care services provided, including the degree of culturally competent communication with the health care service provider.

Diversity in Health Care Services for African Americans

Diversity in health care professional's ethnicity is important in health care services for African Americans. Servaes (2022) stated that diversity in health care services has the potential to affect health outcomes for African Americans. Zephyryn et al. (2023) stated that diversity in health care services improves access and improves perceptions regarding the health care services received by African Americans. Pizio (2020) explained that health care service provider pools should be diverse, filled with individuals who may address patient-specific needs for African Americans. Health care service providers should have diversity within the staff to allow a focus on patient needs.

African Americans' health care service engagement can be affected by the lack of provider diversity present during a health care service engagement.

Diversity in the ethnicity of health care professional's may be a preference for African American when receiving health care services. Mosher (2022) explained that knowledge regarding African American culture could enhance the quality of health care services provided; a providers' practices and beliefs that allow for embracing diversity may provide nonbiased health care services to African Americans. Feldstein (2023) described diversity in the health care provider workforce as employing African American health care service providers; this may have the potential to narrow health care disparities in African American communities. African Americans may have a preference for and respond in a more positive manner to health care service providers of the same race.

Diversity matters for African Americans when they choose to engage in health care services. There is a need for the development of a diverse health care workforce to provide quality health care services to African Americans. Pinsky (2023) stated that African American health care service providers are more prone to work in African American communities and are more likely to provide quality health care services for African American populations. However, it may be challenging to employ and maintain a diverse workforce when African American health care providers are scarce (Taylor et al., 2022). African Americans may have higher quality health care services with an increased availability of African American health care providers.

The Role of Public Policy in African American Health Care

Public policy principles and laws have a role in African American health care services. Health disparities among African American people may be derivatives of discriminatory health policies (Moss & Crewe, 2020). Hathaway et al. (2023) explained that African American people are more likely to succumb to preventable health-related conditions and lack the ability to receive equitable high-quality health care, partially the result of U.S. health care policies. Ferdinand (2021) stated that a lack of humane care and racist undertones are ingrained in the policies that govern African American health care services. The policies that govern health care services for African Americans may not have been created to provide equitable health care for African Americans.

Health care policy in the United States should have a goal of providing quality, equitable health care services for African Americans. Health care policy decisions regarding African Americans are made by leaders in power. Bassett and Galea (2020) explained that power and money shape societal structures and are significant to health care policy regarding African Americans. Yearby et al. (2022) claimed that disparities in the access and receipt of quality health care services are policy challenges for lawmakers. As explained by The National Academies of Sciences, Engineering, Medicine (2023), federal policies may contribute to health care disparities and may also serve as tools to eliminate health care service disparities experienced by African Americans. Keyes et al. (2020) stated that policy changes may be needed to ensure that actions are taken toward the provision of quality health care services and the reform of social systems that have allowed for health care disparities for African Americans. Some policies that were

designed to help can also cause harm. A policy mandated to provide health care may not mandate the quality of the care provided.

Policy makers can create and implement regulations that affect African American health care services. Clabough (2022) reported that policy makers have sought to address socioeconomic issues in African American communities; however, the request to create new policies and regulations to address health care services for African Americans have gone unanswered. Nolan (2021) reported that, in the 21st century, health care service providers should be educated on the practice of advocating for policies that will benefit African Americans. Gu et al (2023) explained that health care equity for the African American community has become an increasing concern to policymakers as health care services may also be covered by state and local laws governing best practices. Health care policies that guarantee quality health care services for African Americans is needed. Health care policymakers have the ability to mandate the actions that may provide actual quality health care services to African Americans.

Privacy in Health Care Services for African Americans

African Americans value privacy when engaging with health care service providers. Privacy in a health care setting is considered a universal human right and should be considered in conjunction with the cultural values of an individual (Bedriye et al., 2021). African Americans may determine the quality of health care services provided by the level of respect for privacy and dignity offered by a health care provider during an engagement (Hamed et al., 2022). African Americans value privacy in care services and may assess the quality of health care services received based on their engagement with

health care service provider. A health care provider who is culturally astute may positively influence the feelings of dignity and respect regarding privacy for African Americans.

African Americans hold beliefs about health care service privacy that are unique to the African American population. The privacy of African Americans has not always been well protected and has caused some African Americans to be vulnerable to predatory health care practices (Allen, 2022). According to Wells and Gowda (2020), most African Americans have some knowledge of health care history, and their concerns regarding health care privacy may be rooted in the historical health care treatment of African Americans. African Americans may have overarching mistrust when receiving health care services (Lakhani & Cegelka, 2022). Hoadley et al. (2022) stated that African American concerns about privacy may lead to mistrust when receiving health care services and is a potential barrier in health care service use. Nuriddin et al. (2020) explained that African Americans are aware of instances in the past in which privacy regarding the protection of health care information has not been maintained. The health care privacy of African Americans has not always been protected. African American beliefs about privacy in health care services are validated by the history of negative health care practices that seem to still exist for African Americans.

Health Care Professionals' Engagement With African Americans

African Americans have a complex history of engagement with health care professionals. Agyemang-Duah et al. (2021) stated that quality health care services for African Americans may be achieved by successful engagement with health care

professionals. Beverley et al. (2022) explained that a successful engagement with health care professionals is a precursor for African Americans' receipt of quality health care services. Artiga et al. (2024) stated that African Americans who receive health care services from health care professionals of the same race and ethnic background report more positive engagement and feel better about the quality of health care services received. Health care professional engagement may be significant for quality health care services for African Americans.

African Americans may make health care decisions based on perceptions of how engaged a health care provider may be. Lakhani and Cegelka (2022) explained that African Americans reported having poor health care experiences of engagement that may be due to the negative nonconscious feelings and beliefs of health care professionals. Reid (2020) explained that African Americans may be hesitant to engage with health care providers because health care professionals are more likely to inaccurately describe the psychological pain of African Americans. African Americans may make judgements regarding the quality of health care services provided based on engagement with health care professionals.

African Americans may benefit from engagement with community health care professionals. According to Elk et al. (2024), a lack of knowledge and respect for the cultural values of a community compromises the quality of engagement between health care professionals with African Americans. According to Arcaya and Schnake-Mahl (2019), African American communities with improved access to community health care professionals receive a better quality of care when they choose to engage. Rosas et al.

(2020) stated that health care professional community engagement is beneficial for addressing health disparities for African Americans. African American communities may not have health care professionals who are engage with the community.

Dental Care or Oral Health Care for African Americans

African Americans may consider oral health care or dental health care as an addendum to current health care services. Quinn (2023) explained that oral health care is the health care of the mouth, and the mouth may be a window through which illness can enter and affect the body. Oral hygiene is the practice of keeping the mouth, teeth and gums in good health, and oral hygiene practices may vary across cultures (Quinn, 2023). Kwak et al. (2023) explained that dentists treat oral health problems and prevent diseases. According to Muthra (2019), there have been improvements in oral health care for African Americans. African Americans may equate dental care or oral health with health care services and have the same hesitancy to engage for care.

Access to dental care for oral health care for African Americans may be challenging. Ethnic minority neighborhoods often lack sufficient numbers of dental care facilities, which is likely a contributor to disparities in access and use (Chan et al., 2019). Northridge et al. (2020) stated that African American people have disparity in access and quality of dental care resources and are more prevalently predisposed to oral health issues and less than adequate levels of dental and oral health care; the presentation of a great smile is an unofficial socioeconomic indicator. According to Spear Education (2023), good oral health is considered a sign of personal well-being and it affects how society

perceives people. African American cultural practices may be a contributor to the challenges encountered with dental and oral health care.

Dental or oral health care providers should offer patient specific, respectful health care services to African Americans. The Department of Health and Human Services (2024) informed that dentist and oral health professionals would benefit from understanding and respecting individual cultural beliefs and behaviors when providing dental care for African Americans. Choi et al. (2023) explained that the restrained ability to access oral health care or deficit of financial resources needed to receive more advanced services, may underpin some oral health care disparities that are driven by sociodemographic and demographic factors. Dental care or oral care that provides patient specific services to African Americans may influence the quality of oral and dental health care services provided.

Behavioral and Mental Health Care and African Americans

The African American community may be prone to high instances of untreated mental health issues. The Office of Minority Health (2022) explained that mental health is comprehensive, the emotional, psychological, and the social well-being of individuals and describes behavioral health as the actions people take in varying life scenarios. Stare and Fernando (2019) stated that African American people have higher risk factors for mental health disorders. Johnson and Lockett (2023) reported that mental illness is a pervasive issue in the African American community. Yoon (2019) explained that African Americans have a high presence of major depressive disorder and social phobia. Cavalhieri and Wilcox (2022) explained that experiences of historical trauma may

influence the mental health of African Americans. African Americans have the propensity for mental health disorders and also have high instances of untreated mental health disorders.

African Americans may be hesitant to use traditional mental health care services. According to Bolger and Prickett (2021), African Americans may prefer to discuss their health needs with their preacher or a clergy member rather than a health care provider. The Substance Abuse and Mental Health Services Administration (2023) stated that African Americans may experience barriers to the receipt of behavioral health services. Turner et al. (2019) explained that the use of mental health care services by African Americans decreases with age. African Americans may prefer not to use traditional mental health care providers as an option to receive mental health care services.

There may be stigma surrounding the use of mental health care in the African American community. Ochieng and Crist (2021) explained that the stigma surrounding mental health care for African Americans derives from negative labeling and characteristics assigned to African Americans who seek mental health care. Mental health care providers should offer care that is individualized for African Americans and seek to have a greater understanding of African American preferences for mental health care services (Bolger & Prickett, 2021). African Americans may attach stigma to mental health care that may hinder engagement with mental health care providers and influence the ability to receive quality mental health care services.

Pharmacists in African American Health Care Services

Pharmacists in African Americans communities should have an understanding of the African American culture. Gregory (2020) explained that, at a minimum, pharmacists should understand African American culture and understand that health care disparities may exist in African American communities across the United States. Chakravarty (2020) stated that African Americans may be reluctant to ask for assistance from pharmacist due to shame or fear. Clark (2020) explained that pharmacists have a role in mitigating disparity and may have influence on health care service issues for African Americans. Understanding African Americans culture may decrease the reluctance to engage with pharmacist for health care services.

The African American community may have a shortage of pharmacists. Guadamuz et al. (2021) explained that African American communities have a high probability of being pharmacy deserts, which means no pharmacy exists in the community. Wisseh et al. (2021) described pharmacy deserts as locations that do not have a pharmacist within 1 mile; communities that may have more African Americans, people that may benefit from an increased access to pharmacists. Elliot et al. (2020) explained that community-based pharmacists can have an influence on the health services received by African Americans and have a positive influence in the community that may reduce health disparities. Pharmacists in African American communities have an integral role in the receipt of health care services for African Americans.

African American may use holistic medicines in conjunction with prescription drugs filled by a pharmacist. Douglas et al. (2023) stated that African Americans are

affected by their health beliefs and socioeconomic status; African Americans traditionally use home remedies alongside any prescribed medications. Guadamuz (2021) explained that the ability of African Americans to access pharmacist services may be an overlooked contributor to socioeconomic related differences in how patients use prescription medications and they utilized health care services. The use of prescription drugs in conjunction with holistic medicine may be financially necessary and not an option for African Americans.

I maintained security of the data collected for the research study. Secure data stored on devices was password protected and encrypted with VPN, the data was secured in a locked cabinet in my home office per (University of Colorado Colorado Springs, 2022) that explained that any hard copy documents, should be kept in a personal secured space, in a safe environment, and locked. I reviewed the dissertation again to ensure all personally identifiable information has been removed. Pfaff et al. (2022) explained that fields that contain personally identifiable data should be reviewed to assure the information is removed. I have made all of the collected data available to my committee members to review. The research study committee members have kept the personally identifiable information of each participant confidential. The data, digital and physical, is being kept for a period of 3 to 7 years, after which the data will be destroyed by shredding, by overwriting.

Summary and Conclusions

Chapter 2 began with an introduction, the literature review strategy and the theoretical foundation. The chapter continued with case reviews using the HBM. The first

section included the HBM used to understand elderly engagement, the HBM and African Americans with sickle cell disease, the HBM to examine African American women's breast cancer, eating disorders and the HBM, the HBM and young adult behaviors, the COVID19 pandemic and the HBM, male teacher quality of life and the HBM, and why the HBM was chosen for the study. The next section began with defining health care service providers and health care access for African Americans, health care equity and health care equity for African American, inequity in African American health care services, African American culture in health care services, African American health care services and race, ethnic minority as identified for health care services for African Americans, provider cultural competence with African American health care services, diversity in health care services for African Americans, the role of public policy in African American health care services, privacy in health care services for African Americans, health care professionals engagement with African Americans, dental care of oral health care for African Americans, behavioral and mental health care and African Americans, and pharmacists in African American health care services.

Chapter 3 begins by discussing the methodology of the study.

Chapter 3: Research Method

Introduction

The purpose of this generic qualitative research study was to explore how middle-aged African American adults experience engagement with non-African American health care service providers. This chapter includes details on the research design and rationale, the role of the researcher, strategies for participant selection, methods of data collection, and data analysis. The chapter also includes details on ethical procedures and trustworthiness that are applicable to this study.

Research Design and Rationale

I used a qualitative research methodology to explore how middle-aged African American adults experience engagement with non-African American health care service providers. Nassaji (2020) defined qualitative research as a naturalistic inquiry that is best utilized with nonnumerical data. The goal of a qualitative researcher is to understand and explore and not attempt to explain and make use of variables. According to Aspers and Corte (2021), qualitative research is a repetitive process in which understanding is gained through revelations of new data with the repetition and review of the research on the phenomenon studied. White and Cooper (2022) described qualitative research as an attempt to comprehend the difficulty of a phenomenon and convey clarity of the phenomenon by highlighting its qualities; hence, the aim of qualitative research is to highlight a point of view on the issue under study. Busetto et al. (2020) explained that essential to all qualitative methodologies is that perspectives related to the topic of interest are necessary and best revealed from personal experience with a topic of interest.

A qualitative research method allowed for gathering of the participants' perspectives and experiences of how middle-aged African American adults experience engagement with non-African American health care service providers.

I used a generic qualitative research study. I chose a generic qualitative research design for its adaptability to the needs of the research. Pilcher and Cortazzi (2024) explained that the generic qualitative inquiry can be used to explore people's recollection of particular opinions, attitudes, beliefs, or memories of their experiences in the world. Ellis and Hart (2023) explained that the generic approach is a standalone design that is inherently flexible and offers descriptive research data that include personal perspectives. Waalkes et al. (2024) explained that the generic qualitative approach has no set philosophical assumptions and no predetermined methods as guides. A generic qualitative research study allowed for flexibility to explore the research topic and gather information for documentation of descriptive details about the research topic.

I considered other qualitative research designs for this study. I considered using a qualitative case study and ethnography for the research design. Priya (2021) defined a case study as a design that uses the researcher to thoroughly examine a program, one or more participants, an event, an activity, or a process in the arena in which it occurs; more than one method may be used. The University of Princeton (2024) described ethnography as a research design that allows for understanding the world from the standpoint of its relationships to culture and people and involves on-the-scene learning. I did not choose to use ethnographic study because it can be specific to a location or the site of a study and

can be lengthy. I did not choose a case study as case studies should be specific to a group of people or circumstance.

Role of the Researcher

The qualitative researcher is considered an instrument of research. Wa-Mbaleka (2020) explained that qualitative research data are collected using varying instruments; however, the qualitative researcher is considered a research instrument. Morselli and Marcelli (2022) explained that a qualitative researcher educates themselves within their environment, seeking to gain clarity on phenomena in regard to the meanings that participants assign to them. Mozersky et al. (2021) stated that qualitative researchers frequently study sensitive, stigmatized issues with vulnerable populations and must take care not to undermine the trust of participants and prevent their honest disclosure. The qualitative researcher as an instrument has an integral role in the qualitative research process. I selected study participants, collected and analyzed data, interpreted results, and created a written report of the research study findings in my role as the researcher.

The researcher must protect participants' safety and seek to protect the data that are provided by participants. I was responsible for being objective and avoiding any perceptions of negative bias that might be reflected in the study. I was responsible for ensuring that the study met institutional review board (IRB) and federal standards regarding ethical research on human participants. I protected participants' privacy and confidentiality. I did not seek to exert power or control over any participant in any manner. I did not have personal or professional relationships with research participants. My role as a researcher was to be impartial.

Ethics are an important consideration in the role of a qualitative researcher. As the researcher, I adhered to the principles of the Belmont report. According to McNair (2022), the Belmont Report is the primary code of conduct for ethical research, establishing three key fundamental principles of research ethics: respect for persons, justice, and beneficence. It was ethical for me as the researcher to offer a token of appreciation. I offered \$15.00 gift cards as tokens of appreciation, which did not interfere with the will to participate or the will not to participate in the study. The Committee (2020) stated that it is ethical to offer a token of appreciation that does not interfere with the voluntariness of participation. As the researcher, I sought to protect the participants' privacy. The research participants were asked to sign a consent agreement documenting participant consent for the study. The ethical considerations in a qualitative research study are aimed at protecting the person and the data.

Methodology

Participant Selection Logic

The target population was African Americans of either gender with the experience of receiving health care services from a non-African American health care service provider. Thacker (2020) described a population as a complete set of people with specified characteristics. Ahmad et al. (2023) explained that having extensive knowledge about a specific segment of people in society allows the researcher to be descriptive about the group and create the relevance boundaries for research information obtained. African Americans of either gender were the selected target population for the research. The selected population for research, the African American population, is dispersed

throughout the United States. Services U. D (2024) explained that identification of a person as African American refers only to people who are born in the United States who have darker skin and have ancestry that originates in Africa. According to Moslimani et al. (2024), the Midwest is host to the second largest African American population in the United States. NUniversity (2023) defined a sample population as a subset of the target population that is labeled with relevant characteristics related to the research being conducted. Middle-aged African Americans were the sample population selected for this research.

I used purposeful sampling to identify the potential participants within the target population. Purposive sampling denotes the selection of research participants who can specifically speak on the research and have direct knowledge of and experience with the topic of study (Doyle et al., 2020). According to Campbell et al. (2020), purposive sampling allows specific matching of the sample population to meet the objectives of research. The sampling strategy was relevant for selecting subpopulations of middle-aged African American adults to potentially participate in the current research study. I purposefully selected my participants by posting on Facebook asking for participants expressing interest in the current research study on how middle-aged African American adults experience engagement with non-African American health care service providers.

I had planned to use snowball sampling if I did not obtain enough participants using purposeful sampling. Chan (2020) explained that researchers use snowball sampling to collect information from connections to the initial sample source, collecting data from the friends, neighbors, or family of the original data source. Simkus (2023)

explained that snowball sampling begins with a few of the remaining members from the initial proposed group, and the original members refer other potential respondents from the identified research study population. The use of snowball sampling is a suitable option for identifying members of a population that may not be easily identified. I would have used selected participants who had been referred from the initial respondents (participants who voluntarily responded to the Facebook posting with interest in participation in the study).

I screened participants to ensure that each participant met the criteria for the study. The participant recruitment announcement was posted on the social media platform Facebook. The potential participants' eligibility was confirmed at the time that their contact request was answered. The participants were identified as middle-aged and African American adults and stated that they had sought health care services from non-African American health care service providers in the past. The participants stated that they were over 18 years of age and did read, write, and speak the English language.

The proposed sample size for the research study was nine to 17. Hennink and Kaiser (2022) stated that qualitative research uses small sample numbers, between nine and 17 interviews. Sharma et al. (2024) explained that the use of six to 12 participant interviews was deemed appropriate for one project using purposive sampling. The choice of nine to 17 as a sample size is common when using qualitative research. However, the final sample size for this research was determined by saturation. The study sample size used for research was nine participants. Mwita (2022) stated that saturation happens when there are no new or relevant data being collected from participants for a study.

Chitac (2021) described data saturation as a yardstick for determining sample size.

Sharma et al. explained that saturation is broadly accepted as the standard that suggests the point to discontinue data collection in qualitative research. I knew that I had reached saturation when the interview responses began to repeat themselves and no new relevant responses were being received. The sample size for the current research was determined based on data saturation.

Instrumentation

I used a qualitative interview protocol to collect data. Crabtree and DiCiccio-Bloom (2006) explained that the purpose of the qualitative interview protocol was to contribute to a body of knowledge based on the experiences of the interviewees. Cohen and Crabtree (2006) explained that the interviewer creates an interview guide and creates a list of questions and topics to be covered in a specific order when collecting data. I created a qualitative interview protocol based on research by Crabtree and DiCiccio-Bloom. I created six interview questions, each focused on the varying aspects of the research question. The exact questions were asked of each participant. The interview protocol is included in Appendix A.

I used an expert panel to review and validate the interview protocol. I requested that a mental health counselor with experience teaching psychology and knowledge of qualitative research review the interview protocol. I also requested a mental health advocate with extensive experience managing patients with posttraumatic stress disorder and other mental health diagnoses. The two professionals had no involvement in the

research being completed. I reviewed and addressed any requested editing of the interview protocol that the expert panel members suggested.

Procedures for Recruitment, Participation, and Data Collection

As the researcher, I needed to seek Walden University IRB approval before I could recruit participants. I planned to recruit participants from Facebook. I created an account specifically for the purpose of the study. The Facebook advertisement included my contact information, a phone number and an email address, to allow interested participants to respond and request more information or make contact and agree to participate. The study flyer provided the study inclusion criteria, the purpose of the study, and my contact information for those interested in participating.

I sent each participant who responded an email with information on the study. A participant who agreed to be a part of the study and met the eligibility criteria was provided an informed consent document that they had to return to me prior to any data collection. I collected their email address at the time of the initial response, which was used to send them a copy of the informed consent form and was also used to schedule the interview. The interview was scheduled at a time that was convenient for each participant. I provided each participant with my return email address for the return of email responses. Except for the consent form, I did not provide any other identifying information on any other form, and I gave each participant a pseudonym that only I knew.

Data Collection

I conducted semistructured interviews via the Zoom platform at the date and time that was scheduled for each participant. I conducted the scheduled interviews from my home, a private and secure location. I conducted the semistructured interviews; each allotted approximately 45 minutes to 1 hour. I possessed onsite a second device that was secured with a passcode as an option for backup recording. I informed each participant again at the start of the interview that I would be using a recording device, the permission for which was obtained in the informed consent. I reviewed the informed consent document with participants prior to beginning each interview. I reminded each participant that agreeing to be a part of the study interview was voluntary and that they could choose not to answer any question or could stop the interview at any time. I then began to record and began to ask the interview questions.

I informed participants of the next stages of the research process at the end of each interview. I informed participants that the information they had provided in the interview would become a transcript and would be reviewed by me and would be transcribed, and the data would be analyzed. I informed each participant that a copy of the transcript would be sent to them in an email for their review. I informed each participant that they would receive a \$15.00 egift card as a token of appreciation for taking part in the study. I asked the participants if they had any questions and addressed any that were asked. I thanked each participant for being a part of the study.

I completed the interviews and began the process of transcription. I used the Zoom transcription service; the Zoom application maintained a record of the interview

and transcribed the interview once it was completed. There was no participant information shown on the final transcripts; participant pseudonyms were used. I offered each participant the opportunity to review a copy of their transcript for accuracy. A participant had the option to make a correction if needed on the transcript.

Data Analysis Plan

I used Saldana's (2013) qualitative data analysis to analyze my data. Saldana listed a four-step process to be followed for thematic analysis of data. The first step is the first cycle coding, which is identifying the codes in the data. The second step is second cycle coding, which involves creating categories of codes in the data and developing high level categories of data. The third step is to review high-level data categories and synthesize each. The final step is to apply any emerged themes to the research question, identify patterns, and iteratively refine categories until theoretical saturation is achieved. The process is described as an iterative and cyclical process.

I conducted thematic analysis using the guiding principles of Saldana's (2013) four-step process for thematic analysis:

- Step 1: First cycle coding or initial coding: I assigned basic codes to the data segments. I used the participants' own words for coding. I took specific phrases or keywords from the information provided by the participants to categorize and analyze the data.
- Step 2: Second cycle coding: I grouped related codes into categories and identified relationships between them. I organized individual codes that shared

similar meanings or concepts under broader headings that would allow me to identify patterns and relationships in the data.

- Step 3: I analyzed the established codes, placed them into categories, and identified any relationships. I categorized them by grouping similar codes together based on their meaning or subject matter. I identified relationships between categories by looking for patterns of co-occurrence in the data.
- Step 4: I identified any emerging themes. I reviewed and compared the coded data in different categories and looked for any recurring patterns, connections, and interpretations that were unique. I took notes to document my insights during the review and identified any overarching themes that emerged from the data.

I repeated the steps in the coding process until no new insights in the data emerged.

I planned to identify collected data that was significantly different or an outlier. Nowak-Brzezińska and Lazarz (2021) defined an outlier as a response that deviates from the recurring themes that have been identified in the majority of the data collected in the study. Janoudi et al. (2024) stated that an outlier deviates from the other data collected, it does not conform to what was normal. I thoroughly reviewed any new information gained from an outlier for new and relevant content. I thoroughly reviewed the collected data and sought to understand any anomaly. I verified with the participants that the statements accurately captured their responses. I explored whether the data should be further explored for the current research. Any data could have been further explored by other research in the future, and I would present the data in Chapter 4.

Issues of Trustworthiness

A study should convey trustworthiness to an audience. Lincoln and Guba (1985) explained trustworthiness as the extent of confidence in the methods, interpretation, and data required to ascertain a study's quality. Lincoln and Guba explained that trustworthiness is determined by the ability for an audience to be persuaded that the results of a study are worthy. There are four pillars utilized to convey trustworthiness in qualitative research: credibility, transferability, dependability and confirmability. The four pillars of trustworthiness are described below.

Credibility

Credibility in research is a pillar of trustworthiness. Credibility is confidence in the accuracy of findings from a study (Stahl & King, 2020). Ahmed (2024) described credibility as key criteria for assuring quality; credible data are considered a true representation of the subject matter. Korstjens and Moser (2018) stated that credibility refers to the degree to which research can be deemed responsible and accurate. Ahmed (2024) explained that credibility involves building a rapport with participants to understand their perspectives, experiences, beliefs, and behaviors. Credibility in qualitative research promotes research accuracy. I conducted a transcript review and member-checking to ensure credibility within the findings. McKim (2023) explained that member-checking is a process in which interview transcripts are provided to some or all participants for feedback. I used member checking to provide credibility for the data. I used reflexivity. Olmos-Vega et al. (2022) explained that the practice of reflexivity is used to improve credibility in the research, as it is aimed at reducing personal bias during

data collection and analysis and actively examining any judgments. I continued to collect the research data through saturation. Rahimi and Khatooni (2024) explained that reaching saturation helps confirm a thorough understanding of the research topic. I conducted a transcript review, member checking, reflexivity, and seek data saturation to confirm credibility in the study.

Transferability

Transferability is a pillar of trustworthiness. Stahl (2020) explained transferability as patterns and descriptions gained from one context that may expand understanding when the findings are transferred to other context, circumstances, and settings. Kakar et al. (2023) explained that transferability is applicable when readers can associate the study results with their own experiences. Drisko (2024) described transferability as a process used to apply information drawn from persons, settings, and eras to others that have not been directly studied. Transferability assures that enough detail is provided in the research data to assess trustworthiness. To ensure transferability, I utilized detailed descriptions and reflexivity. McElfresh (2024) explained that transferability uses thick description that involves providing thorough details on participants, methods, or procedures used to collect data during the study. I used reflexivity for self-reflection to highlight any biases. Peddle (2021) explained that developing personal self-awareness and enlightenment can challenge the researcher to remain ethical. I used thick description and reflexivity to convey transferability.

Dependability

Dependability in research is a pillar of trustworthiness. Megheirkouni and Moir (2023) defined dependability as the stability of research findings over time and the ability to replicate the research using the processes through which the research findings were achieved. Petre (2021) explained that dependability is achieved when the study findings are consistent with the data presented. Dependability, the ability to trust the research, is important for trustworthiness. To ensure dependability, I kept an audit trail and coded and recoded the data to establish dependability. Megheirkouni and Moir (2023) described an audit trail as a transparent description of the stages of research from beginning to end. I documented the data collection methods, provided detailed interview questions, and participant selection criteria with the goal of allowing other researchers to replicate my study. Awan et al. (2023) explained that one mode for maintaining dependability is to code and recode the data. I coded and recoded the data to establish dependability. Dependability was established by keeping an audit trail and coding and recoding the research data.

Confirmability

Confirmability is a pillar of trustworthiness in qualitative research data. Adler (2022) explained confirmability as the degree to which the findings and interpretations are objective, dependable, and credible. Novak and Jen (2024) explained that confirmability is achieved when it was known that the research findings were shaped by the participants' voices and not bias or motivation of the researcher. Nyirenda et al. (2020) described confirmability as researcher neutrality, conducting research that is free

from any conscious bias. Confirmability contributes to trustworthiness when the research data conveys no biases. To ensure credibility, I used reflexivity, member checking, and the use of an audit trail to convey confirmability for the study. Nyirenda (2020) explained that reflexivity may be used to allow the researcher to consider and acknowledge how beliefs and experiences can influence the research process. Megheirkouni (2023) explained that member checking will allow experienced persons to review the data and the research process and challenge the research assumptions. Stenfors et al. (2020) explained that an audit trail can keep track of how the research findings were made through detailed descriptions. I conveyed trustworthiness in the research study by using reflexivity, member checking, and the creation of an audit trail.

Ethical Procedures

I adhered to rules regarding ethical research guidelines and will take appropriate safeguards to respect and protect all participants' human rights and privacy. I obtained approval from Walden University IRB before beginning any research. The Belmont Report (Office for Human Research Protections, 1979) is the seminal document establishing guidelines to do no harm, receive informed consent, and establish that the risk of research may not outweigh the gain. The Belmont Report (Office for Human Research Protections, 1979) further stated there are basic principles relevant to ethical research involving human subjects: respect of persons, beneficence, and justice. The National Organization for Human Services (2024) explained codes of conduct and guidelines are designed to help professionals perform roles in which moral dilemmas may be faced and aide in accountability. Gabel and Mapp (2019) described a just society as

one with inherent dignity and value of all humans and their participation in decision making. I maintained the participant's confidentiality by using pseudonyms. I used pseudonyms that may include letters and numbers to replace any personally identifiable information of the participants.

Ethical considerations should be made to ensure each participant has autonomy. The research participants should not be coerced nor should they be manipulated during the collection of data (Barrow et al., 2022). I used the informed consent document to ensure the participants autonomy. A participant who chooses to sign an informed consent document acknowledged their voluntary decision to become a part of the research study. The informed consent document also informed participants of their rights. Florea (2023) explained that a participant may withdraw from a study at any point; participants do not have to provide a reason for withdrawal and all data collected would be destroyed after any participant withdraws. A participant may withdraw from this study at any point by notifying me in person, by phone, or email. All information collected on the participant will be destroyed if a participant chose to exit the study.

I have maintained security of the data collected for the study. Secure data stored on devices has been password protected and encrypted with VPN; any paper data has been secured in a locked cabinet in my home office. University Colorado Colorado Springs (2022) explained that physical data, such as hard copies of the transcripts, should be kept in a personal safe, protected and locked. I have reviewed the dissertation again to ensure all personally identifiable information has been removed. Pfaff et al. (2022) explained that fields that contain personally identifiable data should be reviewed to assure

the information is removed. I have made all the collected data available to my committee members to review. The data, digital and physical, is being kept for a period of 3 to 7 years, after which the data will be destroyed by shredding or by overwriting.

Summary

In Chapter 3, I provided an overview of the research methodology used in the present study. I used a qualitative research methodology and a generic qualitative approach for the research that allows me to explore the perceived experiences of the participants. The qualitative researcher is an instrument and has an integral role in the qualitative research process (Wa-Mbaleka, 2020). I am the researcher and the developer of the current research design. The general population for the research study is African Americans. The target audience for the research study is middle-aged African American adults who have sought health care services from non-African American health care service providers. I discussed the selection of study participants and the methods. I used purposeful sampling to select nine participants who meet the study criteria. Hennink and Kaiser (2022) stated that qualitative research uses small sample numbers, between nine to 17 interviews. I did not begin the data collection process until I received Walden IRB approval. I discussed the use of the guiding principles of Saldana's (2013) 4-step process for thematic analysis. I discussed issues of trustworthiness, credibility, dependability, transferability and confirmability. I discussed the ethical procedures of the study. In Chapter 4, I discuss the results from the research data.

Chapter 4: Results

Introduction

The purpose of this generic qualitative research study was to explore how middle-aged African American adults experienced engagement with non-African American health care service providers. The following research question guided this study: How do middle-aged African American adults experience engagement with non-African American health care service providers? The sections in this chapter include the study setting, demographic, data collection, data analysis, evidence of trustworthiness, results, and summary.

Setting

The setting for data collection was generally ordinary, as there were no unusual occurrences that would affect the collection of data. The interviews were conducted via the platform Zoom. I preserved the identity of the participants and kept them confidential by using Zoom audio only for the interviews. Each participant selected a private location from which they could connect by phone to Zoom for the interview. I utilized a noise reducing machine for additional diffusion of the noise and for additional privacy during the interviews. The sociopolitical climate in the United States has elevated levels of tension and ongoing public discourse since the 2024 election. African Americans as an ethnic group and the topic of health care can be sensitive to discuss. However, I was not given any indication that any participants were influenced by the sociopolitical climate.

Demographics

The qualitative inquiry did not require the collection of demographic information. There was not any demographic inquiry included in the data collection instrument for the research study. The interested participants were required to meet the inclusion criteria. Data were collected from participants who were African American, ages 35-65, who had sought health care services from a non-African American health care service provider.

Data Collection

To collect data, I placed a recruitment announcement for the research study on the social media platform Facebook upon receiving approval from Walden University IRB. The recruitment announcement was posted on Facebook on March 4th, 2025 and removed on May 13th. The recruitment announcement included my designated contact phone number and email address. I received participant inquires expressing interest in the study. I validated that each participant met the study inclusion criteria to participate. I sent each interested participant an email with a consent form to be returned to me noting, "I consent," indicating their consent to participate in the study. The consent document provided each participant contact info for the Research Participant Advocate at Walden University and the Crisis Line for support while participating in the research study. The consent form includes information for each participant on the risks and benefits of the study.

I scheduled each interested participant's interview and used a Zoom link to make contact on the date and time scheduled. I read the interview protocol to each participant and advised each of the approximate length of the interview, 45–60 minutes, to respond

to the six interview questions. I asked each participant if they had questions before I began. I assured the participants that their personal information will be kept safe and confidential. I informed each participant that the interview could be ended at any time with no explanation. The participants were informed that no identifying information would be published. I thanked each participant for agreeing to become a part of the study.

I used the Zoom platform to record and transcribe the interviews. I reviewed each transcript and cleaned each of obvious grammatical errors and speech nuances. The transcripts were cleared of identifiable information and a copy was sent to each of the participants for their review. Each participant reviewed and returned their cleaned transcript acknowledging the transcript's accuracy.

I completed nine interviews before considering that I had reached saturation. The interviews varied in length. The shortest interview was 9 minutes and 32 seconds. The longest interview was 23 minutes and 39 seconds, making the average time 13 minutes and 36 seconds. The time that each interview began was documented. Zoom recorded the starting time and the ending time of each participant interview.

Data Analysis

I used Saldana's (2013) four step qualitative data analysis process to analyze my data. I reviewed and examined the data thoroughly to become familiar with the data. I reviewed the interview transcripts and notes multiple times before beginning to review the participants' actual words for coding. I added each participant's interview questions and each participant's interview answers with notes to an Excel spreadsheet labeled with a unique identifier for each participant. The Excel spreadsheet had a space for codes,

categories, and themes, and additional space added for notes taken during the interview process. The first step used from Saldana's (2013) four-step data analysis was identifying the codes. I studied each transcript and assigned codes to the data segments using the participants' own words. I created codes by picking meaningful phrases and keywords from the information provided by each participant. The second of the four-step data analysis process followed was to create categories. I organized the codes with similar meanings into broader headings to create categories. The third step was to create themes; themes were the organized high level data categories that conveyed patterns. The fourth and final step in Saldana's (2013) four-step data analysis process was to apply the emerged themes to the research question.

I extracted the codes, categories, and themes from data collected from each participant. Figures 1–5 show examples of the described using Saldana's four-step data analysis.

Figure 1

Qualitative Data Analysis Cloud, Theme 1

Theme 1: Middle-aged African American adults desire health care services considerate of culture

Codes

They did their job
 It was always awkward
 It was not a language barrier
 but a cultural barrier
 It's hard to interact
 Very Black and White
 Get right to business,
 Try to rush you out

Categories

Culturally unresponsive
 Basic health care
 Barriers to care
 Lack of sensitivity
 Discomfort

Figure 2*Qualitative Data Analysis Cloud, Theme 2*

Theme 2: Middle-aged African American adults face challenges communicating with non-African American health care providers

Codes

You've got to tend to the patient's needs
 Have a conversation not be uncomfortable,
 You might be able to help them if you know a little more about them
 I'm going to prescribe you something and usher you out the door

Categories

ineffective communication,
 Impersonal care
 Ineffective patient engagement
 Patient disregard

Figure 3*Qualitative Data Analysis Cloud, Theme 3*

Theme 3: Middle-aged African American adults have varied experiences with non-African American health care providers

Codes

When I have a report that comes in his office is responding to my report within 24 hrs
 To me it makes it difficult to switch providers
 My provider is just phenomenal
 My gynecologist is a Caucasian male
 I am blessed with great providers
 Providers need to be more aware of any unconscious bias
 Providers should not necessarily put all African Americans in some category,
 Providers should not believe myths about African Americans like they have Less pain,
 African Americans may not speak up
 Non-African American providers need to be able to communicate and make comfortable to discuss issues

Categories

Positive experiences
 Satisfactory care
 Efficient care
 Quality care

 Provider engagement
 Responsive care
 Unconscious bias
 Myth based behavior
 Negative experience
 Barriers to care
 Cultural Awareness

Figure 4*Qualitative Data Analysis Cloud, Theme 4*

Theme 4: Middle-aged African American adults experience unconscious bias when receiving health care services from non-African American health care providers

Codes

I was having heart arrhythmia
 He's like, oh, I don't hear any issues, it sounds just fine
 My heart would race really fast and then kind of stop
 I'm not leaving until we figure something out

Categories

Advocate for care
 Dismissal of care
 Unconscious bias
 Perceived judgement

Figure 5*Qualitative Data Analysis Cloud, Theme 5*

Theme 5: Middle-aged African American Adults experience systemic limitations when receiving health care services from non-African American health care providers

Codes

It's kind of a necessity that I kind of don't have a choice
 A return for out of pure necessity
 If I had a choice I would not
 I would not return

Categories

Provider selection limited
 Necessary care usage
 Negative care experience

I used the codes and categories that came from the data to develop themes. I created five themes that came from the codes and categories derived from the data:

- Theme 1: Middle-aged African American adults desire health care services considerate of culture
- Theme 2: Middle-aged African American adults faced challenges communicating with non-African American health care providers

- Theme 3: Middle-aged African American adults have varied experiences with non-African American health care providers
- Theme 4: Middle-aged African American adults experience unconscious bias when receiving health care services from non-African American health care providers
- Theme 5: Middle-aged African American Adults experience systemic limitations when receiving health care services from non-African American health care providers

The final step was applying the themes derived from the codes and categories to the research question.

A potential discrepancy existed. Each of the participants described engagement with a non-African American health care providers, but Participant 8 did not have any engagement with an African American health care service provider; this may be an outlier. I asked Participant 8, “How would you describe the quality of health care service visits that you received from non-African American health care service providers?” Participant answered the question, “Well, because I haven't experienced, I guess African American health providers.” I clarified the question and asked, “ So that I am clear, you've only had experiences with non-African American health care service providers, am I correct?” Participant 8 answered, “Right, so that's the only thing that I have to, you know, base it on.” I determined that there is no discrepant case because Participant 8 was able to address the research question based on health care services received from a non-African American health care provider.

Evidence of Trustworthiness

Credibility

Credibility in the research study was gained from thoroughly reviewing the data to understand its context. The Zoom platform was used to audio record and transcribe the participant interviews. I compared the audio recordings and the transcribed interview copy for accuracy. I maintained a second audio recording device to assure my ability to accurately capture the data. I used member checking to assure that the cleaned transcripts represented the words in the correct context for each participant. The participants were sent a copy of their cleaned transcript via email. The participants reviewed the transcripts and agreed that each was accurate.

Transferability

To ensure transferability, I provided descriptions with in-depth details that explained how the research was completed. I gave details on the setting, the demographics or participants in the research for the current study, and the environment relevant to the study. The details are sufficient to allow a reader to determine if the study may be applicable to another topic or circumstances being researched.

Dependability

The dependability of research is assured through thoroughly documented processes. The participants were each required to meet the participation criteria. I provided each participant with the ability to review and confirm the accuracy of the data gained from their interview. Member checking was used; each participant received a copy of their interview and could respond with corrections to content or context if

needed. To avoid potential bias and assumptions, I utilized self-reflection and documented my thoughts and feelings through the research process.

Confirmability

Confirmability is the ability to verify the legitimacy of the research findings. The confirmability of the current research can be validated based on member checking. I provided each participant with a cleaned transcript to review and confirm the accuracy of its data and context. I used reflexivity to document my personal feelings and potential bias hoping to avoid any influence that could be caused. I have audio recordings and the transcribed data from each participant interview to establish confirmability.

Results

The study findings are reported in Chapter 4. The study findings explored the experiences of middle-aged African American adults seeking health care services from non-African American health care service providers. I used a qualitative research strategy and collected data using semistructured interviews designed to engage participants and allow exploration of their personal experiences of engagement. The chapter is organized to provide a detailed account of the themes that emerged from coding and categorizing the data gained from participants.

Theme 1: Participants Experienced Communication Challenges With Non-African American Health Care Providers

The participants in the study experienced communication challenges engaging with non-African American health care service providers. The participants recounted their experiences of engagement with non-African American providers, highlighting the

significance of effective culturally significant communication. The participants expressed a lack of meaningful engagement, which had the ability to influence the care received.

Participant 4 explained an encounter with a non-African American provider,

I would say that it is a little difficult. I don't know if further down the interview I'll be able to talk about the situation. But I know especially for my OBGYN, I actually had to switch to another Doctor at the beginning of my pregnancy because the care was lacking, and as far as my primary sometimes we have to have more in-depth conversations so that I can get certain types of care. Because some things are just kind of brushed under the rug, you would say when trying to explain an issue that I may have.

Participant 1 detailed an experience of engagement that highlighted similar feelings as Participant 4, a feeling of being unheard or unacknowledged. The participants described feelings of being talked at, instead of being talked with. The participants described difficulty in having their health care concerns addressed. The non-African American health care provider was perceived to be making decisions without full consideration for the patients' actual need.

The participants had experiences in which non-African American health care providers checked blood pressure and performed test without precursory information or exams. The assumptions made by non-African American health care providers based on such experiences may cause African Americans to suffer from illness or disease.

Participant 1 described,

Most times the services were satisfactory and I was pleased. But there, there have been multiple times where I had to force the issue. I had to say, hey, you know I came in here for. I came in here for knee pain, and you haven't done anything to address my issue. You did a checkup, you did blood work, you have done all that, but you still haven't addressed my knee pain. A lot of times you got to hold them accountable and follow up asking questions and make sure you're getting the services that you went in there for.

The participants described feelings of not being acknowledged. Participants discussed communication barriers while receiving health care services from non-African American health care service providers. Participant 7 described an engagement with a non-African American health care provider, "They would have to be open to listening more than anything. So that they can get a better understanding, not just disregarding us and just shooting down what we're saying." The participants recounted experiences that emphasized the importance of communication that incorporates patient input and the conscious effort to make human connections with patients. A conscious effort to connect with African Americans might eliminate breakdowns in patient communication.

Theme 2: Participants' Desire for Health Care Considerate of Culture

The participants shared that they desired health care considerate of culture with non-African African health care providers. The participants provided accounts in which knowledge of African American culture could have been integral to improving the quality of health care services that they each received. Participants expressed feeling that their concerns were dismissed and the responses from non-African American health care

providers were generalized. Participant 2 conveyed the difference in a dismissive non-African American provider and a culturally informed health care provider who validated and addressed the patients concerns. Participant 2 explained,

I think the other experience that I have at times is not indifference, but nonchalance. I still remember, you know being across from my pediatrician at about 18. At that point I was a freshman in college, and I still remember, you know sharing with my then pediatrician to say, I didn't get my Period very often, and he was like, oh, that's no big deal. I'm like that's a big deal, and it was ironic to me that years later, when I had my first, you know, Black health care provider, a woman in New York, an OBGYN. You know she did extensive testing. I didn't even know that I had PCOS until I was 36-years-old.

Participant 3 explained a similar experience receiving services from a non-African American provider lacking cultural knowledge. The participant described an experience in which a non-African American provider did not know how to provide culturally appropriate care for an African American patient. The participant described an experience that could impact the quality of health care services received. Participant 3 recounted,

The quality of service that I get here with the health care provider has been pretty good. But there are times when I cannot get someone to give me the services I need because, they would tell me, some Doctors have told me in the past that they don't know how to take care of African American skin. So I'm not able to get doctors sometimes, or they may say. I don't know if this is going to be a problem for you, based off of fact that African Americans historically have high blood

pressure, because their parents have high blood pressure. I have had statements like that, they say that it is hereditary. I don't know if it is hereditary, I just had high blood pressure, but they weren't able to tell me why was my blood pressure was high? So there are some disadvantages on that part.

The participants recounted experiences with non-African American health care service providers highlighted the generalized and stereotypical health care services received by some African Americans. Non-African American health care providers may base health care decisions on broad assumptions without cultural knowledge. Participant 1 shared thoughts about experiences receiving care from non-African American health care providers,

You get accustomed to going into hospitals, going into clinics, and just expecting that there not be any African American providers, expecting those cultural barriers. You never like them, but you just kind of expect them, and that's unfortunate for African Americans, that you expect that there's not going to be a level of connection with you like there would be for other patients. Because other patients see people like them on the provider side, on the health care provider side." Generalizations, stereotypes, and the lack of diversity left some African American participants feeling that they were not receiving optimum health care services.

Participant 5 and Participant 2 highlight the importance of self-advocacy in health care settings, especially when patients engage with professionals who may operate based on generalized medical beliefs. Participant 5 felt compelled to speak up based on past

experiences. Participant 2 felt concerned by the perceived persistence of bias among health care providers. The concern was more significant when medical professionals rely on inaccurate beliefs that disproportionately affect the African American population.

Theme 3: Middle-Aged African American Adults Have Varied Experiences With Non-African American Health Care Providers

Some African Americans expressed satisfaction with the health care services received from a non-African American health care service provider. The participants expressed interpersonal connections and attentiveness during their engagement with a non-African American health care provider. Participant 9 described a shared interests and an expressed concern for family during the engagement. Participant 9 had an engagement with a health care provider who conveyed compassion and support, feeling that a non-African American provider was developing a rapport that cultivated an environment of respect. A non-African American provider may utilize culturally sensitive language and display genuine concern. Participant 9 explained,

Again, I've had the luck of the gods with on my side. My doctor and I are a year apart. We both love to travel, and we have pretty much. A couple years ago we were doing the same visits, the States. It was like no way and so, to me, I believe I'm incredibly blessed to have found doctors who are awesome who care about me, follow up with me. One thing I'm glad I said, that when my doctor found out that my mom had died, he told me, you know, he said you reach out to me for anything. And that just shows how much he cares and how he knew how important my mom was to me.

A satisfactory experience of receiving health care services from a non-African American health care service provider was shared by Participant 8. A provider's ability to create a personal connection while providing quality care is not solely based on race. The participant felt that issues and concerns were efficiently addressed. Participant 8 described an experience,

I was satisfied with all of the service that I had. I've never had a bad experience. You know, anytime that I've gone in for any type of health care. Everything that I've asked for has, you know, has happened. They provided all services that I've requested.

There were recounts by Participants 8 and 9 of middle-aged African Americans positive experiences receiving health care services from a non-African American health care provider. The participant recounted experience conveys a higher level of quality in the care received. The participant described care that is specific for them, care that is attentive and respectful, and care that met their health care needs. Participant 9 stated,

I had not stopped and realized how great my doctors are. But you made me realize I need to reach out and tell them, thank you for always thinking of me as a person, seeing me as a person, and not me as a Black woman.

Participant 9 described an experience with a non-African American health care provider that was satisfactory and positive. Participant 9 described an engagement that was respectful and culturally appropriate.

Some middle-aged African American adults experienced the receipt of unsatisfactory health care services from non-African American providers. The

participants described feeling overlooked, frustrated, and reluctant to return for care. The participants recounted information that conveyed culturally responsive care. The participants experienced nuances in care that were discomfoting and lacked the depth for providing quality care. Participant 7 recounted subtleties that reflected on an unsatisfactory experience with a non-African American health care provider. Participant 7 explained,

I will say that you can tell the difference, especially with my Primary Care Provider, I will say, and my optometrist, you can kind of just, tell that the quality of service is not as grand as it could be.

Some African American participants felt overlooked and discounted when they had an impersonal engagement with a non-African American provider. Participant 3 described a provider who was reluctant to touch the skin. The experience conveyed a lack of compassion and reinforced feelings of being marginalized as an African American.

Participant 3 explained,

There are times in the past when I have gone to the doctor and they act as if you have a disease. They don't want to take a lot of time out with you. They won't touch the body like they should. If you have something on your hand, look at my hand and see what's wrong with me.

Some participants continued to report the receipt of unsatisfactory health care services from non-African American health care service providers. Despite a description of an instances of heart palpitations, Participant 4 described an experience of not being

evaluated for further care. The example conveyed the frustration that arose when health care issues were minimized. Participant 4 described the following experience,

There was one particular point where I was having heart arrhythmias, like my heart was, it would race really fast, and then kind of stop. Initially bringing that issue to my primary doctor, he listened to my heart rate at the time, and he's like, Oh, I don't hear any issues, it sounds just fine, and so it was just kind of left there. But then the situation occurred a couple of more times, bringing me back to the doctor's office, and that was where we had to have more in depth conversation like, I'm not leaving until we figure something out, which then, we did. But it took me having to go back a second time and actually recording my heart rate on my apple watch to show him like there are periods where my heart would do this Arrhythmia.

The participants illustrated varied interactions with non-African American health care providers. High-quality, culturally sensitive care is possible regardless of the health care provider's race. The participants highlighted the role that provider engagement plays in the health care experience of African Americans patients. These varied experiences convey the need for respectful, personalized health care for every patient.

Theme 4: Middle-Aged African American Adults Experience Unconscious Bias When Receiving Health Care Services From Non-African American Health Care Providers

The research participants recalled experiences in which they had to advocate for themselves while engaging with non-African American health care providers. The

participants conveyed a need for knowledge about their own body, health, and levels of tolerance. Participant 5 recalled an experience with a non-African American provider,

And you know this isn't necessarily a cultural thing, but I mean it can be because people who don't know about themselves, or aren't able to speak up for themselves, wouldn't know how to, may not be able to navigate this scenario very well, but for me, because I know that I need for the anesthesia to sit a little longer than maybe the average person would. I always tell them. No, you can't start right now. I need you to wait another 5 min, because the anesthesia hasn't set in yet. I always have this issue every time I go to the dentist, blah, blah, and generally they accept that because I don't, I don't ask them. I tell them this is what you need to do.

Participant 5 expressed a specific experience with a non-African American health care provider. The participant has received services from a non-African American health care provider, but also works in the health care field. Participant 2 stated,

It's concerning me that you know, I've worked in a hospital previously, and it's concerning that these are very well educated people that are still very much led by some of the prejudices and the bigotry that they may have been exposed to from a personal side. The fact that there are doctors and health care providers that believe myths about black women or black people, for example, that we have a different type of immune system, or that we can withstand pain at a greater period of time, or that, you know, on and on. So it's very concerning, I think there has to continue to be more effort made on their part to become more educated and aware of their

own biases, and to be on the cutting edge of things that are going to be specifically impacting certain demographics.

Participant 5 and participant 2 highlighted the importance of self-advocacy in health care settings, especially when patients encounter professionals who may operate on generalized medical beliefs. Participant 5 felt compelled to speak up based on past experiences. Participant 2 felt concerned by the perceived persistence of bias among health care providers. The concern is more significant when medical professionals rely on inaccurate beliefs that disproportionately affect the African American population.

Theme 5: Middle-Aged African American Adults Experience Systemic Limitations When Receiving Health Care Services From Non-African American Health Care Providers

African Americans experience systemic limitations that make it necessary for them to receive health care services from non-African American health care providers who may not be culturally competent. There are instances in which the only option for receiving health care is from a non-African American health care provider. Receiving care from a non-African American provider was the only option available for Participant 7. The participant explained,

Unfortunately, because that is, who is assigned to me under my insurance plan.

It's kind of out of necessity that I kind of don't have choice. So yeah, a return out of just pure necessity. But if I had a choice I would not. I would not return, no.

Participant 7 recounted an experience that highlighted the challenges that may be faced by African Americans seeking access to culturally competent health care providers. A

lack of provider diversity, in conjunction with insurance restrictions, limited health care provider selection for Participant 7. Participant 1 expressed thoughts regarding limitations on culturally competent health care provider selection. Participant 1 explained,

I think you know, diversity, equity and inclusion in your hiring process, making sure that you've got a good mix of doctors or physicians or providers from culturally diverse backgrounds, and allowing patients to select folks that they feel more comfortable with folks that are like them. I think that's another way that they could improve. I think doing a survey on the back end, not just doing the survey, saying to African Americans, saying, how was your service? But like asking the questions that you're asking? What can we do to improve our service to you? Leave open-ended questions for those African Americans to chime in. But then, once you get that information, do something about it.

Participants 1 and 3 expressed their feelings about feelings regarding non-African American health care providers. Participants 1 and 3 discussed systemic concerns which have influence when receiving care from a non-African American health care provider.

Participant 3 stated,

There is a lot of negative in the system when it comes to African Americans. The way the system is changing, more they need to take a look at the people. I don't like the fact that if I have high blood pressure today and I see it in my family, they give you blood pressure pills from morning, noon and night, and that is wrong. They need to take more time out with the people and see what's causing their

blood pressure to go up, because there's a lot of other people and cultures that have that have medical issues, that they do not give all this medication to. If you look at some African Americans family members, they have 3 and 4 different pills to take just for one condition. Do we need that many pills. Did you look at my history book and see your increase in my medication when the Doctor gave me, and they didn't tell me to get rid of the medication that the previous Doctor gave me. So that's a lot of problems that we have with the system in that way.

Theme 5 conveyed the significance of systemic limitations' influence on the middle-aged African American adults' ability to access culturally competent health care providers. Participant 1, Participant 3, and Participant 7 described barriers, constraints, and lack of diversity as impediments to their ability to access culturally competent health care. The participants conveyed a need for middle-aged African Americans to have access to culturally aligned health care from non-African American health care providers.

Summary

Chapter 4 included data for this qualitative research study. Chapter 4 highlighted the setting, the demographics, the data collection techniques, data analysis process, and the strategies used to establish evidence of trustworthiness. There were five themes identified after the data analysis was completed. Each of the five themes examined the research question, and have provided adequate information to explore the experiences of how middle-aged, African American adults experience engagement with non-African American health care service providers.

The themes derived from the data highlighted the depth and breadth of the experiences encountered by middle-aged, African American adults' engagement with non-African American health care service providers. Theme 1: Communication challenges with non-African American health care providers highlighted how participants often felt dismissed, misunderstood, or unheard by their providers. The breakdowns in communication were attributed to a lack of cultural understanding and failure to address specific health concerns. The participants described experiences of being spoken at, instead of being spoken to, and being engaged in meaningful communication. Theme 2: Desire for health care considerate of culture reflected participants' desire for culturally competent care. The participants recounted that non-African American providers made generalized assumptions based on race or family history, which often led to inadequate or impersonal care. A difference was highlighted with African American providers, the patients felt they were heard. Theme 3: Varied experiences with non-African American providers revealed that some participants had satisfactory health care experiences with non-African American providers. Non-African American providers showed empathy, and created personal connections. Theme 3 also highlighted other participants that recounted unsatisfactory experiences in which a non-African American provider who seemed reluctant to touch them. Theme 4: Experiences of unconscious bias highlighted how some participants perceived that non-African American providers hold biases and believe myths regarding African Americans which influenced the care that they provided. Theme 5: Systemic limitations in accessing culturally competent providers highlighted the existence of barriers such as restricted insurance networks and lack of provider diversity.

The systemic limitations place constraints on the choices available to participants and lessen their options for culturally considerate care.

Chapter 5 highlights the findings of this generic qualitative research study.

Chapter 5 also showcases the findings of the research study, the conclusions, and the recommendations.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this generic qualitative research study was to explore how middle-aged, African American adults experience engagement with non-African American health care service providers. Information from the results of the study may lead to positive social change when it is considered in the creation of social policies and practices that promote health and reduce disparity for middle-aged African Americans. The social determinants of health, the environments in which people live, work, and worship, their age and education level, each help to shape individual health. The results of this study may contribute to positive social change through policies, education, and procedures for non-African American health care service providers working with middle-age African adults.

The data gained from the research study yielded five themes: Middle-aged African American adults desire health care services considerate of culture, middle-aged African American adults experienced communication challenges with non-African American health care providers, middle-aged African American adults have varied experiences with non-African American health care providers, middle-aged African American Adults experience unconscious bias when receiving health care services from non-African American health care providers, middle-aged African American adults experience systemic limitations when receiving health care services from non-African American health care providers. Chapter 5 provides an interpretation of the study findings, the limitations, the recommendations, the implications, and the conclusion.

Interpretation of the Findings

Theme 1: Middle-Aged African American Adults Desire Health Care Services

Considerate of Culture

The theme highlighted that middle-aged African American adults desire health care services considerate of culture in their engagement with non-African American health care providers. The theme aligned with the literature reviewed in Chapter 2, which concurred that the desire for culture to be considered in health care is significant for middle-aged African American adults. Moss and Crewe (2020) informed that establishing a cultural lens from which African Americans receive health care services may be beneficial. In addition, Causadias et al. (2023) explained that African American culture influences health-related values, norms, beliefs, and behaviors. Health care that is not considerate of culture may contribute to experiences of dissatisfaction and lower quality health care for middle-aged African American adults.

The theme aligns with Rosenstock and Kirscht's (1974) HBM). The model states that health engagement requires corporation between the patient and the service provider. The lack of cultural consideration for experiences of African Americans may denote a lack of cultural awareness or unwillingness to engage by a non-African American provider. A lack of cultural awareness displayed by a non-African American provider - may influence middle-aged African Americans' ability to trust or adhere to prescribed guidance. African American patients may find it hard to interact, feel rushed, feel that the engagement is awkward, or believe there are cultural barriers. The desire for health care considerate of culture aligns with the HBM and is beneficial for health care engagement

between middle-aged African American adults and non-African American health care providers.

Theme 2: Participants Experienced Communication Challenges With Non-African American Health Care Providers

The theme highlighted that middle-aged African American adults experienced difficulty when communicating with non-African American health care providers. The theme aligned with the literature reviewed in Chapter 2, which concurred that communication barriers are a significant challenge for middle-aged African American adults when engaging with non-African American health care providers. The U.S. Department of Health and Human Services (2024) stated that communication challenges between the health care provider and patient can lead to poor quality care. Anderson et al. (2020) noted that challenges in communication can hinder functional health care engagement. Clarity in communication is necessary to provide support for many aspects of a person's life. Ineffective communication can cause strain, creating barriers that limit the functional delivery of health care for middle-aged African American engaging with non-African American health care providers.

The theme also aligns with Rosenstock's (1974) HBM. The HBM was developed to explain health behaviors by identifying factors that influence individuals' engagement. An integral part of the HBM is perceived barriers, which refers to an individual belief that there is an obstacle or barrier to care. Communication challenges with non-African American health care providers represent a perceived barrier for middle-aged African American adults. Race and ethnicity are underlying factors of the issue regarding

communication with non-African American health care providers. The ethnicity of a patient is significant at the point of engagement when participants described feeling a conversation was uncomfortable and understood that a provider was going to prescribe medication and usher patients out the door. The HBM was designed to solve real life problems, identifying perceived barriers, such as patient communication. The HBM aids in understanding the challenges in communication faced by middle-aged African American adults engaging with a non-African American health care provider.

Theme 3: Middle-Aged African American Adults Have Varied Experiences With Non-African American Health Care Providers

Theme 3 highlighted that middle-aged African American adults have varied experiences when engaging with non-African American health care providers. The theme aligned with the literature reviewed in Chapter 2. African Americans may report both positive and negative engagements with non-African American providers. Shahidullah and Petts (2023) explained that African Americans are less likely to receive seamless equitable health care services, which may result in an inconsistent quality of care. Flynn et al. (2020) noted that inequity in health care services may contribute to the range of experiences in the quality of informal and formal care. The experiences of middle-aged African American adults engaging with non-African American providers are not all the same. Bulgarelli et al. (2021) explained that inequity in engagement may be subtle and may be expressed by the refusal of treatment, discourteous staff, harassment, or negligence. Middle-aged African American adults' experiences with inequities in engagement with non-African American health care providers range from simple to

complex. Services (2023) explained that the experiences range from the quality of annual exams to treatment received for a life-threatening illness. The findings highlight complexity in health care engagement for middle-aged African American adults with non-African American providers.

The theme also aligns with Rosenstock (1974a) HBM. The HBM addressed health behaviors. The varied experiences of middle-aged African American adults with non-African American health care providers reflects on the HBM's perceived barriers and perceived benefits. The model suggests that assumptions about health behaviors can be both implicit and explicit, but assumptions are essential for meaningful engagement between patients and health care providers. There is no single factor that motivates all people to engage in any health behaviors. Health care providers often form an idea regarding how a patient behaves, why the behavior happens, and how the behavior might be changed. Assumption may influences the quality of communication and care delivery. The HBM aids in highlighting the importance of understanding the varied experiences of engagement between middle-aged African American adults s and non-African American health care providers.

Theme 4: Middle-Aged African American Adults Experience Unconscious Bias When Receiving Health Care Services From Non-African American Health Care Providers

Theme 4 highlighted that middle-aged African American adults experience unconscious bias when receiving health care services from a non-African American health care provider. The topic aligned with the literature reviewed in Chapter 2 which

concluded that middle-aged African American adults have experienced unconscious biases when receiving care. According to Bonham (2024), African Americans are less likely to receive quality health care services when they are stereotypically perceived unequal or undeserving. McClendon et al. (2021) explained that African American people have higher rates of psychological and psychosocial stress because they face unfair treatment for characteristics of their identity such as race, ethnicity, or culture. Unconscious bias not only diminishes the quality of care that African Americans receive but also contributes to broader health disparities that reinforce the need for culturally appropriate health care services from non-African American providers.

The theme aligns with Rosenstock (1974b) HBM. The HBM addresses health behaviors that are shaped by perceptions of risk and benefit. Preventive health behavior is generally motivated by the belief that taking action will moderate risks. The experiences of a patient aid in their understanding and help to shape their perception. The choices a person makes regarding care are a reflection of their personal beliefs and their beliefs about staying healthy. The HBM is significant for understanding the unconscious bias faced by middle-aged African American adults engaging with non-African American health care providers.

Theme 5: Middle-Aged African American Adults Experience Systemic Limitations When Receiving Health Care Services From Non-African American Health Care Providers

Theme 5 highlighted that middle-aged African American adults experience systemic limitations when receiving health care services from a non-African American

health care provider. The theme aligns with the literature reviewed in Chapter 2, which addressed systemic limitations. The Department of Health and Human Services (2022) established that many African Americans do not have access to health care services, and they do not have access to primary health care providers, medications, or specialty care because they lack insurance. African American health care access may be hindered due to prior trauma experiences while attempting to access health care services (Li, 2021). The lack of access to health care services often renders available health care services unavailable for African Americans (Gaitán-Duarte & Estrada-Orozco, 2021). Systemic limitations become barriers for middle-aged African Americans engaging for care from non-African American health providers.

The theme aligns with Rosenstock's (1974a) HBM. The model addressed health behaviors based on the perceptions of participants. The HBM was used to address socioeconomic concerns and convey the need for social policy to be created to address health care disparities. The HBM was developed from a perceiver's perspective, in which it is the perceiver who determines their actions in any environment. A person believes that the challenge of engaging in health care outweigh the benefit. A perceived barrier may hinder and shape health care decisions. Perceived barriers, as described by the HBM, are relevant for understanding systemic limitations faced by middle-aged African American adults engaged with non-African American health care providers.

Limitations of the Study

The current study only looked at research data on middle-aged African American adults. The study did not delve into the experiences of African American adolescents,

young adults, or African American adults over the age of 65. The research study did not explore any other ethnicity and generally is only applicable to African Americans. The limitations in the scope highlight the benefit of exploring other ethnic groups and age ranges within the African American demographic. The widening of the scope may also be a conduit for a more precise understanding of the experiences of middle-aged African adults' experience of engagement with non-African American health care providers.

The generational aspects of the research study may be a limitation for the current study. Generational cultural expectations may be different and may influence how a participant expressed their thoughts and perceptions regarding health care engagement (Pew Research Center 2023). Younger African American adults may seek collaboration and culturally appropriate care from their provider while older African Americans may value long-term provider relationships that follow a hierarchy for their care (Beverley et al., 2022). The differences in health care communication may provide insight on the varying perspectives of engagement and convey the significance of the current research on middle-aged African American adults receiving care from non-African American health care providers.

Recommendations

Although the generic qualitative approach was suitable for this study, future research could expand with the use of other qualitative designs. An option to consider for future research is the use of phenomenology, which could capture the core of the participants' lived experiences and understand how they each make meaning of their interactions with non-African American providers. The use of grounded theory for a

future study is another viable option. The purpose of grounded theory is to develop a theory that is grounded by the data. A future study could utilize grounded theory to build a theory that can be used to explain cultural expectations and systemic barriers that may be influences on how middle-aged African American adults experience engagement with non-African American health care service providers. The two alternate designs may lead to a more thorough understanding of the dynamics of middle-aged African American adults' engagement with non-African health care providers.

The study was comprised of data that represents each of the middle-aged African American adult demographic. Future research could examine adolescents, young adults, and older adults for a more comprehensive understanding of African American adult health care experiences. Future studies may also compare other racial or ethnic groups. Future studies might also explore the generational differences between Baby Boomers, Generation X, and Millennials. The exploration of other demographics could provide insight into differences in health care expectations and health care experiences for African Americans. Expanding the scope of research could strengthen the applicability of the study in future research.

Implications

The findings of this study suggested that health care providers should place greater emphasis on cultural competence and patient-centered communication when engaging with middle-aged African American adults. Participants described experiences of dismissal and lack of sensitivity, which hinder trust with non-African American providers. Increasing non-African American health care provider training on cultural

awareness, culturally appropriate communication, and unconscious bias may strengthen engagements with middle-aged, African American adult patients. The inclusion of culturally responsive practices may allow for the cultivation of environments that are respectful and contribute to improved health for middle-aged African American adults.

The study has implications for health care policy. The participants highlighted systemic limitations that included limited provider choice and unequal access to quality care. Policy makers could use the results of the study to garner support for health initiatives that expand provider networks and decrease the barriers to care. Policy makers could seek to prioritize provider training and accountability for optimal patient care. The creation of incentives for culturally responsive care may aid in reducing disparities in care. Policy makers could designate funds for programs that support cultural competency in care. The study can aid policy makers in strengthening care accessibility and care quality for middle-aged African American adults.

The study revealed implications for societal change through its focus on middle-aged African American adults' experiences of engagement across their lifespans. The study findings highlighted that participants often encountered barriers such as limited provider choice, cultural misunderstanding, and communication breakdowns that contributed to inequity in their care. The participants described how the presence of culturally appropriate care garnered their trust, made them feel validated, and afforded them more satisfaction. The insights from the study revealed opportunities for social change by placing emphasis on the importance of the inclusion of cultural competence, individual patient-focused communication, and systemic accountability for the health

care provided to African Americans. The focus on middle-aged African American adults' experiences of engagement contributes to raising awareness of the cultural and systemic changes needed to reduce barriers to care, promote societal change, and improve the quality of health care for African Americans.

Conclusion

The study recounted middle-aged African American adults' experiences of engagement with non-African American providers. The study examined communication challenges, a desire for culturally considerate care, varied experiences of engagement for care, unconscious bias, and systemic limitations. The research results conveyed that cultural identity is significant in shaping engagement for middle-aged African American adults. The research was grounded in Rosenstock's (1974) HBM and underscored that perceived barriers may influence a patient's willingness to engage in care. The realm to which the research applies may extend beyond academia by highlighting a need for culturally appropriate practices and policies. The additional study of African Americans across generations and a study of other racial and ethnic groups is needed to broaden the scope of the research. The study may contribute to efforts to reduce health disparities and aid in fostering trust and respect for African American patients. The middle-aged African American adults conveyed that culturally appropriate care should not be optional; it is essential when engaging for care with non-African American providers.

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Appendix A: Interview Protocol

Interviewer Name:

Participant Identification:

Interview Date:

Interview Start Time:

Interview End Time:

Hello, thank you for taking time to speak with me today. My name is Sandy Sullivan, and I am a PhD student at Walden University seeking to do research on the how middle-aged African American adults experience engagement with non-African American health care service providers.

I would like to provide you with information related to the interview process.

Participating in this interview is voluntary. You may choose not to answer any question or you may stop the interview at any time.

I request your permission to audio-record the interview. The audio-recording will be stored securely and destroyed after the research is completed.

If you do not agree to have the interview to be audio recorded, I will alternatively take detailed notes throughout the interview.

The interview will take approximately 45 minutes to 1 hour. Each participant will receive \$15.00 egift card for taking part.

Information about who to contact if you have questions about the study after our time today will be provided after completion of the interview. Do you have any questions before I begin the interview?

We will begin the interview at this time:

1. What types of health care services have you received from a non-African American health care service provider?
2. How would you describe the quality of the health care service visit with a non-African American health care service provider?
3. How satisfactory were the services provided to you from a non-African American health care service provider?
4. What, if any, cultural barriers occurred during your health care visit with a non-African American health care service provider? How could these cultural barriers be better addressed?
5. How could non-African American health care service providers improve their services to African American patients?
6. What else would you like to tell me about health care service visits with non-African American health care service providers?

You have answered each of the interview questions that I have for you today. Do you have any final thoughts that you would like to add regarding the study? (Interview end time recorded above)

I want to genuinely thank you for your time and for the helpful information that you provided as part of the research study. Each participant will receive a \$15.00 egift card as a token of appreciation for taking part in the research study. I will send each participant a copy of the transcript for review. I will send an email to each participant with a copy an executive summary detailing the research study results.

Appendix B: Recruitment Announcement

VOLUNTEER PARTICIPANTS NEEDED

The purpose of this study to explore how Middle-aged African American adults' experiences engagement with non-African American health care service providers.

Participants needed are African American: (a) 35-65; (b) have sought health care services from a non-African American health care service provider; (c) read, write and speak English; and (d) agree to participate in a Zoom interview.

If you agree to be in this study, you will be asked to:

- Sign an informed consent form
- Participate in an audio-recorded interview, approximately 45 min -1hour, and
- Review and validate your interview responses

Each participant will receive a \$15.00 egift card as a token of appreciation.

Interested participants may contact the researcher at (XXX) XXX-XXXX or email at xxxxx@xxxxx.edu.

Thank you!