2019

# Utilization of Preventative Care Services by African Americans Post-Affordable Care Act

Madalyn McKnight
*Walden University*

# Walden University

College of Health Sciences

This is to certify that the doctoral study by

Madalyn McKnight

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. Lloyd Ford, Committee Chairperson, Health Sciences Faculty
Dr. Lee Bewley, Committee Member, Health Sciences Faculty
Dr. Patrick Tschida, University Reviewer, Health Sciences Faculty

The Office of the Provost

Walden University
2019

Abstract

# Utilization of Preventative Care Services by African Americans Post-Affordable Care Act

by

Madalyn McKnight

MHA, Belhaven University, 2016

BS, Mississippi State University, 2013

Doctoral Study Submitted in Partial Fulfilment
Of the Requirements for the Degree of
Doctor of Healthcare Administration

Walden University

November 2019

# Abstract

Preventative care services allow patients to be fully equipped with the knowledge, tools, and other resources to help them discover and treat many diseases and illnesses so that the burden of costs will not fall on patients and their families. Since the passage of the Affordable Care of Act (ACA) by President Barack Obama, the requirement for health insurance coverage has not translated to utilization of preventative care services. The purpose of this study is to determine the motivation for African Americans who have insurance coverage and access to care who are not taking advantage of opportunities for screenings and health education. The health belief model was used to determine how belief and modifying factors influence health decisions. The quantitative study required use of a secondary dataset to determine utilization of preventative care services, insurance affordability, future access to care and understanding of the health care law. The study included testing the statistical significance of these factors among African Americans, White Americans, and Hispanic Americans who participated in the Healthy Americas Survey. Using the program SPSS to process data analyzation and organize output, results reveal that African American participants are concerned about the future ability to access and afford care. With a history of distrust amongst African Americans and the health industry, social implications are for administrators and providers to bridge the gap by offering health education to those in their immediate communities and requesting and implementing feedback from those same individuals.

# Utilization of Preventative Care Services by African Americans Post-Affordable Care Act

by

Madalyn McKnight

MHA, Belhaven University, 2016

BS, Mississippi State University, 2013

Doctoral Study Submitted in Partial Fulfilment
Of the Requirements for the Degree of
Doctor of Healthcare Administration

Walden University

November 2019

# Dedication

I dedicate my doctoral study to the families and participants of the Tuskegee Syphilis Study who were taken advantage of by professionals they were supposed to trust. The tireless work that selfless health professionals and researchers perform every day slowly undoes the mistrust that serves as a burden in my community. The work is appreciated and noticed by those who know how far the industry has come.

This doctoral study is also dedicated to young African American girls and women who seek higher education to open more doors for themselves and their families. Learning is the gateway to understanding and the poise, organization, time-management, and stress management skills that education provides carries into every other area in life. Women are some of the strongest of God’s creations, do not leave that potential untapped.

# Acknowledgements

I want to first acknowledge my Lord and Savior Jesus Christ. My God in heaven has provided for me and will continue to be my everything. I also want to acknowledge my unrelenting and immovable foundation I have in my beautiful and compassionate mother Patricia McKnight, my strong and supportive father Alfred McKnight, my protector and first best friend, my brother Bradley McKnight, my godmother in Heaven Frances Burks, and all my extended family.

I want to acknowledge and thank Dr. Aurthur Goodwin for being “my person” in every sense of the word and my backbone throughout this entire process. Dr. Goodwin, your love radiates in my life every single day and I will be forever grateful. I want to give sincere gratitude to my best friend Jeremy Steele, for being my shoulder and cheerleader for as long as we have known each other, and no matter how near or far we are from each other, you get me and accept all of me, thank you. I also thank my friends, who are my heart, have fought for me, and constantly encourage me and make me a better person at every turn, and motivate me to reach higher and dig deeper.

I am thankful for every bit of the outstanding love in my life that propels me forward. Thank you to Damien, the Kelly family, Jessica, Tori, and countless others for making my hard days fade. I am also more than grateful for every educator who took the time and invested in me as a person outside of the lesson plan. I also want to thank my committee chair Dr. Lloyd Ford and Dr. Lee Bewley for their feedback and motivation to continue this race to the finish line.

Table of Contents

# List of Tables

# Section 1: Foundation of the Study

## Introduction

This study was designed to answer questions regarding why African Americans (AA) are not utilizing services and revealing the role healthcare administrators have in creating a bridge of understanding that resonates with AA (O'Lawrence, Martinez, & Solis, 2017). The goal was to contribute to current knowledge on the effectiveness of preventative care services and utilization in the face of the many disparities that plague Americans from various backgrounds, while explicitly addressing factors that the health industry can implement in the effort to widen access and outreach for low-income African American citizens across the country.

The opportunity for social change extends beyond just health coverage and reaches as far as educating citizens on their health rights and access to health services. As students of Walden University, we have the unique opportunity to use our voices and studies to impact our communities and the world around us. As Yob (Laureate Education, 2015) mentioned, we can use the evidence of our research as a gateway to make a difference. As McNeil, Hayes, and Harley (2014) stated, strategy development and collaboration of both consumers' needs and provider knowledge can be a practical approach to addressing the health of at-risk populations. Effective planning and health education can impact future health costs and provide opportunities for communities to be equipped to help themselves (McNeil, Hayes, & Harley, 2014).

## Problem Statement

No country's health care system is without both benefits and drawbacks. Recent attention to the way citizens of the United States maintain health has created controversy in both positive and negative ways. Major legislation in past years has spurred many conversations on the health of Americans and the entire health system for the United States. According to Pieper (2014), The Affordable Care Act (ACA) will propel healthcare organizations into a competitive value-based marketplace. The passage of the ACA immediately created the requirement for millions of uninsured Americans to have health insurance for themselves and their households, while protecting even high-risk beneficiaries from individualized premium increases with the anticipation that these provisions would expand access to care and utilization of services (Gilead & Jackson, 2017). Although more Americans are insured, preventative care and other services are still underutilized by minorities and low-income citizens due to miscommunication of insurance coverage and benefits, thus contributing the continued disadvantage of many Americans post-ACA (Adepoju, Preston, & Gonzalez, 2015). Only 36.4% of all adults are even aware that under ACA, insurance companies are required to cover preventative services (Lantz, Evans, Mead, Alvarez, & Stewart, 2016).

O’Lawrence, Martinez, and Solis (2017) expanded the relationship between a type of insurance (public or private) and quality of care for minorities and how minorities are more than likely to be socially, economically, and educationally disadvantaged thus relying on public health insurance for access. These disadvantages “contribute to a lack of understanding of public health insurance policies and procedures" (O' Lawrence, Martinez, & Solis 2017, p. 2).

Piper (2014) emphasized the importance of having access to all services and health information as a significant benefit from many provisions that are in place that were not accessible before the passage of ACA. According to O’Lawrence, Martinez, and Solis (2017), accomplishing this goal is difficult when there is a disconnect in communication between providers and consumers, a lack of knowledge of the customs of those receiving health services, and special treatment based on race/ethnicity. O’Lawrence, et al., (2017) also stated that “62% of the nation’s physicians indicated that they witnessed patients receiving poor quality health care due to their race or ethnicity” (p.2). In the healthcare community, a lack of cultural competence on behalf of clinicians and administrators in treating a diverse population is fueled by communication barriers that prohibit the promotion of health literacy (Adepoju, Preston, & Gonzalez, 2015). A disregard for safer and quality care based on a person’s race or ethnicity or payer type in underserved communities presents a problem between the health providers and patients from all backgrounds. Consumers want a voice in their coverage, services they have access to, and better health education so that they can make better overall health decisions (Lantz, Evans, Mead, Alvarez, & Stewart, 2016).

## Purpose of the Study

My topic focused on the effects of the ACA and the implications the health care law has on the lack of preventative care services being utilized by low-income minorities in the United States. Mitchell (2015) stated, people of low socioeconomic statuses who have comparatively access to health care coverage, healthy foods, and safe environments as those of higher socioeconomic status, are less likely to receive screenings for HPV, sexually transmitted diseases, diabetes, and cancer. The doctoral study explored how ACA has shaped the health attitudes of African Americans (AA) with a low-socioeconomic status, and the relationship between their negative and positive attitudes have health access and utilization.

According to Pullen, Perry, and Oser (2014), AA are disproportionally exposed to crime and violence which can have a direct effect on health outcomes. In addition to racial discrimination and overall mistrust of healthcare professionals, low-income AA face genetic and additional environmental health risks such as exposure to toxins (pollution) and lead other races and ethnicities in deaths from hypertension, diabetes, and heart disease (Pullen, Perry & Oser, 2014). Also, with the inability to afford health insurance, the discoveries of health problems happen later than those who can afford, have access, and utilize health services (Pullen, Perry & Oser, 2014). These are just a few disparities that encouraged lawmakers to enact the ACA, to help Americans better themselves, and increase their standard of living through healthier choices (Mitchell, 2015). Our healthcare system must accommodate cultural differences and diversity as well to give underrepresented groups, such as AA a chance to be educated on how to make healthier decisions for themselves and their households.

## Research Questions and Hypotheses

1. Is there a relationship between the utilization of preventative care services and affordability of insurance for AA post-ACA?

   *H0*1: There is no relationship between the utilization of preventative care services and affordability for AA post-ACA

   *Ha*1*:* There is a relationship between the utilization of preventative care services and affordability of insurance for AA post-ACA.

2. Compared to White Americans and Hispanic Americans, do African Americans have enough information about the health care law to understand how it will impact themselves and their families?

   *H02*: Compared to White and Americans and Hispanic Americans, African Americans do not have enough information about the health care law to understand how it will impact themselves and their families.

   *Ha*2: Compared to White and Americans and Hispanic Americans, African Americans have enough information about the health care law to understand how it will impact themselves and their families.

3. Is there a statistically significant relationship between race of respondent and future ability to be able to afford to seek preventative care like screenings and checkups?

*H03*: There is not a statistically significant relationship between race and future ability to be able to afford to seek preventative care like screenings and checkups.

*Ha3*: There is a statistically significant relationship between race and future ability to be able to afford to seek preventative care like screenings and checkups.

## Theoretical Foundation for the Study

According to Boslaugh (2013), the health belief model (HBM) is a value expectancy theory that examines why some people utilize health programs or change their overall health while some others do not. The role a person's belief plays in their health decisions is crucial in understanding why some groups or populations make better or worse health decisions than others. The HBM has four main constructs: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers (Sulat, Prabandari, Sanusi, Hapsari, & Santoso, 2018).

The purpose of this study was to determine the motivation of AA in making health decisions. The formula of the HBM and The theory of reasoned action will be used to connect groups of minorities (specifically AA) with health attitudes and behaviors to determine the significance of these relationships, thus proving or disproving if the HBM four main constructs are applied to health choices and options available in the age of the ACA.

## Nature of the Study

Quantitative approaches were used in determining the answer to the research questions, based on the variables in the research questions. According to Barnham (2015), the quantitative research question is used to be factual data, that allows objectivity to be solidified through a series of tests. The research questions involved determining whether there are relationships between variables in the Healthy Americas Survey were answered through a series of regression analyses, crosstabulations, and variance. One goal was to embrace a working hypothesis that there is a strong relationship between African American utilization of preventative care services and African American understanding of ACA provisions by establishing whether there is a relationship, and the strength and significance of that relationship. Another goal was to determine the strength of the relationship between the utilization of preventative care by AA and AA health coverage.  I aimed to use results to explore what these relationships mean for research into health disparities and health climate in the United States post-ACA.

# Review of Literature

## Introduction

The impact of the ACA on the various sectors of health are still being researched and discovered. The purpose of the literature review was to present current information on various health topics such as minority health, health education, and socioeconomics and how all are impacted by the passage of the ACA. In reviewing current research, I aimed to reveal how specific mandates have influenced groups of Americans and suggestions for improvement for research and development for health policies that affect all Americans. Also, I wanted to explore why people are not taking advantage of the many provisions of the ACA and where these motivations originate. The first section of this review detailed the research strategy that yields the information used for this study. The second section consists of topics related to the variables in the research questions, the third section includes of definitions that was useful in distinguishing terms and ideas presented throughout the study, and the fourth section will address assumptions, scope, and limitations.

## Research Strategy

A search of databases accessible to Walden University students yielded many results where various articles related to the ACA were discovered. After initial searches through Academic Search Complete through the library, I created more specific subtopics created, and the addition of healthcare-related databases revealed a vast array of similar research. Through the Center for Research Quality, ProQuest allowed me to explore dissertations and theses available from published authors that helped with paper organization and various articles relating to the overall topic of this paper. ProQuest also has sub-databases that contain materials for specific areas of health, such as ProQuest Nursing and Allied health and ProQuest Health and Medical Complete.

A search of health policy databases resulted in the finding of CINAHL and MEDLINE to find more about all areas of the ACA as a policy and its impact in various areas of healthcare delivery, health education, and healthcare recipients. Also, I used SAGE Premier, Google Scholar, and ABI/INFORM Complete. The search began with keywords and phrases such as: *Affordable Care Act, minority health, health education, health reform, health utilization, preventative care services, minority health utilization, rural health, Affordable Care Act impact, healthcare costs, health insurance and Affordable Care Act, cancer screenings among minorities, HIV/AIDS testing among minorities, health services, mental health, and Affordable Care Act.* The use of these terms and phrases ensures a thorough search into all areas of health impacted since the passage of the ACA, and the revelation ACA did or did not have on health systems, health delivery, health education, and health utilization.

## Affordable Care Act and Preventative Care

One of the aims of the ACA is to propel more Americans to participate and utilize preventative care services, which would be an added benefit for both the patient and lower healthcare costs. Across the board, coverage was low among Hispanics and non-Hispanics in America (VanGarde, Yoon, Luck, Mendez-Luck, 2018). In a follow-up with a group of participants, ACA did provide more options for coverage that young adults are utilizing, but access to health is still an issue among all minorities. With the ACA insurance provisions focused on extending parental coverage, many minorities do not have this option.  And more than just minorities are not utilizing more health insurance options under the ACA. Younger Americans in general also negate the need for coverage and preventative care for various reasons. McGeehan, Demaria, and Batavia (2017) mentioned that younger participants are less motivated to seek health services and health insurance because they feel they do not need it as they are relatively healthy.

Comparing different age groups and the impact of health insurance coverage among those who suffer with mental health issues and substance abuse, Olfson, Wall, Barry, Mauro, and Mojtabai (2018), conducted a mixed method experiment that focused on how newly gained coverage was being utilization and found that more insurance does not always translate to increased usage. This study is limited in scope because it does not distinguish the type of insurance participants have gained and whether there were incentives to take advantage of treatment or health education on insurance options and preventative services.

Moreover, Haselswerdt (2017) mentioned that there was correlation in participation in welfare programs and non-participation in health politics before the ACA. After conducting studies measuring policy participation, Haselswerdt found that increased Medicaid enrollment also increased voter participation in the 2012 and 2014 elections. Many factors could have affected this outcome, but there is no addressing the actual utilization of services provided by increased enrollment. With the controversial Medicaid expansions being a focus for many campaigns, voters and enrollees are becoming more independent in health, but only to a certain degree, there must be targeted interventions towards groups to propel them to take advantage of available health services (McGeehan, Demaria, & Batavia 2017). Also, HIV rates are rising among adolescents, and adult men and this problem developed as a result of men not knowing their status due to lack of testing either initiated by them or encouraged by their physicians (Carter, Owens, & Lin, 2017). These same age groups rank among the lowest under ACA to utilize these services (Mitchell, 2015). The ACA plays a crucial role in the expansion of community health centers to specifically address health disparities by providing not just screenings but also comprehensive care (Carter, Owens, & Lin, 2017).

O’Neal, et al., (2014), examined whether there was a combination of both psychological characteristics and health insurance factors that influenced the decision of whether or not African American use preventative care services. O’Neal et al., (2014) found that those with low psychological competency and high psychological vulnerability and having health insurance increased the use of seeking preventative care. Although their research only used only a few demographics and used few specific inferences to gauge why AA choose not to search for preventative care, O'Neal et al. (2014) concluded that participants felt that more policies and laws that cater specifically to AA could influence their use of preventative services.

### Minority Health and Cultural Competence

Addressing minority health is not a topic that is new to American history and political contests all over the county. Although the health of minorities was not a significant topic until the civil rights era, President Kennedy brought attention and started discussions about the hospitals using federal funds to discriminate against minorities in the United States (Gillion, 2017). Kennedy’s work was continued by President Johnson, who focused on Medicare and the implementation of policies for Medicare patients to be treated equally when receiving health treatment as their white counterparts. Using an aggressive approach toward minority health and also AIDS, President Clinton started a dialogue and created extensive community-based programs through the Health Security Act, which is mirrored in the ACA designed by President Obama (Gillion, 2017). Gillion (2017) argued that there needs to be a more significant push for sitting presidents that extend past statements made during the campaigning process.

Concerning research and representation in clinical trials, men and women from diverse racial and ethnic backgrounds are underrepresented in many findings that may impact them more than Caucasians (Asare, Flannery, & Kamen, 2017). Research participation reluctance among minorities influenced the creation of the social determination framework which includes a social and community context. Asare, Flannery, and Kamen (2017) found a connection between discrimination, mistrust, social integration, and lack of health participation. Recalling the Tuskegee syphilis experiment, the authors suggested taking distrust into account when designing research studies so that outcomes can better reflect the group of persons most impacted. There was a lack of inclusion of ways in which health professionals can address minority health interactions and instill trust within local communities, families, and those of different cultural backgrounds. Minorities who report outstanding care also state that interacting with a diverse health staff that is knowledgeable of cultures and respectful of customs (Shepherd et al., 2018).

Fielding (2012) explores the Healthy People initiative concerning the ACA inception. Healthy People is a multiyear process that has been implemented four times with the current initiatives set to end in 2020. The program is designed to promote preventative services and reverse trends of unhealthiness across the country's workplaces, schools, and homes (Fielding, 2012). Healthy People and the ACA work together to promote health literacy in hopes of encouraging Americans to make healthier decisions. Mitchell (2015) further explores the impact of the Healthy People 2020 initiative and how the ACA is impacting underrepresented groups of Americans. Mitchell states, "People of color in the United States are more likely to experience poorer health outcomes and higher mortality rates from preventable conditions when compared with their white counterparts" (p1). The passing of legislature in 1955 that benefitted the health of Native Americans resulted in limited success (Mitchell, 2015). There is an apparent gap in legislature and literature that accounts for the cultural competence and health for minorities. Further research in this area along with exposure should lead to cultural competency measures being measurements of service both within organization standards and patient care.

Likewise, Shepherd et al., (2018), recalled health statistics regarding lower life expectancies and higher infant mortality rates among AA, Native Americans and Latino Americans. AA have higher mortality rates than white Americans from heart disease and cancer, Native Americans have higher heart and liver disease rates, and Asian Americans have a higher prevalence of diabetes than white Americans. Although these authors also reference the link between practitioner bias and patient outcomes, recorded discrimination practices have enforced cultural barriers. The conclusion of this study emphasized the participants' strong need for cultural aspects to be reflected in the care that is received, which will impact their reception and attitudes of healthy practices. Although it is noted that the participant group was mainly educated and knowledgeable of different cultures, there were still consistent with reports of poor treatment and the suggestion that practitioners, policies, and health initiatives should be culturally aware. Health practitioners and administrators must be continuously trained on how to cater their care to the patient and be sensitive and respectful of customs to ensure that care is satisfactory (Webb Hooper, Carpenter, Payne, & Resnicow, 2018).

## Health Education

When it concerns caring for those who need help in the healing process, it is expected for nurses, doctors, and other health professionals to have adequate training to be able to provide care and health expertise to help the patient overcome their ailment. The focus of this study is on the person or people most intimate with the patient who is there when the nurses and doctors have administered all of their care. The caregiver/companions, although not as versed in health education as those with training and experience must take on the role of a health expert all while caring for the patient in more ways are required in the health setting.  Portela de Azevedo, Cristino, Farias Viana, Parente Medeiros, and Soares de Azevedo (2018) aimed to measure health education of caregivers of patients with infectious diseases. Participants of various age groups were lectured about different health safety practices and held conversations on a weekly basis about the information relayed during the session. Many participants who lacked formal education beyond elementary school but researchers Portela de Azevedo et al., (2018) did not explore the correlation between formal education level and knowledge of basic health practices. Moreover, the exposure of health practices through this experiment did provide knowledge that participants needed to keep themselves and the patients they oversee healthy. It is also important to note that although official caregivers, almost 90% of participants indicated that they were never invited to health education programs locally.

Anderson-Reeves, Goodman, Bragg, and Leruth (2017) explored recommendations by the Center for Disease Control on the delivery of quality health education to address many social determinants of health and health access. Researchers Anderson-Reeves et al., (2017) created a health model that utilizes community-based health education to try to shrink gaps in health education and access. This model is designed around community members who serve as a liaison of health resources for other community members. Through these "house parties," the community can have discussions, address a local and social problem and work with the community to address health barriers. Throughout two years, an organization called the Westside Healthy Start Program targeted high-risk AA women in Chicago to reduce infant mortality rates. At the meetings, questionnaires would be completed by participants selected by the community member in charge of a particular area. The selection of women was not held to the same standard amongst the women, and so it is not known how much health education these women had before attending workshops. Participants sometimes did not finish questionnaires or were not able to make it to all workshops. A more controlled environment would aid this project greatly in clearly interpreting the level of health education participants to have and could benefit from knowing.

Health education provisions outlined in the ACA include community health teams that bring health information into communities to help members help themselves (West, 2013). In coordination with other organizations such as YMCA, health administrators must listen to community members to determine which services they can benefit from and how to relay the information in a way that is sympathetic and more appealing for the audience (West, 2013). More research in this area can expand the usefulness of community health teams as well as house parties.

As easy as it is to search the internet for knowledge, Iammarino and O’Rourke (2018) acknowledged this age of information and how relevant it is to make sure health information is being relayed accurately and to audiences that need to be exposed to health knowledge. With acknowledging the side effects of misinformation on every level of the health community, Iammarino and O'Rourke suggested academic settings filter that can lead students to sources with also the suggestion that students be taught how to evaluate information for accuracy. The authors also suggested catering health education to the audience and meeting those who are more familiar with digital knowledge where they are and those who are less familiar with approaches that will benefit them and share this knowledge with other professionals.

## Health Attitudes

In observing suicidal ideations among college students, Researchers Ashrafioun, Bonar, and Conner (2016) discovered that positive health attitudes reflected positive health behaviors. When participants expressed on the questionnaire more negative health attitudes, they also reported negative health behaviors or outcomes such as depression, alcohol use, low levels of sleep, smoking habits, and lack of exercise. The participant pool should have been more significant than the 690 participants at one university and should be focused on different areas to determine the root of the health attitudes and how participant developed both negative and positive health behaviors as a result of their beliefs.

In studying women with of African Descent, a group that has substantially more breast cancer diagnoses than Caucasians results from a questionnaire revealed three themes regarding participant health attitudes. The first theme of breached credibility which explains the limited trust between patients and health professionals, while mentioning mistrust in the food industry's allowance of pesticides in health foods and how health professionals do not encourage holistic and naturalistic approaches (Marshall & Archibald, 2016). Also, a trend of generational silence or keeping everything within the family and not sharing symptoms or conditions. Like other research presented on health attitudes, the first suggestion is shared responsibility and conversations with community members and health professionals alike with ways of how the industry can move forward with putting the health of citizens first.

The media is also a source for newer enrollees from the ACA Era. Mainly, news coverage has focused on the politics of the ACA and not the benefits of the policy which are attributed to negative attitudes and lack of understanding of many parts of the law (Gollust, Baum, Niederdeppe, Barry, and Fowler, 2017). The polarized views that participants had before the law was passed continued throughout the last few years, and the research participants attributed to any news about ACA as strategy and not what it means for the health of Americans.

## Socioeconomics and Health

Health insurance and coverage have become a significant debate on the topic of access to healthcare by minorities of low socioeconomic backgrounds. Minorities are more than likely to be uninsured and rely on employer-sponsored insurance or public programs (Medicare and Medicaid) than White Americans (Gonzales & Kasim, 2015). For minorities in same-sex relationships, even more, challenges arise as more disparities become present. Using a data that was collected throughout three years to examine disparities, Gonzales and Kasim to find that both men and women minorities in same-sex relationships find challenges in obtaining coverage for their significant others. The participant pool was limited to those who are legally married versus unmarried relationships, but Gonzales and Kasim discovered that those of lower socioeconomic status had lowered levels of coverage compared to participants. The focus should be shifted to income-level and education of participants and their knowledge of their options for coverage.

Colen, Ramey, Cooksey, and Williams (2017) also investigated the link between socioeconomic status and health and considered it to be a strong predictor of health. Their research does not focus on the spectrum of socioeconomic status but rather to prove that even with access to resources, many minorities that experience gains in socioeconomic status still do not have improved health. For example, Colen et al. noted that in spite of low socio-economic status, Hispanics have healthier diets, smoke less than other racial groups, and have more social support. The inference is that discrimination is part to blame for the discrepancy and overall health disparities in minority groups in the United States. Unfair treatment can lead to a decline in both physical and mental health (Colen, Ramey, Cooksey, & Williams, 2017).

Researchers have also established that health disparities are a problem that precedes the ACA. Concerning cancer preventative services, Cooper, Kou, Dor, Koroukian, and Schlucter (2017) determine that before the ACA there was a link between those of lower socioeconomic status and out-pocket-costs that prevent many Americans from seeking health services. In eliminating those out-of-pocket costs, administration and usage of preventative care increased a significant difference from the pre-ACA time frame measured in this study. Increasing access may mean examining the affordability even after insurance coverage is provided (Cooper, Kou, Dor, Koroukian, & Schlucter, 2017). Also, Bromley, May, Federer, Spiegel, & van Oijen (2015) suggests that the health industry focuses on patient fear and patient motivation to combat the underutilization of cancer screenings.

Also, for Americans with disabilities, messages from providers must appeal to those who have felt neglected by the overall health care system the United States has (Turk, 2013). The problem solving creates ways to expand health knowledge to address and eliminate barriers and create a culturally competent system that makes others comfortable enough to seek health services. Turk suggests that in embracing the law, along with formal training for medical professionals, should result in an increase in preventative care across socioeconomic and ethnic groups.

## Definition of Terms

*Affordable Care Act:* A law passed by President Barack Obama, officially titled the Patient Protection and Affordable Care Act (Mendoza, 2016). According to Mendoza (2016), the Affordable Care Act was designed to expand insurance coverage, save on health expenditures for both individuals and the government, and improve health quality for all American citizens.

*Cultural competence:* An understanding and consideration of social variables, such as heritage, culture, ethnicity, socialization, and identity in the scope of diversity, population, immigration patterns, and socioeconomic status. There is a growing need for cultural competency in health interactions to increase health quality and communication between providers and patients (Hudak, Carmack, & Smith, 2018).

*Health disparities:* Health disparities derive from discriminatory practices such as the disproportionate distribution of health services and result in differences in health status of groups of people who are more socially disadvantaged than others (Mitchell, 2015). Americans of low-socioeconomic status, vulnerable populations, and disenfranchised Americans experience more health disparities such as limited access to healthy foods and health care, more than any other groups of people in the United States (Mitchell, 2015).

*Preventative care:* Routine screenings aimed at reducing death by detecting diseases and illnesses in early stages and can reduce health care costs and overutilization of extensive health services (Healthy People, n.d.). Through the ACA many policies include preventative services such as vaccinations, blood pressure tests, and counseling on losing weight, treating mental illness, and reducing alcohol use are free for participants (HHS & Public Affairs, 2017).

## Assumptions

One assumption in this study was that most AA feel negatively about health care services or have a general mistrust of health care professionals. Although there are historical instances in which health quality and health services have been used as avenues of discrimination toward AA, many of the reasons today why AA are not utilizing health care services are not limited to just this group of Americans. Many other factors play a role in the national and individual basis. Moreover, another assumption was that preventative care services would be the key to eliminating many of the sectors of mortality rates concerning AA. Although it has many benefits, affordability of services, long-term care, and health attitude also play a crucial part in improving the overall healthcare of AA.

The general idea with the HBM is that if a person perceives the problem to be severe, the target behavior as having positive benefits, with a low perception of barriers then the action will be adopted (Sulat, Prabandari, Sanusi, Hapsari, & Santoso, 2018). The last assumption was that the HBM could be applied to determining the underutilization of preventative care in the age of the ACA when most preventative care services are free under participating plans (HHS & Public Affairs, 2017).

Assumptions were necessary to determine the root of health inequalities amongst minorities in the United States, and the motivation for seeking information on how the health profession is addressing these issues. And the discovery of methods the health care industry must enact to eliminate this problem. Through evaluating this problem with the health-belief model, my aim was to use this model along with the theory of reasoned action, as tools to fuel effective change of the care they receive.

## Limitations

One limitation is the amount of research done in the short time the ACA has been law. Although there is research starting to track trends over the past ten years, it is hard to track long-term effects as the industry is changing in both approach and economically. Also, the use of secondary presents boundaries on the types of data that can be used. Since it has already been collected, I was not able to collect more data as needed or determine the parameters for the data that was collected.

## Scope and Delimitations

Concerning the variables in the research questions, what is addressed in this study is why specific groups of minorities are not taking advantage of preventative care services. The secondary dataset contains collected data that gauges the motivation for AA who do or do not take advantage of health services. The variables of utilization of preventative care services and affordability aim to establish if there is a relationship to address gaps in the literature that do not address the motivation for AA post-ACA. Also, the variables of negative health experiences and lack of information serve the purpose of determining how much of an impact these factors have on making health decisions.

The primary focus of this study are minorities, but specifically, AA which lead in mortality rates in various areas such as HIV/AIDS, breast cancer, and infant mortality. With the benefits of preventative services and the underutilization, I wanted to determine the "why" and seek knowledge on what areas need to be highlighted by health professionals in promoting health access order to encourage others to seek services that can save their lives. Although the dataset addresses various groups of races/ethnicities, the focus being AA does limit the scope of an issue that is not restricted to AA but other minorities.

## Significance

This study was designed to answer questions regarding why AA are not utilizing services and revealing the role healthcare administrators have in creating a bridge of understanding that resonates with AA. (O’Lawrence, Martinez, & Solis, 2017) The goal was to contribute to current knowledge on the effectiveness of preventative care services and utilization in the face of the many disparities that plague Americans from various backgrounds, while explicitly addressing factors that the health industry can implement in the effort to widen access and outreach for low-income AA citizens across the country.

The opportunity for social change extends beyond just health coverage and reaches as far as educating citizens on their health rights and access to health services. As students of Walden University, we have the unique opportunity to use our voices and studies to impact our communities and the world around us. As Yob (Laureate Education, 2015) mentions, we can use the evidence of our research as a gateway to make a difference. As McNeil, Hayes, and Harley (2014) states, strategy development and collaboration of both consumers' needs and provider knowledge can be a practical approach to addressing the health of at-risk populations. Effective planning and health education can impact future health costs and provide opportunities for communities to be equipped to help themselves (McNeil, Hayes, & Harley, 2014).

This research study was designed to contribute to growing research on how the ACA has impacted the health industry and the perception of health habits and options by American Citizens. The use of the HBM was used as the basis of the hypotheses regarding health attitudes among minorities, and how socioeconomic status, although used as motivation for creating the ACA is a significant factor in the level of trust, access to options, and health decisions that many Americans face daily.

The goals concerning the outcome of this study were to address the literature gap on health motivation and to be a positive contribution to social change and health education for both health professionals and healthcare recipients by highlighting areas of mistrust from Americans. Using health motivations and health attitudes will aid administrators to cater programs or approaches that are diverse and measure competency.

## Summary

The health system in the United states is not without flaws but the ACA serves to bridge the gap and empower Americans to take charge of their health and health decisions. The problem presented in this story is the underutilization of preventative care services by minorities, also the rates at which minorities are still underinsured in the post-ACA era. There continues to be health disparities that affect minorities and those of low-socioeconomic status and a lack of knowledge about what the ACA entails and how health policies affect all Americans (Lantz, Evans, Mead, Alvarez, & Stewart, 2016). Also, although health access is important, minorities require cultural competence, diversity, and promotion of health literacy to be encouraged by the health industry and health providers (O' Lawrence, Martinez, & Solis, 2017). Health administrators should aim to establish avenues of trust with the community and incorporate community member input in major organizational decisions.

The issue of preventative care utilization, minority health issues, and presents research questions are aimed at discovering the relationship between minorities and several factors that are important in determining the motivation for seeking or choosing not to seek health services. The theoretical foundation focuses on both the: HBM, which focuses on health attitudes and motivation for making certain health decisions.

## Conclusion

A review of literature explores the background of the ACA and how it outlines preventative care services. Many of the preventative care services are offered free with insurance coverage which is also deemed unaffordable by some. Also, younger Americans feel that these services are not important if they are in relatively good health This section also reviews the minority health and cultural competence and the way health education is administered and how it is received. Past presidents have all passed policies that have affected minorities and the way health is administered such as the creation of Medicare and Medicaid, but the ACA provides sweeping coverage that targets minorities and those who have limited access. Health education covers the level of knowledge needed for both patients and administrators. Americans need to be able to take care of themselves and their households and administrators must be equipped with what their target demographic needs to know. Health attitudes and their role in health decision is detailed in this section and the intersectionality of socioeconomics and health. AA have a general mistrust of seeking care for fear that discrimination will put them in a position to be mistreated. For other minorities there are language and communication barriers that also affect health attitudes. The affordability of insurance also presents a problem for those who need care and have limited access. The impact for social change presents itself in the form of education for the health administrators on motivations for Americans to ensure that citizens can make more informed decisions. In an age where information can be relayed more quickly and conveniently. The challenge is for the healthcare industry to be more accommodating of the patient voice.

Section 2 provides a detailed account of the research design used to answer the research questions presented in section 1. Also, measures of data analyzation are provided and different threats to the validity of all parts of the study.

# Section 2: Research Design and Data Collection

## Introduction

The purpose of this study was to determine if there is a relationship between the health attitudes of minorities and their utilization of preventative care services, their knowledge of the ACA, and their access to health education and other health resources. A quantitative research method was required to determine the existence and strength of the relationships between the operational variables of utilization of preventative care services, affordability of health insurance, ACA information, and ACA impact. Secondary data from the HAS. This section of the doctoral study will cover the research design and rationale, methodology, secondary data information, statistical analysis, and a threat to validity.

## Research Design and Rationale

The nature of this study is quantitative. Quantitative studies utilize statistical analysis tools to measure collected data (SIS International, n.d.). In the first research question, the independent variable is AA affordability of insurance, and the dependent variable is the utilization of preventative care services. In the second research question, the independent variable level of understanding of the ACA and the dependent variable is the impact the law has on participants' and their families. In the third research question, the independent variable is race of respondent and the dependent variable is the future access and affordability of preventative care services. The quantitative research would be considered correlational as this study aims to explore the relationships between variables.

Specifically, the study will be descriptive correlational and utilize various analytical tests available in SPSS.

## Methodology

The target population are AA men and women from all states who are age 18-64 years old and qualify for insurance coverage available under the ACA. The target population sample size was *N* = 846 participants. Although the primary target group for this study is AA, the entire sample size includes survey results reported from other races ethnicities that are being analyzed for comparison.

### Secondary Dataset Information

The secondary data set that was used for this study was published by the Healthy Americas Foundation, (Healthy Americas Survey) (HAS) which was designed to monitor their health status, activity level, health habits, and knowledge and opinions on ACA through use of telephone-based survey methods (Falcon, 2014). Aside from referencing and examining utilization of preventative services post-ACA, the HAS (Falcon, 2014) contains data on demographics (sex, socioeconomic status, race, education, citizenship, housing, income, and employment) and health affordability, quality of life. These factors play a role in determining intersectionality between specific demographic characteristics. There are also variables in the data that determine awareness of ACA provisions and health condition of respondents. This dataset will be useful in determining how the health of the respondent relates to their knowledge of available ACA programs and characteristics.

## Data Analysis Plan

Regression analyses allow the researcher to examine the relationships between two or more variables. Specifically, this style of testing results in the confidence to determine what factors are more impactful and how factors (variables) influence each other. The HAS is a comprehensive dataset that has identifiable independent and dependent variables. Using the variables in the research questions, multiple linear regression testing in SPSS allow the analyzation of a continuous dependent variable and two or more independent variables. I was able to test the impact of ACA across various ethnic/racial groups. Accompanying this test was the Pearson Correlation to show the relationship between specific variables and most importantly the strength of this relationship. Exploring whether established relationships are meaningful will aid in data interpretation.

## Summary

Section 2 of this doctoral study introduced the methodology and rationale for data analyzation. This doctoral study is quantitative and the variables in each research question are nominal and the research questions are designed to show correlation in the chosen variables and the strength of established relationships. The target group is AA, although close attention. Special attention was made to select a dataset that represents AA, White Americans, and Hispanic Americans. Other demographics will be outlined, such as census region, age, and income range. All variables were included in the HAS and multiple regression analysis along with chi-square tests will determine if the relationships are statistically significant.

Section 3 includes the results of testing that was conducted via SPSS. This section will also highlight the demographics of the study sample, and the cross-tabulation of variables from the research questions, and the results of the hypothesis testing.

## Section 3: Presentation of Results and Finding

### Introduction

The purpose of this study was to determine possible motivation for seeking preventative health care services or the declination to seek preventative care services. Using the data from the HAS, the focus was on AA men and women are old enough and qualify for insurance coverage through the marketplace established as a result of the passage of the ACA. Using quantitative modes of statistical analysis, the data was analyzed to discover relationships and those relationships' significance between the variables chosen from the dataset. Descriptive statistics serve the purpose of distinguishing the variables included in this study that were used to develop the research questions. The established research questions and tested hypotheses are listed as:

1. Is there a relationship between the utilization of preventative care services and affordability of insurance for AA post-ACA?

    *H0*1: There is no relationship between the utilization of preventative care services and affordability for AA post-ACA

    *Ha*1*:* There is a relationship between the utilization of preventative care services and affordability of insurance for AA post-ACA.

2. Compared to White Americans and Hispanic Americans, do African Americans have enough information about the health care law to understand how it will impact themselves and their families?

*H02*: Compared to White and Americans and Hispanic Americans, AA do not have enough information about the health care law to understand how it will impact themselves and their families.

*Ha*2: Compared to White and Americans and Hispanic Americans, AA have enough information about the health care law to understand how it will impact themselves and their families.

3. Is there a statistically significant relationship between race of respondent and future ability to be able to afford to seek preventative care like screenings and checkups?

*H03*: There is not a statistically significant relationship between race and future ability to be able to afford to seek preventative care like screenings and checkups.

*Ha3*: There is a statistically significant relationship between race and future ability to be able to afford to seek preventative care like screenings and checkups.

## Data Collection of Secondary Data Set

The HAS was created by Institute for Health Promotion and Disease Prevention at the University of South Carolina for the National Alliance for Hispanic Health. A third-party research company via telephone during a 3-week time frame from representatives of every region in the country that identify as Hispanic American, White, and AA who are age 18 years or older. The purpose of the survey was to gauge how Americans feel about the ACA and their experiences during the open enrollment period of the Affordable Care. Act.

## Demographic Characteristics of the Survey Sample

A total of *N* = 846 total participants responded to the HAS of which *n* = 286 are AA. Table 1 a provides characteristics of the sample used to answer the research questions created for this doctoral study.

The characteristics of the study that were important in describing the sample are: Race, Household Size, State of Health, Voter Registration, and Census. The variables are important in setting the foundation for the research questions and puts into perspective the type of participants that answered the survey questions. In the HAS, race (PPETHM) is listed in categories for which the participant can identify:  1 = White-Non-Hispanic, 2 = Black Non-Hispanic, 3 = Other Non-Hispanic 4 = Hispanic, and 5 = 2+ Races, Non-Hispanic. Household size is reflected as (PPHHSIZE) and coded as 1 = 1, 2 = 2, 3 = 3, 4 = 4, 5 = 5, 6 = 6, 7 = 7, and 8 = 8 or more. State of health is reflected as Q1: In general, would you say health is: and is coded as Refused = -1, 1 = Excellent, 2 = Very good, 3 = Good, 4 = Fair, and 5 = Poor. Voter registration is listed in the HAS as “Z-11b. Are you registered to vote at your present address or not?” And coded as 1 = Yes, 2 = No, 3 = Don’t know, and 4 = Refused. The last descriptive variable used for this doctoral study is listed by the HAS as “PPREG4: Region 4- Based on State of Residence” and coded as 1 = North East, 2 = North Central, 3 = South, and 4 = West.

The characteristics of the study that are important in describing the sample are: Race, Household Size, State of Health, Voter Registration, and Census. The variables are important in setting the foundation for the research questions and puts into perspective the type of participants that answered the survey questions. In the HAS, race (PPETHM) is listed in categories for which the participant can identify: 1 = White-Non-Hispanic, 2 = Black Non-Hispanic, 3 = Other Non-Hispanic 4 = Hispanic, and 5 = 2+ Races, Non-Hispanic. Household size is reflected as (PPHHSIZE) and coded as 1 = 1, 2 = 2, 3 = 3, 4 = 4, 5 = 5, 6 = 6, 7 = 7, and 8 = 8 or more. State of health is reflected as Q1: In general, would you say health is: and is coded as Refused = -1, 1 = Excellent, 2 = Very good, 3 = Good, 4 = Fair, and 5 = Poor. Voter registration is listed in the HAS as “Z-11b. Are you registered to vote at your present address or not?” And coded as 1 = Yes, 2 = No, 3 = Don’t know, and 4 = Refused. The last descriptive variable used for this doctoral study is listed by the HAS as “PPREG4: Region 4- Based on State of Residence” and coded as 1 = North East, 2 = North Central, 3 = South, and 4 = West.

Table 1

*Demographic Characteristics of the Survey Sample*

| Characteristics | No. | % |
|---|---|---|
| Total | 846 | 100 |
| Race: | | |
| African Americans | 286 | 33.8 |
| White Americans | 260 | 30.7 |
| Hispanic Americans | 300 | 35.5 |
| Household Size: | | |
| One | 193 | 22.8 |
| Two | 231 | 27.3 |
| Three | 151 | 17.8 |
| Four | 124 | 14.7 |
| Five | 68 | 8.0 |
| Six | 44 | 5.2 |
| Seven | 12 | 1.4 |
| Eight or More | 15 | 1.8 |
| Refused | 8 | .9 |
| State of Health: | | |
| Excellent | 150 | 17.7 |
| Very Good | 229 | 27.1 |
| Good | 242 | 28.6 |
| Fair | 166 | 19.6 |
| Poor | 56 | 6.6 |
| Don’t Know | 1 | .1 |
| Refused | 2 | .2 |
| Voter Registration: | | |
| Yes | 638 | 75.4 |
| No | 204 | 24.1 |
| Don’t Know | 3 | .4 |
| Refused | 1 | .1 |
| Census Region: | | |
| North East | 160 | 18.9 |
| North Central | 144 | 17.0 |
| South | 362 | 42.8 |
| West | 180 | 21.3 |

## Crosstab

**Household size.** Table 2 shows the cross-tabulation of race of respondent and household size. 193 of all the participants who responded to the race question on the survey state they are in a household size of just one person, 22.8% of the sample size. Likewise, 231 or 27.3% of the participants report that they live in a two-person household. 151 or 17.8% stated that they live in a three-person household. 124 or 14.7% of the respondents live in a four-person household. 44 or 5.2% report that they live in a six-person household and the smallest number of participants reported that they reside in a seven-person (12 or 1.4%) and eight or more-person household (15 or 1.8%). 8 or .9% of all participants refused to answer this survey question.

Table 2

*Crosstabulation of Race of Respondent and Household Size*

| | | Frequency | Percent | Cumulative Percent |
|---|---|---|---|---|
| Valid | One | 193 | 22.8% | 22.8% |
| | Two | 231 | 27.3% | 50.1% |
| | Three | 151 | 17.8% | 68% |
| | Four | 124 | 14.7% | 82.6% |
| | Five | 68 | 8.0% | 90.7% |
| | Six | 44 | 5.2% | 95.9% |
| | Seven | 12 | 1.4% | 97.3% |
| | Eight or more | 15 | 1.8% | 99.1 |
| | Refused | 8 | .9% | 100.0 |
| Total | | 846 | 100% | |

**State of health.** Table 3 displays the cross-tabulation results for race of respondent and their response to the prompt asking them to rate their health. 150 or 17.7% of the participants reported that their health is excellent. 229 or 27.1% of the participants reported that their health is very good. 242 or 28.6% of the participants reported that their health is good. 166 or 19.6% of the participants reported that their health is fair. 56 or 6.6% of the participants reported that their health is poor. 1 participant reported that they did not the state of their health and 2 participants refused to report the condition of their health.

Table 3

*Crosstabulation of Race of Respondent and State of Health*

| | Frequency | Percent | Cumulative Percent |
|---|---|---|---|
| Excellent | 150 | 17.7% | 17.7% |
| Very Good | 229 | 27.1% | 44.8% |
| Good | 242 | 28.6% | 73.4% |
| Fair | 166 | 19.6% | 93.0% |
| Poor | 56 | 6.6% | 99.6 |
| Don’t Know | 1 | .1% | 99.8% |
| Refused | 2 | .2% | 100.00% |
| Total | 846 | 100.00 | |

**Voter registration.** Table 4 displays the crosstabulation between race of the respondent and whether or not the respondent is registered to vote. Of the $n$ = 846 total participants, 638 or 75.4% responded “yes”. 204 or 24.1% of the participants responded “no”. 3 or .4% responded that they did not know whether or not they are registered to vote, and 1 or .1% refused to answer the survey question concerning voter registration.

Table 4

*Crosstabulation of Race of Respondent and Voter Registration*

| | Frequency | Percent | Cumulative Percent |
|---|---|---|---|
| Yes | 638 | 75.4% | 75.4% |
| No | 204 | 24.1% | 99.5% |
| Don’t Know | 3 | .4% | 99.9% |
| Refused | 1 | .1% | 100% |
| Total | 846 | 100% | |

**Census region.** Table 5 displays the crosstabulation between the race of the respondent variable and the census region or where the respondent was located at the time of the survey. 160 or 18.9 percent of the respondents reside in the North East section of the continental United States. 144 or 17.0% of the respondents reside in the North Central. 362 or 42.8% of the participants reside in the South. 180 or 21.3% of the respondents reside in the West.

Table 5

*Crosstabulation of Race of the respondent and Census Region*

| | Frequency | Percent | Cumulative Percent |
|---|---|---|---|
| North East | 160 | 18.9% | 18.9% |
| North Central | 144 | 17.0% | 35.9% |
| South | 362 | 42.8% | 78.7% |
| West | 180 | 21.3% | 100.0% |
| Total | 846 | 100.0% | |

## Utilization of preventative care services and affordability of insurance for AA

Table 6 displays the percentages of AA respondents who credit insurance affordability as the reason that they did not visit a doctor or another health care provider for a routine checkup in different time frames, listed as: within the past year (anytime less than 12 months ago), within the past 2 years (1 year but less than 2 years ago), within the past 5 years (2 years but less than 5 years ago). Affordability is the reason 11.9% AA respondents have not visited a doctor or health care provider for a routine check-up within the past year (of responding to survey). 88.1% of AA respondents do not credit affordability as the reason they have not visited a doctor or health care provider for a routine check-up. Likewise, 15.4% of *n* = 244 AA respondents deem affordability as the reason they have not visited a doctor or health care provided within the past 2 years. For 14.3% of the AA respondents who have not visited a doctor or health care provider for a checkup within the last 5 years, affordability of insurance was the reason. For all time periods respondents were able to choose from on the survey. Before and since the age of ACA, affordability of services is not a major factor in why AA are not seeking routine care from a doctor or health care provider.

Table 6

*Crosstabulation of last Routine Checkup and Affordability of Services*

| Black Non-Hispanic | | | HA-37b. Thinking about your experiences over the past twelve months was there any time you needed any of following but could not get it because you couldn't afford it? To see a general doctor | | | | |
|---|---|---|---|---|---|---|---|
| HA-17- About how long has it been since you last visited a doctor or other health care provider for a routine checkup? | | | Yes | No | Refused | Total | |
| provider for a routine checkup? is a general physical exam, not an exam for a specific injury, illness, or condition A routine checkup | Within the past year | | 29 | 215 | 0 | | 244 |
| | | | 11.9% | 88.1% | 0.0% | | 100% |
| | Within the past two years | 4 | 22 | 0 | | 26 | |
| | | | 15.4% | 84.6% | 0.0% | | 100.0% |
| | Within the past five years | 1 | 5 | 1 | | 7 | |
| | | | 14.3% | 71.4% | 14.3% | | 100.0% |

## Chi-Square test and multinomial regression

### Utilization of Preventative Care Services and the Affordability of Services

The first research question that served as the basis for hypotheses testing is: Is there a relationship between the utilization of preventive care services and the affordability of insurance for AA? The null hypothesis is that there is not a statistically significant relationship between utilization of preventative care services and the affordability of services for AA. The alternative hypothesis is that there is a statistically significant relationship between utilization of preventative care services and the affordability of insurance. Based on the output in Table 7, the relationship between utilization of preventative care service and affordability of insurance is statistically significant at Pearson Chi-Square value 55.27, p < 0.00. Based on the results of the tests the null hypothesis is not rejected. There is no statistical significance between utilization of preventative care services and the affordability of insurance.

Table 7
*Chi-Square Tests*

| | | Value | df | Asymptotic Significance (2-sided) |
|---|---|---|---|---|
| Black Non-Hispanic | Pearson Chi-Square | 55.273 | 8 | .000 |
| | Likelihood Ratio | 18.109 | 8 | .020 |
| | Linear-By-Linear Assoc | 1.285 | 1 | .257 |
| | N of Valid Cases | 286 | | |
| Total | Pearson Chi-Square | 55.273 | 8 | .000 |
| | Likelihood Ratio | 18.109 | 8 | .020 |
| | Linear-By-Linear Assoc | 1.285 | 1 | .257 |
| | N of Valid Cases | 286 | | |

**Access to information concerning ACA and understanding how it will affect families.** The second research question is: Compared to White and Hispanic Americans, do AA have enough information about the health care law to understand how it will impact themselves and their families? The null hypothesis is that there is not a statistically significant relationship between race and understanding how the law will impact the respondent's family. The alternative hypothesis is that there is a statistically significant relationship between the race of the respondent and their understanding of how the health care law will impact their family. The ANOVA test was used to these hypotheses to determine the difference between the different groups of respondents. With a value of 0.167, $p > .05$, it is concluded that there is no statistically significant relationship between the race of the respondent and their understanding of the how the health care law will affect their families. Therefore, no interpretation of variance between groups or post hoc testing is needed for this research question. The alternative hypothesis is not accepted because the results failed to reject the null hypothesis.

**AA and the future ability to get future preventative care, like screenings and check-ups, affordability of care and length of time since last visit.** The last research question is: Is there a statistically significant relationship between race of respondent and the future ability to get future preventative care such as screenings and checkups. The null hypothesis is that there is no statistically significant relationship between the race of the respondent and the future ability to get future preventative care such as screenings and checkups. The alternative hypothesis is that there is a statistically significant relationship between the race of the respondent and the future ability to get preventative care such as screenings and checkups. A multinomial logistic regression was performed to model the relationship between the variables. In Table 8, The goodness of fit of the entire model yielded a value of .000, $p < .05$, we reject the null hypothesis that there is no statistical significance between race of respondent and the future ability to receive preventative care such as screenings and checkups, and accept the alternative hypothesis that there is statistical significance between race of the respondent and future ability to receive preventative care such as screenings and checkups.

Table 8

*Goodness-of-Fit*

| | Chi-Square | df | Sig. |
|---|---|---|---|
| Pearson | 3232.979 | 52 | .000 |
| Deviance | 80.679 | 52 | .007 |

To determine which independent variables specifically are statistically significant are detailed on the likelihood ratio tests output which is useful for the overall effect of the nominal variables used for this doctoral study. Participants who responded that they on their future ability to receive future preventative care such as screenings and checkups was statistically significant because $p = .000$. Lastly, Table 10 displays results of participants who responded on the length of time it had been since receiving a routine checkup was not statistically significant because $p = .947$.

Table 9

*Likelihood Ratio Tests*

| Effect | Model Fitting Criteria | Likelihood Ratio Tests | | |
|---|---|---|---|---|
| | -2 Log Likelihood of Reduced Model | Chi-Square | df | Sig. |
| Intercept | 223.456 | .000 | 0 | 0 |
| HA-55H. Compared to today, do You think you will be better off, worse Off or about the same next year in terms of? Your ability to get preventative care, like screenings and checkups | 300.918 | 77.461 | 16 | .000 |
| HA-17. About how long has it been since You last visited a doctor or other health Care provider for a routine checkup? A Routine checkup is a general physical exam, Not an exam for a specific injury, illness, Or condition | 234.414 | 10.958 | 20 | .947 |

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

## Summary

Section 3 detailed the results of the data analyzed for this doctoral study. Each research question and set of hypotheses was detailed and the data collection method was described as a survey instrument conducted via telephone from each region in the country, with participants identifying as Hispanic-American, White Non-Hispanic, and Black Non-Hispanic, Healthy Americas Survey (HAS). Characteristics of the *n* = 846 participants included their state of health, household size, voter registration, and census region. Crosstabulations were done on each chosen demographical characteristic which led to the results of the hypotheses testing. For the first research question the results of data analyzation rejected the null hypothesis that there is a not statistically significant relationship between utilization of preventative care services and affordability of insurance for AA. The results of hypothesis testing for the second research question concluded there is statistically significant relationship between race of the respondent and their understanding how the health care law will impact themselves and their family. The last research question concluded that there is a statistically significant relationship between AA respondents and their future ability to receive preventative care, such as screenings and checkups.

The findings as a result of analyzing a secondary dataset are important in understanding where the solution in the underutilization of preventative care services lies. Although the focus of this study was the AA population, this problem is layered, and further knowledge can be useful for future testing and inclusion of the American voice in the ever-changing field of health care. The next section merges the findings from the hypotheses testing with social change opportunities and to apply learned knowledge to professional practices. The findings will also be discussed in context of the theoretical framework and final limitations will be discussed.

# Section 4: Application To Professional Practice and Implications for Social Change

## Introduction

My topic focused on the effects of the ACA and the implications the health care law has on the lack of preventative care services being utilized by low-income minorities in the United States. Mitchell (2015) states, people of low socio-economic statuses who have comparatively access to health care coverage, healthy foods, and safe environments as those of higher socioeconomic status, are less likely to receive screenings for HPV, sexually transmitted diseases, diabetes, and cancer. The doctoral study explored how ACA has shaped the health attitudes of AA with a low-socioeconomic status, and the relationship between health attitudes and health access and utilization. Quantitative approaches were used in determining the answer to the research questions, based on the variables in the research questions. According to Barnham (2015), the quantitative research question is used to be factual data, that allows objectivity to be solidified through a series of tests. I created the research questions to determine whether there are relationships between variables in the Healthy Americas Survey (2016). Through SPSS, the data was analyzed to complete hypothesis testing.

## Interpretation of the Findings

The results of this study provided more knowledge on the relationship between race and health care utilization and affordability. With the first research question, I sought to determine if there was statistical significance in healthcare utilization and health insurance affordability for AA. There was no statistical significance, but the results are meaningful. According to findings from testing older American adults, Liew (n.d.) when health care becomes unaffordability can lead to delay in in seeking treatment and can lead to adverse health outcomes and treatment disparities. Liew suggests that policies be created to reduce out-of-pocket costs for vulnerable populations to improve health access and patient preference needs be included in treatment to feel included in order to encourage continuous treatment as needed.

The second research question required me conduct hypothesis testing on the variables of access to information and the understanding of information related to the ACA. The results of analysis performed in SPSS revealed that there is no statistical significance between the access to information concerning the ACA and the understanding of information concerning the ACA, but the results of this test are also meaningful. In research AA underutilization of colon screenings in spite of having the highest incidence and mortality from the illness, Bromley, May, Federer, Spiegel, van Oijen, (2015) found that knowledge of the ACA mandates and waivers that are available to take advantage of these services falls on the providers and the target population. The authors do note that there is a delay in usage of healthcare when previously uninsured citizens gain coverage and that officials and providers must use ongoing measures of tracking healthcare utilization to track coverage (Bromley, May, Federer, Spiegel, van Oijen, 2015).

The last research question tested hypotheses involving AA and the future ability to get future preventative care and affordability of care and length of time since last visit to a general doctor. The results revealed that there is a statistically significant relationship between AA and future affordability and length of time since last visit to a general doctor. Although the overall test between all of the variable significant, the variable of future affordability was especially significant to the AA participants of the study.

The foundation of this doctoral study consists of the HBM. Although there is no statistical significance between healthcare utilization and affordability, if affordability is an issue for those who normally cannot afford care, the attitude toward having access to care does not just go away just because the door is now seemingly open.

The HBM examines the role a person's belief plays in understanding a person's health decisions. In finding statistical significance in AA and future access to preventative care, further research should explore the motivation on why AA are concerned about the future ability to get preventative care more-so than other races that were surveyed. If more security from policy and healthcare industry leaders along with more effort from providers made AA feel more secure, further research can track preventative care utilization before and after AA initial response.

## Limitations of the Study

The use of a secondary dataset limits the researcher's ability to create an instrument that studies exactly what he/she wants to know. As Hunt, Lee, Harrison, and Smith (2018) state, that details for strategies for data collection are not readily available for future research to ensure that the data is reliable and concrete. Missing data is also a concern to those seeking use of a secondary dataset as a representative sample, as it is important in determining the validity of any conclusions regarding specific demographics (Hunt, Lee, Harrison, & Smith, 2018).

For this dataset, an intentional inclusion of multiple ethnicities was a search parameter and the assurance that there was limited number, if any missing cases. I also had an intentional thought to have an almost even number of representatives for each demographic identified in the research questions and hypotheses. I aimed to locate an initiative that has a solid foundation along with a policy that affects multiple areas of the healthcare industry. The background of the Healthy Americas Foundation and research provided a credible source of sound data that involved participants from every region of the country.

## Recommendations

Future recommendations for research would include updated data collection to be compared to results of the HAS (2014) used in this doctoral study. How Americans feel about their health and health care options and access is imperative in gauging the success and failures of the ACA provisions outside of insurance coverage. The ACA was designed to improve individual health and community health, but it must address the social determinants and health motivation of those who the law was intended to help (Elwood, 2015). Also, state governments must compromise on expansions and mandates that will better the help of the citizens within its borders. When the law was being written, 24 states decided not to expand Medicaid citing the expanded costs, in spite of the federal government pledging to match 100% of the cost for new enrollees (Elwood, 2015). To date, 37 states (including District of Columbia) have decided to expand Medicaid for citizens (Kaiser Family Foundation, n.d.).

The basis of preventative care usage and it’s known health benefits should be more than common knowledge but more common practice. Although mandatory coverage is an unpopular mandate, Americans need to be made aware of the other extraordinary benefits, so that they know just how important access to healthcare is for themselves and everyone in their households (Elwood, 2015). If Americans are required to have this coverage, it is up to healthcare leaders to always inform them precisely what this means.

## Implications for Professional Practice

Healthcare professionals have a duty to ensure that the population they are tasked with serving is equipped with enough knowledge to make sound decisions for themselves, but also that they are providing as much quality healthcare as possible to improve quality of health life and health outcomes. Bromley, May, Federer, Spiegel, and van Oijen, (2015) mention the importance of physicians being more intentional as to not negatively impact the decisions AA make concerning their health. The failure to mention screenings is linked to physician knowledge, lack of outcome expectancy, lack of reimbursement and various other reasons that undermine the promise to do no harm to the patients that are being served, but professionals that they trust to keep them informed and work in their best industries.

## Social Change

Healthcare administrators must work harder at also including the voice of those are being serviced. Community input is vital in ensuring that the healthcare industry is always connected to ever-changing needs to the community. Geography is an important part of health administrators and the location must be reflected in within the organization, including its residents and the residents' needs (Bromley, May, Federer, Spiegel, and van Oijen, 2015). In addition to meeting needs to be able to be functioning and successful, healthcare administrators must ensure that those they are tasked with serving feel included in decision making that impacts them.

# References

Adepoju, O. E., Preston, M. A., & Gonzales, G. (2015). Health care disparities in the post–Affordable Care Act era. *American Journal of Public Health, 105*(S5). doi:10.2105/ajph.2015.302611

Anderson-Reeves, T., Goodman, J., Bragg, B., & Leruth, C. (2017). House parties: an innovative model for outreach and community-based health education. *Maternal & Child Health Journal, 21*, 75–80. doi:10.1007/s10995-017-2378-9

Asare, M., Flannery, M., & Kamen, C. (2017). Social determinants of health: A framework for studying cancer health disparities and minority participation in research. *Oncology Nursing Forum*, *44*(1), 20–23. doi: 10.1188/17.ONF.20-23

Ashrafioun, L., Bonar, E., & Conner, K. R. (2016). Health attitudes and suicidal ideation among university students. *Journal of American College Health*, *64*(3), 256–260. doi: 10.1080/07448481.2015.1081911

Boslaugh, S. P. (2013). Health belief model. *Salem Press Encyclopedia*,

Bromley, E. G., May, F. P., Federer, L., Spiegel, B. M. R., & van Oijen, M. G. H. (2015). Explaining persistent under-use of colonoscopic cancer screening in African Americans: A systematic review. *Preventive Medicine*, *71*, 40–48. doi:10.1016/j.ypmed.2014.11.022

Carter G, Owens C, Lin H. (2017) HIV screening and the Affordable Care Act. *American Journal of Mens Health* [serial online]. n.d.;*11*(2):233-239. Available from: Social Sciences Citation Index, Ipswich, MA. Accessed January 24, 2018.

Cooper, G. S., Kou, T. D., Dor, A., Koroukian, S. M., & Schluchter, M. D. (2017). Cancer preventive services, socioeconomic status, and the Affordable Care Act. Cancer (0008543X), *123*(9), 1585-1589. doi:10.1002/cncr.30476 Cynthia G.

Colen, C.G., Ramey D.M., Cooksey E.C., & Williams, D.R. (2017) Racial disparities in health among nonpoor African Americans and Hispanics: The role of acute and chronic discrimination, *Social Science & Medicine*, *199*, 167-180, ISSN 0277-9536, doi: 10.1016/j.socscimed.2017.04.051.

Elwood, T. W. (2015). Affordable Care Act: A pyramidal success or failure? International Quarterly of Community Health Education, *35*(2), 101–119. Retrieved from https://search-ebscohost-com.ezp.waldenulibrary.org/login.aspx?direct=true&db=psyh&AN=2015-15490-002&site=eds-live&scope=site

Falcon, Adolph. Healthy Americas Survey, (2014). ICPSR36433-v1. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2016-08-31. doi:10.3886/ICPSR36433.v1

Fielding, J. E., Teutsch, S. s., & Koh, H. (2012). Health Reform and Healthy People Initiative. *American Journal Of Public Health*, *102*(1), 30-33. doi:10.2105/AJPH.2011.300312

Gilead, S., & Jackson, A. (2017). The Future of the Affordable Care Act and insurance coverage. *American Journal Of Public Health*, *107*(4), 538-540. doi:10.2105/AJPH.2017.303665

Gillion, D. Q. (2017). Words and deeds: presidential discussion of minority health, public policies, and minority perceptions. *Journal Of Health Politics, Policy And Law*, *42*(5), 841–863. doi: 10.1215/03616878-3940459

Gollust, S. E., Baum, L. M., Niederdeppe, J., Barry, C. L., & Fowler, E. F. (2017). Local television news coverage of the Affordable Care Act: Emphasizing politics over consumer information. *American Journal Of Public Health*, *107*(5), 687–693. doi: 10.2105/AJPH.2017.303659

Gonzales, G., & Ortiz, K. (2015). Health insurance disparities among racial/ethnic minorities in same-sex relationships: An intersectional approach. *American Journal of Public Health*, *105*(6), 11061113. doi: 10.2105/AJPH.2014.302459

Haselswerdt, J. (2017). Expanding Medicaid, expanding the electorate: The Affordable Care Act's short-term impact on political participation. *Journal Of Health Politics, Policy And Law*, *42*(4), 667–695. doi: 10.1215/03616878-3856107

Healthy People 2020. (n.d.). Clinical Preventive Services. Retrieved December 26, 2018, from: https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Clinical-Preventive-Services

Healthy Americas Institute. (n.d.) National Alliance for Hispanic Health.

HHS Office, & Public Affairs. (2017, February 01). Preventive Care. Retrieved December 26, 2018, from https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html

Hudak, N. C., Carmack, H. J., & Smith, E. D. (2018). Student perceptions of providers' cultural competence, attitudes towards providers, and patient satisfaction at a university health center: International and U.S. Student Differences. *Journal of International Students*, (2), 360. doi:10.5281/zenodo.1250395

Hunt, L. J., Lee, S. J., Harrison, K. L., & Smith, A. K. (2018). Secondary analysis of existing datasets for dementia and palliative care research: High-value applications and key considerations. *Journal of Palliative Medicine*, *21*(2), 130–142. doi:10.1089/jpm.2017.0309

Iammarino, N.K., & O'Rourke, T.W., (2018) The challenge of alternative facts and the rise of misinformation in the digital age: Responsibilities and opportunities for health promotion and education*, American Journal of Health Educa*tion, 49(4), 201-205, doi: 10.1080/19325037.2018.1465864

Lantz, P. M., Evans, W. D., Mead, H., Alvarez, C., & Stewart, L. (2016). Knowledge of and attitudes toward evidence-based guidelines for and against clinical preventive services: Results from a national survey. *The Milbank Quarterly*, *94*(1), 51–76. doi: 10.1111/1468-0009.12181

Laureate Education (Producer). (2015). Social impact of a Doctoral Study [Video file]. Baltimore, MD: Author.

Marshall, J. S. Archibald C.M., (2016). Breast health attitudes in Afro-caribbean women. *ABNF Journal*, 27(4), 88–91.

McGeehan, M., DeMaria, R., Charney, P., & Batavia, A. (2017). Insurance enrollment at a student-run free clinic after the Patient Protection and Affordable Care Act. *Journal of Community Health*, *42*(4), 785–790. doi:10.1007/s10900-017-0318-7

McNeil, T. P., Hayes, S. C., & Harley, J. (2014). Addressing health disparities through recommendations from the Jackson heart study. Generations (San Francisco, California), (4). 46

Mendoza, R.L. (2016) "Which moral hazard? Health care reform under the Affordable Care Act of 2010", *Journal of Health Organization and Management*, *30(4), 5*10-529, doi:10.1108/JHOM-03-2015-0054

Mitchell, F. (2015). Racial and Ethnic health disparities in an era of health care reform. *Health & Social Work, 40*(3), e66-e74. doi:10.1093/hsw/hlv038

Liew, H. P. (n.d.). Healthcare satisfaction among older adults. *American Journal of Health Behavior, 42*(1), 99–108. doi:10.5993/AJHB.42.1.10

O'Lawrence H., Martinez L., & Solis E., (2017). Disparities in insurance type among minorities for congestive heart failure diagnosis in the ambulatory care setting. *European Journal of Environment and Public Health, 1*(2). doi: 10.20897/ejeph/81155

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

Olfson, M., Wall, M., Barry, C. L., Mauro, C., & Mojtabai, R. (2018). Effects of the Affordable Care Act on private insurance coverage and treatment of behavioral health conditions in young adults. *American Journal of Public Health, 108(10),* 1352–1354. doi:10.2105/AJPH.2018.304574

Piper, L. E. (2014). The Affordable Care Act. Health Care Manager, *33*(3), 267. doi:10.1097/HCM.0000000000000002

Portela de Azevedo, A., Cristino, J. S., Farias Viana, M., Parente Medeiros, F., & Soares de Azevedo, L. (2018). Health education for companions of hospitalized patients. *Journal of Nursing UFPE / Revista de Enfermagem UFPE, 12(4),* 1168–1173. doi-:10.5205/1981-8963-v12i4a230649p1168-1173-2018

Pullen, E., Perry, B., & Oser, C. (2014). African American women's preventative care usage: the role of social support and racial experiences and attitudes. *Sociology of Health & Illness, (7),* 1037. doi:10.1111/1467-9566.12141

Shepherd, S. M., Willis-Esqueda, C., Paradies, Y., Sivasubramaniam, D., Sherwood, J., & Brockie, T. (2018). Racial and cultural minority experiences and perceptions of health care provision in a mid-western region. International Journal For Equity In Health, *17*(1), 33. doi:10.1186/s12939-018-0744

SIS International. (2018, December 18). What is Quantitative Research? . Retrieved from https://www.sisinternational.com/what-is-quantitative-research/.

Sulat, J., Prabandari, Y., Sanusi, R., Hapsari, E. and Santoso, B. (2018), "The validity of health belief model variables in predicting behavioral change", *Health Education*, *118*(6), pp. 499-512. doi. 10.1108/HE-05-2018-0027

Turk, M. A. (2013). The ACA and preventive health care services for people with disabilities. *Disability And Health Journal, 6*(2), 69-71. doi:10.1016/j.dhjo.2013.01.001

VanGarde, A., Yoon, J., Luck, J., & Mendez-Luck, C. A. (2018). Racial/Ethnic Variation in the impact of the Affordable Care Act on insurance coverage and access among young adults. *American Journal of Public Health, 108*(4), 544–549. doi:10.2105/AJPH.2017.304276

Webb Hooper, M., Carpenter, K., Payne, M., & Resnicow, K. (2018). Effects of a culturally specific tobacco cessation intervention among African American

Quitline enrollees: a randomized controlled trial. *BMC Public Health*, *18*(1). Doi:10.1186/s12889-017-5015-z

West, J. F. (2013). To fight bad suga', or diabetes, my neighborhood needs more health educators. *Health Affairs (Project Hope), 32*(1), 184–187. doi:10.1377/hlthaff.2012.038