2017

# Reducing Health Disparities in African American Communities through Church and Federal Partnerships

Shelia Lassiter Hill
*Walden University*

# Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Shelia Hill

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Elizabeth Hagens, Committee Chairperson,
Public Policy and Administration Faculty

Dr. Eliesh Lane, Committee Member,
Public Policy and Administration Faculty

Dr. Anne Hacker, University Reviewer,
Public Policy and Administration Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2017

Abstract

# Reducing Health Disparities in African American Communities through Church and Federal Partnerships

by

Shelia L. Hill

MSN, Marymount University, 1998

BSN, North Carolina Agricultural State University, 1981

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Policy and Administration

Walden University

December 2017

# Abstract

Despite the passage of the Patient Protection and Affordable Care Act (PPACA) in 2010, the Centers for Disease Control and Prevention identified persistent disparities in health care resources as the primary causes of mortality among minority populations. An underexplored resource for affected African American populations is the church, which is not a recognized stakeholder in the implementation of current health care policy. The purpose of this phenomenological case study was to gather perspectives from African American parishioners who lacked sufficient health care insurance on the roles the church could play. Qualitative data management software was used to organize the data (transcripts of interviews) for coding. The purposeful sample of 12 church attendees came from urban, suburban, and rural African American churches. The Andersen behavioral model and Hochbaum's health belief model were used as the conceptual framework for thematic analysis of health care disparities. Kingdon's multiple-stream framework provided theoretical grounds for policy development and revision. Key findings revealed several interrelated health care disparity themes: the significance of insurance coverages, premium costs, financial barriers, family and personal issues, empowerment strategies, religious beliefs, and roles the church could play in promoting quality community health. The study has implications for positive social change: The results include guidance for the development of a bipartisan health care policy that includes the church as a stakeholder. A partnership between the church and the legislators of health care reform could be a catalyst for improved metrics, trust, accountability, transparency, and opportunities to create tailored health care interventions and thus help alleviate societal health crises.

# Reducing Health Disparities in African American Communities through Church and Federal Partnerships

by

Shelia L. Hill

MSN, Marymount University, 1998

BSN, North Carolina Agricultural State University, 1981

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Public Policy and Administration

Walden University

December 2017

# Dedication

I dedicate this dissertation to my family—my husband in particular, who gave support during times of difficulties, and listened and rendered advice on how to best convey written messages. I also dedicate the passion driving my efforts to make a difference in this world for others in health care to my daughter, a single mom to my granddaughter, who has asthma and multiple allergies. I watched them struggle to gain the most basic maintenance medical care without being subject to exorbitant costs. I also dedicate this dissertation to my dearest mother, who died due to complications of uncontrolled diabetes, along with her brothers, my uncles and cousins who also died because of inadequate monitoring and lack of sufficient health care access and resources that potentially would have saved their lives.

# Acknowledgments

My deepest, most heartfelt appreciation goes to God for blessing and surrounding me with people who helped generate foresight, knowledge, and encouragement to write on this dissertation topic—to name a few, Reverend Dr. Larry Evans, Reverend Dr. Norman Tate, Dr. Bethe Hagens, co-workers in the federal government, and family members and friends who listened and asked those "what if" questions. I also appreciate the constructive feedback I received from many of Walden's faculty along this journey that helped refine and appropriately align this scholarly dissertation. I am most grateful to Dr. Hagens, Dr. Eliesh Lane, and Dr. Anne Hacker who were the team of experts helping me to focus the content and to produce a work of art that other research professionals will utilize—and one that I will always be proud of. I sense that a new-found pathway of social change for health care disparities in the community is beginning to evolve, and I am pursuing a role, at whatever level opens to me, to improve the health care of those most vulnerable.

# Table of Contents

## List of Tables

# List of Figures

# Chapter 1: Introduction to the Study

## Introduction

Since the passage of the Patient Protection and Affordable Care Act (PPACA, 2010), access to health care has become more complex than a singular focus on doctor's visits and care of the sick (Moses et al., 2013). Health care now requires an integrated system approach for services at every delivery level. Through these adjustments in perspectives on health care, government stakeholders intended to decrease health care disparities (Moses et al., 2013). One such example of this developing view is the implementation of accountable care organizations (ACOs)—groups of integrated providers charged with improving care and reducing costs of health care within a specific patient population (Burke, 2011). Another example of a PPACA mandate intended to increase health care quality and decrease disparities is section 9007(a) of PPACA, which requires that local health departments conduct a community health needs assessment (CHNA) every 3 years to maintain their tax-exempt status.

Nevertheless, disparities in health care remain, which suggests that additional measures may be needed to meet the demands of the U.S. population. According to the Centers for Disease Control and Prevention (CDC; 2013), health care disparities continue to exist for minority populations, including a lack of access to care; limited health care coverage; and social, economic, and environmental factors. For example, 2009–2011 statistics demonstrated that African American populations were at a higher risk than European American populations for deaths from heart disease and stroke, hypertension, obesity, diabetes, and infant mortality (Centers for Disease Control and Prevention

[CDC], 2013). To reduce these disparities, the CDC suggested that a comprehensive, community-driven approach was necessary for engaging diverse, nontraditional stakeholders in the health care process. One underexplored stakeholder that could facilitate this process is a church.

Using the Andersen, Rice, and Kominski (2007) behavioral model of health care disparities and the health belief model (HBM, Hochbaum (2010), I explored the potential role of church organizations in the implementation of PPACA, specifically as a source of information for CHNAs and potential stakeholders in ACOs. A strategic, societal deliberation about allocating resources depends on public policies and the population’s values, including both political and environmental perspectives (Dye, 1972). Researchers have previously noted that the church can play a fundamental role in motivating social action among African American communities (Calhoun-Brown, 1996; Pattillo-McCoy, 1998). These potential resources have been largely untapped in systematically reducing national health care disparities among the African American population (Hankerson & Weissman, 2012; Nunn et al., 2012; Williams, Hankerson, & Gorman, 2014).

In this case study, I analyzed the potential role of three large, historically established African American churches in implementing PPACA. The study is expected to provide founded, socially justified reasons to link the church to an existing political means of substantiating health care for more people. Standardizing the church as a constituent organization within an ACO may have three social implications: identifying underserved populations for resources, empowering church attendees with effective strategies, and obtaining funding and resources to improve health care access. The strategies used by the church are transferable opportunities for social change in other communities.

Chapter 1 covers the following topics: introduction and background for the study, the problem statement, purpose, research question, and theoretical framework. Discussion of the methodology in this first chapter includes the nature of the study, definitions, assumptions, scope and delimitations, and limitations, significance of the study.

## Background

Health care disparities persist in the United States despite health care reforms (CDC, 2013). Race, gender, age, culture, income and where one lives are primary factors (Derose, Gresenz, & Ringel, 2011; Gaskins, Dinwiddie, Chan, & McCleary, 2012; Griffith, Yonas, Mason, & Havens, 2010; Kim, Bryant, Goins, Worley, & Chiriboga, 2012). Some additional factors that influence opportunities to access health care insurance coverage were related to illiteracy and personal beliefs (Griffith et al., 2010) and the severity of sickness being a major contributor to seeking immediate access (Heider et al., 2014), warranting increased use and cost of health professionals and medical resources. In the United States, the African American community has a disproportionate number of people with disabilities (Waidmann & Rajan, 2011) and has been identified as the minority group least likely to have quality health care coverage (Gaskins et al., 2012; Miller, Kirk, Kaiser, & Glos, 2014). Recently, Racial and Ethnic Approaches to Community Health (REACH), sponsored by the CDC, has partnered with community organizations to remove cultural barriers limiting health care access. Such barriers include social status, education, race, discrimination, and lack of resource allocation. As a result of REACH, all populations are offered a more equitable distribution of health services (U.S. Department of Health and Human Services, 2016).

According to Andersen et al. (2007), researchers can examine health care disparities through several factors, including *predisposing factors*, or those characteristics that make a person more prone to disparities (e.g., age, race, sex, education, and mental factors); *enabling factors*, or those factors that make a person more likely to receive services (e.g., transportation access, wait times, and health care coverage); and *need factors*, or those factors that increase or decrease the need for health care (e.g., environmental hazards and overall measures of community health). Andersen's model clarifies the multiple indices of potential variables that comprise health care disparities (Babitsch, Gohl, & Von Lengerke, 2012). This same focus on multiple components of health care disparity is evident in the ACO and CHNA provisions of the PPACA, as well as the CDC's (2013) recommendation for the search for additional stakeholders to facilitate the process of increasing and improving health care access.

One potential stakeholder that may improve the effectiveness of PPACA is the church. The Internal Revenue Service (IRS, 2015) denotes churches as being a place where congregations of similar faith worship. Only a few researchers have evaluated the role of religious beliefs in developing coping mechanisms for health-related issues (Allen, Davey, & Davey, 2010; Debnam, Holt, Clark, Roth, & Southward, 2012; Jo, Maxwell, Yang, & Bastani, 2010; Moldovan, 2013). Faith may counterbalance illness and negativism. Having faith can lead to enhanced healing, longevity, empowerment, endurance, joy, and hope (Flannelly & Galek, 2010; Koenig, 2012). Additionally, the ability of the church to cultivate programs based on the shared social needs of the community may empower the community. In fact, researchers have found such programs to improve fiscal support for churches (Davaney, Bowlin, Kerbel, & Valdez, 2012; Wizemann & Thompson, 2015). A comprehensive review of literature indicated lack of church interventions to reduce disparities, which has led some researchers to recommend additional studies in this area (Jo et al., 2010; Levesque, Harris, & Russell, 2013). As of 2016, few researchers had examined the role of faith-based organizations as related to the PPACA (Franz & Skinner, 2016; Galiatsatos & Hale, 2016; Villatoro, Dixon, & Mays, 2016). These researchers have been more concerned with theoretical and hypothetical roles (Franz & Skinner, 2016; Galiatsatos & Hale, 2016) and with Latino populations (Villatoro et al., 2016). Researchers have not yet addressed the perceptions of African American church members about the potential roles of these churches.

Alternative possibilities for health care intervention by churches may help overcome the current and future demands on an already overburdened health care delivery system. Churches have largely been ignored as a potential organization for intervention in improving PPACA data gathering and implementation, including acting as a catalyst for community outreach and preserving the health of the underserved (Bell, Wilson, Bissonnette, & Shah, 2013). Frequently, the church is a place where people may feel comfortable revealing their health care issues before seeking help from nonchurch affiliations (Allen et al., 2010). Therefore, people’s trust in the church organization may provide a means to overcome obstacles and resolve problems with PPACA.

Moreover, effective partnerships between the church and community organizers may be possible because of a shared value system that includes serving others (Wizemann & Thompson, 2015). An integrated community effort from health care agencies, public health agencies, and potentially churches, is needed to end health care disparities (CDC, 2013). As Derose et al. (2011) noted, a realistic framework expanding partnerships with community organizations was a key intervention for churches. A PPACA funded provision of church support would end health care disparities. For instance, breaking through cultural barriers, beliefs, and behaviors that impede health care access is a viable role for churches as agents of social change that improve health in communities.

Health has consequences affecting every society, which justifies reasons to improve public policy standards that are collectively regulated, organized, and distributed to benefit all (Dye, 1972). This study links to the multiple streams framework of the policy process (Kingdon, 2011), in which policies affect people differently based on phenomena at many governmental levels. The PPACA, a public policy that targets improved and equitable health (Blumenthal & Collins, 2014), uses a system-planning model with the collective cooperation of ACOs (Centers for Medicare and Medicaid Services [CMS], 2015) to solicit effective standards and interventions. Coordinated strategic actions between nonprofit hospitals, including faith-based hospitals, and local health agencies improved allocation of government supported resources (Beatty, Wilson, Ciecior, & Stringer, 2015). In this study, I addressed the health care needs of African

American congregations. Thus, I provide additional information on the role a church could play within PPACA implementation.

## Problem Statement

Disparities exist in health care access and health care delivery. Based on the Andersen et al. (2007) behavioral model, these disparities are related to human factors, such as age, gender, and race, along with conditional factors, or the external factors that create social differences. Babitsch et al. (2012) supported the need factors of income and race as being related to health disparity as an expansion of Andersen's research. For example, (a) mortality due to preventable, health-related diseases of children and minorities are 10 times higher in low-income populations than high-income populations (U.S. Department of Health Human Services, 2014); and (b) African Americans, the largest minority group in the United States, have the highest casualty and health disparity rates (Bethall et al., 2011).

While the PPACA (2010) standardizes health insurance reform, access to and the provision of care are more complex and require integration interventions at every level of care delivery. Under section 9007(a) of PPACA, local health departments must conduct a CHNA every 3 years to maintain their tax-exempt status. An underexplored stakeholder that may facilitate CHNA processes and act within an ACO are churches, which support social justice for fairness and equality in the community by increasing access to secular funding sources (Davaney et al., 2012). Little is known about the role of church organizations in health care access, specifically among underserved populations.

## Purpose

The purpose of this phenomenological case study was to explore the potential roles of African American churches in providing health care assistance to underserved parishioners (age 18-65) within the local community. Although faith-based organizations have been identified as potential stakeholders that may work within ACOs and facilitate information gathering during CHNAs (Gourevitch, Cannel, Buford, & Summers, 2012; Majette, 2011), little research exists about the role that churches—under the umbrella of faith-based organizations—play in providing care and support for underserved populations (Franz & Skinner, 2016; Galiatsatos & Hale, 2016; Vallotoro et al., 2016).

I used semistructured interviews with open-ended and follow-up questions to acquire in-depth information on the insurance needs, health needs, and the experiences of 12 parishioners with insufficient health insurance in three African American churches. The study has implications for public health policy, namely, understanding whether and how churches and other faith-based organizations can contribute to CHNAs, ACOs, and community outreach partnerships in order to provide equitable health care coverage and access to services as mandated for PPACA.

## Research Question

This study was guided by the following question: What are the perceptions of African American church attendees on their health care issues and the church role in advocating as a PPACA stakeholder to reduce health care disparities?

## Conceptual Frameworks

A conceptual framework for this study was Kingdon's (2011) multiple streams, which incorporates three streams of a policy process: the problem, the policy, and the politics stream. For this study, the problem stream was health care disparity; the political stream involved bringing attention to the problem and proposing a lucrative, effective, and efficient health care solution within the PPACA, specifically, CHNAs. Howlett, McConnell, and Perl (2015) extended Kingdon's three streams to incorporate cycles and stages of the policy process, which are strategic attempts to account for and justify stakeholders' buy-in. The goal of this research was to determine what the church attendees' perceptions were as to the church's role in the policy stream. Once the church partnered with health care and policy-makers, then it too would become a stakeholder in the discussions and in setting health care agendas for the broader community. See Chapter 2 for further discussion of Howlett et al.'s model and Kingdon's model, and their application to the present study.

I also used two conceptual frameworks to interpret interviewees' understandings of how to maintain their health: the first was the behavior model (Andersen, 1968; Andersen, 1995; Andersen et al., 2007), which supported the need for access to, low cost, and quality of health care. The Babitsch et al. (2012) review of literature reintroduced

Andersen's model as the most widely used for operational research on health care delivery systems. Second, the HBM demonstrated how one's perception could be internalized and thus become a personal belief. This belief will then influence motivations and behavioral responses (Babitsch et al., 2012; Hochbaum, 2010; Janz & Becker, 1984; Rosenstock, Strecher, & Becker, 1988). Although the core of each model has remained constant, other theorists have revamped multiple research applications for its use.

The Andersen behavioral model holds that health care disparities stem from human and conditional factors. Human factors involve demographic characteristics, including age, gender, and race; conditional factors are those external factors that create societal differences (Gaskins et al., 2012). The HBM (Hochbaum, 1958; Hochbaum, 2010; Rosenstock & Hochbaum, 2010), developed by the U.S. Public Health Service in the early 1950s, is a model that assesses patient behavior according to various factors (Janz & Becker, 1984) impacting behavior, as well as creating barriers that prevent positive behaviors. Individuals' health care behaviors depend on sufficient motivation to address health issues, feelings of vulnerability to illness, and the belief that, by following a health recommendation, they will reduce the threat without undue cost (Janz & Becker, 1984). Rosenstock et al. (1988) augmented the concept of perceived benefit with a patient's perceived self-efficacy, noting that when a person feels comfortable with the direction of health care, including preventive health care, he or she is more likely to seek it out. Together, these two models denote the influence of demographic and social factors on health behaviors, and may account for the role that churches might play in addressing health care disparities under PPACA. See Chapter 2 for further discussion of the theoretical models.

The phenomenological approach grounds qualitative research inquiries based on theories and assumptions developed to explore data derived from people's perceptions. Key interviewee responses are significantly influenced by one's beliefs as well as perceived values internalized through perceived susceptibility, perceived needs, perceived severity, perceived barriers (Janz & Becker, 1984), knowledge, experiences, sensitivities, and cognitive abilities. Phenomenology allowed for increased exploration of the sampling area (the church setting) and participants (church attendees with no or insufficient health care coverage), using flexible and open-ended interview methods to collect data while constantly comparing individual responses (Rudestam & Newton, 2015). This design was appropriate for my study because little is known about the attitudes of church attendees and their health care access needs.

The case study approach is linked to the research question because it allows for examination of the role(s) that the church can play in partnering with local health care and public health agencies to create integrated improvements in the overall health care delivery system. The purposefully selected individuals, their families, their perceptions, their situations, their histories, their processes, and their programs were bounded, and through a case study analysis, I uncovered the challenges they face regarding health care disparities and related issues.

## Nature of Study

This phenomenological case study involved a qualitative applied research design from a realist focus. I triangulated support for the in-depth data gained from participants on health care access. The goal was to raise awareness of health care disparity, concerns, and needs for improved developmental strategies within PPACA. The qualitative design permits flexible exploration of the church setting and the participants who attend services (Rudestam & Newton, 2015). I used this design because little information is known pertaining to the church-based populations' attitudes and health care access needs.

A phenomenological approach allows flexibility, but control remains with the researcher. Data for this study were acquired via interviews, audiovisual recordings, and church documents. (See Chapter 3 for specifications on the study's procedures.)

I obtained information about church attendees' perceived access to health care using semistructured, open-ended interviews. This approach allowed me to spend sufficient time with the participants to assure that the data were accurate and exactly what the participant intended. I used purposeful sampling to select church attendees who had insufficient health care insurance coverage or lacked coverage altogether. The qualitative analysis should help other researchers, educators, and health administrators identify themes and patterns associated with individuals having little or no health insurance.

Public health policies are constructed around conceptualized frameworks, legitimizing issues that pose significant risk to special interest groups, the government, and constituent ideologies (e.g., *multiple streams*; Kingdon, 2011; Moloughney, 2012). Understanding the perspectives of individuals in the church community about personal or family disparities in health care access and health services may help policy makers create opportunities for social and political change.

I selected the participants from three African American congregations. The participants had no or insufficient health care access, because of issues obtaining resources in the community. The sample sites consisted of three predominantly African American churches, where attendees varied in age, gender, and to some extent, race. People of any gender or race were able to participate to show greater equity in sample selection. I am affiliated with one of the churches and had conversations with its members that led me to conduct this study. Church members on occasion have inquired or been concerned for themselves or for family members when lack of medical insurance resulted in their not purchasing prescribed medications, needing an ambulance for emergency care, requiring surgery, developing a chronic health condition (i.e., diabetes, stroke, heart disease, etc.), and in some cases dying.

## Definitions

Individuals, groups, and organizations interpret words or groups of words differently depending on personal associations. This study is related to health care and required a mutual understanding of the theoretical and operational use of terms. The following definitions facilitated a better understanding of the study.

*Accountable care organizations (ACOs)*: groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients (Centers of Medicare and Medicaid Services [CMS], 2015).

*Community health needs assessment (CHNA):* a process used to engage partners across sectors to identify and prioritize community health resources (CMS, 2015). To be in compliance with PPACA and maintain tax-exempt status, a local health department must conduct a CHNA every 3 years. The CHNA is a tool used to identify vulnerable populations and health disparities in communities.

*Faith-based organizations:* houses of worship, such as churches, temples, mosques, or any other places of worship (U.S. DHHS, 2014). Faith-based organization is not synonymous with church, though some of their religious missions may be similar; while a church is a faith-based organization, not all faith-based organizations are churches (Dean, 2013). Faith-based organizations may be tax exempted, but would be required to apply for a tax-exempt status from the U.S. Department of Treasury Internal Revenue Service (IRS; 2015), unlike churches.

*Churches*: places of worship, such as synagogues, temples, mosques and similar types of organizations (U.S. Department of Treasury Internal Revenue Service [IRS], 2014, p. 5). The IRS automatic exemption assures church leaders, members, and contributors that the church has an Internal Revenue Code (IRC) 501 (c)(3) qualification for tax exemption (U.S. Department of Treasury IRS, 2015). The IRS is the regulator of CHNA section 9007(a) of PPACA (Pennel, McLeroy, Burdine, & Matarrita-Cascante, 2015) and defines characteristics of the church. The U.S. Department of Treasury IRS (2015), Publication 1828, defines a church as the following:

- a distinct legal existence;
- a recognized creed and form of worship;

- a definite and distinct ecclesiastical government;
- a formal code of doctrine and discipline;
- a distinct religious history;
- a membership not associated with other church or denomination;
- an organization of ordained ministers;
- ordained ministers selected after completing prescribed studies;
- a literature of its own;
- established places of worship;
- regular congregations;
- regular religious services;
- Sunday schools for religious instruction of the young; and
- schools for the preparation of its ministers. (IRS, 2014, p. 5)

*Health care access*: the potential supply and distribution of medical care resources (i.e., insurance, funding, governance, advocacy, mediator etc.) and actual services (treatment or delivered provisions) used within the health care system for a physician, nurse or pharmacist (Bell et al., 2013). An inability to obtain health services to meet health needs adequately would be described as not having access (Levesque et al., 2013). Insurance coverage or opportunities to receive health care services, treatment and procedures is another form of health care access (CMS, 2015).

*Health care practitioner*: a physician, physician assistant, nurse practitioner, or pharmacist (Bell et al., 2013).

*Public health agency*: a nonhospital facility providing services to meet the public's physical health, environmental and safety needs (CDC, 2013). Hospitals and public health agencies perform collective actions of society to help others live healthy lives, and are acknowledged in PPACA as playing an important role in addressing the outcomes of health disparities (Derose et al., 2011). Tax-exempt hospitals and health agents are federally qualified public health agencies (Beatty, et al., 2015).

## Assumptions

Assumptions are the study elements or beliefs of which the qualitative researcher has no control, but must justify, for without these assumptions the study becomes irrelevant (Leedy & Ormrod, 2010). In distinguishing qualitative assumptions from other constraints generally found in qualitative research studies (e.g., scope, delimitation and limitation), first and foremost, assumptions are not controlled by the researcher. Second, to establish value and respond to my readers' "so what" question about the importance of this research, I had to reasonably link assumptions with some truth that revealed trustworthiness in terms of credibility, transferability or conformability. Throughout the study it was essential to demonstrate how to overcome restricted characteristics of the scope, delimitations and limitations in order to enhance trustworthiness of data. For instance, scope establishes the parameter under which the study operates; delimitations restrict the overall scope and sets boundaries on study elements; and lastly, limitation is an inevitable weakness resulting from unanswered questions from a chosen study design or methodology (Simon, 2011). Therefore, unlike assumptions, I had control of the scope, delimitations and limitations. Regardless of constraints and influences, the researcher must acknowledge and reduce each as much as possible. When I conducted this study, I made several assumptions.; I had to be especially careful to evaluate my assumptions and bracket any biased assumptions (L'Anson & Smith, 2004).

- the churches or places of worship studied met the IRS tax-exempt criteria definition.
- the faith-based organizations (the three African American churches) under study had resources to aid in reaching out and supporting the local community.
- a benefit existed in establishing a collaborative partnership among community organizations and health care agencies for health care promotions, wellness, and reducing health care disparities within the community. This assumption involves the CHNA provision of PPACA as well as recommendations from the CDC (2013).
- integrated collaboration among health care agencies and the community would improve planning strategies, such as through CHNA, and quality of care, thereby providing a solution to health care disparities with targeted resources (Beatty et al., 2015).

The assumptions clarify speculations and help determine meaningful factual data to rationalize extended provisions of the health care reform policy to include church-based organizations under the PPACA.

Other assumptions were required regarding the methodology.

- The qualitative research approach, at best, was assumed to provide the most meaningful socially and culturally constructed conditions and values of peoples' perspectives (Rudestam & Newton, 2015); thus, I chose this methodology for the study.
- I assumed participants would answer as honestly and truthfully as they were able.
- In addition, using nonrandom sampling makes it difficult for reliability or inference decision-making relating to the phenomena being studied and creates an assumption that a theoretical foundation informs readers that the researcher at least strives to provide meaningful interpretation of results (Rudestam & Newton, 2015).
- Another assumption was that persons closest to the issues of health care access disparity have knowledge that may potentially inform strategies to improve care disparities. For this reason, I chose a purposeful sample, comprised of individuals who have no or insufficient health care and attend one of three African American churches.
- Another assumption was some populations are still at risk, or potentially at risk, for health care inequality post implementation of PPACA. The PPACA was enacted to reduce health care disparities by increasing health care coverage and reducing the cost of health care (PPACA, 2010), but disparities still exist among low-income minorities (CMS, 2015). The PPACA provides Medicaid coverage for nonelderly adults, the disabled, and families whose

> income is above the 133% poverty level, though adults who are self-employed, recently unemployed, and those consumed with debt who simply cannot afford to pay may be at higher risk of having no health coverage. Federal funding is allotted to states complying with the law to assist with Medicaid costs, but not all states are in compliance with PPACA; some are opting out and challenging legislative changes (CMS, 2015).

## Scope and Delimitations

Delimitations are the personal choices that the researcher makes about the boundaries of the study; the delimitations create the scope of the study (Simon, 2011). The role of church-based organizations in health care delivery for underserved populations is unknown. I confirmed the socioeconomic and underserved status of participants through participants' perceptions of their current states. The phenomenological, reflexive approach used in this study allowed me to capture the natural essence of participants' health care and access experiences in order to acquire the most meaningful results of their social and economic conditions (Dowling & Cooney, 2012). I provided a clear explanation of procedures, the written protocol, and the informed consent disclosures to inform the participants of research details and their rights.

Though health disparities in America are prevalent among other races (e.g., Hispanics and Asians; Gaskins et al., 2012; Jo et al., 2010), I only examined members of three majority African American churches in this case study because this community was the largest minority and the most at risk for health care disparities (CDC, 2013). Because

Medicare or Medicaid covers individuals older than 65 years, children, and the disabled with low incomes (Blumenthal & Collins, 2014), I explored health care disparities among individuals, ages 18 and 65 years, who were not covered by these programs unless they volunteered because of insufficient health care coverage. The participants were church attendees who met the criteria. In addition, the scope of sampling was bounded geographically to the population located within the vicinity of the church.

No transcriber other than myself was present. Therefore, an interview guide and standardized open-ended questions were essential to offer framework and structure that would be useful for future examination of facts and research. The exploration within the semistructured interview was delimited by the interview guide and follow-up questions. The more significant strengths of qualitative inquiry are within the skills of the researcher to direct open-ended questions that encourage elaboration and free-flowing dialogue to get participants to reveal their deepest knowledge and perspectives about the studied issue (Tracy, 2013).

I used a single design, qualitative phenomenology, which has strengths for flexibility and control in the research protocol and planning stages along the way. The interviews were sufficient for understanding the perceptions and lived experiences of the interviewees (Moustakas, 1994). Through a phenomenological case study, I obtained sufficient in-depth information with interviewing as the primary method of data collection (Moustakas, 1994; Yin, 2014). The strength of informal interviewing rests within the flexibility and instinctive responses the researcher is capable of eliciting from the participant (Tracy, 2013).

## Limitations

In a qualitative study, limitations, or shortcomings of the study, stem from the conceptual framework and from the study's design (Marshall & Rossman, 1999). Any research methodology has limitations, and the researcher makes every effort to compensate. Bias is the primary issue to work through, since I was the analytical tool and interpreter. I am a long-standing member of one of the churches used as the sampling site under study. I am also a nurse educator and a military veteran. I mitigated the influence of potential biases by disclosing and clarifying my professional roles and personal associations and biases in protocol procedures and was forthcoming with participants and readers of this study. I also kept an audit trail of all study details.

Limitations of qualitative data include credibility and transferability. The credibility is whether or not the data collected can be trustworthy, transferable from setting to setting, and dependable. Credibility is established with specific procedures of developing a research protocol and recording all processes (Walden University, 2014a). Transferability refers to whether the results of a study can in any way be generalized to a different setting (Houghton, Casey, Shaw, & Murphy, 2013). I provided information about the population settings, and presented results in enough detail that an individual could make his or her own decision about the transferability of the findings.

This study was limited to participants' spoken words. As a result, clarity of information may sometimes be an issue. I asked participants to clarify information during the interview and after the interview when transcripts were verified. Specifically, participants reviewed personal interview data for accuracy prior to finalization, and I incorporated their updates and changes. Credibility, as related to confirmability, transferability, and dependability are issues that arise from interview data. Confirmability involves objectivity in data collection (Petty, Thomson, & Stew, 2012; Walden University, 2009). I used multiple methods of data collection to capture all of the interview conversations, including the use of audio recordings, and written memos during the interviews. Triangulation refers to using different sources to strengthen credibility and accuracy of qualitative research (Laureate Education, 2010a). Dependability addressed the reliability of the results (Houghton et al., 2013). I increased the dependability of the study with documented audit trails, in line with recommendations by Petty et al. (2012). I also documented detailed accounts of study procedures. All information and data are stored and secured in several places to prevent data loss and maintain data integrity.

Purposive sampling is considered a limitation. Sampling errors sometimes occur in qualitative research because of the small sampling size, thus increasing bias. I used open-ended interviews, with flexibility and accuracy, in collecting data. I was confident that purposefully selected individuals adequately represented the community and provided accountability that could help close a research gap in health disparities. A strength of purposeful sampling was that I had little doubt about obtaining the right subjects. Establishing trustworthiness during data collection occurs through audit trails, triangulation, and peer debriefing, and reflexivity and referential adequacy. I employed these strategies to assure confidence in this study. I also frequently consulted with the dissertation chair throughout the research.

## Significance

The results of this study are expected to help church leaders, community leaders, and health educators and researchers improve humanitarian and operational support for health care. Addressing the gaps in health care access and services can also inform policy revisions, facilitate the creation of CHNAs and provision of health care, and promote extended community health care services through churches' networking capabilities.

Conclusions suggested the existence of health care access disparities, and potential solutions for mitigating these disparities through faith-based organizations, could depict a means of strategically gaining support from a social justice perspective. Findings provided enhanced data for PPACA public policy budgetary changes as well as for increased church funds and resources. An untapped stakeholder, such as church support, can be fully viable as a public health policy facilitator. The qualitative analysis should help other researchers, educators, and health administrators identify themes and patterns related to health insurance disparities, past or pending needs for health services, and potential church interventions that may assist in PPACA implementation.

## Summary

Despite the passage of the PPACA, health care disparities persist, particularly among African American populations (CDC, 2013). Faith-based organizations, such as churches, could become an additional community stakeholder, one that could increase health care access and decrease health care disparities. The purpose of this phenomenological case study was to explore the potential roles of African American churches in providing health care assistance to underserved parishioners, ages 18–65.

Semistructured qualitative interviews produced data for analysis and interpretation. I used the conceptual framework in the context of Kingdon’s multiple streams theory that was later expanded by Howlette et al. (2015). The study has significance for church leaders, community leaders, health educators and researchers, as well as policymakers who attempt to address disparities via PPACA.

In Chapter 2, I reviewed the literature to learn about prior research on the topic, including key concepts and theories. In Chapter 3, I explained the methodology used in the study. In Chapter 4, I presented the findings, and in Chapter 5 I discussed them.

# Chapter 2: Literature Review

## Introduction

Policymakers designed the PPACA to eliminate health care disparities (Blumenthal & Collins, 2014). In part, this policy targets underserved populations through various measures, including CHNAs and ACOs (Beatty et al., 2015). Although some researchers have noted that one method of reaching underserved populations may be faith-based organizations (Gourevitch et al., 2012; Majette, 2011), little research confirms or describes this role (Franz & Skinner, 2016; Galiatsatos & Hale, 2016; Villatoro et al., 2016). Nevertheless, research has proven that faith-based organizations can play a role in individuals' health care decision making (Allen et al., 2010). Moreover, stakeholders in these organizations serve as information sources about health care disparities (Wizemann & Thompson, 2015). The purpose of this phenomenological case study was to explore the potential roles of African American churches in providing health care access and support to underserved parishioners 18–65 years.

In Chapter 2, I cover the following topics: the relevant theoretical and research background underpinning the study, the literature search strategy and parameters of the search, and a discussion of the conceptual framework used to provide theoretical backing for the study. Finally, I present the research content relative to the study, including literature about health care disparity, PPACA, African American churches, and what little research has been published about the role of churches in PPACA implementation. The chapter concludes with a discussion of the gap in the literature and a summary of the chapter.

## Literature Search Strategy

To identify the relevant literature, I used the following databases: Academic Search Premier, EBSCO, and Google Scholar. First, I identified the key scholars and seminal works related to the conceptual framework of the Andersen behavioral model, the HBM, and the multiple streams framework; these included Andersen, Hochbaum, Rosenstock, and Kingdon. Then I searched for related content using the following keywords: *PPACA, churches, African American churches, faith-based organizations, implementation, religion, health care,* and *disparities.* Because the searches involving faith-based organizations and PPACA revealed little content, I expanded my search to include *the role of faith in health care*, which yielded more results, although the majority were outdated (published prior to 2012). However, I kept these articles in the review to provide a clear picture of the role of faith in mitigating health care disparities.

To ensure the quality of the literature, I used filters in the chosen databases to ensure that the work was scholarly and peer reviewed; I eliminated outdated research that was not seminal nor necessary to the review. The result was more than 150 resources, which included peer-reviewed articles, books, online websites, databases, and diagrams, most of which were published since the beginning of 2012.

## Conceptual and Theoretical Framework

The problem of health care disparities among African Americans and the policymaking role of African American churches were the focus of the study. In qualitative inquiry, researchers use conceptual frameworks that develop and evolve to provide a multifaceted underpinning for the study (Maxwell, 2013). I used two frameworks to understand the health care disparities: the Andersen behavior model and the HBM. To interpret the policy roles of African American churches, I used Kingdon's (2011) multiple streams framework.

## Andersen Behavioral Model

The Andersen behavioral model promotes the idea that health care disparities stem from human factors and conditional factors (Andersen, 1968, 1995; Andersen et al., 2007). Human factors involve demographic characteristics, including age, gender, and race, and conditional factors that are external forces that create societal differences (Gaskins et al., 2012). Pivotal to Andersen's model is that the beliefs a person has about health care influence both health and receipt of services (Andersen, 1995).

Over time, the model has developed to become more specific pertaining to the factors influencing individuals' health care behaviors (Babitsch et al., 2012). Specifically, the model has further evolved to include predisposing factors, enabling factors, and need factors, ideologically stemming from Andersen's (1995) behavior model, and also is why Andersen was chosen for this study. Predisposing factors consist of innate characteristics, which could influence one's behavior and create enabling factors limiting access to health services, such as one's finances, affordability, and medical insurance coverage (Babitsch et al., 2012). Babitsch et al. (2012) identified a need factor as individuals' perceptions of their needs for health services. The effect of these influences depends heavily on the context of the population (Heider et al., 2014). Slota (2004) elaborated that crises or catastrophic situations can influence an individual's acculturated beliefs and can cause them to return to pre-existing behaviors. Nevertheless, researchers have consistently demonstrated the value of the Andersen model in understanding health care disparities in the United States (Heider et al., 2014). Figure 1 provides a clearer framework of Andersen's proposed relationship among these variables.

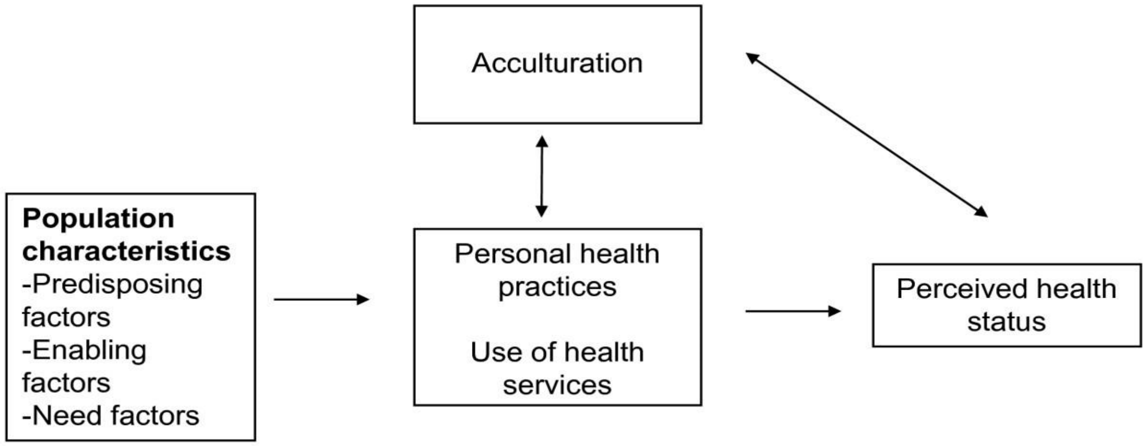


*Figure 1.* Andersen's behavioral health model modified with acculturation on health practices and individual's perceptions. Adapted from "Revisiting behavioral model and access to medical care: Does it matter?" by R. M. Andersen, 1995, *Journal of Health and Social Behavior, 36*, p. 8. Copyright, 1995 by American Sociological Association. Adapted with permission.

**Studies using the Andersen behavioral model.** In several contemporary studies, researchers used the Andersen behavioral model as an explanatory theory to conduct research similar to this study (Doshi, Malebranche, Bowleg, & Sangaramoorthy, 2013; Holtzman, Brady, & Yehia, 2015; Majaj, Nassar, & De Allegri, 2013; O'Neal et al., 2014; Shepherd, Locke, Zhang, & Maihafer, 2014; Wickrama, O'Neal, & Oshri, 2014). For example, consistent with the Andersen behavior model, Wickrama et al. (2014) determined through longitudinal data collected from 12,424 individuals during a period of 13 years (infancy-adolescence) that adolescents who were either rejected by parents, depressed, or experienced precocious adolescent changes also showed evidence of stressed lifestyles (low socioeconomics) and health (high basal metabolic index [BMI] or obesity) as adults. Simply put, deprived resources or feelings of unworthiness in the adolescent years transferred into the same depressed feelings in adulthood, especially if no transforming interventions were taken to improve feelings of adequacies along the life-cycle of experiences. Subsequently, these feelings translated into negative health outcomes (Wickrama et al., 2014).

In many studies pertaining to the Andersen behavioral model, researchers used a similar longitudinal and quantitative approach. Quantitative studies revealed predisposing factors influence care-seeking behavior (Wickrama et al., 2014), as well as revealed convenience and perceived availability of care led to increased treatment compliance (Shepherd et al., 2014). Exemplifying these findings, an exhaustive review of the literature by Holtzman et al. (2015) demonstrated compliance with HIV treatments was facilitated by increasing the antiretroviral therapy regimens to patients’ preference; increasing reminder systems; increasing education and counseling; facilitating more peer, family, and community support groups; and managing insurance and health care costs. Using the Andersen behavioral model to examine the behaviors of uninsured adults in community health management systems, Shepherd et al. (2014, p. 581) indicated statistically significant relationships between population characteristics and health behavior; between health behavior and outcomes results; and between population characteristics and treatment outcomes. In all, these findings suggested increasing access to and familiarizing care led to better patient outcomes.

Other researchers have used the Andersen behavior health model (O’Neal et al., 2014), which provided the groundwork for this study. O’Neal et al. (2014) used the Andersen behavioral model to examine the effects and interactions that health insurance and psychological processes had on the use of preventative services among 200 African American, middle-aged adults. Psychological processes, pulled from the Andersen behavioral model, included competency, or the participants’ perceptions of their abilities to complete and participate in care; and vulnerability, or the participants’ perceptions of harm that could occur during treatment (O’Neal et al., 2014). O’Neal et al. obtained data from six churches enrolled in a National Institutes of Health sponsored program with the goal to reduce cardiovascular risk in middle-aged and older African Americans (73% female and 26% male). Quantitative analyses, including structural equation modeling and correlational analyses, revealed the psychological factors, in addition to having health insurance, influenced patients’ likelihood to comply with preventive health services (O’Neal et al., 2014). These results suggested the importance of the present study to reduce disparities in insurance coverage and care, and also highlighted a program of preventive care within a church setting, although O’Neal et al. (2014) did not consider the religious setting as a factor in their study.

In the qualitative studies that included use of the Andersen behavioral model, researchers also revealed important groundwork relevant to this study. These researchers demonstrated the utility of the Andersen behavioral model in examining underserved populations; Doshi et al. (2013) studied a sample of African American men in HIV-prevalent areas, and Majaj et al. (2013) examined rural Palestinian women. Both groups of researchers found the Andersen behavioral model provided explanatory value in understanding participants’ responses. Unlike quantitative studies, however, the qualitative approach allowed for open analyses of factors related to the Andersen’s model in participants’ own words (Doshi et al., 2013).

Doshi et al. (2013) and Majaj et al. (2013) studies have specific connections with the contemporary quantitative literature and with this study. Consistent with quantitative findings as discussed above, Doshi et al. (2013) found that among a sample of African American males in HIV-prevalent areas, barriers to seeking screening services were work schedules, lack of a primary care provider, and a perception that health promotion behaviors are not masculine; similarly, Majaj et al. (2013, p.8) assessed that health beliefs, affordability and accessibility, perceptions of quality of care, and perceived health needs influenced care-seeking behaviors. Interventions by churches that African American men regularly attend could reduce logistical barriers and work on perceptions of seeking care. Closely related to the present study, Majaj et al. noted religious incompatibility with care (i.e., the Palestinian women believing that Allah would provide care) led to the increased likelihood that a woman would not seek out or receive care. This finding related to religion may intersect with the HBM, in that perceptions related to religious beliefs influenced participants’ perceptions of the efficacy of care.

## Health Belief Model

The HBM (Hochbaum, 1958; Hochbaum, 2010), developed by the U.S. Public Health Service in the early 1950s, is a model that assesses patient behavior according to various factors (Janz & Becker, 1984). Individuals’ health care behaviors depend on sufficient motivation to address health issues, feelings of vulnerability to illness, and a belief that following a health recommendation will reduce the threat without undue cost (Janz & Becker, 1984). Rosenstock et al. (1988) augmented the concept of perceived benefit with a patient's perceived self-efficacy, noting that when a person feels comfortable with the direction of health care, including preventive health care, he or she is more likely to seek it out. Thus, Rosenstock et al. highlighted unless a person feels comfortable seeking out, receiving, and enacting care, then he or she will most likely not engage in a given intervention; this feeling could be influenced by demographic characteristics as well as community and health care provider actions. Figure 2 details the posited relationship of the HBM between individual and demographic variables.

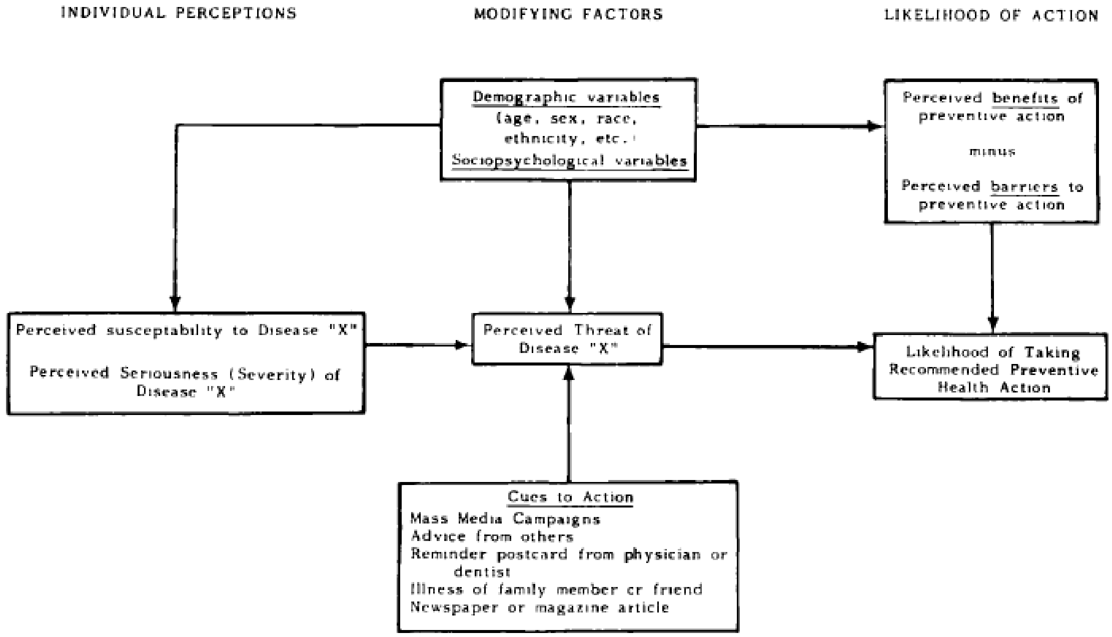


*Figure 2*. Modifying several factors potentially changes perception and behavior using elements of the HBM. Adapted from "The Health Belief Model: A decade later," by Janz, N. K. & Becker, M. H., 1984, *Health Education Quarterly, 11*, p. 4. Copyright 1984 by Society for Public Health Education. Reprinted with permission.

**Studies using the HBM.** In contemporary research, the preponderance of studies into the HBM involved use of the quantitative method (Almadi et al., 2015; Eskandari-Torbaghan, Kalan-Farmanfarma, Ansari-Moghaddam, & Zarei, 2014; Kim & Zane, 2015; Yoo, Kwon, & Pfeiffer, 2013). Many studies used the HBM to address preventative care, including Almadi et al. (2015), who verified that an instrument based on the HBM predicted preventative colorectal cancer screening, and Eskandari-Torbaghan et al. (2014), who found that the HBM constructs of perceived susceptibility, perceived benefits, and perceived barriers formed a model to predict breast cancer screening. Eskandari-Torbaghan et al. slightly contradicted Almadi et al. because only perceived barriers independently predicted breast cancer screening, whereas Almadi et al. found that variables from perceived severity and perceived benefits had independent predictive value. Perceived severity and barriers were also relevant to explaining 21% of the variance in health-seeking behaviors among food-allergic adolescents, according to Jones et al. (2014).

Relevant to this study, Kim and Zane (2015) used the HBM to address racial differences in seeking care. In a sample of Asian and Caucasian Americans students, Kim and Zane assessed factors based on the HBM, including perceived benefits, perceived barriers, and perceived severity, on help-seeking behaviors in psychologically distressed students. Asian American students perceived more barriers to their care, but this factor did not seem to influence care-seeking behaviors when compared to Caucasian students. However, consistent with Almadi et al. (2015), the perception that a treatment would not be beneficial was more prevalent among Asian American students than among Caucasian students, and it did significantly interfere with care-seeking behaviors. Kim and Zane's research suggested that the HBM could help explain racial disparities in health care and health care-seeking behaviors, as discussed in this study.

These researchers validated the use of the HBM to explain health care behaviors in large populations. In particular, factors associated with health care behaviors included perceived severity (Almadi et al., 2015; Jones et al., 2014); perceived barriers to access (Jones et al., 2014; Eskandari-Torbaghan et al., 2014); perceived benefits and treatment credibility (Almadi et al., 2015; Kim & Zane, 2015); and the influence of the media (Yoo et al., 2013). Demographic variables endorsed by the present research were ethnicity and ethnic beliefs (Kim & Zane, 2015); other demographic variables' influence on behaviors in studies using the HBM have not been supported (Almadi et al., 2015).

The HBM has potential utility for explaining data collected in the present study beyond the Andersen behavioral model. One potential area for development is that although researchers who used the Andersen behavioral model hold population characteristics as pivotal to understanding health-seeking behaviors, the HBM treats these characteristics as secondary, modifying factors. In fact, contemporary research has been mixed related to the influence of demographics regarding the HBM with Almadi et al. (2015) finding no demographic influence while Kim and Zane (2015) determined the HBM facet of perceived benefits and barriers were influenced by ethnicity. The HBM also adds the factor of perceptions of treatment efficacy, an element that the Andersen behavioral model does not include. An essential addition of the HBM is the importance of media campaigns and interventions on individuals' health seeking behaviors (Yoo et al., 2013). Among data collected from 5,586 individuals, Yoo et al. (2013) determined the media interventions, in the form of television, print media, and the Internet, as well as conversations within the community, had a direct and significant influence on perceived fears and expectations of colorectal cancer screening. The HBM further specifies the construct of acculturation to account for health care interventions from outside sources, compared to the Andersen behavioral model, which does not. These developments are particularly important for interventions in policy, such as the examination of the role of an African American church in helping underserved populations.

Together, the Andersen belief model and the HBM denote the influence of demographic and social factors on health behaviors, and may account for the role that churches could play in addressing health care disparities under PPACA. Regarding the HBM, Majaj et al. (2013) noted perceptions were essential in determining a person's likelihood to make decisions and act, and Babitsch et al. (2012) noted similar outcomes related to the Andersen behavioral model. Thus, these two conceptual frameworks, as well as the contemporary research published about these two constructs, highlight the need for a qualitative study on the role of faith-based organizations to fully understand the perceptions of the underserved and the role of the church in mitigating health care disparities. These perceptions are irrelevant without appropriate policy measures to support the needs of African American underserved populations; thus, additional theoretical backing was necessary for framing the study.

## Kingdon's Multiple Streams Framework

For the policymaking research component of the study, I used Kingdon's (2011) conception of the multiple streams framework of the policy process. Howlett et al. (2015) added new dimensions in the form of metaphorical stages, cycles to Kingdon's multiple stream policy process. These changes stemmed from the Howlett et al.'s critique that Kingdon's model did not capture policy events past the agenda-setting phase for ongoing decision-making interventions. Kingdon's model remained appropriate as the theoretical grounding for the present study, as the church is still in its infancy regarding its role as a stakeholder in reducing health care disparities. Societal goals, objectives, and purposes are essential to establishing public policy (Dye, 1972), and Kingdon (2011) emphasized policymaking agendas change or possibly are delayed depending on converging circumstances related to the problem, such as resolutions or more pertinent agenda focus. The multiple streams framework allows researchers to understand people's choices and the processes or influencing factors creating the outcomes (Zahariadis, 1995). Essentially, Kingdon proposed three streams exist in every policy process: problem, policy, and politics. When the streams are formulated in isolation of one another, then the likelihood is that no intervention or policy change will occur. If the streams intersect, then it is likely that a policy will be adopted. Figure 3 depicts the basic tenets of Kingdon's multiple streams framework.

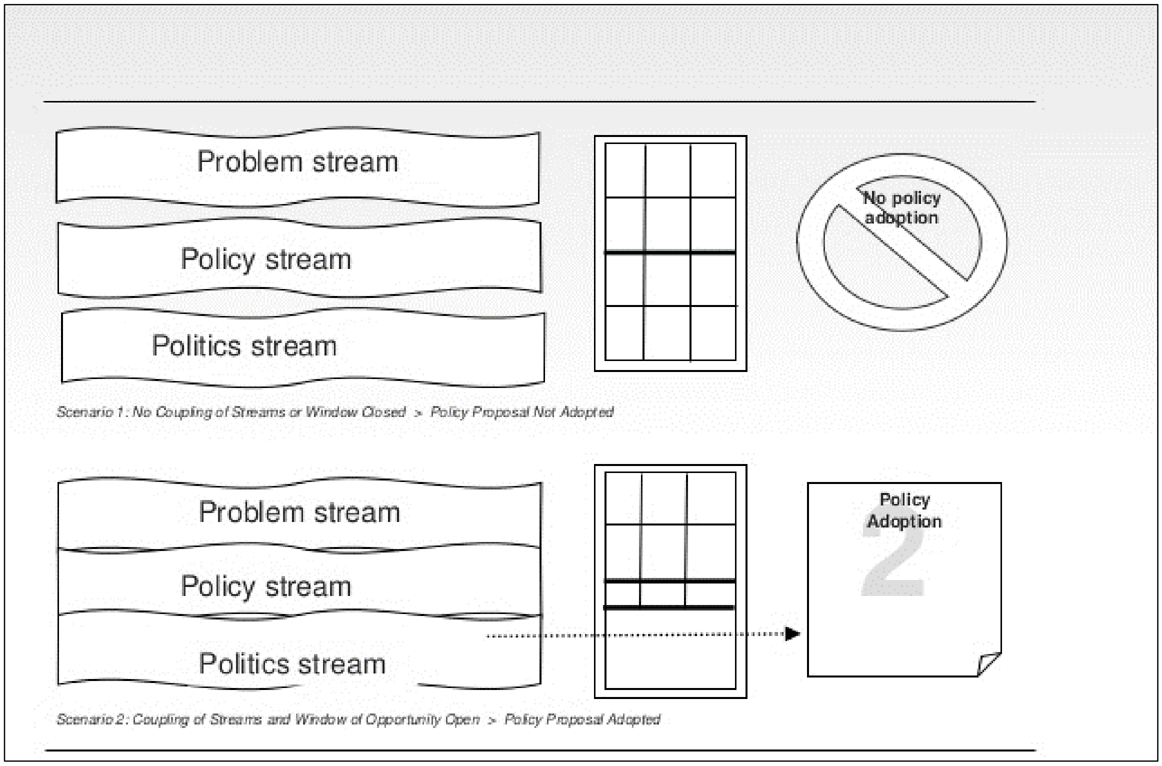


*Figure 3.* Kingdon’s multiple streams model. Adapted from “Emerging issues in understanding evidence in complex public health situations,” by R. C. Brownson, 2014, Health and Medicine, Slide 15. Copyright 2016 by LinkedIn Corporation. Retrieved from www.slideshare.net/Institut_national_du_cancer/21-ross-c-brownson. Reprinted with permission (see Appendix A).

Kingdon’s (2011) theory was heavily influenced by Lasswell’s (1972) research. Lasswell noted that it was essential to understand multiple stakeholders in the policymaking process. In particular, Lasswell called for generalized attention and awareness on the progress of political and policy actions. Through the input of those affected by the policy, Lasswell proposed that the policy could be perfected by providing unbiased appraisals of the actual realities of policies. Kingdon’s theory of multiple streams codified the ways in which these different perspectives contributed to policymaking action. Howett et al. (2015) incorporates real-time problems, policy events, criticalities, decisions, and the many intricate details formulated from the beginning of the policy process through completion. Therefore, strategic analyses and actions can be analyzed and built upon as required.

Based on a systemic review of literature, Moloughney (2012) determined the multiple streams framework was the most common conception of policymaking research, used in approximately two-thirds of policymaking literature. Specifically, Moloughney outlined the multiple streams framework encompassed policy issues, such as chronic disease, infectious disease, child health, environmental health, and urban policy and health assessments. Since Kingdon's multiple streams framework stemmed from analysis of U.S. federal policies, Zahariadis (1995) extended the framework to other countries for comparative purposes. Per Moloughney's analysis and because PPACA is a United States phenomenon, the multiple streams framework as espoused by Kingdon is most appropriate for health-related policy issues addressed in this study considering the proliferation of problems, policies, and politics involved in these decisions. Kingdon's model was expanded by Howlett, et al. (2015) to include tributary model governing resources, three-streams-two-phase model processing new issues, four-stream models consisting of participants and choice opportunities, and the five-stream model pinpointing public policy details and strategic actions taken while maneuvering through policy outcomes.

Several other theorists addressed the policymaking process, but they were not appropriate for the proposed study for various reasons. Rouse (2000), in the theory of complex adaptive systems, noted that organizational and political policy were characterized by nonlinear and nonfixed behaviors from smaller actors, or micro-structures that adapt over time to create a unified and successful whole, or macro-structure. Changes of one’s images or values are criteria for this theory, which did not align with the intended goals of my study. The complex adaptive systems seem to better explain organizational management rather than policy change, specifically when the organizational processes are repetitive and have incremental change over time (Rouse, 2000). Conversely, the PPACA was an overhaul of the health care system on multiple levels, and therefore not fitting for Rouse’s theory.

An additional theory considered was the advocacy coalition theory (Sabatier, 2007). Advocacy coalitions are a theoretical lens used in comprehending political policy processes and the subsystem outcomes. Essentially, an advocacy coalition is a group of actors, including politicians, agency officials, and researchers, who share a common belief and band together to enact policy. Zahariadis (1995) used the advocacy coalition to compare the theoretical lens with rational choice and multiple streams, and found that the advocacy coalition focus on subgroup details was a disadvantage for policies impacting larger groups and systemic changes. For example, an appropriate smaller scale focus was exemplified by Weible and Sabatier (2009), who used the advocacy coalition framework to understand the perceptions of policy participants involved in implementing a water quality policy on Lake Tahoe Basin. Conversely, this study is intended to provide explanatory value for underserved African Americans, who have diverse experiences and beliefs that may come from the intersection of multiple aspects of experience, including the problem, politics, and policy. Therefore, advocacy coalition was not appropriate for understanding the systemic influence of the PPACA.

Thus, the multiple streams framework (Kingdon, 2011) was the theoretical basis for understanding the complex policy adoption process at work in addressing health care disparities considered in this study. The multiple streams framework is the only lens allowing for broader understanding of the unlimited controlled and uncontrolled variables influencing values and beliefs in policymaking (Zahariadis, 1995). Kingdon's multiple streams model provided the bases in aforementioned traditional studies and was expounded upon in recent empirical-theoretical studies (Weible & Schlager, 2016), including enhanced knowledge of public policy processes and analysis, which is the rationale for utilizing it in this study application. For the present study, the problem stream was health care disparities, and the politics stream was assessing critical factors linked to the problem for improved PPACA implementation, specifically CHNAs. Adding the Andersen (2007) behavioral model and the HBM (Hochbaum, 2010) helped to explain the problem stream. The goal was to determine whether faith-based organizations potentially play a role in the policy stream. Fundamental policy elements were based on understanding, defining and framing problem(s), such as, health care disparities, to create value-added and persuasion through evidence of data (Presidents and Fellows of Harvard College, 2016). First, however, it was fundamental to understand the current problem of health care disparities.

## Health Care Disparities

Health care access is the ability to obtain or receive services to meet health needs adequately (Levesque et al., 2013). Conversely, health care disparities are the inability to receive this care, often linked to predisposing factors (Levesque et al., 2013). Levesque et al. (2013) cited clearer definitions for access to care (i.e., clarifying *access* to include multiple interfaces between people, their conditions, and their connection to health services) are important as the demand for care increases and reform policies develop. According to Levesque et al. (2013) and Waidmann and Rajan (2011), access to care is associated with situational factors, human features and traits, community support, work performed (care giver and care agency), operational need (market requirement), and expenditures (insurance, fee-for service).

As noted in the Andersen model (1968, 1995), predisposing factors included race, gender, age, residency, culture, and income. Without accounting for these factors, researchers cannot fully grasp or understand the extent of health care disparities and how they influence at-risk populations in the United States (Levesque et al., 2013). Improved communications between health care providers and agencies built around universally defined concepts are needed to enforce consistent health care standards.

As Andersen et al. (2007) noted, health care disparities in the United States have been an ongoing issue, resulting from problems with access to care, cost control, and assuring quality. Minority populations, including African Americans, Hispanics, Asians, American Indians, and Native Alaskans, were the disparity populations more likely to receive less quality of health care (Andersen et al., 2007). Specifically, Andersen et al.

(2007) found the African American population was at the highest risk of morbidity and mortality because of health care disparities. Andersen et al. proposed the most effective method to reduce health care disparities was to implement community-based outreach programs effectively.

Similarly, Waidmann and Rajan (2011) determined ethnic differences fundamentally influenced the health care disparities experienced by people in the United States. Waidmann and Rajan attempted to address a gap in the literature on health care disparities by using a data set from multiple states, the National Survey of American Families (NSAF). The NSAF collected data from more than 40,000 noninstitutionalized individuals in the United States. Waidmann and Rajan utilized this retrospective data, as well as data from insurance surveys and other national surveys, to make determinations about health care disparities in 13 states.

Using this quantitative analysis, Waidmann and Rajan (2011) determined significant differences in health care disparities existed among the different ethnic groups. Nationally, Latinos are more disadvantaged than Caucasians for ethnic disparities as related to insurance (23.5% and 8% gap unexplained), income (28%), citizenship (14%), education (11%), demography (5%) and family (1%). A gap of approximately 14% is unaccounted for in income and citizenship. Health disparities among nonEuropean American Hispanics related mostly to lack of citizenship. Conversely, African American populations' disparities with nonHispanic European Americans were somewhat smaller than those indicated with Latinos, and noted as income (45%), family (16%), education (10%), insurance (8.6%), demography (4%) and citizenship (3%).

Income and marital status were key reasons for health care disparities among African Americans (Waidmann & Rajan, 2011). Waidmann and Rajan explained their findings suggested that different strategies were necessary for reaching different ethnic populations and addressing their health care disparities. Limitations included their data set was fairly outdated and did not account for the implementation of the PPACA, which may have improved or changed factors influencing health care disparities.

Health care disparities may stem from systematic racism within health care systems (Griffith et al., 2010). Griffith et al. (2010) used a phenomenological approach to historical research assumptions that there were links between disparities, ethnic factors, and racial factors. The purpose of this article was to explore institutional and organizational racism in an effort to construct a strategic framework of interventions to reduce health care disparities. The researchers performed two studies to address systemic and conceptual racism in health care organizations. An educational model was designed and used to improve competence in professional communications as a treatment for one group (Griffith et al., 2010). Customer service surveys indicated clear distinctions of staff members' treatment of patients cared for by ethically trained professionals compared to staff not trained. In addition, follow-up discussions revealed that differences in treatment were noted at all operational levels for African Americans in the health care setting; for example, African Americans were offered fewer treatment options. The research supports the fact that racism is more prevalent in the absence of cultural diversity and sensitivity training programs, workshops, and other activities (Griffith et al., 2010). The framework incorporated measures for breaking down racism and had benefits for changing environmental (cultural, social, physical, etc.) factors influencing behaviors and improving hospital outcomes to provide the highest quality in care to all patients.

In 2015, despite measures and policies implemented to counteract the problem, health care disparities remained common in the United States. According to the CDC (2013), as of 2012, health care disparities continued to exist for minority populations, including the lack of access to care, limited health care coverage, and social, economic, and environmental factors. For example, 2009–2011 statistics demonstrated African American populations were at a higher risk than European American populations for deaths from heart disease and stroke, hypertension, obesity, diabetes, and infant mortality (CDC, 2013). Moreover, families with higher incomes may be more likely than those with low incomes to engage in physical activity and other positive preventive health behaviors (Thompson, Berry, & Hu, 2013).

These remaining disparities suggested that, in line with Slota's (2004) findings among 110 Mexican Americans in Milwaukee County, simply having health care insurance did not remove disparities. Rather, per the Andersen model, Slota (2004) found demographic factors, such as marital status, language, and ethnicity, were more likely to influence health care access issues, and barriers to receiving care included cost and availability of services. Race, gender, age, residency, culture, and income influence health care disparities in the United States (Derose et al., 2011; Gaskins et al., 2012; Griffith et al., 2010; Kim et al., 2012). To address these disparities, the CDC (2013), as proposed by Andersen et al. (2007), suggested a comprehensive, community-driven approach to reducing disparities was necessary, one that engaged diverse, nontraditional stakeholders in the health care process. These disparities continue to exist despite the PPACA, which was designed to help eliminate health care disparities.

## PPACA and Health Care Disparities

The PPACA (2010) standardizes health insurance reform; however, access and provision of care are more complex and require integration interventions at every care delivery level. Since the passage of the PPACA, Moses III et al. (2013) noted that providers have tended to develop a complex comprehension of health care consistent with theoretical views of health behaviors (Andersen et al., 2007; Hochbaum, 1958; Hochbaum, 2010). Under PPACA, particular emphases are placed on preventive care and education, which require the involvement of the community, as well (Krist et al., 2013). Through these adjustments in perspectives of health care, government stakeholders intended to decrease health care disparities (Moses et al., 2013). Nevertheless, health care disparities under the PPACA persist (CDC, 2013), suggesting only having health insurance is not enough intervention to reduce disparities (Slota, 2004).

Using data from the Health Communication Research Laboratory, Kreuter et al. (2014) used pre-existing mixtures of study information and reports from 1990–2013, to gain insight on improving effectiveness of communications to individuals needing health insurance access. The populations of focus were individuals with low-incomes, who lacked college educations, had one-parent households, and were minorities because of racial or ethnic backgrounds. The goal was to represent the same population targeted by PPACA for insurance coverage. For instance, Kreuter et al. found approximately 40% of people calling social workers for shelter and food assistance were uninsured. Therefore, Kreuter et al. highlighted a need to partner with programs better known to low-income populations, such as public housing, low cost energy assistance programs, unemployment agencies, schools, and churches, to address health care disparities under PPACA. Empirical findings supported recommendations for enhanced partnerships by cultivating and prioritizing outreach initiatives, messaging techniques, and information systems for low-income participants.

Miller et al. (2014) contrasted data for the influences on health care disparities (i.e., minorities, low socioeconomics, physical or mental disabilities, and lack of health insurance) and found insurance coverage as the major contributing factor. The researchers used a quantitative research model, including multistage probability design, descriptive comparing, multivariate regression, and post estimate tests to analyze data from the Agency for Health Care Research and Quality regarding the U.S. population. Findings suggested despite health reform policies promoting expanded insurance coverage, disparities continued to exist. For example, more disabled European American adults were covered by private insurance than African American or Hispanic adults, but African American adults had more Medicare and Medicaid coverage than the European American populations. Miller et al. also noted low socioeconomic status increased the likelihood of health disparities within the sample. Moreover, disparities in health care insurance led to increased use of the emergency rooms rather than preventative care.

Both Kreuter et al. (2014) and Miller et al. (2014) suggested that contrary to Slota’s (2004) findings, PPACA coverage may be slightly changing the issues with health care disparities experienced in the United States, including increasing preventative care for those with coverage and the necessity of partnership with outside organizations; however, socioeconomic and racial barriers remained (Miller et al., 2014). Because the focus of Miller et al. (2014) was primarily on individuals with disabilities, the results may not transfer into general populations, though previous researchers suggested these are common issues (Andersen et al., 2007; CDC, 2013). Derose et al. (2011) noted an emphasis on public health could potentially work to minimize the disparities in health care. To accomplish the goal of improving health care access, a more in-depth knowledge was needed of the underlying determinants from under represented and underserved populations (Derose et al., 2011).

To address the remaining health care disparities under PPACA, stakeholders may need to implement an integration framework (Krist et al., 2013). Using multisite qualitative data collected by 50 research professionals, Krist et al. (2013) noted that given the expanded coverage of insurance and technology advance, the frameworks that integrated clinical and community services are most promising to improving overall health care quality. In other words, to derive appropriate health care quality for all individuals, managers of health care systems must create and engage communities as constituencies with aligning goals, financing, and monitoring over time (Gibbons & Casale, 2010; Krist et al., 2013). Two relevant integrated framework interventions from PPACA’s accountable care organizations and CHNAs described in this study helped to further reduce health care disparities are ACOs and CHNAs.

## Accountable Care Organizations

One example of a PPACA requirement that may influence health care disparities is the implementation of ACOs, or groups of integrated providers charged with improving care and reducing costs of health care within a specific patient population (Burke, 2011). The creation of ACOs emphasizes health care is a complex system that extends beyond the relationship between provider and patient (Burke, 2011). Currently, ACOs include only health care providers (Ryan, Shortell, Ramsay, & Casalino, 2015), but expanding ACOs to include community agents, such as faith-based organizations, could potentially help to fill the gap for underserved populations through PPACA provisions. According to Gourevitch et al. (2012), nongovernmental organizations could share accountabilities and rewards in expanded population health care outcome goals through ACO contracts. These changes would be in line with recommendations from Andersen et al. (2007) and the CDC (2013) about involving the community in reducing health care disparities.

## Community Health Needs Assessments

Another example of a PPACA mandate intended to increase health care quality and decrease disparities is section 9007(a) of PPACA, which requires that local health departments must conduct a CHNA every 3 years to maintain their tax-exempt status. The IRS oversees this process (Pennel et al., 2015). Hospitals, public health departments, 501(c) 3 agencies, and other federally funded agents conduct quarterly CHNAs as evidence-based data for continued support from the federal government (Alberti, 2014). Moreover, community agencies can pull the data from CHNAs to improve health care delivery and interventions (Pennel et al., 2015). Thus, the CHNA works as a national monitoring tool, intended to improve the detection of health care disparities while intervention is still viable (Alberti, 2014).

As a relatively new process, CHNAs required some additional validation. In an effort to provide this validation, Alberti (2014) collected qualitative and quantitative population health data produced from multilevel health care systems, health researchers, and health professionals and leaders in the health arena. The resultant data were analyzed for degrees of enhanced health services and indicators of improved health outcomes. Findings suggested successful CHNA models improved agencies' likelihood of meeting target goals (Alberti, 2014). Alberti also found agencies were inconsistent in CHNA utilization, and few CHNA sponsored health agencies solicited researchers as principle stakeholders in planning endeavors. Alberti's research proved that when appropriately implemented, CHNAs were valuable in mitigating health care disparities, although this successful utilization required input from multiple data sources in the community, which might include faith-based organizations.

Using quantitative analysis, Pennel et al. (2015) collected data from 179 nonprofit health agencies in Texas to assess factors that contributed to report quality. From these agencies, Pennel et al. reviewed 95 CHNAs and implementation strategies reports and scored them using 16 specific criteria items from a public health framework. Analyses included Pearson correlations and Spearman rank correlations to determine relationships between variables. Findings showed wide-ranging diversity in hospitals' and public health departments' CHNA approaches and in reporting quality. The reports led by consultants with collaboration from local health departments were of a higher quality, but only 13% of the hospitals had meaningful collaborations with health departments (Pennel et al., 2015). Pennel et al. used a 6-point scale, ranging from 0 (*not addressed*) to 5 (*high quality*). The areas requiring the most improvement was identifying issues and strategies that considered social determinants of health (1.15), use of evidence-based strategies (1.34), consideration of local contextual factors (1.40), and examination of contributing causes to health issues (1.70). The highest mean score was for the criteria item on examination of data using reliable sources and multiple data collection sources and methods (3.35). These results indicated more needed to be done with the data collected from multiple sources and stakeholders to identify the social, environmental, and other contributing causes to health issues (Pennel et al., 2015).

As an example of how the data from a CHNA can be used, Alfano-Sobsey, Ledford, Decosimo, and Horney (2014) collected data from the CHNA conducted in Wake County, North Carolina. Alfano-Sobsey et al. considered community opinion surveys, focus groups, and interviews, as well as data from state, county, and local sources. Stakeholders included Wake County Human Services (Lead), WakeMed Health and Hospitals, Duke Raleigh Hospital, Rex Health care, Wake Health Services, United Way of Greater Triangle, Wake County Medical Society Community Health Foundation, and Urban Ministries. Poverty, unemployment, health care access and utilization, mental health, and substance use were areas of concern. Public opinion surveys revealed the people requested increased positive teen activity opportunities and healthy eating resources. The findings subsequently appeared on the county’s website to increase transparency (Alfano-Sobsey et al., 2014).

A contribution of Alfano-Sobsey et al.'s (2014) with relation to the present study involved the collection of CHNA data through the community. By adding public opinion surveys to the CHNA, Alfano-Sobsey et al. received a clearer picture of the disparities between public perceptions of needs in public health and solely including hospital data. Community forums were held in places, such as a senior center, hospitals, churches, and the regional health department in Wake County. The multiple sources allowed the assessment strategy to capture increased visibility and broader, more diverse participants. The overall collaborative process introduced opportunities for partnership with other organizations for improved action plans, resource pooling, integrated participation in CHNAs, and reduction of health disparity needs. Specifically, Alfano-Sobsey et al. used churches as one of their methods of gathering a large population together easily.

Based on findings from Alfano-Sobsey et al. (2014) and Pennel et al. (2015), collaboration as a community offers benefits of improving the overall quality of CHNAs. Through increased quality of reporting, communities can more easily identify and intervene in areas of need (Pennel et al., 2015). Pennel et al. suggested policymakers and designers of programs intended to reduce health issues must redirect their focus for helping the socially and economically disadvantaged through the use of multiple community approaches. Churches may be untapped nonprofit organizations that can conduct CHNAs in collaboration with public health and nonprofit hospitals to gather data and research on human factors (age, gender, cultural, socioeconomic, behavior, etc.) to assess health beliefs, environmental challenges, and other determinants or factors associated with health disparities.

Faith-based organizations may facilitate both CHNA processes and ACOs by increasing underserved populations' access to secular resources through counseling and advising (Davaney et al., 2012). As Moloughney (2012) proposed, for health policies to be successful, multiple diverse stakeholders must engage in the policymaking and implementation processes. Furthermore, faith-based organizations may allow for an alternative community information source in adequately evaluating the state of health care in CHNAs. This potential role is evident in the success that faith-based organizations have had previously in health care interventions.

## Religion, Faith, and Health Care

For some individuals, their places of worship play an integral role in their day-to-day lives and decisions (Theuns, Baran, Van Vaerenbergh, Hellenbosch, & Tiliouine, 2012). For example, when a Christian person is sick, he or she may reach out to a church congregation or church leaders for intervention, guidance, and support (Levin, Chatters, & Taylor, 2010). Moreover, religion may influence a person's state of mind, which can contribute to mental well-being (Levin, 2010) and potentially increase a person's self-efficacy regarding health care behaviors. Increasing self-efficacy is essential for health care action according to the HBM (Janz & Becker, 1984).

Religion can significantly influence a person's willingness to seek out and complete medical care (Chaze, Thomson, George, & Guruge, 2015). Specifically, as Koenig (2012) noted based on an extensive review of the literature, research demonstrated religion and spirituality had significant positive effects on emotional wellness, hopefulness and escalated self-esteem, coping mechanisms for overcoming health issues, and dealing with adversities (environmentally, genetically, and mentally). Religion may also influence individuals' perceptions of specific treatments and interventions, making them more or less willing to receive medical interventions (Chaze et al., 2015). Religious individuals may be more equipped to handle adversity and to take preventive actions to maintain their health (Holt, Clark, Debnam, & Roth, 2014).

To demonstrate the potential role of religion in health care, Theuns et al. (2012) performed a cross-cultural analysis of opinion differences among groups of individuals to assess the relationships among life satisfaction, health, religion, and personal relations. Theuns et al. used an information integration theory to discern meanings for quality of life as expressed by surveyed study participants. The researchers used a Personal Wellbeing Index to measure personal security, health, religion, and quality of health. Theuns et al. hypothesized prevalence of different health care concepts existed across cultures. Another hypothesis was that religion, beliefs, and personal health beliefs are stronger among certain cultures. Findings indicated cultural differences in the conceptualization of life satisfaction existed. In addition, the findings indicated personal relationships, health, and spirituality yielded overall satisfaction with life and improved accessibility to health care provisions. The findings suggested influences existed regarding individuals' belief systems with cultural mixing or diversity. Theuns et al., however, did not assess the specific relationship between religion or religious interventions and health care access, which I examined in the present study.

For the purposes of the present study, the role of the faith-based organization was isolated to the case of three African American churches. Whereas a faith-based organization is any organization led by a religious group, a church is specifically the place where members of that religious group congregate for religious services—not all faith-based organizations are churches (Chai, 2015). According to the IRS (2015), a church must have a distinct legal existence; a recognized creed and form of worship; a definite and distinct ecclesiastical government; a formal code of doctrine and discipline; a distinct religious history; a membership not associated with other church or denomination; an organization of ordained ministers; ordained ministers selected after completing prescribed studies; a literature of its own; established places of worship; regular congregations; regular religious services; Sunday schools for religious instruction of the young; and schools for the preparation of its ministers. With increasing technology, the definition of a church has become broader (Dean, 2013); however, for the present study, and in the majority of the literature pertaining to churches and health care, the presence of a specific physical location is important.

Davaney et al. (2012) and Ward (2011) noted the influence of churches as institutions in promoting social change within communities. Specifically, Davaney et al. (2012) determined churches and community organizations share similar visions and values to guide and pursue beneficial actions as change agencies within the community. Ward (2011) also proposed that a church was like an organization, with its own organizational culture and the need for clear leadership, mission statements, and goals. Through the development of these tenets, the church can be a viable source of stability for individuals, as well as act in the promotion of resources (Krist et al., 2013). The role of the church may be limited by the lack of funding and support for faith-based organizations, unlike those resources afforded to official government-based organizations that do receive formal support (Davaney et al., 2012).

Researchers have supported the role of faith-based organizations in potentially increasing the outcomes of health care interventions in underserved populations. As Chai (2015) noted, faith-based organizations, specifically churches, must adapt to the context of their time and the demands of their communities. Churches often have specific racial makeups of their congregations, rather than being fully multicultural (Brotherton, 2010). Spiritual effects may be particularly experienced among underserved African American populations, because African American populations may place more trust in their church leaders than in medical professionals (Allen et al., 2010; Jo et al., 2010).

Unlike Theuns et al. (2012), other researchers, such as Moldovan (2013), have specifically outlined the role of churches in making health care interventions. Using data from the Romanian National Anti-drug Agency and reports from the European Monitoring Centers for Drugs and Drug Addiction, Moldovan assessed the relationship between the Orthodox Church in Romania and the implementation of a substance abuse health care system. Specifically, Moldovan assessed whether the Orthodox Church could assist in advancing systems for health services to persons suffering from substance abuse (particularly alcoholism) based on the researchers who found religion played a positive role in improving overall health. Findings indicated church leaders, decision-makers, and organizers acknowledged spiritual or religious interventions, but their goals did not lead to integrated partnerships. Moldovan contrasted these findings with successful church interventions for substance abuse sufferers in the United States, but less progression was noted with the Romanians because of political fears, overwhelming responsibilities of church ministries, and having few resources to carry out the demands of local communities.

Despite the unrealized role of the Orthodox Church in mitigating these health care problems, Moldovan (2013) maintained nongovernmental organizations were essential to implementing successful national health care policies. Specifically, Moldovan outlined that a church could improve individuals' access to programs and services. Through the integration of such organizations and government policies, Moldovan argued the disparity in health care among Romanian substance abusers could be significantly mitigated, based on an exhaustive review of literature. Thus, Moldovan's research supported the potential role that churches may be playing or could play in PPACA implementation. Moldovan noted this effect was particularly evident in religious communities, which is often the case in African American churches, such as those examined in this study.

As an additional intervention, some researchers concentrated on faith community nursing within churches (Donnelly, 2014; Pappas-Rogich, 2012; Sheehan et al., 2013). Faith community nurses are not hired by the church, but volunteer their time to provide health services by collaborating with church leadership, administrators, grant writers, information technologists, advertisers, and other health care parishioners (Donnelly, 2014). Faith community nurses must have 5 years of experience, have a recommendation from the clergy of the church, and complete a 40-hour training course (Sheehan et al., 2013). The American Nurses Association and Health Ministries Association supported faith community nurses as a means of integrating health into the beliefs, cultures, and practices associated with the faith communities (Sheehan et al., 2013). An organized effort, according to Donnelly (2014), has been taken to correlate nursing and medical-related practices to the church nationally and internationally.

Findings related to the use of parish nurses demonstrated several benefits to their inclusion (Donnelly, 2014; Pappas-Rogich, 2012; Sheehan et al., 2013). Donnelly (2014) examined how nurses used their skills to address the health needs of the congregation of a Lutheran church in Tennessee. Donnelly noted members of the congregation gained health care benefits when nurses were integrated into the church, such as church members seeking answers and assistance with health-related problems. Pappas-Rogich (2012) examined 19 parish nurses working in 22 congregations in the United States and found that within these congregations, elderly parishioners were more likely to receive vaccinations. In part, this increased vaccination rate was credited to parish nurses' abilities to bridge the gap between perceived incompatibility between religion and medicine (Pappas-Rogich, 2012). The results from both studies suggested providing health care within church settings may increase the likelihood that individuals will take part in these health care behaviors, potentially because of increased self-efficacy and familiarity, as suggested by the HBM (Janz & Becker, 1984).

Through qualitative inquiry, Sheehan et al. (2013) specifically studied the outcomes of a program run by faith community nurses to assess outcomes within the community. The faith community nurses implemented a program, called Defy Diabetes, for providing diabetes education to individuals below the poverty line. The Defy Diabetes goals were to increase community resources by identifying adults with diabetes, providing education to prevent diabetes risks, and improving diabetes management. Prospective participants were screened at health fairs at parishes and invited to attend four educational courses in a church, if considered at risk or had a diagnosis of diabetes, resulting in a sample of 150 graduates. Subsequently, focus groups of open-ended questions were held with the nurses to collect data and evaluate their experiences.

Sheehan et al. (2013) yielded two themes based on data analysis, both of which have significance for this study. The first was that faith community nurses noted that the congregations made lifestyle changes based on the implementation of the program. Church members participating in classes initiated bonding relationships and helped each other with new food and shopping ideas for nutritious eating. In the process, participants gained a heightened awareness of steps they could take to control and improve diabetes, leading to increased compliance. The second was that the nurses had personal benefits from implementing the programs, including empowerment and opportunities for instructional development. These findings are significant because they showed integrating health care into a congregation led to increased, long-lasting health outcomes among an underserved population (Sheehan et al., 2013).

Debnam et al. (2012) also demonstrated the role of religious support in receiving health care. The method of data collection was by telephone interviews with African American men and women in the United States. Findings indicated behavior modifications in diet, exercise, and avoidance of alcohol and tobacco added years to one’s life; and that religious group support was the most effective outside intervention in prompting health care behavioral change. Particularly in a group predisposed to health care disparities similar to those of African American communities, these interventions are valuable to establishing accountability for life changes that may decrease these health care disparities (Debnam et al., 2012); however, the results were not limited to only African American churches.

Specific behaviors from churches may be necessary for these interventions to be successful, and a faith-based organization must be willing to fulfill this role and understand the responsibilities of doing so. For example, Werber, Mendel, and Derose (2014) used 14 case studies from diverse congregations in Los Angeles County, CA (57 leadership and congregation members) to assess the role of church interventions in church members’ health needs. Werber et al. collected data regarding participants’ health activities, worship participation, and neighborhood contexts via in-depth interviews. The findings indicated that among these participants, health activities were episodic, small scaled, and local. Social factors and trust played an important role in the success of church initiatives, including responses that the church provided a safe and confidential environment. The researchers noted churches may not have the infrastructure for service provisions, but are strong in identifying unmet health needs and can network productively in the community (Werber et al., 2014). Ultimately, Werber et al. concluded these faith-based organizations engaged in behaviors typically associated with entrepreneurship as a means of intervening in the health care needs of their congregations.

Thus, numerous researchers have demonstrated that faith-based organizations play a role in individuals' health care decisions and actions (Allen et al., 2010; Debnam et al., 2012; Theuns et al., 2012; Werber et al., 2014). Particularly within underserved populations, these types of resources may be essential to ensuring that communities receive necessary health care interventions (Debnam et al., 2012; Davaney et al., 2012; Sheehan et al., 2013). Moreover, faith-based organizations, through increasing self-efficacy in care and general personal well-being (Koenig, 2012; Levin, 2010; Sheehan et al., 2013), may increase the likelihood that an individual seeks out health care interventions under the Andersen model and the HBM (Heider et al., 2014; Rosenstock et al., 1988). Multiple researchers have examined this health care influence within African American churches based on the disparities experienced in this population.

## African American Churches and Health Care

Based on the integral role of the church in African American communities, many researchers have examined the potential for the church in intervening in health care programs (Allen et al., 2010; Holt et al., 2014; Lumpkins, Greiner, Daley, Mabachi, & Neuhaus, 2013; Thomas, Quinn, Billingsley, & Caldwell, 1994; Thompson et al., 2013). In early research, Thomas et al. (1994) found that well-established African American churches with larger congregation sizes, lower socioeconomic status, higher number of paid clergy and staff, and presence of highly educated clergy were more likely to have health care programs integrated into their congregations. The findings from previous research regarding the influence of African American churches on health care outcomes suggested the intervening role of the church could provide either beneficial or detrimental influences, based on the attitudes of the church toward the particular intervention (Lumpkins et al., 2013).

One important figure in determining the role of the church in health care interventions is the pastor (Lumpkins et al., 2013). Using semistructured qualitative interviews with several African American clergy, Lumpkins et al. determined that within this sample, the pastor was likely to view health, belief, and spirituality as vitally interconnected. Moreover, the clergy shared their previous experiences with health issues with their congregations in an attempt to promote the general health of their followers. Thus, Lumpkins et al. stated pastors viewed themselves as vital players in addressing and promoting health among their congregations. Researchers described pastors as behavioral change agents based on their constructed and interpreted communications pertaining to health issues, though none of the pastors participating in this had formal medical or health-related training or credentials (Lumpkins et al., 2013). Lumpkins et al. only assessed the opinions of pastors; therefore, the research did not demonstrate whether these pastors' views of themselves translated to congregation members or if they increased positive health behaviors.

In an effort to assess the influence of church interventions on physical health, Thompson et al. (2013) assessed the influence of a church-based program for weight loss and health among African American girls, ages 12–18, attending a single African American church in the Southern United States. Data collected from the participants included health history, weight, height, BMI, size, and vital signs before and after the intervention, as well as pre- and post-program Likert-type questionnaires. Using Pearson correlations and descriptive statistics, Thompson et al. determined the intervention of the church program led to primarily positive attitudes within this sample. No statistically significant difference in outcome existed dependent on the culture, age, or gender of the participant, although higher income families were more likely to engage together in physical activities. However, positive attitudes contributed significantly to the individual's likelihood to engage in physical activity, which was promoted by family support and goal setting. According to Thompson et al., the findings showed that along with family support, church-based programs could enhance the health of young adolescents. The results are restricted because of a single-site population as well as the monetary compensation offered to participants. The compensation may have been a confounding factor in increasing enthusiasm, rather than the intervention of the church.

Similarly demonstrating the value of partnering with African American churches, Colon-Otero et al. (2012) conducted a translational pilot research study to examine the role of the church in promoting health care engagement in African American churches in Duval County, FL. Among the sample, Colon-Otero et al. collected blood specimens to evaluate for *t* (14, 18) and monoclonal proteins initially, showing an increased cancer risk and the need for educational awareness program. After selecting participants, methods of data collection included surveying subjects after conducting several educational programs focused on multiple myeloma and five behaviors that would reduce cancer risks, such as exercise, healthy nutrition, tobacco use, alcohol control, and breastfeeding benefits, as well as demographic information. Findings suggested partnerships with African American churches in the community improved awareness of educational projects and research, causing more people to participate in research and educational activities (Colon-Otero et al., 2012). The church was a venue linking to translational research and knowledge expansion of community resources, specifically for multiple myeloma.

Likewise, Allen et al. (2010) attempted to improve professional mental health care services for the African American population by enhancing partnerships with respected church leaders. Using Andersen’s behavioral model, Allen et al. used univariate and bivariate statistical analysis within a single mega church with a primarily African American congregation. Findings indicated that within the African American community, several barriers existed to seeking out mental health care, including financial reasons, fears, guilt, shame, mistrust, misunderstanding, or misdiagnosing. Allen et al. noted within this population, church members were more likely to first seek out the input of church leaders before attempting to receive medical care for their issues. Although these findings were limited to a single congregation, Allen et al. highlighted national surveys indicated African American church members have high trust in their church, and on average they reported low trust in health care providers.

Relative to this study, Allen et al.’s (2010) findings supported the potential intervention that the church could provide by referring underserved populations to mental health care resources. Allen et al. also determined the primary cited source of intervention was prayer and church counseling within this population. Therefore, conversely, church counseling could prove as detrimental to individuals receiving medical interventions in cases where faith was cited as a primary intervention for their health care issues (Allen et al., 2010), in which case churches may need to be solicited as stakeholders to avoid these negative interventions. Through this study, I added to these findings by clarifying whether churches, with their base of trust among members, can be utilized in PPACA implementation

Like Allen et al. (2010), Isler, Eng, Maman, Adimora, and Weiner (2014) also found African American churches could have mixed effects on public health interventions. To investigate the role of the church in mitigating stigma related to diseases, specifically HIV/AIDS, Isler et al. used a grounded theory, case-based qualitative approach to collect data from participants in eight African American Baptist churches in two counties in North Carolina (36 congregants and 12 church leaders). Through focus groups and one-on-one interviews, Isler et al. acquired data. Then, the researchers employed open coding and case level comparisons to analyze the acquired data.

Findings from Isler et al.'s (2014) study revealed several benefits and potential detriments of involving a church in the public health matter of addressing HIV/AIDS. As a potential detriment, based on these data, Isler et al. determined constructions of HIV/AIDS prevention were much different in churches than from a public health standpoint. Specifically, when discussing prevention, churches had a focus on avoiding sin, rather than avoiding infection. As such, church-based interventions were more likely to focus on abstinence, rather than safe sex, as a means of avoiding infection. Nevertheless, churches were a positive influence on referrals to community services and support for individuals who contracted HIV/AIDS. Thus, Isler et al. stated churches were potentially under-utilized resources in intervening in the public health.

Therefore, the research regarding Allen et al.’s (2010) findings were similar to Levin’s (2010) in terms of the role of religious beliefs in regulating mental well-being, and like Isler et al. (2014), demonstrated mixed results pertaining to reducing stigma for health care interventions when this focus was implemented in a church program. These results prove the African American church is currently influencing health care decisions within the high-risk African American community. Whether those interventions are positive or negative depends on the orientation and education of the church members involved in the intervention (Allen et al., 2010; Isler et al., 2014). These findings provided further support for public health partnerships with African American churches as a means of reducing health care disparities, supporting the general role of faith-based organizations in PPACA implementation, discussed in the next section.

## Faith-Based Organizations and PPACA

Presently, little formal research exists related to the role of faith-based organizations in PPACA implementation. Prior to 2015, scholarly literature was limited to the suggestion or implication that faith-based organizations could influence health care behaviors and policies as espoused by Isler et al. (2014) and Lumpkins et al. (2013). Promising scholarly evidence for the role of churches, particularly in CHNA reporting, was revealed in workshop proceedings from the National Academy of Sciences, which conducted a specific session on the role of communities in health care disparities under PPACA (Wizemann & Thompson, 2015). Wizemann and Thompson (2015) reported two workshop participants were faith-based organizations, and they provided invaluable information regarding disparities in health care in their communities. Research connecting individuals' stories from a narrative perspective presents possibilities related to health needs and lack of health care access for community changes, but policies are the enforcements towards actual improvements (Wizemann & Thompson, 2015). To have the power to make changes, Wizemann and Thompson noted community stakeholders, such as churches, require direct political involvement, organizational structure, and insight and global perspectives. Similarly, Moldovan (2013) stated sanctioned partnerships among faith based organizations and public policies could significantly increase the chances of positive outcomes stemming from these interventions.

Even Wizemann and Thompson's (2015) limited, informal proceedings underscored the potential use of churches as information and referral sources in implementing PPACA and decreasing disparities. For example, the CHNA reports showed vast social influences, such as inadequate food, jobs, transportation means, and support systems, inadvertently led to increased hospitalizations and noncompliance with medical regimens (Alberti, 2014). Churches at the community level revealing an individual's difficulties paying for medications or co-pays can bring additional awareness to church leaders and health ministries to help close a gap by addressing the problems or referring them to appropriate professionals and support systems (Jo et al., 2010). Conversely, if church leaders are unfamiliar with or uncomfortable with services, they may function as frontline intervention stakeholders and potentially deter individuals from receiving care (Allen et al., 2010). This deterrence would result in these church leaders tacitly functioning as negative community members of an ACO, and would suggest alternative community resources needed to be sought out to meet these needs (Andersen et al., 2007; CDC, 2013).

Demonstrating the promise of faith-based organizations, specifically churches, in addressing health care disparities, three articles were published in 2016 that addressed the role these organizations could play in PPACA implementation: Franz and Skinner (2016), Galiatsatos and Hale (2016), and Villatoro et al. (2016). These studies did not assess the underserved parishioners' perceptions of roles that the church could or does play in PPACA and health care disparities. Moreover, none of these studies specifically addressed African American churches, instead focusing on comparing African American and Latino churches' outreach programs (Galiatsatos & Hale, 2016), using evangelical pathways for community health care outreach (Franz & Skinner, 2016), and the theoretical role of churches for improving health care among Latinos (Villatoro et al., 2016). These articles do nevertheless have findings and implications applicable to the current study, as reviewed below.

Villatoro et al. (2016) conducted a literature review to collect the research regarding faith and the role of churches in Latino communities to assess the role faith-based organizations could play in PPACA implementation. Faith-based organizations already provided some health care services, including pastoral counseling for bereavement, divorce, and other losses, health care education, and preventative services in the Latino community (Villatoro et al., 2016). Notable in the current health care situation was that community organizations, including faith-based organizations, improved screening, delivery of care services, and general wellbeing by identifying those individuals specifically qualifying for Medicaid (Villatoro et al., 2016). Villatoro et al. indicated that funding restrictions limited the participation of faith-based organizations in providing Medicaid patient-centered health home services for vulnerable populations similar to those in secular community health centers. Villatoro et al.'s primary focus was on mental health services for Latinos, yet the determination based on the literature that the faith-based organizations could help with preventative and outreach care among these underserved populations to increase PPACA outcomes was directly relevant to the current study.

Closely related to the current study, Franz and Skinner (2016) conducted a qualitative grounded theory study in order to assess the influence of evangelical churches on PPACA and the role of religious beliefs, health beliefs and behaviors, social engagements, and perspectives in facilitating the PPACA. Franz and Skinner identified 29 participants (ages 29-65; 19 females and 10 males; 26 Whites, 1 Black and 2 Asians) through snowball convenience sampling in three evangelical churches, and conducted personal interviews about religious beliefs, health beliefs and behaviors, social engagements, and perspectives on PPACA. Many participants noted that their churches could play a key role in the PPACA implementation by providing community-based primary care. A limitation of Franz and Skinner's study was that the participants were overwhelmingly Caucasian; thus, their results may not generalize to other populations, such as African Americans and Latinos, who disproportionately experienced health care disparities (CDC, 2013). Factors, such as distrust in the health care community among African Americans, could potentially alter the findings (Galiatsatos & Hale, 2016).

Franz and Skinner's (2016) study nevertheless had potential implications for the current study. Interviewees felt that health inequalities should not be allowed to persist, with many participants expressing disbelief that health care disparities persisted in the United States compared to unindustrialized countries and noting that other countries may not have the same standards of reporting as in the United States (Franz & Skinner, 2016). Some participants also suggested that introducing community involvement through Protestant Evangelicals would potentially cultivate a nonreligious-based clinical and social climate for improved health care delivery services. Franz and Skinner noted that the participants found health care outreach in line with their religious beliefs, though they did not necessarily have faith in the PPACA's ability to address these issues. Not all participants believed the church should have a role in the PPACA, but some felt the church should be involved with the process to some degree to improve health outcomes (Franz & Skinner, 2016).

Galiatsatos and Hale (2016) conducted a longitudinal qualitative case study of a lay health educator program in two churches, an African American Methodist church and a Latino Spanish-speaking Catholic church. Prior to the study, individuals with no backgrounds in health volunteered to participate in the Lay Health Educator Program, a 12-week course sponsored through Healthy Community Partnership and Medicine for Greater Good from John Hopkins Bayview Medical Center. Galiatsatos and Hale conducted interviews pertaining to the influence of the program during a period of 4 years.

Through these data, Galiatsatos and Hale (2016) determined that well-trained personnel as lay health educators had a positive effect on the collaboration of the faith-based community with PPACA stakeholders. Lay health educators provided information to physicians in the community regarding health needs. Lay health educators also increased trust in health agencies and helped the church parishioners overcome health and language barriers (Galiatsatos & Hale, 2016). Specifically, for African American congregations, trust in health care workers was limited and lacking; Galiatsatos and Hale’s findings suggested that collaboration between churches and health care agencies could improve the trust and thereby mitigate health care disparities. The program examined by Galiatsatos and Hale required significant resources for training individuals as well as lay health educators as liaisons; the researchers did not assess whether and how individuals already in the church could potentially fulfill these roles. In addition, the focus was split between Latino and African American churches, different populations with different health concerns (Villatoro et al., 2016).

The recent literature suggested that additional partnerships are essential for meeting health care disparities under the PPACA (Kreuter et al., 2014). According to Galiatsatos and Hale (2016), Jo et al. (2010), and Villatoro et al. (2016), church and health care organization partnerships play a role in collaborating and implementing health promotion programs, thereby closing the gap on disparities. As demonstrated by Franz and Skinner (2016) and Galiatsatos and Hale (2016), the potential roles of churches in PPACA need further exploration through qualitative methods, as the current study addressed within a population previously unexamined as the sole focus of a study: underserved African Americans. Based on the dearth of knowledge regarding the partnerships between churches and stakeholders in the PPACA, however, further formal research is necessary to understand the role of faith-based organizations, specifically African American churches, as stakeholders in the PPACA processes.

## Summary and Conclusion

The CDC (2013) and Miller et al. (2014) found health care disparities continue to exist in the United States, even under the PPACA. Though policymakers designed the PPACA to address these disparities, research has shown the mere availability of health care is not enough to fully address the problems with the health care system, including racial, environmental, and social factors described by Andersen’s model of health care disparities and the HBM. In this vein, many researchers and health care advocates have outlined the necessity of involving multiple stakeholders, including nongovernmental organizations, in the policymaking process to reduce health care disparities (Andersen et al., 2007; CDC, 2013; Moloughney, 2012).

Interventions involving multiple stakeholders that approach from different angles may be the key to eliminating health care disparities. Kingdon’s (2011) multiple streams framework provided guidance for understanding the complex processes of policymaking implementations. In line with Kingdon, Derose et al. (2011) determined public health could play a role in narrowing the gap in disparities through partnerships with community-based organizations by linking any individual who is uninsured or uninformed to the proper resources for help. Because effective communication is essential for delivering culturally sensitive and linguistically appropriate messages regarding the importance of health care and the available resources (Chaze et al., 2015;

Yoo et al., 2013), finding stakeholders with a record of effective communication records is essential to making lasting interventions in the lives of underserved populations.

In 2015, research relating to one particular potentially effective stakeholder, the church, is lacking. Researchers have noted a relationship between religious beliefs, overall well-being, and health care access (Theuns et al., 2012), and other researchers have determined church interventions may successfully implement health care programs and positive health care behaviors (Allen et al., 2010; Lumpkins et al., 2013; Thompson et al., 2013). Moreover, it is well known that predisposing factors and beliefs may have some influence on one's willingness to seek health care services (Miller et al., 2014). No researchers, however, have formally examined the role of the church in providing support for the implementation of PPACA in service of reducing health care disparities.

It is therefore necessary to understand the health care disparity needs of the African American church population to determine what potential roles the church can play in the PPACA implementation. Previous researchers have focused on this potential role through literature review (Villatoro et al., 2016) and through qualitative methods (Franz & Skinner, 2016; Galiatsatos & Hale, 2016), yet they have not focused on African American churches alone or the perceptions of parishioners as to the role of their churches in addressing health care disparities. Specifically, the church may act as a participant of an ACO and gather data for CHNA evaluations to better collaborate, regulate and monitor disparity health situations within the community. Through this intervention, churches may mitigate health care disparities and reduce social inequalities.

What research does exist on the intervention of churches in health care programs primarily involved case-based approaches (Allen et al., 2010; Galiatsatos & Hale, 2016; Thompson et al., 2013). For those researchers who examined disparities, specifically, a qualitative approach provided information regarding barriers and the role of the church in reducing those barriers (Allen et al., 2010; Franz & Skinner, 2016; Galiatsatos & Hale, 2016; Lumpkins et al., 2013). Researchers have noted faith-based organizations may play a role in providing health care interventions (Allen et al., 2010; Thompson et al., 2013), but few studies suggested a similar effect may carry to PPACA implementation (Franz & Skinner, 2016; Galiatsatos & Hale, 2016; Villatoro et al., 2016; Wizemann & Thompson, 2015). Seeking out these alternative community-based interventions are essential to mitigating health care disparities (Andersen et al., 2007; CDC, 2013), which is the ultimate goal of PPACA (Blumenthal & Collins, 2014).

The qualitative case study was the most appropriate approach to explore the opinions, feelings, and attitudes of those experiencing the phenomenon and revealed what works best for them in addressing the particular health problems self-identified. Through this study, I addressed a significant gap in the literature regarding the role of the church in PPACA implementation. To address the gap, the purpose was to conduct a qualitative, phenomenological case study to explore the potential role of the African American church in providing health care assistance to the people it serves and the community it serves.

Chapter 3 presents the methodology of the study.

# Chapter 3: Research Method

The purpose of this phenomenological case study was to explore the potential roles of African American community churches in providing health care access to underserved parishioners, ages 18–65. Although researchers have identified faith-based organizations as potential stakeholders that could work within ACOs and facilitate data gathering during CHNAs (Gourevitch et al., 2012; Majette, 2011), there is research on the role that churches—under the umbrella of faith-based organizations—play in providing care and support for underserved populations (Franz & Skinner, 2016; Galiatsatos & Hale, 2016; Villatoro et al., 2016). I used semistructured interviews with open-ended and follow-up questions to acquire in-depth data on insurance needs, health needs, and the experiences of 12 church parishioners with insufficient health insurance in three African American churches. The study has implications for public health policy. Specifically, the study demonstrates how churches and faith-based organizations can contribute to CHNAs, ACOs, and community outreach partnerships in support of equitable health care coverage and access to services as mandated when implementing PPACA.

In Chapter 3, I present information pertaining to the research design and rationale, role of the researcher, instrumentation, data collection, data analysis, issues of trustworthiness, and a discussion of ethics.

## Research Design and Rationale

The guiding question for this study was as follows: What are the perceptions of African American church attendees on their health care issues and the church role in advocating as a PPACA stakeholder to reduce health care disparities? I chose a qualitative methodology with a phenomenological design. I chose a qualitative approach to explore a phenomenon from the participants’ viewpoint (Rudestam & Newton, 2015) to reach a deep understanding (Bloomberg & Volpe, 2015). The qualitative design enhances the richness of data as parishioners reveal their actual encounters with the healthcare system, therefore elevating confidence and geniuses of this study.

Qualitative research offers the researcher an opportunity to acquire meaningful information on social issues involving individuals or groups of people (Bloomberg & Volpe, 2015). A qualitative design allows for increased exploration of the setting (the church) and the participants (those attending services in the church) with the ability to collect data directly from the participants through the use of a semistructured open-ended interview (Rubin & Rubin, 2012). Qualitative research is inductive in nature, with the results arising from analysis of the data (Merriam & Tisdell, 2015). When employing qualitative research, the results are based on the experiences and perceptions of individuals with a specific phenomenon (Stake, 2010).

The hallmarks of qualitative research include (a) rich and thick data used to explore a phenomenon holistically, (b) seeking to gain an understanding of the phenomenon under study, and (c) focusing on the experiences and perceptions of the participants (Tracy, 2013). Researchers implement qualitative research to explore the self, relationships, groups, cultures, and contexts (Tracy, 2013). Qualitative research has a plethora of designs, including but not limited to: narrative, grounded theory, ethnography, phenomenology, and case study (Bloomberg & Volpe, 2015).

Researchers who employ quantitative research seek to prove or disprove hypotheses through statistical methods (Tracy, 2013). Researchers employing quantitative methods work with the assumption that one ultimate reality exists independently of the researcher and participants, and that reality can be measured (Berg, Lune, & Lune, 2004). Mixed method studies incorporate both qualitative and quantitative methods to examine and explore a specific phenomenon. This design is effective when researchers are attempting to both explore and measure a phenomenon using statistical methods and qualitative analysis (Teddlie & Tashakkori, 2009). Neither of these designs were appropriate for this study, as the object of this study was to describe and explore the lived experiences or perceptions of the participants, rather than measure their reactions to the phenomenon under question.

I considered several qualitative designs for this study. The designs included narrative inquiry, grounded theory, and ethnography. The narrative approach originates from step-by-step reflective narrative of the participants' experiences with social interactions (Clandinin & Connelly, 2006). The narrative approach is appropriate for use when collecting chronological story details on a variety of social and science disciplines related to historical research or real-life experiences (Merriam & Tisdell, 2015). The findings are developed from interactive conversations between the researcher and the participant(s) regarding the research topic. I did not choose this method as the focus of this study pertained to a specific phenomenon, rather than a story of participants' life experiences over time.

Researchers use a grounded theory design when seeking to create a theory about a specific phenomenon (Tracy, 2013). Using a constant comparison data analysis method and exploring past and present data, while working in an inductive manner, theories arise from the information gathered that provides an explanation or theory of a phenomenon (Glaser & Strauss, 1967). Though theoretical knowledge is used to support possible research findings, the purpose of this study was not to derive theory; therefore, this approach was not appropriate.

Researchers who employ an ethnographic approach to research seek to understand a culture or group, and focus on aspects including rituals, relationships, rules, and language usage (Tracy, 2013). Researchers who employ ethnography often become a member of the group under study and take on the roles of researcher, interviewer, participant, and observer (Tracy, 2013). As the focus of this study was to objectively understand health care utilization where I remain separated from the culture or group dynamics, ethnography was not appropriate. There potentially could be many unknown factors contributing to underutilization of health care services and obtaining health care coverage, unlimited to culture or group dynamics.

For this study, I chose a phenomenological case study design. When using a phenomenological design, researchers explore the nuances, thoughts, and emotions that underlie a phenomenon to create a representation that aids in an increased understanding of the phenomenon under investigation (Moustakas, 1994). The prime focus of this type of design is to explore how individuals interpret their experiences, and the meanings they ascribe to the phenomenon being explored (van Manen, 2014). Markers of phenomenological research include (a) identification of participants’ shared experiences,

(b) a search for the universal meaning of those experiences, (c) finding that universal experience by exploring the shared phenomenon, and (d) emerging with a description of the essence of the experience (van Manen, 2014). Thus, the results of a phenomenological study arise from the lived experiences and perceptions of the participants (Moustakas, 1994). The discovery of church participants' shared experiences potentially could link to factor(s) associated with not having health insurance or being among the underserved health care population. Employing this approach revealed evidence to support the need for improved health care policy interventions.

A researcher uses the case study approach when seeking to answer how and why questions about the phenomenon under study (Yin, 2014). In addition, this design is appropriate when it is difficult to separate participants from their context, and the sample is bounded (Stake, 2010). Yin (2014) added a more holistic viewpoint contributes to achieving the uniqueness of the phenomenon studied to gain knowledge. For this case study, I studied a specific group (i.e., African American church attendees representing the largest minority population most affected by the problem of health care disparity), singled out in order to maximize research comprehension for the existing health disparities among this population. The case study approach in conjunction with the use of phenomenology to focus on the actual lived experiences and perceptions aided me in gaining the richest and most meaningful comparative data possible to address the research question and also to justify the implications for policy and social changes.

I used a phenomenological case study to explore the perspectives of African American church participants from a single setting regarding encountered health issues and health disparities. Qualitative research is constructed to achieve meaningful information comprehended from world-view perspectives (Yin, 2014). Yin described qualitative approaches where transparency of experiences yields social, cultural, and physical information that adds richness and depth to the data. Case study designs are used when a researcher seeks to answer how and why questions, the participants are enmeshed in their setting, and the sample is bounded (Yin, 2014). As this applied to the participants in this study, and the experience explored was universal, the combination of case study and phenomenology was an effective design.

## Role of the Researcher

As the researcher for this qualitative study, I served as primary instrument in collecting, analyzing, interpreting, and reporting all information. A qualitative researcher's role, regardless of the type of data collection method, is to first develop the research protocol, then gain research approvals from the Institutional Review Board (IRB), select participants, and conduct the study (Tracy, 2013). Additionally, the researcher's primary and on-going goal throughout the study was assuring the research question aligns with the research purpose and objectives. Tracy (2013) emphasized the importance of the qualitative researcher understanding the world as perceived through the lens of those being studied as a requirement for effective and nonbiased data collection. Trust is essential in the management strategies of qualitative researchers, especially in terms of acquiring personal and confidential information (Laureate Education, 2010).

My relationship with the church is nonmember of two and a member of one. I am affiliated with two ministries, the choir and health ministries at the church where I hold membership. I did not solicit participants from the choir and health ministries of this particular church. My relationship with the pastor and other staff is friendly and trusting, which allowed for successful interactions and completion of this study.

My background as a health professional added to the validity and richness of data descriptions and findings for this study. Approximately 10 years ago, I taught Cardio Pulmonary Resuscitation (CPR) classes at one of the selected churches, but I did not teach there at the time of this research. I do not supervise anyone who could have potentially been a participant for this study. I realized that as a qualitative researcher, health professional, and a member at one of the churches, biases were likely. During each interview, I bracketed my personal beliefs about health and religion by using semistructured interview scripts, member checking, neutral opinions and expressions to responses and reveal the study purpose and all my affiliations upfront with all participants to increase accuracy, confirmation and authenticity in order to obtain the truest phenomenal details.

## Methodology

### Participant Selection Logic

It is essential to have a well-defined strategy for choosing a sample (Wilmot, 2005). Qualitative researchers generally use nonprobability sampling because the goal is not to have a statistically representative sample, as statistical inferences are not required (Wilmot, 2005). The sampling method was purposeful sampling. This type of sampling is suitable when the researcher is seeking participants with relevant experiences (Coyne, 1997). The selection criteria for this study was African American church attendees between the ages of 18–65 who had no or insufficient health care access. The selected participants were chosen because of their closeness to the realities of issues and resources in the community. Other Age Groups, 0-17 and older than 65 years, are excluded in this study. Individuals between the ages of 0-17 are minors and do not make decisions about access to health care. Individuals above the age of 65 have access to Medicare and other health care supplement programs that do not fall within the scope of this study. In addition, both of these groups are considered to be vulnerable populations, and for their protection from harm they were excluded from this study. I solicited 4 participants from each of the three churches for a total of 12 participants (inner city, $n$ = 2; suburban, $n$ = 5; and rural, $n$ = 5). I solicited as many candidates as possible to have stand-by participants; Extra candidates were alternates and only interviewed if there were cancellations. I did not receive incentives nor did participants receive incentives in this study. I protected participants' identities by the use of pseudonyms, and did not use identifying information in presentations or publication of this research.

Sample sizes in qualitative studies are much smaller than those found in quantitative studies. A criterion required to complete a sample is saturation. *Saturation* is the point in which adding new participants to the data gathering process does not add new themes (Bowen, 2008; Tracy, 2013). I did not use saturation, but I chose instead to sample an equal number of participants ($n$ = 4) from each church site to represent community residential differences. When examining the data, researchers need to parse out the meanings assembled and examine them for robust, thick descriptions that show the theme variances and interconnections between themes (Glaser & Strauss, 1967;

Mason, 2010). Researchers measure data in terms of concepts, themes, variations, and properties pulled from all the participants' words (Glaser & Strauss, 1967). A prerequisite to participation was that they had no or inadequate insurance coverage. Participants were interviewed until iterative themes and no new themes appeared from each individual face-to-face conversation.

A plethora of guidelines are available that offer practical suggestions regarding how to determine sample size. Tracy (2013) suggested five to eight participants in a qualitative study should give the researcher enough information to analyze. For phenomenological studies, Morse (2000) reported the minimum number of participants was six. Based on these numbers, I selected a sample size of 12 for this study.

### Instrumentation

I conducted semistructured interviews using open-ended questions (Rubin & Rubin, 2012). In phenomenological inquires, the participants were asked broad questions that enabled them to keep focus, but still allowed for in-depth elaborations that lead to rich and thick descriptions of their experiences (Tracy, 2013). I created an interview protocol (see Appendix B) that provided structure (i.e., interviewee's name, date, time, other demographics, and prewritten open-ended questions) to assure key information is obtained while not diverging from the research objective. The interview questions were reviewed by subject-matter experts to assure the questions were open-ended and addressed the research question. Semistructured interviews allow for flexibility of participants to expound and reveal in-depth meaningful data and for the researcher to gain clarification with probing or follow-up questions (Rudestam & Newton, 2015). I adjusted interview questions as needed to improve communication and better address the research phenomena or research question on the interview protocol.

I provided a detailed account of all actions taken before, during, and after interviewing procedures. This involved taking notes regarding the interviewing guide to account for details not recorded or clearly revealed on the audio recording devices or in the instance of a failed recorded event (user or equipment faultiness). I had two recording devices at each interview as a backup strategy.

I informed potential participants of the purpose of the study, including their human rights, and addressed ethical and confidentiality concerns. Participants were informed of their right to opt out of the research at any point during the research study. If a participant agreed, I obtained written consent immediately after introductions and after having explained the informed consent (see next subsection). The interview then occurred.

The interview protocol is used to consistently document and lead prompts for collecting information on the date, time, interviewee identification number, interviewee-interviewer introductions to establish rapport, open-ended sub-questions, probing questions with permission to have a follow-up conversation to clarify and conduct member checking data accuracies, and finally reminders to thank and acknowledge the participant for time committed to the interviewing session (Tracy, 2013). Researchers use the interview protocol as a guide to stay on track and assure relevant information is obtained (Rubin & Rubin, 2012). The interview questions were open-ended and developed from subsets of the primary research question, often beginning with either *what* or *how* words that aim at gaining the participants' most in-depth perspectives while breaking down the primary question (Rubin & Rubin, 2012). The primary research question for this study was: What are the perceptions of African American church attendees on their health care issues and the church role in advocating as a PPACA stakeholder to reduce health care disparities? The list of interview questions (see Appendix C) were prefaced with "Please tell me."

## Procedures for Recruitment, Participation, and Data Collection

I submitted an IRB application for study approval. I talked with the senior pastors of three African American churches, introduced myself, and informed them of my research study purpose. I assured them that church participants' human rights would be protected and that their information would remain confidential. I then shared the recruitment strategy and gained permission to announce the study on the church bulletin and requested to use a room for private interviews. I sent letters of site request describing study details, prerequisites for informed consents, criteria for ages between 18-65 and no or insufficient insurance coverage, list of interview questions, and a template for letter of cooperation (Appendix D) authorizing use of the church as a sampling site. After addressing questions from various pastors, letters of cooperation and administrative contacts were received to accommodate study requirements. After IRB approved data collection, a written announcement or flyer for participant volunteers, explaining criteria, and providing my contact information was given to church administrators for insertion in church bulletins and posted on the church website. The written invitation allowed for self-selection and provided a higher degree of confidentiality. I also contacted church administrators to make arrangements for interview room reservations as required.

The sampling site and participants were purposefully selected from three predominantly African American churches (Church A = 1,520 members; Church B = 300 members and Church C = 30 members). Though other races attend these churches, only those identifying as African Americans from demographics were solicited to participate. I was the primary researcher and the only person collecting data. I called, texted, or emailed candidates according to how they contacted me. At that point, I shared information regarding the purpose of the study, criteria for participation, and requested an appointment if the participant met the inclusion criteria.

I verified that the room was organized, clean, and ready at least 30 minutes in advance of the interview session. A sign for the door was created and placed on the door to ensure privacy. Participants received a follow-up reminder (in the form of an email, text, or phone call) of appointment informing them of the date, time, and location of the interview a week in advance. Exceptions were made for participants desiring to interview at the moment. In such instance, the same privacy and interviewing procedures occurred. All participants received an interview protocol, which included the interview questions for their review to aid them in gathering their thoughts and so they were not surprised by any of the questions. Options to refuse to participate remained open, and participants were informed that there were no repercussions for nonparticipation or for leaving the study at any time.

I greeted the participant on his or her arrival, introduced myself, showed him or her the bathroom facilities, and offered a bottle of water, which I had on site. I then proceeded to the room where the interview session took place. I explained the purpose of the study and informed the participant that I would be taking notes and audio recording the face-to-face sessions. I also informed the participants of all interviewing procedures (i.e., following the interview protocol, audio recording, asking additional questions as needed, jotting down notes, etc.) and that the interview could last up to one hour. I explained that I would not go beyond the specified time unless the participants approved or felt it necessary. I obtained permission to follow-up with the participant after the interview to gain clarification and to allow member checking to verify the information in

I then reviewed the informed consent (see Appendix F), explained participants' rights, the procedures of protecting confidentiality, and privacy. I did not disclose personal identifiers during the research. I assigned a number to each interviewee and only that number was used to identify the participants. All personal identifiers associated with the assigned numbers are secured in my home office. I addressed all participants' concerns before obtaining any written consent to conduct the interviews.

Once all the preliminaries and ground rules were discussed, the participants were encouraged to ask questions. I addressed each participant's questions and turned on the recording devices. I performed note taking of all procedures from the beginning of introductions through the end of sessions using the interview protocol as a guide to cover all essential elements, such as jotting down remarks, ideas, new themes, reflections, observations, and so forth.

Information from interviews was obtained using digital audio recording devices and field notes to capture all accounts of interview details (i.e., observations, questions asked by participants, shared ideas, and generated themes) during each individual face-to-face session. Using the primary research question as a focus for data collection, I asked the open-ended semistructured questions from the interview protocol. Semistructured interviews were employed because this technique allows flexibility and allows the participants to express their deepest concerns and thoughts. I gained clarification of responses as needed and encouraged the participants to talk. I maintained eye contact as much as possible while writing brief notes so as to not distract from the conversation. I asked probing questions to gain a deeper and meaningful understanding of their perspective.

At the end of each interview, I thanked the participants for their input, shook their hands as appropriate, asked if they had any questions, which I answered, if needed. I asked if I could contact them later to clarify any information as needed. The sampling size is usually small for a phenomenological case study approach, and data saturation and redundancy indicate when to cease candidate interviews (Tracy, 2013). At the conclusion of data collection, participants received a letter of appreciation. I required no additional participants. I focused on the study details to specifically highlight the respect and need to fully introduce the process to these participants who might otherwise feel disrespected.

Church documents, interview sessions, and recordings within this case study setting depicted only the raw data collected. I immediately reviewed information obtained from each interview session, transcribed with a digital transcriber, checked for mistakes, and coded terms and phrases for comparisons while checking for coding consistencies with an intent to heighten data reliability (Merriam & Tisdell, 2015). I contacted participants for follow-up to member-check the transcripts. Only three participants asked for modifications in transcripts and these were incorporated. Field notes and the protocol guide allowed me to explore observed and expressed details that were transcribed and categorically coded according to information generated from participants and my notes. This data includes processes, emotions, values, evaluations, observations of *dramaturgical* factors (exploring human actions and interactions), provisions (based on prior investigations), hypotheses (theory related), protocols (standardized and systematized), causals (extracting the *how* and *why* attributes, motives, beliefs, etc.), attributes (basic field note descriptions), magnitudes (degrees and intensities), and type codes (Tracy, 2013). All information collected on participants was safeguarded using a password-protected computer. I will delete, shred, and destroy participant information in approximately 5–7 years according to IRB recommendations.

## Data Analysis Plan

I used thematic analysis (TA) to produce meaningful conclusions from data collected during this study. The TA processes proposed by Braun and Clarke (2013a) for analyzing data are most appropriate for phenomenological type data because of their flexibility. When using this method, the order of steps is not required, and adherence to a theoretical framework is not an initial criterion. A researcher can examine the data for patterns across languages and can extend the information to a wide range of frameworks when applied. This method is also useful when using a variety of data collection methods (e.g., questions, surveys, media transcripts, and interviews) with small and large data sets as data-driven or theory-driven. Braun and Clarke (2013a, 2013b) constructed a qualitative method of identifying and analyzing patterns as a teaching tool for new researchers with basic principles; this method was an appropriate strategy for this particular study.

Braun and Clarke's (2006) Thematic Analysis (TA) is a method employed by researchers to analyze qualitative data. Use of this method provides a clear step-by-step method to employ when analyzing and interpreting data (Braun, Clarke, & Terry, 2014). Thematic analysis consists of six steps (Braun & Clarke, 2013a). It is essential to note that the nature of this analysis is recursive. Working with the data entails movement across the different stages, and some stages blur together (Braun et al., 2014). Codes can be moved from place to place throughout the analysis process. The objective of this analysis is the creation of themes that reflect the participant's experiences with the phenomenon. In addition, by placing any biases to the side through the use of epoché or bracketing, a researcher focuses on the experience of the participants, and embraces the voice of the participants which creates a rich and full description of their lived experiences (Tracy, 2013).

Stage 1 involved the transcription of the interviews. During Stage 2, the transcripts were read and reviewed several times. As the transcripts were read, I wrote memos, reflecting my thoughts and ideas, as well as any patterns, repeated words, and ideas the participants expressed (Tracy, 2013). Stage 3 focused on coding the data (Braun & Clarke, 2013a). The data were broken down into chunks. Each data fragment carried a meaning and varied in lengths from a few words to an entire paragraph (Braun & Clarke, 2013a). A code was assigned to the data chunk that describes the contents of the code. A good code should be a short and clear label used to capture the key idea of the gathered data (Braun et al., 2014). Code can be descriptive or interpretive; the code was used to convey the meaning is such a way that seeing the data was not necessary (Braun & Clarke, 2013b).

In Stage 4, like codes were gathered into categories, which were formed by finding codes with a similar or connected meaning. These codes were then assigned a descriptive label. As categories were formed, a constant sweeping overview occurred to see if categories merged to form a larger category. Once no further reduction of categories was possible, the categories became emergent themes. When creating emergent themes, researchers must consider the following questions: (a) could the theme be used to answer a research question, (b) were there several codes and participants in the theme, and (c) was the information organized by a central idea (Braun & Clarke, 2013a). At this point, each emergent theme was reviewed for clarity, richness, and alignment with the phenomenon under study. After completing this stage, I wrote a description of the emergent theme, which included an initial definition, possible relationships between the themes, and sample quotes.

Stage 5 involved an in-depth review of the emergent themes. The themes were reviewed for quality and accuracy. A thematic map was created, which illustrated the relationships between themes (Braun & Clarke, 2013b). At this point, themes were analyzed to see if they could be grouped together under a superordinate theme, with the emergent themes nested within the overarching theme. The summary created in Stage 4 was reviewed, assessed, and edited. After this stage of analysis, the summary consisted of a complete description of the theme with definitions, relationships, and supporting quotes. The description had details and included information from a minimum of three sources (transcripts).

I reviewed data to confirm that essential information was not overlooked and coding errors did not occur. I ensured that codes were correctly placed and organized. I explored the created categories and established that the appropriate and relevant codes were included. Then, I assessed the emergent themes to ensure that the emergent themes matched the initial summary.

Stage 6 consisted of finalizing all themes. I named each theme used to capture and describe its essence. The selected name of each theme arose from words used by the participants. I used the names in the organization and analysis of the data, as well as for ease of reporting and exploring the results. Making sense of the raw data lies at the heart of qualitative research, and creation of themes was the final step in explaining the results. The final stage of the analysis consisted of writing, reporting, and editing the results of the analysis for presentation.

I used the described principles and incorporated the TA processes with the following actions. After the face-to-face interview, I (a) reviewed field notes and added any comments I was not able to write; (b) listened to the audio recording and filled in gaps of information while combining all three data collection methods (i.e., audio recording, field notes, and observation); and (c) transcribed recorded data into a digital document using a digital transcriber.

As part of the analysis process, I used a set of predetermined codes that were added to as the analysis process continued. As I coded, then thematized the data, I ensured that the themes were logical and consistent, that the codes were aligned with the themes, and that they addressed the research question.

The theoretical frameworks of the Andersen (1995) behavioral model and the HBM (Hochbaum, 1958) were used for this study to identify and understand potentially preexisting behaviors, cultures, religion, and health beliefs for the general underserved health populations. This was where precoding of terms and phrases began. Computer Assisted Qualitative Data Analysis Software was used to store and keep data organized. The following themes and patterns were identified and predicted from literature review: components of theoretical frameworks and research question on the role the church could play in PPACA. The collected data centered on the following groups and subgroups from reoccurring themes and patterns derived from literature reviewed (i.e. theoretical models, articles and books):

- *Data Source* (DS*)*: subgroups: People (Peo) – sex (M/F); race (AA or other); age (Group 1 = 18–30 years, Group 2 = 31–40 years, Group 3 = 41–50, Group 4 = 51–65); Field notes (FNote); Literature Reviews (LitR); Devices (audio recordings [AUDIO]; transcriber (DTRANS); Pictures (Pic); Media (TV, Radio, or Newspaper); Computer files (Nvivo)
- *Health Care Coverage*: none (HCCNo), limited (HCCLow)

- *Health care knowledge of resources* (HKSAs); in church (CHUR); in community (COMM); Patient Protection and Affordable Care Act, Yes or no (PPACA-Y or N)
- *Attitudes (ATTTD)*: subgroups: about health care injustices (INJUS), health care disparities (not able to get or access health care services for self and or family) (HCDISPAR); Needs (NEEDHCSERV) for Health care; Church roles (CHURROLE); Personal roles (MYROLE): other attitudes about health care. Beliefs (BELIEF); Influences of faith/religion (RELIGINFLU)
- *Barriers to health care* (HCBARRIER) Subgroups: money ($), personal choice (MYCHOICEPER), not eligible (NOTELIG), waiting (WAITTIME), distance (FAR), transportation (TRANSP), inconvenience (INCONV), customer service (CUSTOMSERV), nothing-just lack of desire (MYCHOICEDES), and other themes as derived.

After creating transcripts, I read and reread the transcripts to become familiar with everything said by the participants. I then uploaded the data into Nvivo 11 to aid in the organization and analysis of the information. I assigned relevant labels, known as *codes*, to data collected as it is linked to the research question. These codes were used consistently for every interview and throughout the research process. Thus, checking the data for inconsistences in coding was important for sorting, organizing, and analyzing the information collected. I coded all data items. When analyzing and joining codes, I sorted out those codes that did not apply to the research question from the data needed for the study.

Searching for the right themes can be challenging, because all information relevant to the research question must be grouped under themes developed from the interviews by the researcher. I ensured the themes were logical and consistent with the message being conveyed by the participants and that the codes aligned with the themes to fully address the research question. I completed this process by collating all coded data relevant to each theme developed. For example, an interview question pertaining to past experiences of illnesses when no health or insufficient health insurance coverage existed had the potential to generate the following responses: (a) used the emergency room; (b) stayed home from work; (c) bought flu and cold medicine at nearby grocery store; or (d) hospitalized several days. A coded theme from responses would be compromised health because of any of Andersen's (1995) human factors or Hochbaum's (1958) health belief behaviors, which led individuals to settle for a less promising option to achieve the best health care outcome of early diagnosis and treatment that prevents health disparity conditions. A compromised health condition could potentially be an indicator for more expedient identification and eradication of health problems through improved policy and health interventions for underserved communities.

The next step required evaluating the themes for operational purposes, which is part of the theme analysis phase. I checked to ensure each theme was pertinent by careful reflexivity, asking myself, Does this theme provide convincing enough information that renders compelling logic, or does this theme relate to other themes? If discrepancies existed in the answers to these questions, I made adjustments in the theme's creation by either separating it into two themes, by combining themes, or by discarding a theme altogether and creating a new theme.

I sorted data obtained from candidates' responses into themes. Themes as noted by Braun and Clarke (2013a) must be informative and strongly emphasize a point. Analytical challenges evolve with incoherent descriptions: gaps, contradictions, and inconsistencies force higher risk to qualitative collected data (Miles, Huberman, & Saldana, 2014) and quality processes in analyses are most essential. Therefore, I made every effort to mitigate circumstances of errors, inconsistencies, and discrepancies with advance planning, clarifying, and consulting with my dissertation Chair and committee, as appropriate.

## Issues of Trustworthiness

The strength of a qualitative study is measured by different standards than a quantitative study (Petty et al., 2012). Rather than measuring validity and reliability, qualitative studies are assessed by the levels of credibility, transferability, dependability, and confirmability. Credibility is defined as the truthfulness and value of the research findings (Houghton et al., 2013). I checked and rechecked for consistencies in theme development. Qualitative researchers utilize techniques, such as member checking and triangulation, which enable them to compare and contrast the data and ensure that they have an accurate reflection of the experiences of the participants (Hanson, Balmer, & Giardino, 2011). I used member checking by following up with participants to confirm the accuracy of the transcribed data collected from respective interview sessions.

Transferability is the generalizability to different research settings to support trust in this research (Houghton et al., 2013). Transferability was dependent on how closely the sample site and participant characteristics resemble other church settings and congregations. I provided information pertaining to the population, setting, and results in enough detail that appropriate judgment can be made regarding transferability and for study applications. To further increase trustworthiness, detailed accounts are captured through an audit trail, where step-by-step descriptions of the research process are documented from start through completion (Petty et al., 2012). This produces the type of consistency that enhances reliability for other researchers to cross-reference and use data without reservations. Triangulation strengthens trustworthiness and reliability of research results by using a variety of data collection methods, theories, or participants (Rudestam & Newton, 2015). I used multiple data sources to create triangulation, such as observations, interviews, field notes, audio recordings, literature sources, church documents, and PPACA policy documents to corroborate findings.

For a study to have confirmability, it must reflect the honest opinions of the participants rather than those of the researcher (Petty et al., 2012). A high level of confirmability suggests the research results are valid. Confirmability is enhanced through researcher reflexivity (Houghton et al., 2013). Reflexivity is defined as an attitude of continual self-reflection and monitoring of personal biases. I identified my feelings and relationship to the church to set aside my personal biases. I bracketed personal emotions and remarks and did not disclose such information to participants during study procedures. Chapter 1 presented known biases of a personal nature and limitations of the study. Some discoveries occur after study implementation, such as the participant coding does not represent the general population or the population of most concern (Tracy, 2013). A researcher can save time and money if anticipating potential obstacles, such as not being able to gain organizational access or permission for participant responses. For this reason, I had an alternate church site for sampling participants, if needed.

Ensuring I adhered to the standards and evaluation criteria enabled the results to be authentic and accurate. This process also enables other researchers to examine the results and decide if the findings are relevant for their settings. In addition, this assurance will enable future researchers to ensure the study met high standards and was an accurate reflection of the experience and perceptions of the participants.

### Ethical Procedures

Ethical issues can surface at any research phase and are a significant concern for direct observational methods that require the researcher to conduct advance planning, anticipating and monitoring for issues throughout the research process (Tracy, 2013). I did not collect any data nor select participants before the IRB granted approval to conduct the study. The participant consent form (see Appendix F) informed participants about the study, the risks, the use of an audio recorder, and all other pertinent aspects of the study. I submitted this form and other study documents (see Appendixes A–F) to the Walden University IRB for review and approval. As previously mentioned, I explained the entire procedures to potential participants before consent was requested, and participants received a copy of the consent form to keep upon agreement to participate. Participants were at liberty to cancel their participation at any time during the research or interviewing process with no fear of repercussions. All names of participants and the sampling site remained confidential. Participants were referred to by pseudonym. All data connected to this study are kept confidential and in a secure locked file cabinet in my home office. Only I have authorization to access the data. I will securely store all materials connected to the study for 7 years, after which I will destroy them.

## Summary

In this phenomenological case study, I addressed the research question: What are the perceptions of African American church attendees on their health care issues and the church role in advocating as a PPACA stakeholder to reduce health care disparities? I chose the qualitative research approach for this study because of its power to more appropriately identify and address unique barriers in poverty communities. I described and considered qualitative designs (i.e., narrative, grounded theory, ethnography, phenomenology, and case study); a phenomenological case study was utilized because of its structural flexibilities to gain essential, rich, and meaningful data from participant perspectives, which best addressed the research question.

As the primary qualitative researcher, I managed all phases of the research. Relationships (professional, supervisory, instructor, and church affiliations) had the potential to pose influencing powers on participants and were disclosed. I used bracketing as a strategy for controlling personal feelings while conducting research professionally and respectfully. I described the methodology procedure in detail by identifying the population, sampling strategy, selection criterion, sample size selection descriptions, instrumentation, participant recruitment procedures, data collection, and plan for data analysis. The chapter also presented credibility, transferability, confirmability, and dependability descriptions along with actions to be taken to assure the overall trustworthiness and quality of this study.

In Chapter 4, I discuss the results of the implementation of the described methodology.

# Chapter 4: Results

## Introduction

The purpose of this qualitative, phenomenological study was to explore potential roles of African American churches in providing health care assistance to their parishioners. The primary research question for this study was as follows: What are the perceptions of African American church attendees on their health care issues and the church role in advocating as a PPACA stakeholder to reduce health care disparities? In this chapter, I offer a detailed account of the study procedures; the qualitative data analysis; and the trustworthiness of results.

## Setting

Conducting interviews at the sampling site, the church setting, may have caused some to be reluctant to share information freely about their health needs. The church is a place of worship, founded on principles of God (Matt 16:18), but it is also social in nature. Though people in the church share a common religious value, their experiences and professions are diverse. There was risk of information sharing amongst parishioners that would affect data collection results. Additionally, the political climate changed with a new President in office who opposed elements of PPACA, as executive orders were signed on January 20, 2017, "minimizing the economic burden of the Patient Protection and Affordable Care Act pending repeal" (see Appendix H). This order led many candidates to ask questions about the impact of the new rulings and whether there would be a replacement for Obama Care. When participants brought this concern to my attention, I explained that, regardless of the new orders, the disparity of those requiring health care remained an issue, and since health policy is an area of political focus, there was now a window of opportunity to close health care disparity gaps.

## Demographics

The congregational size and geographic location of the three churches varied. I used inner city (30 members), rural (300 members), and suburb (1500 members) congregations as sampling sites. Participants, ages 18-65, were grouped as follows: (a) Age Group 1 (18–30); (b) Age Group 2 (31–40); (c) Age Group 3 (41–50); and, (d) Age Group 4 (51–65). Most candidates who volunteered for this study were female; only two were male. One female candidate said she had two male family members with no health care coverage. Ten candidates indicated that their race was African American; one identified race as Black; and one identified race as American Indian and Black (see Table 1).

Table 1

*Demographics*

| Participant | Age group | Gender | Race | Location |
|---|---|---|---|---|
| 1 | 4 | Male | African American | Inner City |
| 2 | 4 | Female | African American | Suburbs |
| 3 | 4 | Male | African American | Rural |
| 4 | 2 | Female | African American | Rural |
| 5 | 4 | Female | African American | Inner City |
| 6 | 3 | Female | Black Native Indian | Suburbs |
| 7 | 1 | Female | African American | Suburbs |
| 8 | 1 | Female | African American | Suburbs |
| 9 | 1 | Female | Black | Suburbs |
| 10 | 2 | Female | African American | Rural |
| 11 | 4 | Female | African American | Rural |
| 12 | 3 | Female | African American | Rural |

## Data Collection

After receiving approval from IRB (Number 10-27-16-023813, see Appendix F), I contacted the three church sampling sites and sent the approved flyer for advertising this research study in the church bulletins to solicit for volunteers. Two weeks passed, and no potential candidates responded. After I personally visited the churches—publicly announcing and explaining the purpose, criteria, and meaningfulness of the study—candidates came forth. I spoke with and screened 15 potential candidates, but only interviewed 12 participants. One potential candidate did not meet the age criteria, and two others were no-shows for interviews.

Several participants volunteered, but wanted to contact me later for more information. Some contacts wanted telephone interviews rather than face-to-face sessions. After consulting with my Dissertation Chairperson and noting the low participation count, I changed the interviewing strategy to better recruit participants. I submitted a Request for Change in Procedures form to IRB, requesting an interviewing method change. The reason for the change was to meet participants' preference in conducting interviews via phone, computer video, or on-the-spot (i.e., face-to-face). Advanced technologies in communication, such as phones, computers and faxing conserved time and offered greater convenience for participants and researcher. In addition, this change in method increased confidentiality for individuals interviewed. This change in method was approved by the IRB on December 21, 2016.

During the data collection process, during one candidate's interview, a church administrator came into the room. I politely reminded that person that this was a private session and in order to protect participant's confidentiality, it was incumbent for them to leave. Retrospectively thinking, church administrators or church staff room schedulers really did not need to know when interviews would occur or what candidates were involved. Approximately one week post request submission, IRB granted approval to change interviewing method. The informed consent number remained the same, and all related documents required no changes. I gave a copy of the interview protocol to all participants, as it was part of the informed consent. After the change of procedures, it was not always necessary to greet participants, explain ground rules, or offer water as previously planned.

Over an 8-week period, I interviewed 12 purposefully selected candidates either by phone or face-to-face for this qualitative, phenomenological study. Face-to face interviews were not always convenient due to distance and time. To conserve time and offer greater flexibility, interviews were conducted by phone, computer, or in person for the convenience of participants. The quality of interview responses did not change for each strategy used, but I did not get visual data from these interviews. Instead, I focused on auditory cues, such as vocal inflection, and made note of them when appropriate. I solicited five interested candidates while visiting church sites and others volunteered via phone call or text. There were two face-to-face interviews (one at church and one at person's home) and all others were via phone. I used semistructured, open-ended questions from an interview protocol to collect data as related to each individual's perspective on their and their family members' health care needs. The interview session time ranged from 20–40 minutes not including time for the informed consent and verification of the candidate’s understanding of the study. I informed participants that the interview would be recorded, and their human and ethical rights would be protected. I explained that they could opt out of the study at any point.

I informed participants that confidentiality would be maintained, meaning that every effort would be made to not reveal personal information. I would not publish personal identifying information, and I would be the only one privy to personal identifiers, such as name and contact information. In a field journal, I recorded a detailed account of all activities and procedures. I addressed participants’ questions and concerns, and I acquired the informed consents prior to the actual interviews. A disadvantage of not conducting all interviews face-to-face was the need to delay interviews while waiting for consents to be either mailed, emailed, or faxed back. I mailed 10 participants informed consents, which included a self-stamped and self-addressed envelope for returning the extra last page of the signed consent. I made several follow-up calls and texts to get positive returns on consents and have participants ensure the accuracy of the recorded interview responses. Prior to each interview, I started two recorders (I-phone 6 memo recorder and Olympus LS-100). For the initial interview, Nuance Dragon for Mac was installed to transcribe data during the interview, but the information transcribed was difficult to control and decipher. It required much time and effort removing inaccurate transcript materials. I manually transcribed all succeeding interviews. This was very time-consuming as well, but was the personally-preferred method, which became easier while progressing through each case, especially when using the interview protocol as a guiding template typing up each respective candidate’s responses. I conducted member checking in all cases. Post data collection, each interview session was transcribed and sent to each respective participant either via email (*n* = 2) or postal mail (*n* = 10) for them to review the accuracy of data collected. I later called and confirmed whether they had received mail and set up a time for discussing and editing the transcribed data. Three participants requested changes and these changes were incorporated.

I filed and stored paper copies of field notes, interview protocols, translated drafts, verified member-checked translated data collected, and signed informed consents in a locked office cabinet. I stored any electronic files on a password-protected computer with two back-up drives. I labeled each case with a six-digit number (e.g. xxxx-xx). These files and all digital information will be stored for five years and then destroyed (See Appendix F).

At the end of data collection and after member checking for accuracy, I sent an appreciation thank you card to each participant for his or her contribution. Interestingly, many of the participants replied with a “thanks” and indicated that they were pleased that this type of study was being done.

## Data Analysis

Before I began the analysis, I identified a set of predetermined codes that I amended and added to as the analysis process continued. I employed the theoretical frameworks of Andersen behavior model and the HBM to identify and understand potentially pre-existing behaviors, cultures, religion, and health beliefs for the general underserved health populations. I identified the following themes and patterns from literature review, components of theoretical frameworks, and research question on the role the church could play in PPACA.

- *Data Source* (DS): subgroups: People (Peo) – sex (M/F); race (AA or other); age (Group 1 = 18–30 years, Group 2 = 31–40 years, Group 3 = 41–50, Group 4 = 51–65); Field notes (FNote); Literature Reviews (LitR); Devices (audio recordings [AUDIO]; transcriber (DTRANS); Pictures (Pic); Media (TV, Radio, or Newspaper); Computer files (Nvivo)
- *Health Care Coverage*: none (HCCNo), limited (HCCLow)
- *Health Care Knowledge of Resources* in church (CHUR); in community (COMM); Patient Protection and Affordable Care Act, Yes or No (PPACA-Y or N)
- *Attitudes (ATTTD)*: subgroups: about health care injustices (INJUS), health care disparities (not able to get or access health care services for self and or family) (HCDISPAR); Needs (NEEDHCSERV) for Health care; Church roles (CHURROLE); Personal roles (MYROLE): other attitudes about health care. Beliefs (BELIEF); Influences of faith/religion (RELIGINFLU)
- *Barriers to Health Care* (HCBARRIER) Subgroups: money ($), personal choice (MYCHOICEPER), not eligible (NOTELIG), waiting (WAITTIME), distance (FAR), transportation (TRANSP), inconvenience (INCONV), customer service (CUSTOMSERV), nothing-just lack of desire (MYCHOICEDES), and other themes as derived.

The data analysis framework arose from Braun and Clarke's (2006) thematic analysis (TA). Thematic analysis consists of six steps (Braun & Clarke, 2013a).

Stage 1 involved the transcription of the interviews. Once this was completed I uploaded all transcripts into Nvivo 11. During Stage 2, I read and reread the transcripts several times to get a sense of the participants' experiences and perceptions. As I read the transcripts, I made notes about my thoughts and ideas, as well as any patterns, repeated words, and ideas the participants expressed.

After I had completed my notes I began Stage 3, coding the data. The data were broken down into data units--which were specific words, phrases, sentences, or paragraphs--that I identified as having a specific meaning. Using the initial preliminary codes, analysis began. I soon expanded beyond those constructs to create codes that were more expressive of the contents of the data (see Table 2).

I assigned a code to each data unit; when a participant included a response relevant to a code, I labeled it with that code. In other words, a data unit may be a specific group of words combined together, and when a participant used said group of words in relation to the code, I labeled it with said code. I noted how many participants mentioned the code, and noted the number of data units associated with that code. After I went through each transcript and coded all data, I examined the codes. I removed information not relevant to my research question, leaving a set of codes related to the study.

Table 2

*Sample of Initial Codes*

| Code | Participants | Data units |
|---|---|---|
| Church could be a resource | 8 | 13 |
| Church could be an advocate | 5 | 6 |
| Church has health ministry | 3 | 4 |
| Church role | 1 | 1 |
| Church should offer private counselors | 1 | 1 |
| Does not want to share health info with church | 3 | 1 |
| Faith has no impact on care | 3 | 3 |
| Faith supports me—keeps me hopeful | 9 | 10 |
| Minor levels of help requested from church | 11 | 11 |
| Pays out of pocket for medication | 1 | 1 |
| Regular church attendance | 12 | 12 |
| Use my judgment even with faith | 2 | 2 |
| Would use other resources instead of church | 1 | 1 |

In Stage 4, I began to examine the codes for commonalities. Like-codes were grouped into categories that shared some meaning. Once I sorted all codes and no further reduction was possible, I explored all categories to search for likeness and relationships. I sorted and joined categories until none remained unexplored. The categories became emergent themes (see Table 3).

Table 3

*Sample of a Theme*

| Theme and associated categories | No. of participants | No. of data units |
|---|---|---|
| Insurance and Finances | 12 | |
| Can afford care as long as people are healthy | 2 | 2 |
| Can get care when needed | 2 | 2 |
| Cost of care is too high | 6 | 16 |
| Cut back on other expenses to pay for care | 1 | 1 |
| Family helped | 1 | 1 |
| Feels insurance is not fair | 1 | 1 |
| Find a job with insurance | 1 | 1 |
| Had to stay on parent's plan | 1 | 1 |
| I can pay for services | 4 | 6 |
| Insurance does not cover everything | 2 | 2 |
| Lack of money effects care | 4 | 8 |
| Lacked preventative care causing issues | 1 | 1 |
| Lost insurance due to student status change | 1 | 1 |
| Need to find a better job | 1 | 1 |
| No issues paying for care | 1 | 1 |
| Unemployment | 1 | 1 |
| Would reach out and ask for help if needed | 1 | 1 |

When creating emergent themes, questions to consider included (a) could the theme be used to answer a research question, (b) were there several codes and participants in the theme, and (c) was the information organized by a central idea (Braun & Clarke, 2013a). I reviewed each emergent theme for clarity, richness, and alignment with the phenomenon under study.

During Stage 5, I reviewed all of the data to ensure that I did not overlook any essential information and coding errors did not occur. I reviewed the data to ensure that I placed and organized codes correctly. The exploration of the created categories confirmed that all appropriate relevant codes were included.

Stage 6 consisted of finalizing all themes. I assigned each theme a name used to capture and describe its essence. The created names aided in the organization and analysis of the data, and increased ease of reporting and exploring the results.

## Evidence of Trustworthiness

To ensure that the results of the study were both reliable and valid, I employed a variety of measures. Lincoln and Guba (1985) recommended many options including triangulation, member checking, field notes, and audit trails. Methodological triangulation was employed to ensure that the results were trustworthy and accurately reflected the experiences of the participants. I achieved triangulation through (a) member checking of audio recorded interviews after transcribed, where each participant reviewed and verified their information for accuracy; (b) literature review; (c) my field notes (d) memos and other documents. Pyrczak (2008) recommended checking the results against multiple sources to ensure validity. I began my assessment of the results by first checking and rechecking for consistencies in theme development and dependability. I reviewed the data analysis process to make sure all information was included and organized correctly. I used member checking after transcribing data collected and also after the analysis to review summary of themes for authenticity. When unsure of what a response meant, I contacted the interviewees to gain clarification and further information. The participants requested no changes to summarized details. Finally, all interviews, transcribed audio recordings and all aspects of the study were documented as I created an audit trail in my field notes.

Transferability is the generalizability to different research settings to support trust in this research (Houghton et al., 2013). Transferability is dependent on how closely the sample site and participant characteristics resemble other church settings and congregations. I provided information about the sample demographics, the settings, and results in enough detail to allow for appropriate judgment about transferability of these results. To further increase trustworthiness of this study, I created a detailed audit trail, which included systematic descriptions of the research process documented from start through completion.

For a study to have confirmability, it must reflect the honest opinions of the participants rather than those of the researcher (Petty et al., 2012). Throughout the study, I maintained a sense of reflexivity and engaged in continual self-reflection and monitoring of personal biases. I identified and recorded my feelings and relationship to church in order to set them aside. I bracketed and made notes in my field journal about personal emotions and remarks.

## Results

The results of the data analysis are reported in this section. A total of eight themes were uncovered. The themes were (a) the effects of being non- or underinsured; (b) understanding the relationship between insurance and finances; (c) cost of care is too high; (d) insurance is important vs. insurance is not important; (e) issues related to health care and insurance; (f) self-empowerment is essential; (g) role of the church in health care; and (h) connections between health care and family. Each theme is reported, with supporting quotes from the data and includes any associated sub themes.

## Effects of Being Non- or Underinsured

The participants in the study spoke at length about the effects of lacking the required health insurance necessary for them to ensure they received regular health care. Participants reported seeking care only when they deemed it to be necessary.

Several participants spoke about being unable to access the care they required. One of the primary areas of concern was access to regular maintenance medication. Participant 1 (male; Age Group 4) who was waiting for insurance to become active said, “Right now, I would not be able to get services or buy all medications needed. So, I can only just do what I am told and stay calm until my coverage kicks in.” This participant needed medication but could not afford to buy it without insurance coverage. The solution the participant proposed was to be calm and hope for the best. Participant 11(female; Age Group 4) spoke about having a similar experience. She remarked:

> I have hypertension and take a lot of high blood pressure medicines. I have arthritis and [am] prescribed a [brand named medication]… by my doctor for 3 months before [switching to a] new [insurance] plan. After 3 months, I was in limbo because my plan had changed with high unaffordable cost of this medication and I was switched to a generic brand, which didn’t work well. So, I went back to the [name brand], which worked, but I had to pay a tremendous out-of-pocket cost for my medicine. My insurance no longer would cover this medicine.

The participant had found a medication that was effective and covered by her insurance. When her health care plan switched, the copayment cost became astronomical and she switched medications, to one better covered by her current insurance. The new medication was ineffective leaving her only two choices – to continue to use a medication that was ineffective or to assume the cost of the more effective medication. Although the expense was a heavy burden she chose to pay for her medication out of pocket. This required sacrifice in other areas of her life. She had to choose to rearrange her finances simply to receive the medication she needed. Although she had insurance, it did not cover the medication she needed, leaving her in a position where her underinsurance compromised her health. These medications were not a choice, but a requirement to maintain a basic level of health. The church could be a venue for closing gaps on health education, resources and programs of support. Health resources and programs can be shared through congregational announcements and also shared with the community on websites and newsletters.

Other participants reported the deleterious effect of a lack of insurance on their health because they could not access any health care easily. Participant 4 (female; Age Group 2) only sought out health care when she perceived it to be necessary stating, “If I really need to seek care that is necessary or that is emergent, I just go and pay.” She did not seek out any routine care and saved her medical visits for when an issue arose. Participant 3 (male; Age Group 4) did not have the funds required to see medical professionals and ended up becoming ill and suffering severe health related consequences. He spoke about his experience and said, “I had no insurance, no car and no money. I ended up having a stroke, I fell at home several times, felt dizzy and not feeling well and then my family took me to the hospital."

Participant 3 compromised his health because he could not afford to access health care because of lack of insurance coverage:

> Before I got coverage after being unemployed, I was on a waiting list for 1-2 years with no insurance. . . then had a stroke, so I went back to work, but the damage was done. I guess if I had proper health insurance, I would not have had the stroke.

Despite serious health issues, such as repeated falls, he did not seek care until his family took him to the hospital. Even after this experience he continued to not seek medical care. He stated, "With no insurance, I am reluctant to go to the doctor for anything. I am waiting for disability and Medicaid."

Another participant reported a similar avoidance of routine care. Participant 2 (female; Age Group 4) said, "I am due for yearly physicals, such as, mammogram and colonoscopy, which are needed." She knew she was overdue for routine preventative health measures but could not afford to seek out care. One of the reasons she gave for this reluctance was, "Since May 2016 I have taken diabetic, high cholesterol and blood pressure meds which have been paid for out of pocket." She needed her medication and had to make a choice between seeking care and paying for her medication.

## Understanding the Relationship Between Health Insurance and Finances

This theme arose from the data with all participants contributing information. The participants indicated that the links between finances, having insurance, and seeking care were inherently joined. Participants had a range of experiences including having insurance, losing insurance, lacking insurance, and being underinsured. Their level of care entwined with their finances

**Cost of care is too high.** Many of the participants indicated that they felt the cost of care was too high. Participant 12 (female; Age Group 3) spoke about her experiences with accessing care related to the birth of her son. She described her experience:

> After having my son, I was hit hard. I was given a hospital bill that I had not saved up for that totally depleted my savings and am now in debt for a lot more. I joked about it a lot saying that I will be paying for my son's birth until he is grown. The hospital cost became astronomical, for instance I was put in one hospital room at one cost, but when that room changed into a delivery room the cost doubled, which was highway robbery in every sense. I wanted a water birth, but could not afford it either after realizing the cost.

She spoke about preparing for the birth and tried to plan for the expense. She did not have insurance at the time. She was self-employed and explained, "It was just unaffordable to me. The $400 monthly was too much, I looked at marketplace, outside insurance companies, and found one that was about $326 a month, but decided not to go with it. I still chose to save my money and pay out of pocket." Knowing she had to pay for the birth without insurance, she asked about costs in order to plan and save. Unfortunately, she was not told the entire cost of the birth and did not have enough money put aside. Overall, she believed that cost was a factor she could not overcome. She said, "The barrier is cost for services." It seems that a situation like this and others who choose not to buy a traditional insurance should have alternative solutions based on monitored and reported health care situations projected from church data.

Participant 3 (male; Age Group 4) also did not have insurance. He said, “I am just not able to pay for insurance, especially with a part-time job.” He denied himself health care and stated, “Can’t get health services with no money. Even a $20 co-pay was impossible to pay. I couldn’t afford proper foods and medications either.” He had very little income but did not qualify to receive aid. Because of his finances, he could not access any type of health care or health care coverage. Participant 2 (female; Age Group 4) had to cut back on other expenses to access medical care because she “had to pay out of pocket.” Participant 8 (female; Age Group 1) found herself having to put her child’s health at risk because she lacked insurance. She spoke about her situation and stated:

> Also, medications for child are expensive for asthma and allergy treatment. Epi pens were $1000 when I was in between jobs and I had to wait until insurance coverage actually took place before purchasing the meds.

Epi-pens are a medication prescribed for a life threatening allergic reaction. She was unable to afford the medication without insurance and had to run a substantial risk until she acquired health insurance. Even after she had insurance she said, “I avoid going to doctors for things that I can treat myself.” She would rather rely on her own judgment than go to a physician unless absolutely necessary. A positive social change would be the church advocating for less expensive medications and becoming a research player in data collection for evidence-based knowledge strategically making medications more affordable.

**Costs associated with being underinsured.** Other participants had health care but reported being underinsured. For example, Participant 4 (female; Age Group 2) had insurance and generally accessed health care when she needed it. She said, “For the most part, I do have access to care, but the co-pay is so expensive.” She elaborated on this and remarked, “I may hesitate when going to a specialist when I have to pay another co-pay, which is expensive. . . I didn’t go to the specialist recommended by my primary care physician and just followed my doctor’s instructions and bought a generic brand of over the counter medication for my issue.” She did receive some medical care for her issue, but chose not to follow up and work with a specialist because of the expense. She felt that she could not afford to take that money from her daily budget and chose a less effective method to treat her medical issue. The concerns and fears of individuals not being able to afford recommended care are real problems that could escalate and become devastating to the individual, their family, the church and or the community. Again, awareness of these issues must be brought to the forefront of policy-makers. The church as a stakeholder of PPACA or health care policy implementations would serve as a political activist for more positive social changes within the communities.

Participant 6 (female; Age Group 3) reported similar experiences and said she did not always access the care she needed because of “high out of pocket expenses.” She reminisced about an experience associated with the cost of care and said, “Although it was difficult I had to pay out of pocket expenses for doctors that are not in my network or for emergency room visits.” She sought out care that she needed but paid more than she felt she could afford to access that care.

Participant 9 (female; Age Group 1) was a recent college graduate and had lost coverage under her parent's insurance policy. She has a small supplemental policy and expressed shock in the difference in coverage. She said:

> I feel there are gaps in insurance coverage for services. I have been denied some claims, such as for OB/GYN care. I had to pay an out-of- pocket expense for a bill received unexpectedly after OB/GYN appointment. I was told that I couldn't come back for another appointment until that bill, which was $400, had been paid. The insurance I have was good as supplemental, but now it is not good for certain procedures /exams. Now if I had another insurance, primary insurance, it will pay a remaining balance as done for me while I was in school, but it is not a good standalone insurance.

Because of the high cost of care and the state of her finances, she could not return to see her physician until she had paid her outstanding bill. She was in a position where she could not access the care she needed even though she had insurance. She spoke about the financial challenges she faced and said, "I am not doing well financially, with limited salary and being a single mom increased living expenses." She went on to speak about the effect of medical expenses and said:

> In the past, I have had to be put on payment plans to pay high unexpected bills, such as a $500 charge from my OB/GYN after a routine checkup. I had to skip payments when other things took priority for my child or myself. Not only does this reflect negatively on my credit, but they do not allow you to return until the bill is paid in full.

The consequences of underinsurance affected more than just her medical care; it also negatively affected her financial future. She had to make choices because of her limited income and could not afford to support herself and her child while paying her medical bills.

**Lack of money affects care.** Participants found regardless of insurance status, that lacking money affected their ability to seek out medical care. Participant 10 (female; Age Group 2) remarked, “I have no problem paying for health care so far, as long as everyone is healthy.” She felt health care was affordable, but qualified her statement. As long as no serious issues arose she could afford health care. However, she was in a position where issues could arise because she lacked preventative care. Participant 7 (female; Age Group 1) also indicated she could manage the cost of basic care. She spoke about the use of physicians and said, “It has to be something drastic for me to actually take myself or my daughter to the hospital or doctor, outside of normal check-ups.” She was not a medical professional, but nevertheless, she made medical decisions for herself and her child. She understood that her finances were finely balanced and she could not afford for anything out of the ordinary to occur.

Other participants had similar experiences. Participant 4 (female; Age Group 2) stated, “I can get services when needed when absolutely necessary.” Participant 8 (female; Age Group 1) made a similar statement and remarked, “I can do it if really sick, for health is important to me. It’s about saving money.” She went on to contradict herself when she continued and said, “as long as it’s not cancer or something terminal and completely unaffordable.” Although she said she valued her health, she discounted the inherent importance of preventative care, and went on to say she could not afford a severe illness even though she saved money.

**I can afford to pay.** Some participants felt they did not need to worry about insurance. They expressed little concern about the cost of care and believed they could access the care they needed. Participant 11 (female; Age Group 4) felt she had good coverage. She said, “Now, the local government pays for my plan as part of my retirement package. I pay the co-pay. I am still fortunate because I have secondary insurance also with my husband, which helps some.” She could afford her co-pays and believed that her coverage was good. Participant 11 indicated she accessed care when she needed it.

Two other participants did not have insurance but believed they could manage their health care expenses. Participant 8 (female; Age Group 1) said, “I would have to save, use my resources, use emergency credit card for routine check-ups, etc., unless if something really major occurs and I exhaust all resources.” She felt she generally had the resources she needed. Participant 12 (female; Age Group 3) agreed and said:

> Since, I didn’t have insurance, I asked about the cost for pregnancy was told it would cost me about $4000. So, I set up a payment plan to save money for that expense. Thank God, I had been healthy most of my years, and I had never been in the hospital nor had not been pregnant before this time. I had always saved and paid for care as I go.

She did not realize there would be more costs associated with the hospital and only saved to pay her doctor. She received a bill for $12,000, then set up a payment plan with the hospital. She investigated ways to lower the bill, but only found plans for low-income individuals. She did not identify herself that way and set up a payment plan directly with the hospital and had been paying off the bill every month.

### Insurance is Important vs. Insurance is Not Important

This theme was made up of responses from six participants. These participants made specific comments related to the importance or nonimportance of health insurance. The comments were evenly divided. Three of the participants felt health insurance was important. Participant 9 (female; Age Group 1) said, “Obamacare helped with health care seeking for I feel health care is important. Though it was annoying, it was good to have something in place. I value health care and realize that I need it.” Although she found the process of seeking health care challenging, she believed it was important. She wanted to be sure she could take care of her health because she regarded it as vital to life. Participant 4 (female; Age Group 2) had employer-provided health care and said, “My employer pays and I really don’t think about it much until I look at the bill or have to pay co-pay, but insurance is something you have to have and going to the doctor is what you have to do when sick.” She indicated that having health insurance was a basic necessity because being able to access a physician’s care without worry was important. She took for granted that seeking care was essential, especially when ill. Although Participant 10 (female; Age Group 2) did not have insurance, she still believed it was essential. She worried what could happen to her family or herself and stated, “I’m often concerned about non-work-related incidents. Not sure what I would do if child or husband got a severe illness. It would have a major effect or impact on them and me.”

The three participants who did not feel insurance was important had other priorities. Two of them simply stated they did not see any importance in having insurance. One person felt that she had other priorities. She listed other things she found important and said, “Spiritual needs are most important. . . People’s basic needs (i.e. hunger, sickness, bills) must be met before they can even begin to understand other things such as insurance.”

**Issues related to health care and insurance.** The participants spoke about a wide variety of topics related to insurance and health care. They expressed concerns about the quality of insurance coverage and health care. Some participants spoke about difficulty in accessing care while others mentioned challenges in getting insurance.

**Negative feelings about insurance coverage.** Many participants had negative feelings about their health care insurance. Participant 11 (female; Age Group 4) was unhappy with her insurance coverage. Participant 11 was a retired government worker and concerned with the many changes in and lack of knowledge about her health care policy. She said:

> I am a retired government worker with some insurance, but it seems the government is always looking for what they call, “better plans” and when plan changes, which is every year, it causes me to have higher deductibles. I am not sure if and when I will reach my deductible. For instance, I got a new card recently, but I don’t know what my co-pay is going to be. I am not comfortable with what I have, but I have to pay because I need my medicines. I am fearful, and feel disappointment when I say I worked after 30 plus years in the

> government you wouldn’t think you would worry about health. I lose hope, and possibility and don’t know what the future holds and question whether I can afford the increasing deductibles, co-pays and increasing medications cost. I am just not comfortable with what I have.

She did not feel confident in her health care coverage. She had no clear idea of the coverage in her policy, the associated costs, and worried about the future. She feared even with insurance, she would eventually be in a position where she could not afford her health care. Participant 1 (male; Age Group 4) worried and simply stated, “I don’t feel good about my insurance right now.”

Two participants wanted insurance but did not have it. Participant 2 (female; Age Group 4) had lost insurance when her husband retired. She said:

> I don’t feel good about not having insurance. I had it for 44 years, but was dropped from husband’s insurance about a year ago when he turned 65 years and was able to get Medicare. I purchased insurance, but then it got so expensive I couldn’t afford it, so, I stopped it in May 2016.

She had insurance for many years and took it for granted. Once she had to purchase insurance, it became so expensive, she could not afford to continue coverage. She worried about her health and the effect of not having insurance. Participant 3 (male; Age Group 4) could not get insurance from his employer. He said:

> I wanted insurance, but [my] employer would not give me full-time work or benefits after four years of work. Others were brought in that I had to train and they were given full-time schedules and benefits, but not me. I got angry and

> stressed out most of the time.

He felt that insurance was important. He wanted coverage and felt unfairly treated because his employer did not offer it to him. The lack of insurance left him feeling stressed and worried.

**Insurance companies and customer service.** Several participants had issues with their insurance companies and the customer service they received. Participant 12 (female; Age Group 3) spoke about a recent interaction with her insurance company. She said, “I spent hours on the phone going over insurance information, just to be told something I couldn’t do. They should shorten the questioning and the process. The new policy could also allow more for pre-existing plans.” The participant expressed frustration with the amount of time required to receive answers and understand her benefits. She believed that the insurance company needed to have more respect for her time and could have offered better customer service. Participant 1 (male; Age Group 4) had difficulties making his insurance work when needed. He stated, “Well, when I go to the doctor or hospital, sometimes my insurance doesn’t click. I have to come back. In other words, I don’t get treated.” He believed that something that should be straightforward, such as a visit to the doctor became needlessly complicated when his insurance coverage did not work. Because of glitches with his coverage, he made several trips to receive treatment, rather than one appointment where everything could be handled.

**Quality of health care is not good.** A few participants also felt that many medical professionals showed a lack of care for their patients. Participant 11 (female;

Age Group 4) had a very negative feeling about the quality of care she received from her medical provider. She spoke about a recent incident and stated:

> What it comes down to is when you have a patient with medical problems and needing care, there is break down in the process. Customer service was very lacking. There could have been a break down in communications that lead to my delayed treatment. When I called back to see what had happened, they just said I haven't done it yet. I felt there was lack of importance to them, but I feel every patient should be very important.

She felt that she received substandard follow up from her medical provider. She was waiting to receive treatment and did not hear from the office. She followed up, only to find that her orders had not been processed. This made her feel uncared for and as if her health was not important.

Participant 1(male; Age Group 4) had difficulties making his insurance work correctly. Rather than being treated and then straightening out any paperwork, his physician's office refused him care. He said, "I'm a sick man and for six months I am told to come back and forth because insurance is not working." This situation made him feel as if he was nothing more than the sum of his insurance coverage. He found the lack of compassion and care he received from medical professionals disturbing.

**Accessing medical care is challenging.** A few participants spoke about difficulty accessing medical care. Barriers included transportation and location. Participant 11 (female; age Group 4) spoke about challenges associates with residing in a rural location. She stated, "Due to living in a rural area with few medical resources, transportation and distance are barriers and would require perhaps being airlifted to a better facility." She indicated the closest quality health care center available to her was a 45-minute drive from her home. She traveled great distances to receive, what she perceived as quality care. As an example, she said, "For instance, I had a particular mammogram recommended, but it was not done here, so I had to travel outside the area to get it done." In order to access the level of care she required, based on her physician's recommendation, she had to travel outside of her area. Participant 6 (female; Age Group 3) mentioned similar issues and stated, "To receive treatment from a psychiatrist, I trust I have to travel a great distance, which increases costs of travel." Not only did she have to deal with the cost associated with health care, she also had to assume additional costs in order to travel to and access her physician. Participant 5 (female; Age Group 4) also had difficulty getting to appointments. She said, "Now, I've lost my job again and had my car repossessed. So, transportation to appointments is an issue. There is bus for pay and that costs $3, but that is sometimes hard to get when you have no job." She had no reliable transportation available, and often did not have the money she needed to access public transportation, making it difficult for her to get to any appointments.

Technology can be an issue. For some of the participants, using technology to access care or insurance was very challenging. They had little experience or knowledge of computers. Participant 12 (female; Age Group 3) said, "These people sometimes are not telephone or computer savvy. Many do not even have Internet services, and many may not be able to help themselves when needed." She saw that technology could function as a barrier for some people. Participant 10 (female; Age Group 2) exemplified this barrier. She said, “The policy can make sure the website is user-friendly and [you are] able to speak to a person. I have yet had anyone call me back or anyone to clarify questions and for signing up.” She was attempting to sign up for health insurance and had difficulty navigating the website. She had questions she needed answered but was not able to contact anyone via phone. This left her feeling frustrated and unsure of what to do next. She went onto say,

> I attempted to browse the marketplace site for other insurance companies, but that website was not user friendly. The information put in goes everywhere. I don’t like my information shared across the board. You put information in and don’t get to talk to anybody. I wanted to call and talk to someone specifically, because the website buffered and everything I put in froze and seemed lost. So far, I have not talked to anyone.

She did not know how or where to go to get questions answered. She was nervous about sharing personal information on the computer. She felt if she could talk to someone and get her questions answered she could understand how the website worked and how to sign up for insurance.

**Self-empowerment is essential.** The majority of participants in the study supported the idea that self-empowerment was an important skill. They generally believed that people needed to work hard to help themselves. Participants spoke about the need to educate themselves about health care and insurance, to be responsible for their own health, to increase knowledge, and to be an advocate.

When speaking about health care and health issues participants stressed the importance of self-education. They believed that they needed to seek out knowledge and ask important questions. Participant 12 (female; Age Group 3) spoke about herself and said:

> I can educate myself, and prepare myself, which is what I have done, before a health situation. If you don't have health insurance, try to get some before existing conditions arise, such as pregnancy, because after it happens it is null and void. I would try to educate others on my situation and tell them to get insured before a pre-existing health issue.

She believed in the power of knowledge and always tried to do research in order to learn more about her health and any related conditions. She spoke about the importance of getting health insurance and why it should be a priority. She wanted to reach out and share her knowledge in order to act as an educator and advocate for others. She felt if others could learn from her experience she could make a difference in her community.

Participant 5 (female; Age Group 4) also spoke about the importance of self-education. She spoke about her experiences and stated:

> I can read more about my policy, or ask more questions and learn all my available options. I am so used to asking my dad to explain things to me that I am not as attentive as I should be. Not knowing has issues. For instance, I didn't know what vision insurance I have and it cost me a second office visit when they didn't see me in their system. I had given them the wrong insurance name.

Although she had depended on her father to explain information, she learned through trial and error that she needed to be responsible for learning about her health care and insurance. She found education important and committed herself to learning more. She continued on and remarked, “I do a good job. I just need to identify the best doctors for my care.” She chose to take control of her health and know the next steps.

Several participants spoke about the importance of keeping themselves healthy. It was up to them to understand what options they had and how to learn to make positive choices. Participant 10 (female; Age Group 2) spoke about this in relation to her own life and said, “I can be healthier and keep family healthy by eating healthier foods, encourage others to be healthier in exercising.” She expressed concern about her family as well as herself and was able to easily list a variety of methods to employ to improve health. Participant 4 (female; Age Group 2) also took responsibility for herself and stated, “I go to the doctor and take care of my health-related issue and also pray about it too.”

Participant 11 (female; Age Group 4) felt that it was a personal obligation to reach out to others. She recounted her experiences and said:

> Before retiring, I worked as a social worker, now I am on the other side as a patient, needing care and can really understanding what others may be going through. I am in a better position than most, because I am aware of the health resources in this community. So, I can advocate and speak for those who express their needs. Family and friends call on me for information about services.

She felt thankful for her base of knowledge. Thanks to her professional experience she was able to advocate for herself. In addition to this, she reached out to help others navigate the health care system. She believed it was her calling to help others and ensure they received the care they needed. Participant 1 (male; Age Group 4) believed the sheer act of participating in the study was a strong way to help and advocate for others. Through sharing his experiences, he could contribute to this topic and help effect change.

**Role of the church in health care.** Most of the participants in the study believed the church could and should take a strong role in health care advocacy and education. These participants regarded the church as a resource that should be used to advocate and educate the community. All participants in the study reported regularly attending church. The range of attendance was from once a week to once a month. The majority of the participants indicated they attend two to four times a month. They were active members of their church and formed a relationship with their congregation.

**The church as a resource.** Many of the participants believed the church could be a resource for people in need of help with health-related issues. Many of the participants saw the role of the church as a clearinghouse of information. Participant 12 (female; Age Group 3) spoke about this and gave examples. She stated:

> The church could be a resource to get help, for instance if someone said, where should I go to get this problem taken care of, or what should I do for this health issue? The church could be an avenue, resource, or guide, especially for the young and the elderly. The young and elderly have a need to know more, say for instance when we had the flood, the church could tell people where to go. It would be good to have people in place to answer any medical or emergency

> questions. I have an 86-year-old granddad that didn’t even know about FEMA in place and asked the question of where to go for safety and health.

She saw a community need for information and support. Participant 12 (female; Age Group 3) worried that young adults and elderly members of the community did not have any resources to aid them in understanding issues related to health and wellness. Participant 12 continued on and stated:

> There are things that happen in the community that many people would never know unless someone brought it to their attention. I don’t think the church can help with the financial aspect of anything, because I don’t think they will do that. They could help with providing information on resources as needed.

She believed there were many people who needed support and were not receiving it. Although she did not think the church could help in a monetary manner, she mentioned the simple act of acting as a resource could aid members of the community in accessing the health care they needed. Participant 12 (female; Age Group 3) believed that others were more likely to trust information about wellness, health care, and insurance if that information came from a fellow parishioner. She said:

> Just three people in the church can spread the word in a small town enough to reach everybody that someone is there to help fill out an application and give information about insurance benefits. I think people in the church will be more incline to learn from someone coming to the church setting versus going to a town hall meeting, which I know they will not go. They will [understand] the information better in church setting. I know they will. You are most attentive in

> the church. And people sometime think when it is coming out of the church it is the gospel.

She believed that people would trust the information because it came from the church. Participant 12 (female; Age Group 3) thought that the relationship of trust created between a parishioner and the church would add credibility to the information and incline people to ask for help to understand the insurance market.

Other participants also believed the church should function as a resource for the community. Participant 2 (female; Age Group 4) stated, "if someone else needed help in the church, then the church could provide contact resources in the community for help. Maybe someone could help others better understand the policy and assist completing the application for insurance." He imagined the church taking on a helping role for the community.

Participant 4 (female; Age Group 2) suggested that, "seminars can be given on health insurance and options; also, the church can provide transportation and way to get to their doctor, etc. for people as needed." She pictured the church taking on an active role in providing information and aiding parishioners in accessing care." Participant 5 (female; Age Group 4) entertained a similar vision and said, "having a representative to come to church to talk to people regarding health care. Let people know what the facts are, options and how to go about getting care." She believed, like Participant 2 (female; Age Group 4), that the church could provide a service to the community by sharing information and education about health care. Several other participants made similar remarks with Participant 8 (female; Age Group 1) stating, "The church can have a nurse visit once a month to educate people about the resources in the community." Participant 8 (female; Age Group 1) suggested something similar with more specifics and said:

> They could also provide educational courses through the church to assist people with making healthier lifestyle choices and disease prevention. I also think there should be a program specifically catered towards young adults who have recently graduated, are not employed, or not receiving adequate health benefits.

Many other participants had similar ideas. The participants believed the church should take an active role in education and information sharing in order to better support the community.

**Churches should offer health care services.** Some participants believed that churches should offer actual health care services. They believed by doing so, people would have better access to care, specifically preventative care. Participant 9 (female; Age Group 1) gave several examples of this and stated, "the church could hold marathons for reduced plans/wellness events (health screenings done to provide tax credits for members); hold health fairs and other activities to promote healthiness." She felt large events would enable many to receive services that they might otherwise be unable to access. Participant 2 (female; Age Group 4) remarked, "I could easily access services and would use the church if screenings or health testing can be done at the church." She could see a direct benefit to herself and believed she could improve her level of self-care. Participant 9 (female; Age Group 1) suggested that churches should be able to "receive tax breaks and have insurance attainable through the church." She believed this would create increased access to insurance and also enable the church to reap some benefits.

There were a few participants who did not want churches involved in health care. They worried about issues of confidentiality and loss of privacy. Participant 8 (female; Age Group 1) was adamant and stated, “I don’t want the church knowing my business regarding personal health. Even if the hospital sent someone there, I would feel the information may be shared with church staff.” Participant 6 (female; Age Group 3) agreed and said, “Ministry leaders’ behavior and professionalism are lacking; which affects the creation of a trusting relationship. . . information is not totally kept confidential between the leader and the member.” In her personal experience, after using counseling services through the church, she was not comfortable sharing any personal information. She believed churches should employ “licensed psychiatrists to treat its members because the level of trust between doctor and patient would be greatly increased.”

**Faith and health care.** Some participants believed that faith helped them deal with health care issues. Participant 11 (female; Age Group 4) said:

> I have a strong faith and belief in God that allow me to have the frame of mind to know what I need and follow-up and assure my health is taken care of. For instance, when I was told that I had cancer, but my faith and trust helped me with my fear. Then I was told there was no cancer. Faith and belief in God helps me know that He is a healer.

She found that having faith enables her to manage her fears and concerns about her health. She believed and worried less. Several participants spoke about the power of prayer. Participant 3 (male; Age Group 4) said, “I believe and pray that everything will work out things for the best. God knows what I’m going through.” Participant 6 (female; Age Group 3) agreed and also spoke about the importance of using prayer. These participants believed that their health care issues would be resolved if they had faith. They had a fatalistic viewpoint and believed that God would manage to help them though their health care issues

Other participants employed a combination of faith and practicality. Participant 10 (female; Age Group 2) remarked, “I have a strong faith in God and go on that. I trust things will be fine with prayer. However, I use common judgment about when to go the doctor.” Although she relied on her belief in God, she combined that with seeking medical care when necessary. She felt the combination of faith and common sense was important. Participant 5 (female; Age Group 4) agreed and said, “I know the difference between having faith and that seeking medical care can be my healing. I balance it out and try to be realistic also.” They used faith to help them get through difficult times and sought out medical as necessary.

A few participants indicated they did not see any link between faith and health care. Participant 8 (female; Age Group 1) stated, “It doesn’t affect me seeking medical care. If I get sick or daughter is sick, I go to the doctors.” She believed her faith was separate from her health and did not see any connection between the two. Participant 12 (female; Age Group 3) remarked, “Faith has no impact regarding me seeking health care. I just try to do what I can to save money for care and go from there.”

**Monetary support from the church.** The participants in this study were aware that they could reach out and ask for financial support if they needed it. However, none of them reported asking for aid. Most believed that there were others whose level of need was greater. The participants did report seeking and receiving minor forms of aid or seeing others receive aid. Participant 11 (female; Age Group 4) said, “I personally have not [sought out aid], but I have seen others who do.” She felt she did not need any aid but was approving of the fact others did. Participant 9 (female; Age Group 1) said, “I know I could go to the church and they would help.”

Even the participants who received financial support from the church did not access these funds for medical care. They requested aid with bills or funeral expenses. Participant 3 (male; Age Group 4) spoke about his experience and stated, “Church has given me money to pay bills.” It was interesting to note that even participants who reported issues paying for health care services or insurance did not request any aid. Participant 2 (female; Age Group 4) summed up their comments and said, “I am trying to do it myself. There may be others in greater need.”

## Connections Between Health Care and Family

The participants spoke about the effects of no insurance or a lack of adequate insurance on their families. Even though many reported struggling with finances or not accessing care, none seemed to feel that their situation had an effect on their families. When asked further about this topic most projected or described a scenario where they would get help if needed. Generally, all participants indicated they would call on their family for help if needed. Participant 2 (female; Age Group 4) stated:

> I will call on family, first husband then other family members if absolutely necessary. My husband can take care of me if I get sick. There are other family

> members outside of my immediate family, who could also help. I would call on them before calling on the church to help me because I can.

Participant 2 believed that family was the safety net for care. Rather than going outside the family to receive aid, Participant 2 believed family would be the first called for help. Other participants had similar responses. Participant 5 (female; Age Group 4) spoke about her situation and said:

> My insurance doesn’t cover everything, so, if a health condition is not covered, I would have to call on family. I experienced a situation today where I needed an ultrasound that wasn’t covered because they said it was related physical therapy. The hospital indicated they could set up a payment plan. I want to also. I am afraid of the piling up of cost. I also need to have knee surgery and rehab is not covered, so I may have to call on family to get with rehab as much as possible.

Rather than reaching out for financial support, she focused on getting aid with transportation. She indicated that she did not care about the rising costs of her care because she would set up a payment plan. Although she would have to divert funds earmarked elsewhere to pay for her medical services, she did not seem to see this as a struggle.

Other participants had similar responses to Participant 8 (female; Age Group 1) stating, “I would certainly ask my parents to help me with expenses. In the past, they helped pay for medications which were too expensive for me.” She knew she could receive help from family, but again, like the others, made no connections to further negative effects of this lack of adequate care.

## Summary

The participants in this study spoke at length about health care. The themes uncovered included (a) the effects of being non- or underinsured; (b) understanding the relationship between insurance and finances; (c) cost of care is too high; (d) insurance is important vs. insurance is not important; (e) issues related to health care and insurance; (f) self-empowerment is essential; (g) role of the church in health care; and, (h) connections between health care and family. I was able to explore the participants lived experiences and use their words to learn about their thoughts and perceptions about health care and health care insurance. Greater insight was gained using the Kingdon (2007) and Howlett et al. (2015) multiple streams frameworks in identifying participants' health disparity *problems* (esp. lack of education, lack of resources and the impact of access on finances). The generated themes revealed areas to improve the health care system through *policy* implications with church partnerships, such as, broadening community-based monitoring, tailoring need-specific-expanded-resources, and evaluating and re-evaluating processes as time and conditions evolve. As Howlett et al. (2015) noted, new problems will surface, requiring cycles of reassessing, reprioritizing and re-adapting policy procedures based on measured results. The *political* atmosphere must be one that comprehends, values and welcomes with little reservation that policy changes would promote the healthiest outcome(s) for all people.

In this chapter I presented a description of the demographics and the setting of the study. I described the data collection process and indicated how I ensured trustworthiness of the results. I discussed the analysis process and reported my results.

In Chapter 5, I cover the following topics, the study findings, limitations of study, study recommendations, implications of study and conclusions. In addition, I include contributions to scholarly research literature and positive social change implications.

# Chapter 5: Discussion and Implications

## Introduction

As the new White House (2017) under the President Donald J. Trump administration proposed reforms or revisions to the PPACA (see Appendix H), opportunities to promote better access to health care remained a public health and social change focus. The PPACA was designed to provide affordable health insurance coverage, but there are still disparities, especially among the African American population, the largest minority group in the United States (CDC, 2013; Hankerson & Weissman, 2012; Nunn et al., 2012; Williams et al., 2014). The purpose of the phenomenological case study was to explore the potential roles of African American churches in providing health care assistance to underserved parishioners (ages 18-65) within the local community. This study explored the attitudes, beliefs, and opinions of 12 purposefully chosen participants, specifically those closest to health care disparity, African Americans (CDC, 2013). The study also addressed the research question: What are the perceptions of African American church attendees on their health care issues and the church role in advocating as a PPACA stakeholder to reduce health care disparities?

The key findings included many factors that could align strategically with policy provisions and thus yield solutions. Parishioners' perspectives on the church's role to advocate as a PPACA stakeholder revealed eight themes that portrayed the dynamics of family, resources and one's ability or inability to access health care services as needed. Some primary roles that the African American church could play in providing health care assistance to underserved parishioners were as follows: (a) supporting and keeping parishioners hopeful (75%); (b) being a resource (66%); and (c) being an advocate (42%; see Table 2).

In this chapter, I discuss the results, limitations of the present study and recommendations, as well as the broader implications of these results for theory, researchers, practice, and positive social change.

## Interpretation of the Findings

The findings on the health care disparities experienced by participants—including the negative effects of being uninsured or underinsured and their relation to personal finances—supported the existence of a health care disparity despite the passage of PPACA. Of the 12 participants, four said they had no insurance and eight said that their insurance was insufficient, meaning it did not cover all care needed, such as gynecological exams, tuberculosis screenings, prehealth screenings, brand-name medicines, specialty care, and psychological counseling. As a result of no or insufficient health insurance, some participants mentioned worsening of illnesses that, in turn, led to chronic disabling conditions and a lack of future health care access until the previous care bills were paid off. The health disparities identified from several themes in this study (i.e., lack of resources, lack of education, and lack of finances) aligned with the data representing those in deprived locations and reveal the genuine context of lived experiences of people with no or insufficient health care insurance for focused programs of care (NAS, 2015). The health care disparity may have significant influence on society. For instance, if an individual is infected with a contagious disease and goes untreated due to their uninsured status, that person could easily transmit to others in the community, which potentially could be fatal. The church could monitor the needs of the its community and present the metrics justifying deprived resources for targeted programs for improved transportation for medical needs, educational resources, advanced technology access and use, health advocacy call center for resources, managed care teams for ongoing surveillance of deprived people and situations within the community based of federal standards and CDC goal priorities. The currently fragmented health care system can be savaged in terms of Kingdon's policy stream with the identified problem stream of a need for improved health education, resource allocation, and fiscal reduction for individuals and the country as a whole. Though the third of Kingdon's (2011) multiple stream (politics) is complex due to the already huge number of players (e.g., legislators, special interest groups, politicians, medical professionals, insurance companies, and special interest groups), the framework reveals a significant gap of *no* African American church participation. Fragments of the current health policy can be strategically revamped utilizing Kingdon's (2011) and Howlett et al.'s (2015) frameworks. Findings from this study will close the gap on health disparity when people's opinions resonate and are valued significantly enough to be prioritized objectives in the CDC's *Healthy people* (U.S. Department of Health and Human Services, 2016) goals improving public health for all Americans. The plague of diseases and mortalities due to health disparity may well bring the demise of a significant portion of African Americans if the church does not have essential and substantial representation in health policy-making.

Other issues with PPACA insurance included expensive co-pays leading to unexpected debts, negative feelings about inadequate coverage, nonempathizing customer service representatives, lack of transportation to and from medical appointments, and cumbersome websites with no human beings to address health policy questions. One participant felt that the PPACA plan was unfairly priced per individual and did not think it should be income-based for the same type of care received. There were recent college graduates who felt they needed to stay on their parents' plan longer, at least until they found lucrative jobs and could afford comparable insurance. The health needs identified by participants in this study provided evidence to support the quarterly monitoring conducted by CHNA according to section 9007(a) of the PPACA mandate that would decrease health disparity in each respective community (Alberti, 2014; Pennel et al., 2015). Majaj et al. (2013) ties health promotion in the form of health education as a tool to release perceived barriers formulated into beliefs (Janz & Becker, 1984) preventing use of health services. The results suggested the church could provide valuable information for understanding the socio-cultural needs of the church and community fostering a tailored health care policy from real individuals' perspectives.

Despite the state of uninsured and underinsured individuals in the present sample, approximately 50% of participants realized the importance of insurance and described initiatives taken to get and keep their children insured. A couple of single mothers who participated said they would never let their child go without medical benefits and that they were seeking better job opportunities to improve the quality of insurance coverage. When severity of illnesses increased, participants were more likely to seek out care regardless of cost, consistent with Heider et al. (2014). Cost was even less of an issue when life-threatening medications or care were needed for a child, even if the participants had to borrow from family or sacrifice paying household bills.

The phenomenological analysis employed in the present study allowed for a clearer view of the flexibility of beliefs regarding health care costs and insurance, which fluctuated depending on the seriousness of illness and potential consequences of not having health insurance, such as tax risks, debts, and physical consequences for lack of health care. Moreover, participants also had fluctuating opinions on whether insurance was valuable depending on their prior experiences and their confidence that having health insurance would be a solution, consistent with the HBM (Janz & Becker, 1984; Rosenstock et al., 1988). In other words, participants who felt that PPACA insurance was unlikely to completely cover their health care costs and needs without undue cost were unlikely to purchase insurance, consistent with health care seeking behaviors as described in the HBM (Janz & Becker, 1984). The results suggested the church could provide valuable information for understanding the sociocultural needs of the church members and community, fostering a tailored health care policy based on real individuals' perspectives.

The present study supports findings from several recent studies (Hamrin, Sinclair, & Gardner, 2017; Hochbaum, 2010; Kehm, Hearst, Sherman, & Elwell, 2017) which suggested that an individual's health care seeking desires must be valued, and believed to be meaningful enough, to seek care, even when a person is healthy. Many individuals who were healthy assumed they would remain healthy, especially those in the younger groups, and that they could afford to pay the expense of medical care if they became sick.

Spiritual beliefs minimally affected whether participants would seek medical care. Seeking health in one instance was viewed as God’s way of helping one find healing measures. As Hamrin et al. (2017) and Kehm et al. (2017) noted, health-seeking behaviors were dependent on motivation, previous experiences, barriers, and benefits, yet individuals maintained a sense of autonomy in their decisions. For example, a person's willingness and their motivation to comply with health regimes is based on, to some extent, how they are feeling at that moment, their pre-existing health conditions (chronic diseases), family history exams (cancer screenings, colonoscopies, diabetes), female issues (obstetrical/gynecological, mammograms), age-related exams (arthritis, Alzheimer’s), a recent costly health encounter, or children needing care. Several participants ($n = 4$) could pay for particular health services, but opted not to or were waiting to find better health care insurance options. Most of the study participants contributed lack of seeking particular care to the cost of insurance premiums or their co-pays. Overall study findings indicated, consistent with the findings of Majaj et al. (2013), that cost for care, the individual’s perception of health needs, and the individual’s belief that the degree of severity warranting care played a significant role in seeking and obtaining health care and insurance coverage.

Andersen’s (1968) behavioral model of health care disparities related to predisposing factors supported the findings with relation to the influence of demographics on health care disparities. Andersen indicated health disparities were due in part to predisposing or demographic characteristics based on one’s age, gender, and race; and/or conditional factors, such as residential segregations which separated societies of good and bad health (Gaskins et al., 2012). The present study also showed that demographic factors converged to influence health insurance coverage and care. The factors that most individuals have no control of due to being born with or into, or factors that the participants could not change, appeared to be the primary reason for not being insured. For example, some participants received adequate care at specific ages, such as while on their parents' insurance, or prior to retirement, but the age factor was what resulted in health care disparities.

An additional demographic issue unveiled that increased health care disparities was rurality. Several individuals living in rural districts indicated that the nearest hospital was approximately 20 minutes away from their place of residency and that many times, the nearest health facility was ill-equipped to handle certain emergencies, causing individuals to need air evacuation to a more proficient hospital. Also, one would need to drive or get transportation to a health facility approximately an hour away to obtain specialty care.

Differences in how males and females respond to seeking care confirms that gender is certainly one of the factors that affects health disparity, consistent with previous literature (Andersen, 1968; Andersen et al., 2007; Derose et al., 2011; Gaskins et al., 2012). The medical conditions presented by the two male participants, including delayed access to care and a lack of preventative care, represented the detrimental effects of having no insurance coverage. Neither male participant had health insurance prior to having a stroke. Both male participants were linked into a health care system, PPACA, after hospitalization, and waited to receive care for chronic conditions. One of these participants described how he tried to get employer benefits, but was denied full-time working hours to qualify. Seemingly, men were more reluctant in their responses to the interview questions, which perhaps reflected that they were more reluctant to seek medical care when necessary, and that they did not feel comfortable freely disclosing their health care experiences with me. This reluctance could confirm that men may perceive health seeking tendencies as not being masculine or that seeking health care would interfere with their jobs, which identifies a significant barrier for males seeking and promoting better health care behaviors (Doshi et al., 2013). One female participant reported that there were two male family members in her household with no health insurance, but when I attempted to solicit one of these males for the study, there was no response. However, the small number of male participants requires that these results be interpreted with caution.

Similarly, socioeconomic status influenced the extent to which health care disparities affected participants. The results suggested that lacking finances contributed to insurance status and to health care behaviors. For example, some participants mitigated health care issues through assistance from their families or parents, which was not available to those whose families were of lower socioeconomic statuses. Most participants believed and understood that if they did not have the finances or the right job that would earn them the finances to purchase insurance, then their health or family's health would be affected. In addition, one participant expressed eagerness to obtain insurance because of the penalty required to pay during tax season. Nevertheless, several of the participants had an income that disqualified them for PPACA or quoted premiums that were astronomical from their perspective. Participants who could have been eligible for PPACA were not knowledgeable enough on how to get in the computerized application system, which confirms Griffith et al.'s (2010) findings, that illiteracy or lack of knowledge and resources contributed to health care disparity.

Two participants indicated they saved money to pay for future health care expenses when needed. In one instance, a participant stated she did not save up enough for the birth of her son and had to go on a payment plan, one that would last until son is seventeen years old or older. Understanding the relationship between insurance and finances also meant that participants had a choice of not using their finances to purchase health insurance. The finding that income affected insurance status and health care decisions was consistent with Andersen's (1968) initial model as well as with follow up studies, which showed that socioeconomic status affected health care (Babitsch et al., 2012) and that individuals from higher socioeconomic statuses were more likely to engage in preventative health care behaviors (Thompson et al., 2013).

Despite the potential health care effects resulting from socioeconomic status, the findings of the present study also showed that self-empowerment was essential for overcoming health care disparities. Few researchers in reviewed literature explored people's opinions on personal empowerment drive with relation to health care, but the findings regarding personal empowerment supported that coping skills for health care issues and disparities generated in the time of need often stemmed from one's belief and faith (Allen et al., 2010; Flannelly & Galek, 2010; Koenig, 2012). Most participants felt there was something they could do to improve their or others' health care situation, such as become more educated on policies, motivate others by telling stories, find better jobs with improved benefits, set priorities for spending, and search for other insurance options.

Of the 12 participants, 6 indicated that the cost of medical care was too high, and 4 described how lack of money affected their seeking health services or medical care (see Table 3). Both the insured and uninsured individuals reported having to pay for care, from high premium rates, to copays, to medical procedures. In fact, paying for health care required several participants to go on a payment plan and not be eligible to seek care until prior used services were paid. The cost of health care being too high was confirmed in several studies (Derose et al., 2011; Gaskins et al., 2012; Griffith et al., 2010; Kim et al., 2012). Furthermore, socioeconomic influences unduly affected family members. Participants also noted that there were connections between health care and family. Whereas most participants admitted that they knew of no impact on their families, one participant said he stayed with a daughter and then with a son during his rehabilitation after a stroke. Several participants perceived it was very important to have insurance for their family members, especially for their children. There was also one participant whose husband had no insurance, who got a job-related injury that was thankfully covered by the company for which he worked. She pondered what it would have been like if they had that particular medical expense, especially without having insurance coverage. This participant and husband were in Age Group 2, and had no previous experiences with any severe medical conditions that they could not afford to pay out-of-pocket. Recent college graduates cited that they still relied on parents financially and to help buy expensive medications at times. Most participants did not want to ask family members for assistance, but said they would ask their primary family (such as, husband, mother, father, sister or brother) before going to the church for assistance.

Because of the unaffordable cost of care and its disproportionate influence on underserved populations, Slota (2004) recommended that a more diverse and comprehensive strategy be used to overcome and control the issue of health care disparity by partnering with nontraditional stakeholders, and the present study partially supported this recommendation by indicating that the African American church was perceived as a potential resource for addressing health care disparities. Under PPACA, there was a lack of church-related stakeholders in health policies to date in spite of recommendations to determine a comprehensive plan improving overall population health (CDC, 2013). Past researchers noted how churches traditionally functioned as an essential social change cornerstone for African Americans (Calhoun-Brown, 1996; Pattillo-McCoy, 1998), yet the role of churches in PPACA implementation was limited in the literature review (Bell et al., 2013; Franz & Skinner, 2016; Galiatsatos & Hale, 2016; Villatoro et al., 2016).

The role of faith in health care behavior was a potential influence primarily supported by the present study. Faith did seem to play some role in the majority of participants’ decision making; less than 30% stated that their faith in God had no impact on their seeking health care. Some noted they would use their own judgement, along with faith and prayer, to make their decisions. The majority of participants (75%) iterated that faith supported and kept them hopeful. As one feels, more comfortable with their health care options and believes in their pathway to healthiness, they will seek care more often, to include seeking care that prevents illnesses (Rosenstock et al., 1988). Therefore, the comfort of religion might lessen the distrust of health care noted among African American populations (Allen et al., 2010).

According to the present study, the church could serve several potential roles in addressing health care disparities. Analyzing the data from participants' opinions, the church can act in several ways to support health care reform: to gather information on the needs of parishioners, family members and the neighboring communities; to advocate, to make resource referrals, network with local health agents and health care professionals, and secure health insurance; to educate, to provide current online and hard copies of health materials; and to initiate health ministries, for example, as quoted by a participant, to bring a health professional in from local hospital monthly or routine to conduct screenings and address health concerns would be of a more trusted source when done at the church compared to a town hall facility. All study participants indicated that the church could be a resource, providing education, counseling, health monitoring, health screening, and community outreach to parishioners.

The participants' recommendations supported previous findings that services provided through the church cultivated trust, comfort, and hope that expanded paths for broader social solutions, such as meeting individuals' health disparity needs (Lumpkins et al., 2013) and addressing negative health care attitudes or behaviors associated with lack of resource knowledge (Allen et al., 2010; Colon-Otero et al., 2012), which hindered access to care. Previous researchers have had mixed findings relating to the church's role in such programs, with some research suggesting a positive effect for interventions based in African American churches (Colon-Otero et al., 2012; Lumpkins et al., 2013) and others showing a more mixed effect (Allen et al., 2010; Isler et al., 2014). Franz and Skinner (2016) and Galiatsatos and Hale (2016) supported primary care provided through church as a positively perceived role for the church to play in PPACA. A potential caveat was that two participants were adamant about church leaders being professional enough and maintaining people's confidentiality. Parishioners feeling uncomfortable with the church delivering care in a confidential manner may not utilize the services by the church, according to the HBM (Rosenstock et al., 1988).

Furthermore, 42% of the participants noted the church could advocate for the community it serves. The church, as one participant said, can "be a voice" to the political world. Politicians come to the church during election times, trying to familiarize themselves to the congregation, so it seems that the church would be an excellent forum in legislative changes for community health disparities. This recommendation is relatively novel with regard to the research on the role of churches in health care reform, as previous researchers have primarily focused on the church as a health care provider or source of health care information (Franz & Skinner, 2016; Galiatsatos & Hale, 2016; Villatoro et al., 2016). The recommendation that the church act as a policymaking advocate is consistent with Kingdon's (2011) multiple streams framework, in that the church could act as a representative of the problem stream through its congregation members' views, and become involved in the politics and policy stream, therefore blending the streams and enacting change. The present study did not indicate similarity to Allen et al.'s (2010) findings that though African Americans trusted the church, their anxieties and reluctant behaviors related to their faith limited their seeking of health care and services. However, there may be a cultural implication of the gender differences in care that could be related to or underscored by religious entities, which future researchers may explore.

The results seem to confirm that it is through policy, such as the PPACA or any future health care reforms, that population health disparity would be properly addressed. Researchers have similarly noted the importance of churches in addressing health care disparities (Donnelly, 2014; Isler et al., 2014; Jo et al., 2010; Kreuter et al., 2014; Lumpkins et al., 2013; Wizemann & Thompson, 2015). Though not inclusive of African American populations, evangelical churches found key roles for PPACA to provide primary care initiatives (Franz & Skinner, 2016), but the present research also indicated the potential role of the church as a stakeholder within the policymaking process.

The overall findings aligned with the theoretical and conceptual frameworks of Andersen's (1968) behavioral health model and Hochbaum's (1958) HBM to some degree. Participants sought or did not seek health care and or health insurance for multiple reasons, which were directly due to cost-benefit analyses and predisposing factors, as previously discussed. Furthermore, participants encouraged churches to act as stakeholders which would merge the identified problems, politics, and policy streams, as consistent with Kingdon's (2011) for appropriately analyzed Howlett's et al.'s (2015) theoretical solutions. Additional discussion of the significance of the present study in terms of Kingdon's theory is discussed in the implications section of this chapter.

In summary, parishioners' health care issues and their perspectives on the church's role as a PPACA stakeholder, uncovered eight categorized themes explained above in greater detail: (a) the effects of being non- or underinsured; (b) understanding the relationship between insurance and finances; (c) cost of care is too high; (d) insurance is important vs. insurance is not important; (e) issues related to health care and insurance; (f) self-empowerment is essential; (g) role of the church in health care; and, (h) connections between health care and family. Cost and financial deficit were the primary reasons for not seeking health care services and insurance coverage. All, except one participant perceived the church had a role in health care services, but all participants felt the church could educate and advocate for its parishioners on health care issues.

## Limitations of the Study

This study may offer transferability to multiple religious groups, ethnic groups and communities, yet limitations in this study could influence transferability and credibility, therefore weakening study results (Simon, 2011). For example, one potential limitation was the eventual makeup of the participants (races: African American (11) and African American/Indian (1); genders: male (2), female (10); Age Groups: 18-30 (3), 31-40 (2), 41-50 (2), and 51-65 (5); residence: inner city (2), suburban (5), and rural (5). Thus, the sample included a small number of inner city African Americans. In addition, more females (10) volunteered for this study than males (2). I speculate that the females identified with me, as a female, and felt more comfortable approaching, as well as disclosing their information. It is also noteworthy that these two males appeared to have the most severe medical problems such as a history of diabetes, strokes, and heart disease. Therefore, the study may exclude the perceptions of African American males, especially those who are healthy.

Another potential limitation was the use of a purposive sample. Using purposive sampling could have presented limitations. However, the right selection of participants, parishioners with no or insufficient health insurance, was important to address the research question: What are the perceptions of African American church attendees on their health care issues and the church role in advocating as a PPACA stakeholder to reduce health care disparities?

Due to the qualitative nature of this study, additional limitations were also inevitable. One potential limitation was researcher bias. To increase trustworthiness of the data collected, I developed a study protocol, took detailed field notes, and used triangulation data collection approach, including interviewing, audio recording, transcribing, member checking, note and memo writing. Participants reviewed all written interviews for accuracy in the final write-up. Field notes and memos also were designed to produce an audit trail for increased dependability of documented data as recommended by Petty et al. (2012). My personal biases as a nurse and a member in one of the churches were identified in an earlier chapter and provided to participants prior to data collection. I also bracketed my personal opinions about health care during the interview in order to not influence participants' opinions. The information obtained from literature and from consulting my Chair were very helpful to better understanding the type of information expected from participants and types of themes that would derive, so little of my professional experience was needed.

The minimum number of participants (*n* = 12) were solicited, which was appropriate for this case study approach, but could have interjected biases, for the data collected were limited to just a few people's responses to a list of preset questions. I asked open-ended questions, using flexibility to get as much accuracy and the fullest perspective, possible, from each individual participant. A potential limitation may be that all the right questions were not asked. For instance, in talking to male participants, more details could have clarified why they chose not to seek health services prior to being hospitalized. It was an assumption that money was their reason, but it could have been due to lack of knowledge or illiteracy. Also, how would the researcher address such an issue when the conversation is limited to people's opinions for pre-established interview questions? An additional potentially limited question was about health care coverage or inadequate coverage impacting families; I had to probe to be sure the question was understood and get an accurate response. Participants may have been too proud to admit that they relied or in the future may have to rely on family members for help or that family members may sacrifice time and effort or be deprived because of the participant's lack of or inadequate health care coverage.

Clarity of information became an issue in one instance when asking questions. An assumption was that all participants would understand all interview questions, while many did, but a few did not seem to comprehend what was being asked. I had to break down terms and explain some questions in the simplest manner possible. Upon clarification, however, participants were more forthcoming about the influence of their health care status on their families; it may be that participants had trouble being forthcoming about this particular aspect of health care because of the introspection required. Alternatively, the question as initially asked may have been confusing, and therefore may have limited the data regarding this aspect of the study.

## Recommendations

The limitations of the present study led to several recommendations for future researchers. First, the study participants consisted of a limited sample, within a limited geographic region, three specific congregations, and with a small proportion of African American males. Future researchers may consider conducting a similar study among churches in a different locale, or attempting to gain a wider national sample to provide further transferability of the results. The present study also opens an opportunity for further qualitative research to be conducted utilizing other churches, ethnic groups and nonchurch samplings within the community to determine if a management strategy for health care disparity can be better addressed. If replicating this study, future researchers should consider clarifying the questions related to the influence of their insurance status on their families.

It is recommended that more quantitative studies be conducted in multiple churches regionally to get a better idea of where the health disparities are located in relation to health facilities, public health resources, and locations of assigned ACOs to examine and compare benefits and how to allocate expanded resources to deprived areas to better address health care disparities. Further research that involved larger sample sizes, as common in quantitative studies, would support broader generalizations.

Future researchers on this topic should prepare to obtain details on participants' demographics and to pay close attention to the influence of these factors, consistent with Andersen's (1968) framework. Perhaps the demographics could focus on the poverty conditions of those individuals who developed chronic diseases after not seeking medical care or not having health insurance. Demographics should also focus on participants' educational level. As mentioned earlier, educational deficiencies or lack of knowledge is an important factor in one acknowledging the seriousness of their health condition and how to obtain insurance. Urban and rural areas have the highest challenges in health care delivery due to predisposing factors of race, income, education, and gender (NAS, 2015), and these factors should be accounted for in future research. Gender and socioeconomic status were also essential factors revealed as playing a role in health care disparity in the present study.

Standardization of metrics to monitor and report on deficiencies, progress and the joint efforts made, between local agencies, such as churches, public health and health care agencies, on health disparity supports formation of policy, needed to sustain the national healthiness goals (NAS, 2015).

## Implications

### Theoretical Implications

The present study supported the joint use of Andersen's (2007) and Babitsch et al. (2012) predisposing factors, in addition to the HBM (Hochbaum, 2010), the three multiple streams (Kingdon, 2011) and the five-stream expanded model (Howlett et al., 2015) in identifying and understanding health care disparities and interventions.

Andersen’s framework helped guide the research to emphasize demographic factors that contributed to health care disparity. The study also implied that the HBM not only explained health care behaviors of participants, but also their willingness to obtain insurance coverage. Much like health care, if participants perceived that health insurance would not meet their needs in a cost-effective manner, then they were unlikely to purchase. I did not identify other research that showed the extension of the HBM to insurance coverage, which is a potential implication of the present study. The study does, however, imply that the expanded Kingdon and Howlett et al.’s frameworks may provide explanatory value for researchers studying this problem, as well as similar problems.

## Implications for Future Research

Public health stakeholders’ most prominent goal is to diminish health disparity across cultural lines. Though the establishment of REACH (U.S. Department of Health and Human Services, 2016) and other program strategies are designed to meet this goal, bridging the gaps among communities deprived of equal health access requires more players be brought to the table of negotiation and policy decision-making. For researchers, the study implies the ongoing need to evaluate and understand the underlying factors influencing ongoing health care disparities. Qualitative research may continue to provide insight about those experiencing the problem and their attitudes towards specific nontraditional stakeholders in public health and public health policy, as was the case in the present study. However, it is essential that qualitative researchers understand their population and potential barriers, such as a lack of understanding of the subject of health care, a lack of introspection or understanding about the influence of their actions, and cultural attributes, such as gender roles, that might influence behaviors. This study also promotes awareness to other researchers of the need for tools, such as frameworks, conceptual models, strategic plans, and educational plans for church-related solutions to end health disparities among the African American parishioners.

Given the importance of transparency in maintaining trust in health care initiatives, especially among the African American community, it is recommended that future researchers increase the transparency of the actions taken to improve health disparity, including frameworks designed, programs developed, metrics monitored and health statistics. The National Academy of Sciences (2015), in conjunction with the Institute of Medicine, examined policy methods in conjunction with public health issues, and reported that a particular strategy to earn the public's trust is to incorporate transparency where data and metrics demonstrate quality indexes. Therefore, researchers should be transparent in their data collection procedures; researchers should reveal the details of their data collection and methods to the public to increase public trust in research. Such transparency can also spread accountability throughout the health care system.

It is especially recommended that churches, community organizers, and health care administrators partner with researchers to improve population health outcomes. Finally, after the researchers collect data, they should disseminate the information on publicly available resources, such as through the church or on a website, about how the data are being used to effect positive social change. These practices may increase the relationship among researchers, African American churches, and their parishioners.

## Implications for Practice

The results revealed several recommended functions that churches could serve in reducing health care disparities. First, church health ministries could provide health prevention and health promotion activities. The church may serve within the local health care system by sharing resources, providing disease screening, distributing insurance information, providing transportation assistance, supporting or housing a local free clinic, or serving in other functions based on assessed health needs in the communities. One participant felt that information coming from the church was accepted “as the gospel” and suggested that information and resources would be better received if shared by the church in multiple ways, such as Frequently Asked Questions, Nurse Advice phone lines, health screenings (i.e., cancers, diabetes, high blood pressure, dietary, poor dental/gum diseases and other diseases) to meet the routinely assessed needs.

Additionally, professional hospital staff can visit the local church and conduct preventive care measures routinely, either monthly or quarterly. The church could then become the venue that indirectly over time reduces the infrastructure and personnel cost in the hospital due to fewer people becoming sick with preventative measures in place. African Americans, especially those in hard to reach geographical areas, would require fewer clinic, hospital, and emergency room visits. An integrated community effort is essential to affect societal change and end health care disparities (CDC, 2013), and church stakeholders should work to serve as an integrated stakeholder.

For example, a role the church can play is providing information to parishioners about common health issues for African Americans. The church could inform parishioners of the warning signs of heart disease and encourage men in particular to seek medical care sooner for earlier life-saving interventions. The CDC (2013) indicates that more than 600,000 people die from heart disease in the United States each year, which is about 1 in every 4 deaths, and more than ½ of those are in men. The results of the present study suggested African American men may only seek care when symptoms become catastrophic based on their insurance status and the cost of care. If churches provided information about warning signs of heart disease, then parishioners may seek out care more quickly. Previous researchers have similarly indicated positive benefits stemming from such church-supported preventative medicine initiatives (Colon-Otero et al., 2012; Thompson et al., 2013).

The findings supported the church as a potential place for health care information and intervention to be provided, yet participants also noted the need for professionalism and discretion on the part of church members. The church personnel, like many employees of other organizations would need training on customer service, professionalism, information management training when it comes interacting with the public and handling personal information. The church, like any organization would be accountable for services provided. Therefore, churches who implement care provision should have a well-trained medical and administrative staff (Villatoro et al., 2016).

Many participants also noted that the church could serve as an advocate for the community. In other words, churches should advocate for their underserved parishioners and serve to increase their access to cost-effective, quality health care. Participants noted that currently, politicians already attend church services as a method of gaining support.

Therefore, church leaders should encourage and increase their participation and networking with both politicians and policymakers, so the needs of the parishioners with respect to health care are heard and met.

## Implications for Policymakers

Being able to identify a social change issue, while understanding the values impacting particular populations, sets the stage for public policy reform (Dye, 1972). Therefore, this study provides several indications of the needs of a specific population regarding the PPACA, or other health care reforms undergone by future policymakers. These implications may be especially salient for reducing health care disparities as Congress takes actions to reform, revise, or replace PPACA. Kingdon’s (2011) multiple streams (problem, policy and politics) were used to derive policy implications from the present study. Parishioners’ health needs as identified from this study and their perspectives generated some essential themes, which were the beginning steps of stakeholder’s responsibility to the people it serves.

This study supports Kingdon’s (2011) integrated three streams to formulate policies, wherein the needs identified by parishioners are the problems of health disparity from their perspective. The policy and agenda for change is the PPACA or health care reform as it may be integrated in the future. Uniformity of the public’s goals, their objectives, and their purposes are needed to revise, form or make policy (Dye, 1972). As Kingdon and Howlett et al. alluded, circumstances diverting attention from the problem can impact any element of the policy process. Each step of the policy reform must be accurately documented, assessed, vetted, and evaluated routinely to analyze alternative strategic solutions until the health disparity goals are met. Cost-effective, quality health care and health services should continue to be a focus for the nation, as the present study indicates continuing health care disparities with devastating effects within the community under study. The problem should drive the effort for greater coordination with nontraditional stakeholders, such as the churches examined in the present study. Having stakeholders with experience in the problem, such as churches from underserved populations, as active agents in politics and policymaking can limit distractions that inhibit positive change. Corroborating on the needs identified from this study with other community leaders and hospital agencies would bridge the gap to better manage population health (NAS, 2015).

An implication stemming from the present study is incorporating policy revisions that mandate enhanced partnerships that include the church as a stakeholder and venue to address issues of health disparity. Such stakeholders can provide insight into the problem and also advocate for improved policy. Having stakeholders that straddle multiple streams may help to integrate perspectives and prevent distractions, such as political biases, from interfering with public policy that can address the issues currently faced by underserved populations. Policymakers may use this information to overcome the demands for health care coverage, while reducing the cost on an already burdened country. This study can also inform future policy strategies based on the theoretical perspectives of Kingdon and Howlett et al.

### Implications for Positive Social Change

This study provided required knowledge identifying parishioners' health needs. The American Nurses Association corroborated with Health Ministries Association to bridge medical service gaps between health and faith organizations, but a tool was missing for assessing church members' needs (Donnelly, 2014). The study may have significance for social change by informing the development of metrics to understand community needs. A standardized and national approach currently exists with the CHNA utilized by ACOs (CDC, 2013), yet the current system may not account for the needs of individuals who do not seek care until it is too late. Also, one participant thought that information could be shared by the church on insurance coverage, job training skills, how to get assistance with medications costs, and the locations of free clinics or social services, and how to get transportation, and how to link to communication services (i.e. telephones, computers, internet, support systems such as family, friends, caregivers), all of which enhance knowledge and may increase future healthiness. Many of these aforementioned health-related activities could be done through PPACA supported grants, as a couple of participants suggested.

This study will have influence on legislators and policymakers at the local, state, and national level. It demonstrates the need to work on the prohibitive cost of insurance and health care to address disparities among underserved communities. A participant in this study emphasized efforts to get insurance from his employer, but was nevertheless denied after being on a job several years. As such, the individual waited until hospitalization and a disabling illness warranted insurance through PPACA. It is reasonable to think that the medical condition of this participant, if educated on the warning signs of heart disease, proper nutrition for diabetes, and resources for medicines or health services could have precluded the chronic, many times fatal, disease of a stroke and heart disease. Integrating the church in providing such resources at lessened cost to the individual could therefore have helped to prevent the person's worsening condition, as well as lessened the overall cost of government subsidization of the catastrophic care the person eventually had to receive. Through more affordable services and insurance coverage, there could be significant social change for not only underserved individuals, but also their communities.

Finally, this study has social change implications for health care policy, specifically, churches partnering with public health and health care agencies, networking with other ACOs, and contributing to CHNAs for better capture the metrics and data for improved population health and ending disparities in health. It is highly recommended that legislators review research data collected on those mostly impacted by diseases and chronic health conditions to discern how future health reform bills should be implemented. Data gathering could be vastly improved by integrating data from disproportionately affected populations. However, such populations, especially African Americans, may distrust health care in general, and therefore be inaccessible (Allen et al., 2010). The church may provide a liaison between affected communities, policymakers, and legislators, therefore ensuring the integration of the three streams and leading to positive social change through lessened disparities (Kingdon, 2011).

Expanding church partnerships into health care policy function and operation will improve the overall monitoring for health disparities in the community, assessing the needs of parishioners and community members. This work is currently completed with the CHNA for ACOs and other health care organizations, but the failure of individuals to receive care before it is an emergency may limit such organizations' abilities to gather accurate data regarding community needs. As mentioned previously, this is the beginning stage in developing a role for the church as a social change implementer of policy to help resolve the problem of health disparity in the African American community, but these strategies are transferable to other affected communities.

A framework expanding partnerships with ACOs, a key intervention strategy, with PPACA or any new health reform bill could fund such support, helping to end health care disparities (Derose et al., 2011). The disparities revealed in the present study could potentially provide a first step in developing effective metrics for understanding community needs, and churches can continue to act as a method of gathering data about the true extent of health care disparities. The findings ultimately suggest a significant positive social change, with improved communications, networks, outreach promotion, and prevention of health disparity of the community, if future health care policy includes the church as a social change agent.

## Summary and Conclusion

African Americans are the largest minority population at risk for deaths from heart disease and stroke, hypertension, obesity, diabetes, and infant mortality (CDC, 2013). This study was conducted to explore the potential roles of African American churches in providing health care assistance to underserved parishioners. Data was collected from direct sources, the parishioners, attending three selected African American churches. Andersen's (1968) seminal behavioral model and Hochbaum (1958) HBM were used to understand the factors and characteristics of church attendees with possible health care disparities as qualified as having no or insufficient health insurance, and Kingdon's (2011) multiple streams framework provided explanation for the policy implications of including African American churches as stakeholders. It was found that some demographic factors mattered, such as residency, availability of services, lack of transportation, income, race, gender, age, and culture may have presented as barriers to health care access influencing health care disparities (Derose et al., 2011; Gaskins et al., 2012; Griffith et al., 2010; Kim et al., 2012).

Primary roles potentially played by the church were being parishioner's support, hope, resource and advocate for health assistance and access to health services. Having insurance options and insurance coverage were important to parishioner participants in this study, yet the majority of participants were either uninsured or underinsured. Some preferred to save money for future medical procedures and pay out of pocket fees and any penalties, rather than purchase an insurance plan. On the other extreme, several participants just could not afford insurance and did not access support for health care until an acute situation occurred. The church could potentially sponsor or contact a managed care team of resources to establish routine medical check-ups, obtain medications needed and assess the effectiveness of medications, such as, when generic brand names change or when medications are unaffordable.

Furthermore, there seems to be gaps in coverage in the health care delivery system for individuals, especially when the health care system confirms deprivations of resources, such as during the waiting or processing period for Medicare or OBAMA care. Medications or necessary routine care should be available during the waiting period. The church organization could be the initial contact source, which would save lives and reduce costly unplanned emergency room visits, chronic diseases and deaths.

Parents have the desire to protect their children's health irrespective of cost, and participants understood the value of health care and insurance; some, however, felt it was a luxury they could not personally afford, despite some acknowledging adverse effects on their families. Certain freedoms are understandable, but participants feared what would happen if a catastrophic illness occurred where the expense drained most of or all their savings. Participants in these situations such as this, would just hope that they could handle related medical expenses when occurring.

The primary barrier to health care service was cost. It seems that individuals preferring not to purchase the traditional health care plan should have unique insurance coverage plans, such as, cash savings options to cover unforeseen and foreseen medical expenses. Such plan could earn interest for as long as paid into, with no penalties if used for medical needs and services. A medical savings plan would at least reduce some of one's personal expenses and perhaps government expenses as well. The church could monitor and report health care needs such as this and others as time progressed and situations evolved.

Also, pharmaceutical cost is a barrier preventing many from care access and as noted from some participants' situations, this cost factor puts the most vulnerable, such children, at risk of death. Congress, legislators and our leaders certainly have a need to know how the cost of medications and how inefficient benefits on individuals' jobs are impacting the health of that person, their family and the community, especially the already deprived, underserved minority populations. The church as an advocate could bring awareness and voice to policy-makers, especially when politicians visit the church to gain acknowledgment, people's support and vote. The church could also produce research knowledge based on this study and other evidence monitored on health care assessed needs in addition to identifying lucrative solutions from church attendees' perspectives.

I have been in the military health care system as a dependent most of my adult life. I feel comfort knowing that when I have a medical concern that there is a nurse or medical advice line of communication via phone or computer that can be used in effectively addressing my health care needs without being overly concerned about cost. Community call centers or crisis lines already established can integrate services to community churches broadening outreach capabilities to those in desperate need and seeking medical knowledge or assistance.

Interviews also revealed that the participants were passionate about faith and employed their faith in personally handling health care decisions. The church was perceived as a source of help for those in need. It was a social setting that routinely brought groups of people together to learn, teach, and share information and experiences. Church leaders also identified human challenges, and helped parishioners overcome them through faith and prayer. Therefore, the church played a role of empowering the people it served resulting in self-motivating actions improving their lives. African American churches would benefit in having a voice in politics and policy-making decision affecting the African American communities' health. The participants from this study were excited to give voice to their challenges, and to hopefully have an influence on addressing health care disparities. Fully understanding the problem of health care disparities is most essential to designing targeted, and effective policy reform.

The church is equipped through its empowering role to help parishioners break through the barriers predisposing them to health disparity or disbeliefs resulting in lack of health care access. African American churches may develop programs to educate and advocate based on the needs of parishioners and advocate the needs of their congregations to policymakers and legislators. Other churches can focus on the needs identified from this study, assess their health care needs and evaluate what type of respective actions are needed for improving the health their parishioners. Furthermore, they may communicate these actions to Health and Human Services and other legislators for standardization in policy support. Partnering with health care system agencies as a stakeholder in the PPACA or other health reformation initiatives will facilitate better programs, such as education, counseling, health fitness and wellness, nutrition, and resource referral.

A community-driven approach that engages diverse, nontraditional stakeholders may help to reduce health disparities. There is a significant relationship between people’s traits, health behaviors and health behavior outcomes (Shepherd et al., 2014), which suggest that once the resources are provided or people know more from being well informed, statistical outcomes will be better for improved health for those with diseases such diabetes, heart disease, stroke, obesity, and suicide and depression among adolescents (U.S. Department of Health and Human Services, 2017). I feel strongly about the goal to end all health care disparity in the nation. Every individual can make a difference in the lives of others by managing within their realm of power. In this study, I disclose the voices of the African American minorities denied, discounted and who have suffered astronomically for reasons beyond their control. I acknowledged and brought the health care needs and concerns to the forefront. I now will relentlessly provide evidence found to legislators, community leaders and health care organizers with a personal goal to end the unnecessary struggles for those affected by lack of health care access and disparity issues. The more strategies and more organizations and communities involved in facilitating accountability and addressing health care disparities, the more likely it is that underserved communities will experience a better quality of life.

# References

Alberti, P. (2014). Community health needs assessments: Filling data gaps for population health research and management. *eGEMs*, *2*(4), 1174. doi:10.13063/2327-9214.1174

Alfano-Sobsey, E., Ledford, S. L., Decosimo, K., & Horney, J. A. (2014). Community health needs assessment in Wake County, North Carolina. *North Carolina Medicine Journal*, *75*(6), 376-383. Retrieved from http://www.ncmedicaljournal.com/

Allen, A. J., Davey, M. P., & Davey, A. (2010). Being examples to the flock: The roles of church leaders and African American families seeking mental health care services. *Contemporary Family Therapy, 32*(2), 117-134. https://doi.org/10.1007/s10591-009-9108-4

Almadi, M. A., Mosli, M. H., Bohlega, M. S., Al Essa, M. A., AlDohan, M. S., Alabdallatif, T. A., . . . Mandil, A. (2015). Effect of public knowledge, attitudes, and behavior on willingness to undergo colorectal cancer screening using the health belief model. *Saudi Journal of Gastroenterology, 21*(2), 71-77. doi:10.4103/1319-3767.153814

Andersen, R. M. (1968). *Behavioral model of families' use of health services.* Illinois: University of Chicago.

Andersen, R. M. (1995). Revisiting behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*(3), 1-10. https://doi.org/10.2307/2137284

Andersen, R. M., Rice, T. H., & Kominski, G. F. (2007). *Changing the United States health care system: Key issues in health services policy and management* (3rd ed.). San Francisco, CA: John Wiley and Sons.

Babitsch, B., Gohl, D., & Von Lengerke, T. (2012). Re-revisiting Andersen's behavioral model of health services use: A systematic review of studies from 1998–2011. *GMS Psycho-Social-Medicine*, *9*, Doc11. http://doi.org/10.3205/psm000089

Beatty, K. E., Wilson, K. D., Ciecior, A., & Stringer, L. (2015). Collaboration among Missouri nonprofit hospitals and local health departments: Content analysis of community health needs assessments. *American Journal of Public Health*, *105*(Suppl 2), S337–S344. doi:10.2105/AJPH.2014.302488

Bell, S., Wilson, K., Bissonnette, L., & Shah, T. (2013). Access to primary health care: Does neighborhood of residence matter? *Annals of the Association of American Geographers, 103*(1), 85-105. https://doi.org/10.1080/00045608.2012.685050

Bennett, A. (2008). Building communities, bridging gaps: Alexander George's contributions to research methods. *Political Psychology, 29*(4), 489-507. doi:10.1111/j.1467-9221.2008.00646.x

Berg, B. L., Lune, H., & Lune, H. (2004). *Qualitative research methods for the social sciences* (Vol. 5). Boston, MA: Pearson.

Bethall, C. D., Kogan, M. D., Strickland, B. B., Schor, E. L., Robertson, J., & Newacheck, P. W. (2011). A national and state profile of leading health problems and health care quality for us children: Key insurance disparities and across-state variations. *Academic Pediatrics, 11*(3), 22-33. doi:10.1016/j.acap.2010.08.011

Bloomberg, L. D., & Volpe, M. (2015). *Completing your qualitative dissertation: A road map from beginning to end*. Thousand Oaks, CA: Sage.

Blumenthal, D., & Collins, S. R. (2014). Health care coverage under the Affordable Care Act—A progress report. *New England Journal of Medicine*, *371*(3), 275-281. https://doi.org/10.1056/nejmhpr1405667

Bowen, G. A. (2008). Naturalistic inquiry and the saturation concept: A research note. *Qualitative research, 8*(1), 137-152. https://doi.org/10.1177/1468794107085301

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013a). *Successful qualitative research: A practical guide for beginners*. Thousand Oaks, CA: Sage.

Braun, V., & Clarke, V. (2013b). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *Psychologist*, *26*(2), 120-123. Retrieved from http://eprints.uwe.ac.uk/21155

Braun, V., & Clarke, V. (2014). What can ‘‘thematic analysis’’ offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-Being*, *9*. http://dx.doi.org/10.3402/qhw.v9.26152

Braun, V., Clarke, V., & Terry, G. (2014). Thematic analysis. *Qualitative Research in Clinical and Health Psychology, 95*. https://doi.org/10.1007/978-1-137-29105-9_7

Brewer, J., Benz, C. R., & Newman, I. (1998). Qualitative-quantitative research methodology: Exploring the interactive continuum. *Contemporary Sociology, 28*, 245-246. https://doi.org/10.2307/2654917

Brotherton, D. B. (2010). *Renewing life and society: The lived experiences of racial inclusion in a Protestant evangelical parachurch organization* (Doctoral dissertation, Fielding Graduate University). Available from ProQuest Dissertations and Theses database. (UMI No. 3432656)

Brownson, R. C. (2014). *Emerging issues in understanding evidence in complex public health situations.* LinkedIn Institute of National Cancer Conference Presentation. Retrieved from www.slideshare.net/Institut_national_du_cancer/21-ross-c-brownson

Burke, T. (2011). Accountable care organizations. *Public Health Reports*, *126*(6), 875–878. https://doi.org/10.1177/003335491112600614

Calhoun-Brown, A. (1996). African American churches and political mobilization: The psychological impact of organizational resources. *Journal of Politics*, *58*(04), 935-953. https://doi.org/10.2307/2960144

Campbell, M. K., Demark-Wahnefried, W., Symons, M., Kalsbeek, W. D., Dodds, J., Cowan, A., … McClelland, J. W. (1999). Fruit and vegetable consumption and prevention of cancer: The Black churches united for better health project. *American Journal of Public Health*, *89*(9), 1390-1396. doi:10.2105/AJPH.89.9.1390

Centers for Disease Control and Prevention. (2013). *CDC health disparities and inequalities report 2013.* Retrieved from http://www.cdc.gov/

Centers for Medicare and Medicaid Services. (2015). *Public policy and program information on the health care law: Full law patient protection and Affordable Care Act.* Retrieved from https://www.cms.gov/

Chai, T. (2015). A look at contextualization: historical background, definition, function, scope and models. *Asian Journal of Pentecostal Studies, 18* (1), 3-19. Retrieved from http://www.apts.edu/index.cfm?menuid=94&parentid=54

Chaze, F., Thomson, M. S., George, U., & Guruge, S. (2015). Role of cultural beliefs, religion, and spirituality in mental health and/or service utilization among immigrants in Canada: A scoping review. *Canadian Journal of Community Mental Health. 34*(3), 87-101. doi:10.7870/cjcmh-2015-015

Clandinin, D. J. (Ed.). (2006). *Handbook of narrative inquiry: Mapping a methodology*. Thousand Oaks, CA: Sage.

Colon-Otero, G., Albertie, M., Lesperance, M., Weis, J. A., Coles, A., Smith, N., … Rajkumar, S. (2012). A pilot program in collaboration with African American churches successfully increases awareness of the importance of cancer research and participation in cancer translational research studies among African Americans. *Journal of Cancer Education*, *27*(2), 294–298. doi:10.1007/s13187-011-0288-x

Coyne, I. T. (1997). Sampling in qualitative research. Purposeful and theoretical sampling: Merging or clear boundaries. *Journal of Advanced Nursing*, *26*(3), 623-630. https://doi.org/10.1046/j.1365-2648.1997.t01-25-00999.x

Davaney, S. G., Bowlin, J., Kerbel, J., & Valdez, E. (2012). Funding and teaching challenges facing faith-based organizations. *Journal of Public Theology, 6*(4), 479-486. doi:10.1163/15697320-12341250

Dean, J. E. (2013). Do you have that new church app for your iPhone? Making the case for a clearer and broader definition of church under the Internal Revenue Code. *Crieghton Law Review, 46*(2), 173-206. Retrieved from https://www.creighton.edu/groups/lawreview/

Debnam, K., Holt, C. L., Clark, E. M., Roth, D. L., & Southward, P. (2012). Relationship between religious social support and general social support with health behaviors in a national sample of African Americans. *Journal of Behavioral Medicine*, *35*(2), 179-189. doi:10.1007/s10865-011-9338-4

Derose, K. P., Gresenz, C. R., & Ringel, J. S. (2011). Understanding disparities in health care access-reducing them-through a focus on public health. *Health Affairs, 30*(10), 1811-1851. doi:10.1377/hlthaff.2011.0644

Donnelly, M. E. (2014). Faith community nursing: Health care in the church. *Tennessee Nurse, 77*(1), 9. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/24693624

Doshi, R. K., Malebranche, D., Bowleg, L., & Sangaramoorthy, T. (2013). Health care and HIV testing experiences among Black men in the South: implications for "seek, test, treat, and retain" HIV prevention strategies. *AIDS Patient Care and STDs, 27* (2), 123-133. doi:10.1089/apc.2012.0269

Dowling, M., & Cooney, A. (2012). Research approaches related to phenomenology: Negotiating a complex landscape. *Nurse Researcher, 20*(2), 21-27. https://doi.org/10.7748/nr2012.11.20.2.21.c9440

Dye, T. R. (1972). *Understanding public policy*. Englewood Cliffs, New Jersey: Prentice-Hall.

Eskandari-Torbaghan, A., Kalan-Farmanfarma, K., Ansari-Moghaddam, A., & Zarei, Z. (2014). Improving breast cancer preventive behavior among female medical staff: The use of eEducational intervention based on health belief model. *Malaysian Journal of Medical Sciences, 21*(5), 44-50. Retrieved from http://www.ncbi.nlm.nih. gov/pmc/articles/PMC4418125

Flannelly, K., & Galek, K. (2010). Religion, evolution, and ETAS Theory. *Journal of Religion and Health, 49*(3), 337-350. https://doi.org/10.1007/s10943-009-9247-9

Franz, B., & Skinner, D. (2016). Evangelical Protestants and the ACA: An opening for community-based primary care. *Social Work in Public Health*, *31*(4), 231-245. https://doi.org/10.1080/19371918.2015.1099497

Galiatsatos, P., & Hale, W. D. (2016). Promoting health and wellness in congregations through lay health educators: A case study of two churches. *Journal of Religion and Health*, *55*(1), 288-295. https://doi.org/10.1007/s10943-015-0069-7

Gaskins, D. J., Dinwiddie, G. Y., Chan, K. S., & McCleary, M. (2012). Residential segregation and disparities in health care service utilization. *Medical Research and Review, 69*(2), 158-175. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/21976416

Gibbons, M. C., & Casale, C. R. (2010). Reducing disparities in health care quality: The role of health it in under resourced settings. *Medical Care Research and Review Supplement, 67*(5), 1555-1625. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/20829238

Glaser, B. G., & Strauss, A. (1967). *Discovery of grounded theory*. Chicago, IL: Aldine.

Griffith, D., Yonas, M., Mason, M., & Havens, B. E. (2010). Considering organizational factors in addressing health care disparities: Two case examples. *Health Promotion Practice, 11*, 367-376. https://doi.org/10.1177/1524839908330863

Gourevitch, M. N., Cannel, T., Buford, J. I., & Summers, C. (2012). The challenge of attribution: Responsibility for population health in the context of accountable care. *American Journal of Public Health, 102*(Suppl 3), S322-S324. doi:10.2105/AJPH.2011.300642

Hamrin, V., Sinclair, V. G., & Gardner, V. (2017). Theoretical approaches to enhancing motivation for adherence to antidepressant medications. *Psychiatric Nursing, 31*(2), 223-230. https://doi.org/10.1016/j.apnu.2016.09.004

Hankerson, S. H., & Weissman, M. M. (2012). Church-based health programs for mental disorders among African Americans: A review. *Psychiatric Services (Washington, D.C.)*, *63*(3), 243–9. doi:10.1176/appi.ps.201100216

Hanson, J. L., Balmer, D. F., & Giardino, A. P. (2011). Qualitative research methods for medical educators. *Academic Pediatrics, 11*, 375–386. doi:10.1016/j.acap.2011.05.001

Heider, D., Matschinger, H., Müller, H., Saum, K., Quinzler, R., Haefeli, W. E., . . . König, H. (2014). Health care costs in the elderly in Germany: An analysis applying Andersen's behavioral model of health care utilization. *BMC Health Services Research, 14*(1), 1-21. doi:10.1186/1472-6963-14-71

Hochbaum, G. M. (1958). *Public participation in medical screening programs: A socio-psychological study*. Washington, DC: Public Health Service.

Hochbaum, G. M. (2010). Changing health behavior in youth. *American Journal of Health Education, 41*(3), 130-133. https://doi.org/10.1080/19325037.2010.10599888

Holt, C. L., Clark, E. M., Debnam, K., & Roth, D. (2014). Religion and health in Africans Americans: The role of religious coping. *American Journal of Health Behavior, 38*(2), 190-199. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/24629548

Holtzman, C., Brady, K., & Yehia, B. (2015). Retention in care and medication adherence: Current challenges to antiretroviral therapy success. *Drugs,75*(5), 445-454. https://doi.org/10.1007/s40265-015-0373-2

Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigour in qualitative case-study research. *Nurse Researcher, 20*, 12-17. doi:10.7748/nr2013.03.20.4.12.e326

Howlett, M., McConnell, A., & Perl, A. (2015). Forum section: Theoretically refining the multiple streams framework stream and stages: Reconciling Kingdon and policy process theory. *European Journal of Political Research, 54*, 419-434. doi:10.1111/1475-6765.12064

Isler, M. R., Eng, E., Maman, S., Adimora, A., & Weiner, B. (2014). Public health and church-based constructions of HIV prevention: African American Baptist perspective. *Health Education Research*, *29*(3), 470-484. doi:10.1093/her/cyu006

Janz, N. K., & Becker, M. H. (1984). The health belief model: A decade later. *Health Education Quarterly 11*(1), 1-47. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/6392204

Jo, A. M., Maxwell, A. E., Yang, B., & Bastani, R. (2010). Conducting health research in Korean American churches: Perspective from church leaders, *Journal of Community* Health. *35*(2), 156-164. doi: 10.1007/s10900-009-9213-1

Jones, C. J., Smith, H. E., Frew, A. J., Toit, G. D., Mukhopadhyay, S., & Llewellyn, C. D. (2014). Explaining adherence to self-care behaviours amongst adolescents with food allergy: A comparison of the health belief model and the common sense self-regulation model. *British Journal of Health Psychology,19*(1), 65-82. https://doi.org/10.1111/bjhp.12033

Kehm, R., Hearst, M., Sherman, S., & Elwell, K. (2017). The FAV-S pilot study: Increasing self-efficacy and fruit and vegetable intake among Somali women and children. *Health Education and Behavior Journal, 44*(1), 52-58. https://doi.org/10.1177/1090198116646367

Kim, G., Bryant, A. N., Goins, R. T., Worley, C. B., & Chiriboga, D. A. (2012). Disparities in health status and health care access and use among older Americans Indians and Alaska natives and non-Hispanic Whites in California. *Journal of Aging and Health, 24*(5), 799-811. https://doi.org/10.1177/0898264312444309

Kim, J. E., & Zane, N. (2015). Help-seeking intentions among Asian American and White American students in psychological distress: Application of the health belief model**.** *Cultural Diversity and Ethnic Minority Psychology.*

doi.org/10.1037/cdp0000056

Kingdon, J. W. (2011). *Agendas, alternatives, and public policies* (2nd ed.,). Boston, MA: Pearson Education.

Koenig, H. (2012). Religion, spirituality and health: The research and clinical implications. *Psychiatry, 2012,* 1-33. doi:10.5402/2012/278730

Kreuter, M. W., McBride, T. D., Caburnay, C. A., Poor, T., Thompson, V. L. S., Alcaraz, K. I., … Casey, C. (2014). What can health communication science offer for ACA implementation? Five evidence-informed strategies for expanding Medicaid enrollment. *Milbank Quarterly*, *92*(1), 40–62. doi:10.1111/1468-0009.12040

Krist, A. H., Shenson, D., Woolf, S. H., Bradley, C., Liaw, W. R., Rothemich, S. F., … Anderson, L. A. (2013). Clinical and community delivery systems for preventive care: An integration framework. *American Journal of Preventive Medicine*, *45*(4), 508–516. doi:10.1016/j.amepre.2013.06.008

L'Anson, R. A., & Smith, K. A. (2004). Undergraduate research projects and dissertations: Issues of topic selection, access, and data collection amongst tourism management students. *Journal of Hospitality, 3*(1), 19-32. https://doi.org/10.3794/johlste.31.54

Lasswell, H. D. (1972). Communications research and public policy. *Public Opinion Quarterly, 36*(3), 301-310. Communications research and public policy. Public Opinion Quarterly

Lasswell, H. D. (2015). The influence of the intellectual in exile. D. *Social Research, 82* (1), 35-45. Retrieved from http://www.jstor.org/stable/40981564

Laureate Education. (Executive Producer). (2010). *Overview of qualitative research methods.* Baltimore, MD: Author

Laureate Education. (2010a). *Doctoral research: Ensuring quality in qualitative researc*h. Baltimore: Author.

Laureate Education. (2010b) *Doctoral research: Preparing for qualitative research*. Baltimore: Author.

Laymon, B., Shah, G., Leep, C. J., Elligers, J. J., & Kumar, V. (2015). The proof's in the partnerships: Are Affordable Care Act and local health department accreditation practices influencing collaborative partnerships in community health assessment and improvement planning? *Journal of Public Health Management and Practice*, *21*(1), 12-17. doi:10.1097/PHH.0000000000000087

Leedy, P. D., & Ormrod, J. E. (2010). *Practical research: Planning and design,* (9th ed.). New York, NY: Merrill.

Levesque, J., Harris, M., & Russell, G. (2013). Patient-centered access to health care: Conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health, 12*(1), 18-26, doi:1186/1475-9276-12-18

Levin, J. (2010). Religion and mental health theory and research. *International Journal of Applied Psychoanalysis Studies, 7*(2), 102-115. doi:10.1002/aps.24

Levin, J., Chatters, L., & Taylor, R. (2011). Theory in religion, aging and health: An overview. *Journal of Religion and Health, 50*(2), 389-406. https://doi.org/10.1007/s10943-009-9319-x

Lietz, C. A., & Zayas, L. E. (2010). Evaluating qualitative research for social work practitioners. *Advances in Social Work, 11*(2), 188-202. Retrieved from https://journals.iupui.edu/index.php/advancesinsocialwork

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Lumpkins, C. Y., Greiner, K. A., Daley, C., Mabachi, N. M., & Neuhaus, K. (2013). Promoting healthy behavior from the pulpit: Clergy share their perspectives on effective health communication in the African American church. *Journal of religion and health*, *52*(4), 1093-1107. doi:10.1007/s10943-011-9533-1

Majaj, L., Nassar, M., & De Allegri, M. (2013)."It's not easy to acknowledge that I'm ill": A qualitative investigation into the health seeking behavior of rural Palestinian women. *BMC Women's Health, 13*(1), 1-10. doi:10.1186/1472-6874-13-26.

Majette, G. R. (2011). PPACA and public health: Creating a framework to focus on prevention and wellness and improve the public's health. *Journal of Law and Medical Ethics 39*(3), 366-379. doi:10.1111/j.1748-720X.2011.00606.x

Marshall, C., & Rossman, G. B. (1999). *Designing qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum: Qualitative Social Research, 11*(3), Art. 8. Retrieved from http://nbn-resolving.de/urn:nbn:de:0114-fqs100387

Maxwell, J. A. (2013). *Applied Social Research Methods Series: Vol. 41. Qualitative research design: An interactive approach*, (3rd ed.). Thousand Oaks, CA: Sage.

Merriam, S. B., & Tisdell, E. J. (2015). *Qualitative research: A guide to design and implementation*. New York, NY: John Wiley & Sons.

Miles, M. B., Huberman, A. M., & Saldana, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). Thousand Oaks, CA: Sage.

Miller, N. A., Kirk, A., Kaiser, M. J., & Glos, L. (2014). The relation between health insurance and health care disparities among adults with disabilities. *American Journal of Public Health, 104*(3), 85-93. doi:10.2105/AJPH.2013.301478

Moldovan, S. (2013). An elusive partnership: The orthodox church and substance abuse health care system in romania. *Social Research Reports, 13*(23), 39-56. Retrieved from http://www.researchreports.ro/an-elusive-partnership-the-orthodox-church-and-the-substance-abuse-health-care-system-in-romania

Moloughney, B. (2012). *The use of policy frameworks to understand public health-related public policy processes: A literature review* (Final Report for Peel Public Health). Retrieved from http://www.peelregion.ca/health/library/pdf/policy_frameworks.PDFhttp://www.peelregion.ca/health/library/pdf/Policy_Frameworks.PDF

Montanaro, E. A., & Bryan, A. D. (2014). Comparing theory-based condom interventions: Health belief model versus theory of planned behavior. *Health Psychology, 33*(10),1251-1260. doi.org/10.1037/a0033969

Morse, J. M. (2000). Determining sample size. *Qualitative Health Research*, *10*(1), 3-5. https://doi.org/10.1177/104973200129118183

Moses, H. III, Matheson, D. H., Dorsey, E. R., George, B. P., Sadoff, D., & Yoshimura,

S. (2013). The anatomy of health care in the United States. *Journal of the American Medical Association, 310*(18), 1947-1964. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/24219951

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

National Academy of Sciences. (2015). *Vital signs: Core metrics for health and health care progress*. Retrieved from pdf available at http://nap.edu/19402

Nunn, A., Cornwall, A., Chute, N., Sanders, J., Thomas, G., James, G., … Flanigan, T. (2012). Keeping the faith: African american faith leaders' perspectives and recommendations for reducing racial disparities in HIV/AIDS infection. *PLoS ONE*, *7*(5). doi:10.1371/journal.pone.0036172

O'Neal, C. W., Wickrama, K. A. S., Ralston, P. A., Ilich, J. Z., Harris, C. M., Coccia, C., … Lemacks, J. (2014). Health insurance status, psychological processes, and older African Americans' use of preventive care. *Journal of Health Psychology*, *19*(4), 491–502. doi:10.1177/1359105312474911

Pappas-Rogich, M. (2012). Faith community nurses: Protecting our elders through immunizations. *Journal of Christian Nursing, 29*(4), 232-237. doi:10.1097/CNJ.0b013e31826f955e

Patient Protection and Affordable Care Act. (2010). 42 U.S.C. § 9007(a) (2010). Retrieved from www.njha.com/media/55105/CHNA_PPACA.pdf

Pattillo-McCoy, M. (1998). Church culture as a strategy of action in the African American community. *American Sociological Review*, 767-784. Retrieved from http://www.jstor.org/stable/2657500

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Pennel, C. L., McLeroy, K. R., Burdine, J. N., & Matarrita-Cascante, D. (2015). Nonprofit hospitals' approach to community health needs assessment. *American Journal of Public Health*, *105*(3), e103-e113. doi:10.2105/AJPH.2014.302286

Petty, N. J., Thomson, O. P., & Stew, G. (2012). Ready for a paradigm shift? Part 2: Introducing qualitative research methodologies and methods. *Manual Therapy, 17*(5), 378–384. doi:10.1016/j.math.2012.03.004

Presidents and Fellows of Harvard College. (2016). Evaluation based on theories of the policy process. *Harvard Family Research Project*. Retrieved from http://www.hfrp.org/evaluation/the-evaluation-exchang/issue-archive

Pyrczak, F. (2008). Evaluating research in academic journals: A practical guide to realistic evaluation (4th ed.). Glendale, CA: Pyrczak.

Rosenstock, I. M., & Hochbaum, G. M. (2010). Some principles of research design in public health. *American Public Health Association. 100*(10),1861-1863. https://doi.org/10.2105/ajph.51.2.266

Rosenstock, I. M., Strecher, V. J., & Becker, M. H. (1988). Social learning theory and the health belief model. *Health Education Quarterly. 15*(2), 175-183. doi:10.1177/109019818801500203

Rouse, W. B. (2000). Managing complexity: Disease control as a complex adaptive system. *Information Knowledge Systems Management. 2*(2), 143-165. Retrieved from https://dl.acm.org/citation.cfm?id=1234158

Rubin, H. J., & Rubin, I. S. (2012). *Qualitative interviewing: The art of hearing data*. Thousand Oaks: Sage.

Rudestam, K. E., & Newton, R. R. (2015). *Surviving your dissertation: A comprehensive guide to content and process* (4th ed.). Thousand Oak, CA: Sage.

Ryan, A. M., Shortell, S. M., Ramsay, P. P., & Casalino, L. P. (2015). Salary and quality compensation for physician practices participating in accountable care organizations. *The Annals of Family Medicine*, *13*(4), 321-324. doi:10.1370/afm.1805

Sabatier, P. A. (2007). Theories of the policy process (2nd ed.). Boulder, CO: Westview Press.

Sheehan, A., Austin, S. A., Brennan-Jordan, N., Frenn, D., Kelman, G., & Scotti, D. (2013). DEFY diabetes! Impact on faith community/parish nurses teaching healthy living classes. *Journal of Christian Nursing, 30*(4), 244-247. https://doi.org/10.1097/cnj.0b013e3182a364b9

Shepherd, J., Locke, E., Zhang, Q., & Maihafer, G. (2014). Health services use and prescription access among uninsured patients managing chronic diseases. *Journal of Community Health. 39*(3), 572-583. https://doi.org/10.1007/s10900-013-9799-1

Simon, M. K. (2011). *Dissertation and scholarly research: Recipes for success*. Seattle, WA: Dissertation Success.

Slota, R. G. (2004). *Barriers to health care utilization among older adult Mexicanamericans in Milwaukee county* (Doctoral dissertation, Walden University). Retrieved from http://walden.kohalibrary.com/cgi-bin/koha/

Stake, R. E. (2010). *The art of case study research*. Thousand Oaks, CA: Sage.

Teddlie, C., & Tashakkori, A. (Eds.). (2009). *Foundations of mixed methods research: Integrating quantitative and qualitative approaches in the social and behavioral sciences*. Thousand Oaks, CA: Sage.

Theuns, P., Baran, B., Van Vaerenbergh, R., Hellenbosch, G., & Tiliouine, H. (2012). A cross-cultural Experimental approach to the contribution of health, religion and personal relations to subjective satisfaction with life as a whole. *International Journal of Methodology and Experimental Psychology, 33*(3), 599-608. Retrieved from http://eric.ed.gov/?id=EJ980496

Thomas, S. B., Quinn, S. C., Billingsley, A., & Caldwell, C. (1994). The characteristics of northern African American churches with community health outreach programs. *American Journal of Public Health*, *84*(4), 575-579. https://doi.org/10.2105/ajph.84.4.575

Thompson, W. M., Berry, D., & Hu, J. (2013). A church-based intervention to change attitudes about physical activity among Black adolescent girls: A feasibility study. *Public Health Nursing*, *30*(3), 221-230. doi:10.1111/phn.12009

Tracy, S. (2013). *Qualitative research methods - Collecting evidence, crafting analysis, communicating impact.* New York, NY: John Wiley and Sons.

U.S. Department of Health and Human Services. (2014). *Healthy People 2020: Access to health care.* Retrieved from http://www.healthypeople.gov/2020/default

U.S. Department of Health and Human Services, (2016). *Strategies for reducing health disparities-Selected CDC sponsored interventions*. Retrieved from https://www.cdc.gov/minorityhealth/strategies2016/index.html

U.S. Department of Health and Human Services. (2017). *Healthy People 2020 leading health indicators: Progress update.* Retrieved from https://www.healthypeople.gov/2020/leading-health-indicators/Healthy-People-2020-Leading-Health-Indicators%3A-Progress-Update

U.S. Department of Treasury Internal Revenue Services. (2014). *Tax exempt and government entities, exempt organizations. Applying for 501(c)(3) tax exempt status*. Publication 4220, Catalog Number 37053T. Retrieved from https://www.irs.gov/

U.S. Department of Treasury Internal Revenue Services. (2015). *Tax exempt and government entities, exempt organizations. Tax guide for churches and religious organizations publication 1828*, Catalog Number 210966. Retrieved from https://www.irs.gov/

Van Manen, M. (2014). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing* (Vol. 13). Left Coast Press. Retrieved from http://www.maxvanmanen.com/files/2014/10/MvM-Phen-of-Practice-chapter1.pdf

Villatoro, A. P., Dixon, E., & Mays, V. M. (2016). Faith-based organizations and the Affordable Care Act: Reducing Latino mental health care disparities. *Psychological services*, *13*(1), 92-104. https://doi.org/10.1037/a0038515

Waidmann, T. A., & Rajan, S. (2011). Race and ethnic disparities in health care access and utilization: An examination of state variation. *Medical Care Research and*

*Review, 57*(4), 55-84. doi:10.1177/107755800773743600

Walden University. (2009). *Dissertation proposal*. Retrieved from http://researchcenter.walden.edu/

Walden University. (2014). *My doctoral research (Mydr) student process*. Retrieved from http://researchcenter.waldenu.edu/Student_MyDR.htm

Walden University, (2014a). PhD. Academic Residency, Orlando, FL.

Ward, A. J. (2011). *Church organizational culture: construct definition and instrument development* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3487849)

Weible, C. M., & Sabatier, P. A. (2009). Coalitions, science, and belief change: Comparing adversarial and collaborative policy subsystems. *Policy Studies Journal, 37*(2), 195-212. doi:10.1111/j.1541-0072.2009.00310.x

Weible, C. M., & Schlager, E. (2016). Multiple streams approach at the theoretical and empirical crossroads: An introduction to a special issue. *Policy Studies, 44*(1), 5-12. doi:10.1111/psj.12143

Werber, L., Mendel, P. J., & Derose, K. P. (2014). Social entrepreneurship in religious congregations' efforts to address health needs. *American Journal of Health Promotion, 28*(4), 231–238. doi: 10.4278/ajhp.110516-QUAL-200

Whitehouse. (2017). The White House: President Donald J. Trump. Retrieved from https://www.whitehouse.gov/the-press-office/2017/01/2/executive-order

Wickrama, K., O'Neal, C., & Oshri, A. (2014). Are stressful developmental processes of youths leading to health problems amplified by genetic polymorphisms? The case of body mass index. *Journal of Youth and Association, 43*(7), 1096-1109. doi:10.1007/s10964-014-0109-8

Williams, L., Hankerson, S., & Gorman, R. (2014). Implementing a mental health ministry committee in faith-based organizations: The promoting emotional wellness and spirituality program. *Social Work Health Care*, *53*(4), 1-21. doi:10.1080/00981389.2014.880391

Wilmot, A. (2005). Designing sampling strategies for qualitative social research: With particular reference to the Office for National Statistics' Qualitative Respondent Register. *Survey Methodology Bulletin-Office for National Statistics*, *56*, 53. Retrieved from https://www.ons.gov.uk/

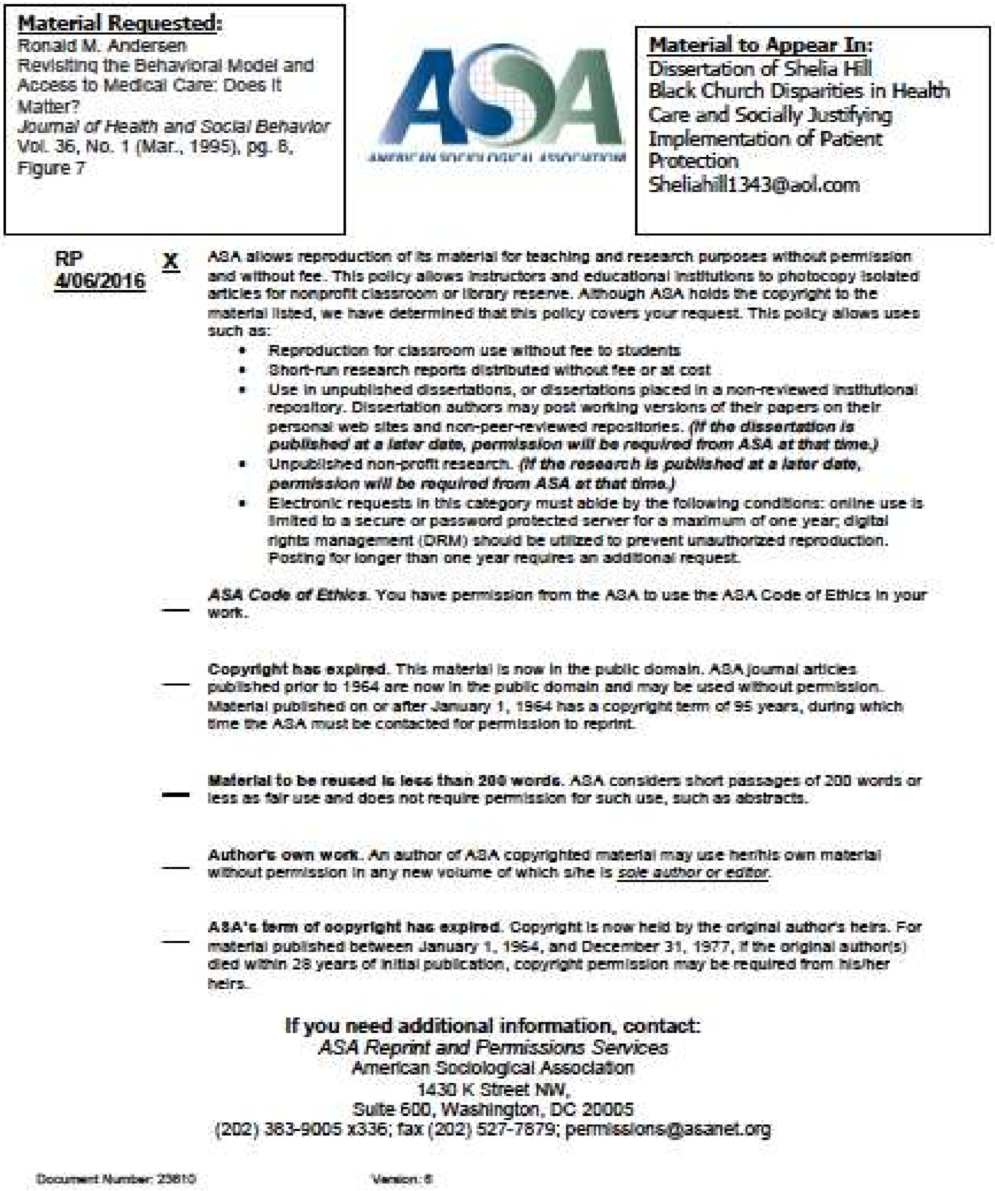
Wizemann, T., & Thompson, D. (2015). *The roles and potential of communities in population health improvement: workshop summary*, National Academy of Sciences. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK284635/pdf

Yin, R. (2014). *Case study research: Design and methods* (5th ed.). Los Angeles, CA: Sage.

Yoo, W., Kwon, M., & Pfeiffer, L. J. (2013). Influence of communication on colorectal cancer screening: Revisiting the health belief model. *Journal of Communication in Health care, 6*(1), 35-43. doi:10.1179/1753807612Y.0000000023.

Zahariadis, N. (1995). Comparing lenses in comparative public. *Policy Studies Journal, 23*(2), 378-382. doi:10.1111/1541-0072.ep9512094111

# Appendix A: Permissions to Reprint and Adapt



**Material Requested:**
Ronald M. Andersen
Revisiting the Behavioral Model and Access to Medical Care: Does It Matter?
*Journal of Health and Social Behavior*
Vol. 36, No. 1 (Mar., 1995), pg. 8, Figure 7

**Material to Appear In:**
Dissertation of Shelia Hill
Black Church Disparities in Health Care and Socially Justifying Implementation of Patient Protection
Sheliahill1343@aol.com

RP
4/06/2016

**X** ASA allows reproduction of its material for teaching and research purposes without permission and without fee. This policy allows instructors and educational institutions to photocopy isolated articles for nonprofit classroom or library reserve. Although ASA holds the copyright to the material listed, we have determined that this policy covers your request. This policy allows uses such as:

- Reproduction for classroom use without fee to students
- Short-run research reports distributed without fee or at cost
- Use in unpublished dissertations, or dissertations placed in a non-reviewed institutional repository. Dissertation authors may post working versions of their papers on their personal web sites and non-peer-reviewed repositories. ***(If the dissertation is published at a later date, permission will be required from ASA at that time.)***
- Unpublished non-profit research. ***(If the research is published at a later date, permission will be required from ASA at that time.)***
- Electronic requests in this category must abide by the following conditions: online use is limited to a secure or password protected server for a maximum of one year; digital rights management (DRM) should be utilized to prevent unauthorized reproduction. Posting for longer than one year requires an additional request.

___ ***ASA Code of Ethics.*** You have permission from the ASA to use the ASA Code of Ethics in your work.

___ **Copyright has expired.** This material is now in the public domain. ASA journal articles published prior to 1964 are now in the public domain and may be used without permission. Material published on or after January 1, 1964 has a copyright term of 95 years, during which time the ASA must be contacted for permission to reprint.

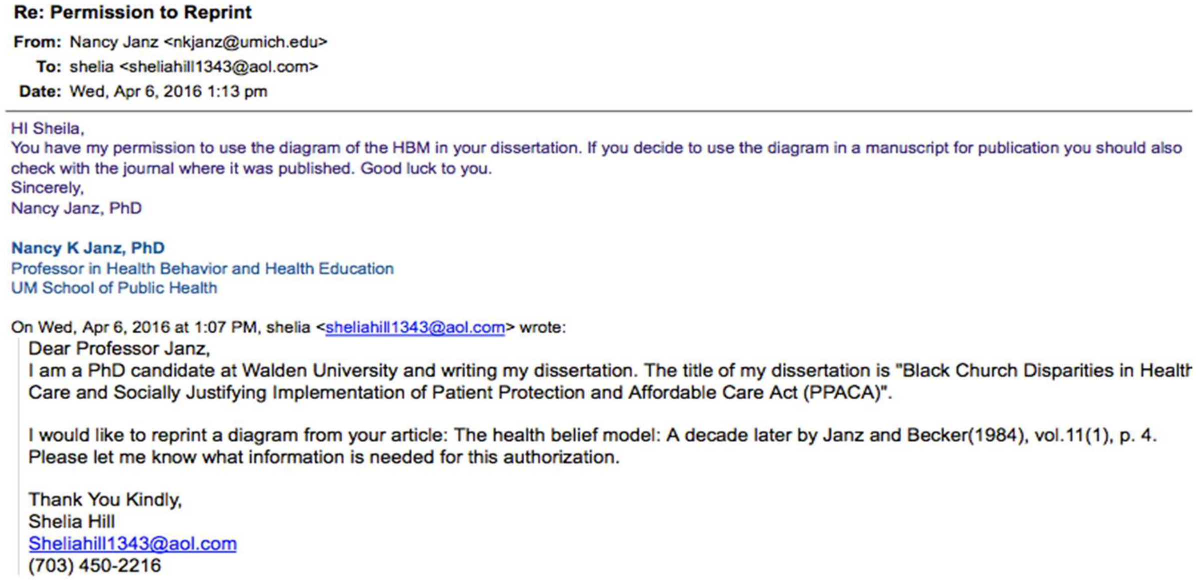
___ **Material to be reused is less than 200 words.** ASA considers short passages of 200 words or less as fair use and does not require permission for such use, such as abstracts.

___ **Author's own work.** An author of ASA copyrighted material may use her/his own material without permission in any new volume of which s/he is <u>sole author or editor</u>.

___ **ASA's term of copyright has expired.** Copyright is now held by the original author's heirs. For material published between January 1, 1964, and December 31, 1977, if the original author(s) died within 28 years of initial publication, copyright permission may be required from his/her heirs.

**If you need additional information, contact:**
*ASA Reprint and Permissions Services*
American Sociological Association
1430 K Street NW,
Suite 600, Washington, DC 20005
(202) 383-9005 x336; fax (202) 527-7879; permissions@asanet.org

Document Number: 23610 Version: 6



**Re: Permission to Reprint**

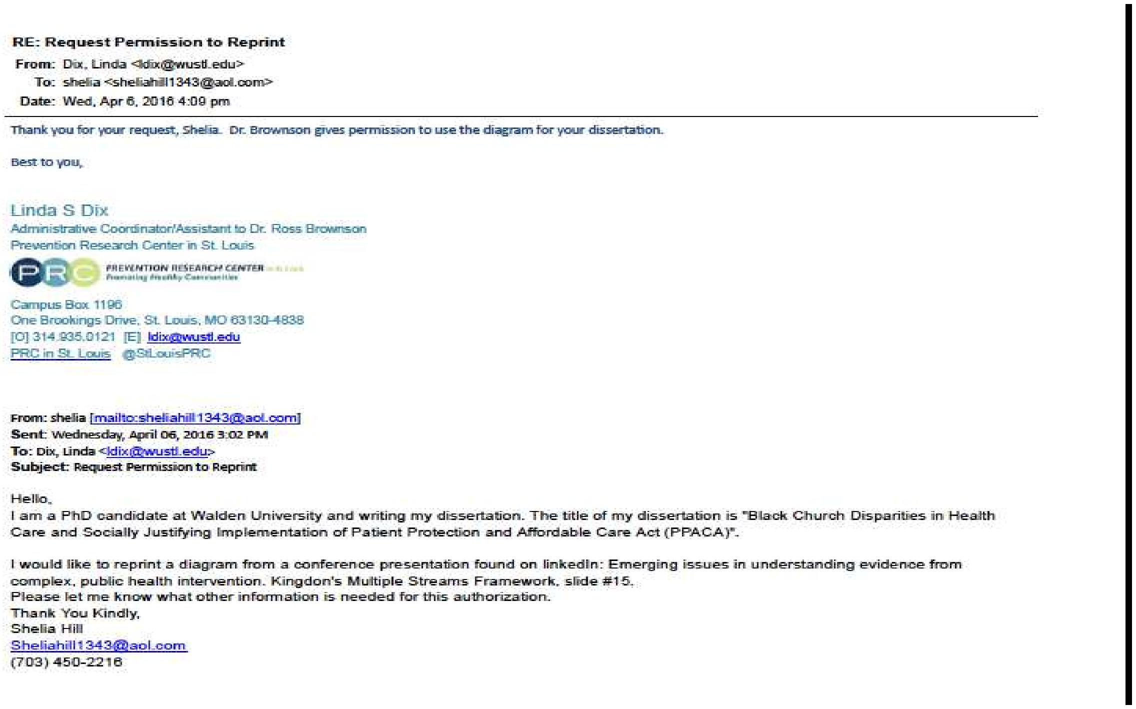
**From:** Nancy Janz <nkjanz@umich.edu>
**To:** shelia <sheliahill1343@aol.com>
**Date:** Wed, Apr 6, 2016 1:13 pm

HI Sheila,
You have my permission to use the diagram of the HBM in your dissertation. If you decide to use the diagram in a manuscript for publication you should also check with the journal where it was published. Good luck to you.
Sincerely,
Nancy Janz, PhD

**Nancy K Janz, PhD**
Professor in Health Behavior and Health Education
UM School of Public Health

On Wed, Apr 6, 2016 at 1:07 PM, shelia <sheliahill1343@aol.com> wrote:

> Dear Professor Janz,
> I am a PhD candidate at Walden University and writing my dissertation. The title of my dissertation is "Black Church Disparities in Health Care and Socially Justifying Implementation of Patient Protection and Affordable Care Act (PPACA)".
>
> I would like to reprint a diagram from your article: The health belief model: A decade later by Janz and Becker(1984), vol.11(1), p. 4.
> Please let me know what information is needed for this authorization.
>
> Thank You Kindly,
> Shelia Hill
> Sheliahill1343@aol.com
> (703) 450-2216



**RE: Request Permission to Reprint**

**From:** Dix, Linda <ldix@wustl.edu>
**To:** shelia <sheliahill1343@aol.com>
**Date:** Wed, Apr 6, 2016 4:09 pm

Thank you for your request, Shelia. Dr. Brownson gives permission to use the diagram for your dissertation.

Best to you,

Linda S Dix
Administrative Coordinator/Assistant to Dr. Ross Brownson
Prevention Research Center in St. Louis

Campus Box 1196
One Brookings Drive, St. Louis, MO 63130-4838
[O] 314.935.0121 [E] ldix@wustl.edu
PRC in St. Louis @StLouisPRC

**From:** shelia [mailto:sheliahill1343@aol.com]
**Sent:** Wednesday, April 06, 2016 3:02 PM
**To:** Dix, Linda <ldix@wustl.edu>
**Subject:** Request Permission to Reprint

Hello,
I am a PhD candidate at Walden University and writing my dissertation. The title of my dissertation is "Black Church Disparities in Health Care and Socially Justifying Implementation of Patient Protection and Affordable Care Act (PPACA)".

I would like to reprint a diagram from a conference presentation found on linkedIn: Emerging issues in understanding evidence from complex, public health intervention. Kingdon's Multiple Streams Framework, slide #15.
Please let me know what other information is needed for this authorization.
Thank You Kindly,
Shelia Hill
Sheliahill1343@aol.com
(703) 450-2216

# Appendix B: Interview Protocol

## **Interview Protocol**

(Introductions and Ground Rules)

**Interview Protocol for Project:** Addressing Health Care Disparities in Minority Congregations: The African American Church as PPACA Stakeholder

**Time of Interview**: (no more than 90 minutes)

**Date**:

**Place**: Church A___; B___; C___ Room# _____

**Interviewer**: Shelia Hill

**Interviewee**: ____________________

**Project Description:** Disparities in health care are still significant in many communities despite the passing of the Patient Protection and Affordable Care Act (PPACA), which is also known as Obama Care, according to World Health Organization. The Centers of Disease Protection and Control emphasizes a greater need for communities to become more creative in closing the existing gaps in health disparities. The church is a venue used by many in despair as a place of refuge and will seek help here as a first option. The research purpose is to *explore the opinions of church attendees on health care access needs, how the church may support the needs of the people and determine the potential role of the church in providing health care assistance.* The participants are purposefully selected as having no or insufficient health care insurance coverage.

**Instructions:**

1. Explain that participant may withdraw from study at any time without repercussions.
2. Explain that this research study is conducted to explore the opinions of individuals who have no or insufficient health care insurance.
3. Explain all information is confidential, identifying participants by a coded number only.
4. Explain the interview sessions: 1) Open-ended interview questions will be asked; 2) You will be asked to confirm responses; 3) I may need to call you after the interview to clarify some responses; 4) You will be asked to clarify and confirm written transcript information.
5. Please sign informed consent (give a copy)
6. Audio recorders started.
7. Interview questions asked for the following research question: What are the perceptions of African American church attendees on their health care issues and the church role in advocating as a PPACA stakeholder to reduce health care disparities?
8. Thank participant for contributing to this research study and ask about following-up as needed to clarify information.

# Appendix C: Interview Questions

## Interview Questions

Demographics/Prescreening Questions:

1) What is your age category? (18-30); (31-40); (41-50); (51- 65)

2) Are you male; female; and other? 3) How would you describe your race or culture?

4) Are you a member of the choir or health ministry of HFC?

5) Are pregnant, (if female)?

6) Do you live or reside in a protected institution, such as, a prison, treatment facility, nursing home, assisted-living or group home for minors?

7) Are you emotionally disabled?

8) Are you mentally disabled?

1) Do you have health insurance? Or enough health insurance?

2) How do you feel about not having health insurance or having inadequate insurance coverage?

3) What situations have actually occurred or been caused by not having any health insurance or not having enough health insurance?

4) What are some known or future barriers preventing you from receiving or seeking health or medical care (i.e., routine physicals, medications, symptoms, injuries, vaccinations, counseling, mental support)?

5) What has been the effect on your family of not having any or not having enough health insurance?

6) How often do you attend church services and church activities?

7) Have you ever needed any kind of assistance from the church? If yes, what kind of assistance?

8) How do faith and belief impact your health and your seeking health and medical care?

9) In your opinion, what are some things the church or the community in which you live could do to improve your situation now?

10) What are some things that you feel you can do to improve your situation?

11) How would you describe your ability to obtain health services when it is needed?

12) What are some changes that can be made in PPACA to assist the church helping you as a church attendee with no or not enough health insurance?

13) How would you describe your ability to pay for health services?

## Appendix D: Site Permission Request

Date: ______________________

Rev. _______________________

Dear Rev. _____________,

I am writing you to let you know about a research study that I would like to conduct at Heritage Fellowship Church. The research study is being sponsored through Walden University. This study is being done to learn more about the health disparities in our local community and to determine if the church can play a greater role to ending health disparities for patients with difficulty accessing health care.

I would like to insert a flyer into the church bulletin to solicit participants for this research study. Each participant will take part in a 1-hour interview session held at the church in a private meeting room. A review of church documents may be needed to ensure the church meets IRS criteria as a nonprofit organization. I would also like to take this time to request a room to hold these interview conversations at the church.

This research study is being conducted to explore the potential role of churches in providing health care assistance. The reason I want to know more about their health and medical situations is to establish the context of health disparities to those with no or insufficient health insurance coverage. There are an increasing number of people with health-related issues. I am trying to understand what these issues are and how to best mitigate these conditions through policy provisions and partnership opportunities with the Accountably Care Organization (ACO) through improved community monitoring and allocations of health resources.

*Note*: Taking part in research is always optional and participants can choose to leave the study at time without repercussions.

Please let me know if this place of worship can be used as a site to look for people who want to take part in this research study and who are:

- Between ages 18-65
- Identify themselves as having no or insufficient insurance coverage

If they decide to take part in the study, I will:

- Review the study with them. This would be at a time that was convenient for them and in a room assigned by the church.
- Answer participant questions.
- Explain the research procedure.
- Obtain a written informed consent.
- Ask the following interview questions:

- What
- What is your age category? _____ (18-30); ____ (31-40); ____ (41-50); ____ (51-65)?
- Are you ____male; ____female; or ____other?
- Do you have no health insurance ___, or not enough health insurance ___?
- How do you feel about not having health insurance or having inadequate insurance coverage?
- What situations have actually influenced or been caused due to your not having any health insurance or inadequate health insurance?
- What are some perceived barriers to your receiving or seeking health or medical care (i.e., routine physicals, medications, symptoms, injuries, vaccinations, counseling, mental support)?
- What affect has not having or having insufficient health insurance had on your family?
- How often do you attend church services and church activities?
- What assistance have you ever needed from the church?
- How does faith and belief impact your health and your seeking health and medical care?
- In your opinion what are some things the church or community can do to improve your situation now?
- What are some things that you feel you can do to improve your situation?

  - How would you describe your ability to obtain health services when they are needed?
  - What are some changes that can be made in health policy to assist the church in helping you as a parishioner with no or insufficient insurance?
  - How would you describe your ability to pay for health services?

- I will then, clarify their responses to interview questions.
- Transcribe their responses and confirm written transcriptions with participants.
- Give them a summary of the research report when it is completed if desired.

I have included a consent form, which explains the research study in detail. Please read this and feel free to write any questions you have on it.

Thank you in advance. Please contact me via phone or email with your questions and answers to this request.

Shelia Hill
(703) 727-0022

Heritage Fellowship CHURCH

**Rev. N. A. Tate, D.Min. ♦ Senior Pastor**

*"And the Lord was with them"*
*Acts 11:21*

## Letter of Cooperation from a Research Partner

June 21, 2016

Dear Mrs. Shelia Hill,

Based on my review of your research proposal, I give permission for you to conduct the study entitled *Addressing Health Care Disparities in Minority Congregations: The Black Church as PPACA Stakeholder* within the Heritage Fellowship Church. As part of this study, I authorize you to insert announcements into church bulletins to solicit participants for data collection, member checking for follow-up responses, and results of dissemination activities. Individuals' participation will be voluntary and at their own discretions.

We understand that our organization's responsibilities include: Inserting announcements provided by you into bulletin, authorizing room use for interviews during regular business hours (non-worship service times) and the facility's use of resources (i.e. lighting, electricity, temperature control and chairs) during interview sessions. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

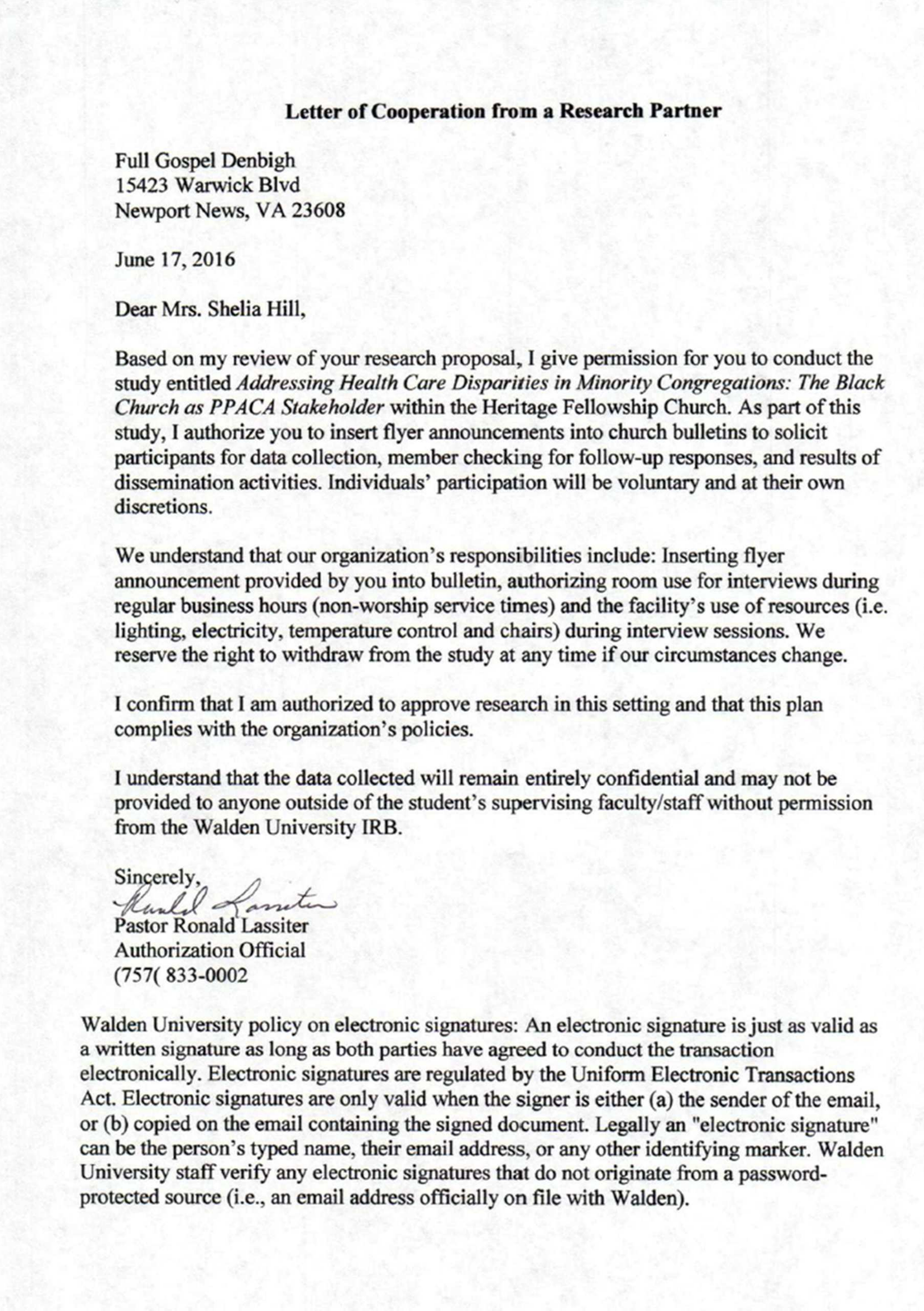
Sincerely,

N. A. Tate

Reverend Dr. Norman Tate
Authorization Official

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person's typed name, their email address, or any other identifying marker. Walden University staff verify any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file with Walden).

**2501 Fox Mill Road, Reston, Virginia 20191**
**Phone 703-620-9515 ♦ Fax 703-620-9670**
**www.heritagefellowshipchurch.org**



## Letter of Cooperation from a Research Partner

Full Gospel Denbigh
15423 Warwick Blvd
Newport News, VA 23608

June 17, 2016

Dear Mrs. Shelia Hill,

Based on my review of your research proposal, I give permission for you to conduct the study entitled *Addressing Health Care Disparities in Minority Congregations: The Black Church as PPACA Stakeholder* within the Heritage Fellowship Church. As part of this study, I authorize you to insert flyer announcements into church bulletins to solicit participants for data collection, member checking for follow-up responses, and results of dissemination activities. Individuals' participation will be voluntary and at their own discretions.

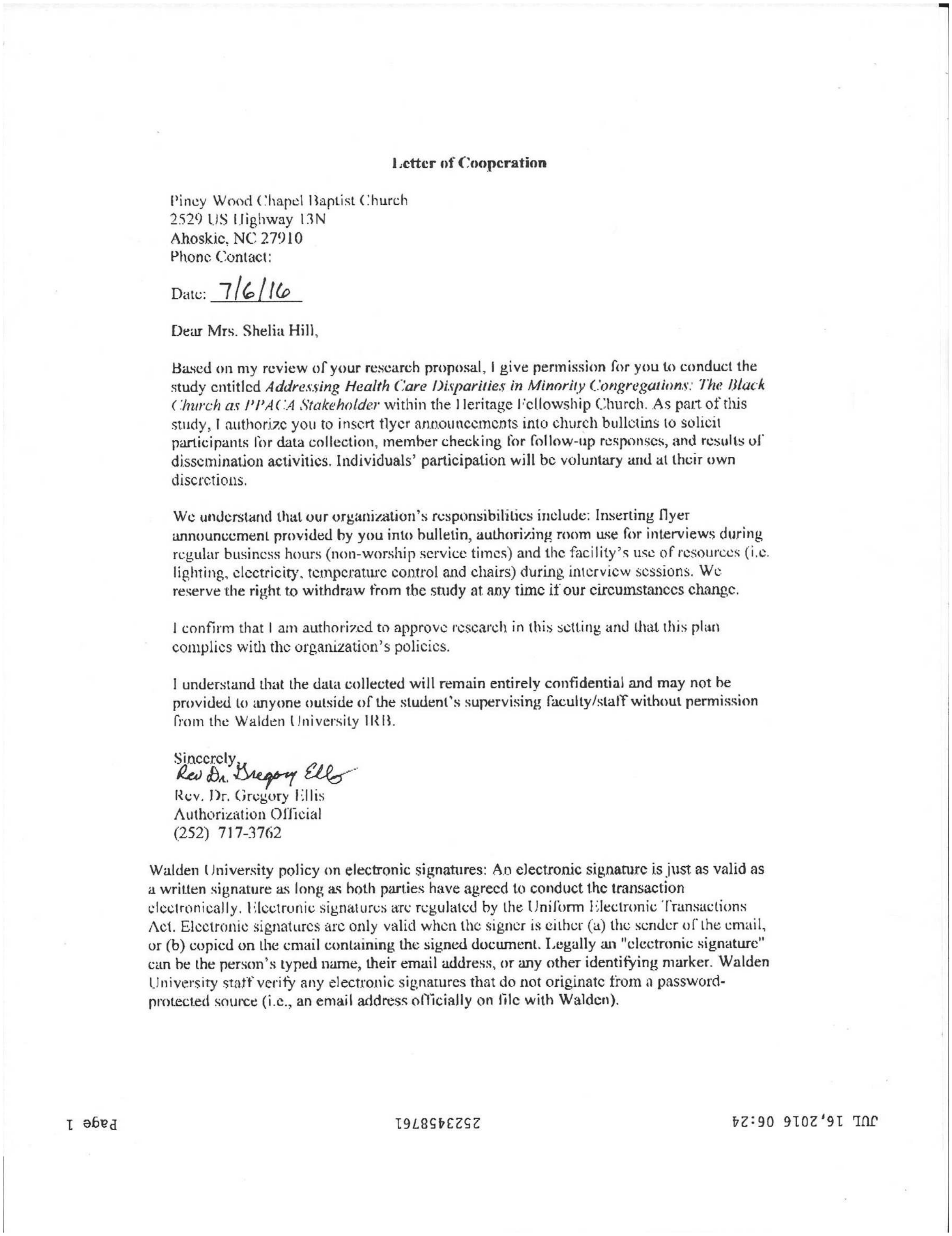
We understand that our organization's responsibilities include: Inserting flyer announcement provided by you into bulletin, authorizing room use for interviews during regular business hours (non-worship service times) and the facility's use of resources (i.e. lighting, electricity, temperature control and chairs) during interview sessions. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,
Ronald Lassiter
Pastor Ronald Lassiter
Authorization Official
(757( 833-0002

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person's typed name, their email address, or any other identifying marker. Walden University staff verify any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file with Walden).



**Letter of Cooperation**

Piney Wood Chapel Baptist Church
2529 US Highway 13N
Ahoskie, NC 27910
Phone Contact:

Date: 7/6/16

Dear Mrs. Shelia Hill,

Based on my review of your research proposal, I give permission for you to conduct the study entitled *Addressing Health Care Disparities in Minority Congregations: The Black Church as PPACA Stakeholder* within the Heritage Fellowship Church. As part of this study, I authorize you to insert flyer announcements into church bulletins to solicit participants for data collection, member checking for follow-up responses, and results of dissemination activities. Individuals' participation will be voluntary and at their own discretions.

We understand that our organization's responsibilities include: Inserting flyer announcement provided by you into bulletin, authorizing room use for interviews during regular business hours (non-worship service times) and the facility's use of resources (i.e. lighting, electricity, temperature control and chairs) during interview sessions. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,
Rev Dr. Gregory Ellis
Rev. Dr. Gregory Ellis
Authorization Official
(252) 717-3762

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person's typed name, their email address, or any other identifying marker. Walden University staff verify any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file with Walden).

JUL 16,2016 06:24 2523458761 Page 1

N.B. Full Gospel Denbigh is a research site, not a research partner.

Appendix E: Recruitment Handout

## RESEARCH STUDY

Greeting Church. My name is Shelia Hill, a PhD candidate at Walden University. I am conducting a research study to find out what role the church could potentially play in providing health care assistance to the people it serves as related to the Patient Protection and Affordable Care Act.

***Participation is voluntary.***

- Participants must be African American and between 18 – 65 years of age.
- Participants must have no insurance coverage or feel they have insufficient insurance coverage.
- There are no monetary incentives or money paid to participate in the study.
- Each participant will be asked to take part in an interview session to address questions about their or family members' health situations, resources, and insurance coverage for health services.
- Interview sessions will be confidential and take place in a private room located at this church.

If you meet the criteria above and wish to volunteer, please contact me at:

**(703) 727-0022**

**or**

**shelia.hill@waldenu.edu**

Thank you kindly,

Shelia Hill

# Appendix F: Informed Consent

## INFORMED CONSENT FORM

You are invited to take part in a research study to discuss what it is like to not have health insurance or not enough health insurance while living in this area. African Americans are the largest non-Caucasian group in the United States, and the most impacted by health conditions such as heart disease, stroke, and diabetes. They are the most likely race to die from these diseases. I would like to interview volunteers who attend this church to determine if there are needs for improved access to health resources, health insurance, medical services and health-medical education, which can potentially be provided through the Patient Protection and Affordable Care Act (PPACA), known as Obamacare. Adults between ages 18-65, who identify themselves as having no health insurance or not enough health insurance are invited to take part in this study. This is the Informed Consent Form that documents your understanding of this study before deciding whether to take part.

I am Shelia Hill, a PhD student at Walden University, and I am conducting this study for my doctoral dissertation. You might already know me as a Nurse Educator and an affiliated church member and active church attendee, but this study is separate from those roles.

**Background Information:**

The purpose of the proposed research study is to explore the potential roles of African American churches in providing health care assistance to individuals with no or not enough health care insurance coverage for reasons unknown. Despite the passage of PPACA, the lack of health care continues to be a major issue among the African American groups according to reports from the Centers for Disease Control (CDC). My goal is to address ways the PPACA could decrease health related issues among African Americans if church organizations are active members in assessing health needs of individuals within their congregation.

**Procedures if you agree to participate in this study**

- You will take part in an audio-recorded interview with me for 1 hour.
- You will have the option to withdraw at any time with no questions asked.
- The recording of your interview will be assigned a number, and your name will never be revealed or connected to the study in any way.
- I will ask you to give your opinions about your health care experiences and how the church could possibly help.
- I will be in touch with you after the interview to answer any questions and to add any information you might have forgotten to mention. This will take no longer than 15 minutes.
- I will also ask you to look over a printed copy of your interview to be sure I quoted you correctly. You may make any additions that you wish. This should not take more than 20 minutes.

Here are some sample questions:

1) What is your age category? ___ (18-30); ___(31-40); ___ (41-50); ___ (51- 65)
2) Are you male ___; female ___; or other ___?
3) How would you describe your race or culture?
4) Do you have health insurance? ____Enough health insurance? ___

5) How do you feel about having no health insurance or having inadequate insurance coverage?
6) What situations have actually occurred or been caused by not having any health insurance or not having enough health insurance?
7) What are some known or future barriers preventing you from receiving or seeking health or medical care (i.e. routine physicals, medications, symptoms, injuries, vaccinations, counseling, mental support)?
8) What has been the effect on your family of not having any or not having enough health insurance?
9) How often do you attend church services and church activities?
10) Have you ever needed any kind of assistance from the church? If yes, what kind of assistance?
11) How do faith and belief impact your health and your seeking health and medical care?
12) In your opinion, what are some things the church or the community in which you live could do to improve your situation now?
13) What are some things that you feel you can do to improve your situation?
14) How would you describe your ability to obtain health services when it is needed?
15) What are some changes that can be made in PPACA to assist the church in helping you as a church attendee with no or not enough health insurance?
16) How would you describe your ability to pay for health services?

**Voluntary Nature of the Study:**

All details of who participates or volunteers will be kept completely confidential. If you decide to join the study now, you can still change your mind later. You may stop at any time. I want to interview people spanning in age ranges and varying life situations. There is a chance that not everyone who volunteers will be interviewed. I will follow-up as soon as possible with volunteers to let them know whether or not they were chosen.

**Risks and Benefits of Being in the Study:**

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as, the potential for anxiety, fatigue, stress, or being upset. Being in this study would not pose risk to your safety or wellbeing.

This research case study fully and genuinely explores the viewpoints of church attendees regarding their health issues and experiences. It will benefit the larger community by explaining how the church as a partner with the PPACA could better identify people at risk of failing health issues, such as heart disease, strokes, diabetes, communicable diseases, and more.

**Payment:**

There will no compensation for your participation. I am most appreciative of your willingness to serve the community.

**Privacy:**

Any information you provide will be kept private. Your name will not be used in any reports or publications. I will be the only person privy to your personal identifiers. I will not use your personal information for any purposes outside of this research project. Also, I will not include your name or anything else that could identify you in the study reports. Data I collect will be kept secure in a locked file in my home for at least five years, as required by the university. After that time, it will be destroyed.

**Contacts and Questions:**

You may ask any questions you have now. If you have questions later, you may contact me by phone at (703) 727-0022 or via email (shelia.hill@waldenu.edu). If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss any questions with you. Her phone number is 612-312-1210. Walden University's approval number for this study is 10-27-16-0238131 and it expires October 26, 2017.

## Obtaining Your Consent

If you feel you understand the study well enough to make a decision about it, please indicate your consent by signing below. A signed copy of this document will be given to you to keep.

________________________________________________________

Participant's Printed Name

________________________________________________________

Participant's Signature Date

________________________________________________________

Researcher's Signature Date

This has been approved by the
Institutional Review Board of
WALDEN UNIVERSITY
as an acceptable documentation of the
informed consent process and is valid
for one year after the stamped date.

2016.10.2
7 17:50:26
-05'00'

Appendix G: Request to Share PHI

## Authorization to Use or Disclose PHI for Research Purposes

The top portion of this form (above the dotted line) should be completed by the researcher. A copy of the form should be given to the research participant for his/her personal records.

Researcher Name: Shelia Hill

Phone: (703) 727- 0022

Address: 4 Prescott Ct Sterling, VA 20165

**Discloser of Information**: ______________________

**Recipient of Information**: __Researcher and readers of research project

**Means of disclosing information (i.e., verbal, written, etc.): written transcripts**

**Information to be disclosed:**

- ☐ Insurance coverage status
- ☐ Medical /Health data
- ☐ Educational data
- ☐ Other (specify)____________________________________________________

**Reason for the Release:** This information is being released/obtained for the purpose of

- ☐ Identifying health disparity issues
- ☐ Identifying health disparity of resources
- ☐ Identifying needs for health care coverages and services

---

**Authorization Provided by Research Participant:**

I understand that this authorization permits the release of information between the two parties named above.

I understand that I have the right to refuse to sign this release form.

I understand that upon release, this information will be kept confidential; my identity will be concealed and data will not be re-disclosed outside of the specified individuals or agencies.

I understand a photocopy of this release will be as effective as the original.

I understand this authorization will be in effect for 12 months from the date signed unless cancelled by me in writing. Upon receipt of the written cancellation, this release will be void.

Signature Date

(Signature of a Parent/Guardian if the person is under 18 or incompetent)

Witness Signature Date

# Appendix H: Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section 1. It is the policy of my Administration to seek the prompt repeal of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended (the "Act"). In the meantime, pending such repeal, it is imperative for the executive branch to ensure that the law is being efficiently implemented, take all actions consistent with law to minimize the unwarranted economic and regulatory burdens of the Act, and prepare to afford the States more flexibility and control to create a more free and open health care market.

Sec. 2. To the maximum extent permitted by law, the Secretary of Health and Human Services (Secretary) and the heads of all other executive departments and agencies (agencies) with authorities and responsibilities under the Act shall exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, health care providers, health insurers, patients, recipients of health care services, purchasers of health insurance, or makers of medical devices, products, or medications.

Sec. 3. To the maximum extent permitted by law, the Secretary and the heads of all other executive departments and agencies with authorities and responsibilities under the Act, shall exercise all authority and discretion available to them to provide greater flexibility to States and cooperate with them in implementing health care programs.

Sec. 4. To the maximum extent permitted by law, the head of each department or agency with responsibilities relating to health care or health insurance shall encourage the development of a free and open market in interstate commerce for the offering of health care services and health insurance, with the goal of achieving and preserving maximum options for patients and consumers.

Sec. 5. To the extent that carrying out the directives in this order would require revision of regulations issued through notice-and-comment rulemaking, the heads of agencies shall comply with the Administrative Procedure Act and other applicable statutes in considering or promulgating such regulatory revisions.

Sec. 6. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person. DONALD J. TRUMP (The White House, 2017).

Author note: Participants were informed that regardless of the new orders, the disparity of those requiring health care remains an issue and since health policy is an area of focus, a window of opportunity remains open for generating social changes to close gaps where needed.