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An Examination of African Americans' Utilization of Health Care

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NATIONAL LOUIS UNIVERSITY

AN EXAMINATION OF AFRICAN AMERICANS’ UTILIZATION OF HEALTH CARE

A DISSERTATION SUBMITTED TO

THE GRADUATE SCHOOL IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE

DOCTOR OF PHILOSOPHY

COMMUNITY PSYCHOLOGY DOCTORAL PROGRAM

IN THE COLLEGE OF ARTS AND SCIENCES

BY

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Abstract

The study examined the relationship between perceptions of discrimination, social support, quality of health care received, and utilization of health care services among African Americans. Data was analyzed from 99 African American respondents that completed either an online or paper questionnaire. The responses demonstrated significant relationships existed between discrimination and quality of health care as well as social support and utilization of health care. Results concluded that the more discrimination one perceives, the lower quality of health care they are to expect, and therefore they are less likely to utilize services. However, the data also reflected that even in the presence of discrimination, the right social support is enough to influence more frequent usage of health care services.
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An Examination of Barriers to African Americans’ Utilization of Health Care

African Americans (AA) experience higher rates of illness and death from many cancers as well as health conditions such as heart disease, stroke, diabetes, HIV/AIDS, asthma, and obesity (Copeland, 2005). They have a 2.5 times greater incidence of infant mortality than Caucasians; African American women are 18 times more likely to be diagnosed with HIV and 10 times more likely to die of breast cancer; African American men are also two times more likely to develop prostate cancer (Agency for Health Care Research and Quality, 2006).

In 2009, the average Caucasian American could expect to live 78.8 years, but the average African American could only expect to live 74.5 years (Center for Disease Control and Prevention, 2011). The CDC report also noted that African American women and men 45-74 years of age in 2006 had the largest mortality rates from heart disease and stroke compared with the same age women and men of other racial and ethnic populations. AA women ages 45-54 had a mortality rate of 56 per 100,000 from heart disease versus their Caucasian counterparts who had a mortality rate of 24.1 per 100,000. AA men 45-54 had a mortality rate of 130.9 per 100,000 while Caucasian men in that same age group had a mortality of 86.2 per 100,000. Based on the 2011 CDC report this same type of disparity can be seen when comparing the mortality rates of stroke. African American men ages 45-54 have a stroke mortality rate of 43.5 per 100,000, Caucasian men similarly aged have a stroke mortality rate of 12.8 per 100,000. Copeland (2005) notes that these striking disparities have been documented for many years, however, little progress has been made in reducing the numbers.

African Americans underutilize medical services, even when formal healthcare services are available (Clay, 2008). The first National Health and Nutrition Examination from 1984 to 1988 revealed that AA men were three times less likely to receive a total knee arthroplasty
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compared to Caucasian American men, despite the fact that AA men have a higher prevalence
and more severe osteoarthritis (Green, Baker, & Ndao-Brumlay, 2004). These findings suggest
that factors outside of the actual need for care motivate African Americans utilization of health
care services.

**Healthcare Utilization Models**

A number of models have been created to attempt to describe what influences one to
utilize health care services. A few of the seminal pieces, which are still being referenced today,
are the Andersen Health Behavior Model, Rosenstock’s Health Belief Model, and the Young
Choice Making Model. One thing that these models have in common is that they link utilization
to a set of enabling or predisposing factors. The models are still being used today for systematic
reviews of health care utilization rates in the United States.

**Andersen health behavior model.**

Ronald Andersen, a UCLA health services professor, argued that the use of health
services is determined by three dynamics, as pictured in Figure 1: predisposing factors, enabling
factors, and need (Anderson, 1968 as cited in Gamble, 2009). Gamble defines predisposing
factors as race, age, and health beliefs. He suggests that examples of enabling factors could be
familial resources, access to health insurance, or one's community. According to Gamble, in
Andersen’s model “need” represents both perceived and actual need for health care services.
Figure 1 Andersen Model (Gamble, 2009)

The strengths of the Andersen Model lie in its ability to link social determinants to health and illness behaviors. The model demonstrates that the practical desires of a population dictate their choice to utilize health services. Solely following this assumption may lead one to conclude that it is not possible to improve utilization of health services by altering organizational structure (Whaley, 2001). That is a limitation of this model, its underestimation of the importance of organizational structure of the health care delivery system. Utilization of health care services is affected by the organization providing the services and this model fails to take that into consideration (Ford, 1993).

Rosenstock’s health belief model.

An additional foundational piece of health care utilization theory that is still being used today is Rosenstock’s health belief model, as shown in Figure 2. The model bases an individual’s choice to utilize health care on four central variables: 1) the individual’s perceived susceptibility to disease; 2) the individual’s perception of illness severity; 3) the individual’s rational perception of benefits versus costs; 4) the individual’s cues to action (Hochbaum, 1958). While the model succeeds in areas like accounting for individual differences in beliefs and attitudes,
AA Health Care Utilization recognizing cues to action, and considering the cost-benefit aspect, it fails in other areas (Janz, 1984). The model does not account for environmental factors outside of an individual’s control that may prevent utilization of health services. For example, one may acknowledge they are severely ill and want to seek care but, if a barrier such as transportation exists, it may prevent that person from actually being able to access the needed care (Janz, 1984).

**Figure 2 Rosenstock Health Belief Model (Janz, 1984)**

**Young Choice Making model.**

Based on ethnographic studies of health services utilization in Mexico, Young (1981) produced a choice-making model based on four components:

1) Perceptions of gravity. This refers to both the individual’s perception and their social network’s consideration of illness severity;

2) The knowledge of a home treatment. If a person is aware of a home remedy then they will likely seek that option before seeking professional treatment;

3) Faith in treatment. An individual will not utilize a treatment if they do not think it will be effective;
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4) Access to treatment. According to Young, this may be the most important influence on health care utilization. Accessibility incorporates the cost of health services and the availability of those services.

The Young model stands out from others previously mentioned by beginning to take into consideration alternative medicine and social networks. These additions are key influencers in a person’s decision of whether or not to seek health services. However, one limitation of the model is that it does not consider an individual’s past experience with a particular illness. For example, a person may be diagnosed with cancer, have no symptoms, and therefore does not return to the physician for treatment. On the other hand, if a person has had a previous experience with cancer either, personally or observed, and has no symptoms, they will still reference that previous experience, understand the severity of the illness, and may make a decision to actually seek care.

Healthcare Utilization Studies

Studies have examined the factors that influence a person’s choice to utilize health care services: discrimination, social support, quality of care, patient-physician communication, physiological well-being, several socio-demographics and healthcare perceptions and beliefs. These studies each looked at one particular variable and analyzed its influence on some form of healthcare utilization. Results of these studies clearly demonstrate that the mere presence of illness is not the sole motivating factor in one’s choice to access services or not.

Discrimination.

The King County Ethnicity and Health survey conducted in 1995-1996 revealed that nearly one in three (32%) of African Americans residing in King County, Seattle felt they had been discriminated against when receiving health care services (Hobson, 2001). In order to provide a better understanding of the King County Ethnicity and Health Survey results, 51 African Americans residing in King County were interviewed during 1999 concerning their
experiences of racial discrimination when seeking or acquiring health care services. Results revealed that on average 1.5 incidents of discrimination were reported per interviewee over the 2 years preceding the interview. Most interviewees reported changing their health seeking behavior as a result of the discriminatory events and now actively avoid those health care institutions (2001).

Social Support.

Researchers Salloway and Dillon (1973) examined social networks and how they influenced the utilization of health services. From a suburban area of Boston, two hundred individuals of varying races and incomes were interviewed about their decision-making process for utilizing health care. The results indicated that secure friendship networks tend to correlate with utilization of health services, whereas the presence of family networks is related to diminished use of health services (1973). The authors assumed the decrease in frequency of health service utilization related to family networks was related to the increased support gained from familial relationships vs. friendships. Thus, in line with their model, as a result of family networks providing bigger social support, a person with strong familial ties may tend to seek help from members of their family for the resolution of health issues instead of with a health care professional.

St. Clair, Smeriglio, Alexander and Celentano (1989) studied the effects of social support networks on the utilization of prenatal health services with 185 Baltimore inner city women (84% of the original sample) who delivered their child at a specific teaching hospital in Baltimore. The women either received prenatal care from the hospital or not at all. The sample was primarily Black (78%), unmarried (68%), unemployed (53%) and young (mean age= 21.3). In short, these women were of socio-demographic backgrounds which tend to under-utilize health care services. Although findings from their study are not generalizable to the population as a
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whole, they did find that women who did not utilize available prenatal care had social networks
characterized by stronger ties to relatives or immediate family members who lived within close
proximity to the woman, but friendships that were weaker.

Broadhead, Gehlbach, deGruy and Kaplan (1989) studied healthcare utilization of an
outpatient clinic in North Carolina. Three hundred forty-three patients were surveyed by
questionnaire and medical record audits were used to evaluate the relationship between social
support and healthcare utilization. Social support was divided into structural and functional
dimensions. Structural social support includes concepts such as family size, proximity, and
frequency of contact. Functional social support addresses the role of the support and includes
such constructs as emotional, appraisal, and informational support. Broadhead and his colleagues
found that structural measures of social support variables had no significant relationships with
utilization behavior. However, patients who either lacked a confidant, or who had little faith in
the advice of a confidant outside the clinic did have longer visits and higher total charges for the
year. Respondents with low levels of functional support did show higher rates of utilization and
costs. Furthermore, this effect was magnified for women, AA, and people who were
unemployed.

Patient-Provider Factors.

A Los Angeles group of researchers tested whether patient and provider factors impacted
Colo-rectal cancer (CRC) screenings (2014). The study included 174 Black patients over the age
of 45 and 174 non-black patients over the age of 50 that were eligible for CRC screenings
between January 1996 and October 2012. The studied measured the independent effect of being
Black on screening uptake while controlling for other factors such as access, income, and
previous disease history. A review of patient charts found that black patients were 51% less
likely to uptake CRC screening by any method (2014). The study also found that patients that had a primary care visit within two years were four times more likely to have had a least one CRC Screening.

Patient satisfaction and patient-physician communication can also be used as an indicator of healthcare utilization. Cleeland (1997) interviewed 300 Medicare patients and found that racial minorities in general were at risk for the under-treatment of cancer pain and speculated that communication issues contributed to these problems. Cleeland also reported that many African Americans are dissatisfied with their healthcare providers. In general, African American patients report that their providers did not probe about their experience with pain, thoroughly discuss treatment options or test results, or provide information on how long it would take for pain medication to work. Many of the patients interviewed in the Cleeland study cited that they were less confident that they would ever receive good quality care. Specifically, one father indicated that the quality of care you received was contingent upon the type of health insurance you had. Therefore, since African Americans are more likely to use public health insurance they assumed that they would receive a reduced quality of care. These studies illuminate the fact that racial differences in attitudes towards pain, health, and healthcare do exist.

**Psychological Well Being**

Aside from social networks and communication, psychological well-being also has been shown to affect utilization trends. Gortmaker, Eckenrode, and Gore (1982) utilized a diary method with 96 female patients of a Boston community health center to estimate the relationship between daily stress and utilization of health services. They found a positive association between the presence of stress and likelihood of utilizing health services. This relationship, although
weaker, still remained significant when other characteristics about the individual and their family were controlled. Browne, Arpin, Corey, Fitch and Gafney (1990) studied psychological adjustment to illness as a predictor of utilization in two hundred fifteen newly referred chronic illness patients that participated in a psychosocial intervention designed to promote their adjustment to illness. Controlling for health status and certain key socio-demographic characteristics, they found that the patient's inability to cope psychologically with a health problem is a very strong predictor of increased utilization of all health services, but also with increased cost. These results were magnified for patients with high insurance benefits.

**Socio-demographic variables.**

Another set of studies examined how socio-demographic variables influence health care utilization. The factors most frequently considered are age, sex, income, race, education, and family size (Snowden, 1997). Utilization rates are lowest for the poor at all age groups, even when they have prepaid health plans (Snowden, 1997). Studies have found that differences in utilization rates between income strata can best be explained by other variables such as differences in education or health. When examined in greater detail, there still remain several income-related differences in the consumption of medical services, especially with regard to the quality of care received by the poor, who frequently utilize clinics of substandard quality (Cockerham, 1986). In addition, the reduced utilization rates among those of average income should come as no surprise as they more frequently hold occupations with reduced or no health insurance benefits but have incomes which are too high to qualify for government assistance programs. While demonstrating that differences in utilization do exist across demographic boundaries is important, there is not much to be gained by continuing to amass large quantities of data on the subject.
Disparities within healthcare utilization begin with the decision to seek care (Schnittker, Pescosolido & Croghan, 2005). The lower frequency with which African Americans consume health care, or the way in which they seek healthcare, suggests that there is some skepticism on their part as to the importance of prevention methods. This fact can be highlighted when looking at the increased use of emergency rooms by African Americans when compared to their Caucasian counterparts (2005). African Americans are more likely to receive their care in a hospital setting as opposed to an outpatient visit with a primary care clinician. Along those same lines African Americans are less likely to have a medical home and seek care less regularly (2005).

One of the first theories that examined patients knowledge of, beliefs about, and attitudes towards his/her symptoms, physicians, and health services in general was Parson’s sick role theory (Parson, 1951). The theory suggests that perception of symptoms and the individual's response to them are the major considerations in a decision to seek medical care. The more seriously the symptoms interfere with a person's normal functioning, the greater the potential for seeking medical care. However, that the final decision depends on the patient's and his/her social environment's tolerance for the behaviors or problems associated with the illness, his/her knowledge of the medical problems that underlie the symptoms, other needs competing with decisions to seek help (i.e., time off work), and the availability of medical care.

Outside of perceptions associated with the healthcare one is going to receive, African Americans also have certain concepts regarding the seriousness and source of his/her health problem. According to Copeland (2005) these perceptions are related to interpretations of symptoms of illness, values, knowledge, attitudes, and health beliefs; services received; and a
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sense of control over their treatment. Other factors include social relationships between majority and minority populations and group loyalty to autonomous institutions in their racial or ethnic minority community. Copeland notes this suggests the importance of social environment and the connection that it has to health problems. Chadiha and Brown (2002) point out that African Americans are more likely to live in urban areas and be faced with unique challenges such as overcrowding, lack of adequate housing, and high crime rates. Internalizing these effects can impose psychological stress on community residents and also lead to poorer health outcomes. The prolonged impact of racism, discrimination, poverty, substandard housing, and neighborhood conditions have all been linked to poor health outcomes for African Americans (Chadiha & Brown, 2002).

**Black men and prostate cancer prevention.**

Research was conducted to assess attitudes and behaviors linked to prostate cancer prevention activities in black men (Blocker et. al, 2006). In the fall of 2002 and winter of 2003, two gender-specific focus groups involving black men and women were conducted at two churches in North Carolina. Fourteen black men and 15 black women, whose ages ranged from 34-68 years, participated in the focus groups. The results of these focus groups revealed an overall good understanding of prostate cancer and what the risk factors for the disease were. Barriers to screening identified by the focus groups were embarrassment or shame regarding the nature of the screening, a lack of confidence in the health care system, lack of physician recommendation for the screening, and fear of cancer. While some of the results of this study are consistent with literature on the topic, the small convenience sample of church members may not make results generalizable to the larger black male population.
Bailey, Erwin, and Belin (2000) conducted two sets of focus groups with Black women and gathered data to create a framework that uses culture to encourage mammography utilization. The first set of focus groups from 1989 to 1991 consisted of sixty women (median age 50 years). Sixty percent of the sample had a high school degree or less, and 62% had annual incomes below $15,000. The second set of focus groups were held in 1996 and consisted of thirty-nine women (median age 50 years), with over 50% of the sample having a high school degree or less and over 50% having annual incomes less than $15,000. Analysis of the first data set revealed that the women saw breast cancer as primarily a white woman’s disease; fatalism regarding cancer; care is received from social and cultural networks; and educational messages from familiar sources are seen as reliable. Analysis of the second data set revealed different themes such as, the individual is responsible for maintaining their health; the individual is responsible for their illness; bad illnesses symbolize loss of faith; lack of rapport exists with local health care facilities and health care professionals. The emerging themes created the foundation for The Witness Project, an intervention geared at increasing mammography screening rates among Black women in Arkansas. Messaging that included individual Black women sharing their cancer stories and creating Witness Role Models led to the program’s success. Data from follow up surveys of women that participated in the program demonstrated that 67% of the women had a mammogram since they participated in the Witness Project. 100% of the women surveyed also stated that they were willing to complete their next scheduled mammogram.

In an attempt to understand why many black women do not utilize mammography screening services and to create interventions to address the issue, researchers looked specifically at how family history of cancer influences screening behaviors (Williams, 2008). Using the
1,531 Black women in the sample, 38% of those women had a family history of cancer. Women with a family history of cancer were 39% more likely to have a recent mammogram compared to those with no family history of cancer. Eighty-Five percent of Black women over the age of 40 with a family history of cancer attested to having a mammogram in the past compared to nearly 70% of Black women without a family history of cancer. The results indicated that a family history of cancer independently and positively predicted mammography screening behaviors.

Summary

As reflected in the studies previously mentioned, African American’s perceptions of the lack of quality in care (Cleeland, 1986), the internalization of societal discrimination and racism (Hobson, 2001), and the lack of physician-patient communication (Cleeland, 1986) may all be valid contributors for AA underutilization of health care. Another idea that emerges is that while the actual need for care is critical, the decision to actually seek medical care is influenced by several other key variables. Models that are developed to explain this behavior must take all of these factors into account to take full advantage of their potential effects on decision-making. The variables identified in Andersen's behavioral health utilization model are widely accepted as the most useful as they include a person's culture, demographic position, psychological condition, as well as the structure of the health care system itself (Whaley, 2001). These findings suggest that cultural theories must be further investigated and defined. It is important that more empirical evidence is gathered to explore the differences in perceptions and attitudes of African Americans towards healthcare to garner a better understanding that can ultimately lead to better health outcomes.

Patient perceived cultural barriers originate from several sources, including a combination of personal experience, institutionalized discrimination, and cultural separation -
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which is part of the history of minority relations in the USA (Gamble, 2009). This discrimination has direct effects on society’s perceptions depending on skin color. These perceptions include images of racism, discrimination, ethnic bias, and cultural incompetence and run the continuum from real, to exaggerated, to imagined but are none the less perceived as accurate views of society by the beholder (Gamble, 2009).

Theoretical Frame

The theoretical framework in Figure 3 is based on a model initially developed by Salloway and Dillon (1973), and represents African American healthcare utilization. The left side of model displays the current set of prominent issues and attitudes, based on research, among many African Americans, that may be causing them to underutilize health care. Macro and social factors such as a history of discrimination often leads to a sense of cultural mistrust (Hobson, 2001). Certain familial relationships and cultural norms within the network can lead to perceived barriers (Salloway & Dillon, 1973). The negative implications of these attitudes and preconceptions all contribute to a mind-set that does not see the immediate value in utilization of health services, which then leads to poor health outcomes as displayed in the middle of the model.
The Purpose of this Study

The purpose of this study is to examine a model of prediction with the goal of identifying which variables (perceptions of discrimination, social support, and expected quality of care) most significantly affect African Americans’ utilization of health care services. The following research questions will be explored:

1) Do African American men and women differ in their perceptions of discrimination, social support, and expected quality of care? If so, do these differences impact their utilization of health care services?

2) Do African Americans’ perceptions of discrimination, social support and expected quality of care impact their utilization of health care services.
Method

Participants

The study participants were 22 men and 77 women, who self-identified their race as African American, and were eligible for the preventative services described in the study. Lower income and older participants were purposefully recruited in person as they were harder to reach via social networks and email blasts.

Instruments

A number of instruments were combined to create one questionnaire that examined each variable: discrimination, social support, expected quality of care, and utilization. Additionally, socio-demographic information on age, marital status, income, and educational attainment was also collected.

Discrimination

In an attempt to capture varying sources of discrimination data, the following measures were combined to make one complete discrimination scale:

1. Everyday Discrimination Scale
2. Experiences of Discrimination Scale
3. Racism in Health Care Index

Experiences of Discrimination.

Nine items from the validated and reliable Experiences of Discrimination (EOD) tool (α=.74) were used as a measure of personal discrimination (Krieger, 2005). The original EOD asks if a person has experienced discrimination at school, while getting a job, at work, while getting housing, while getting medical care, while getting service in a store, while getting credit, on the street, and from the police. The original scale also asks how often (never, once, 2 or 3
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times, 4 or more times) it has occurred. I have modified this tool to omit questions related to the
frequency of the occurrence as this information is captured in The Everyday Discrimination tool
which will also be utilized in this study.

**Everyday Discrimination.**

A short version of Williams’ validated and widely used Everyday Discrimination
measure was used to assess personal discrimination. The original measure assesses how often
(never, once, 2 or 3 times, or 4 times or more) one has encountered 9 types of unfair treatment
and the reason for the treatment (eg, race, sex) (Williams, 1997). In previous studies (Chicago
Community Adult Health Study 2011), a shortened version was created specifically to assess
race-based unfair treatment encountered within health care settings. The shortened version has
shown good reliability ($\alpha=.77$) in diverse populations and was used in this study.

**Racism in Health Care Index.**

The 4 item Racism in Health Care Index was used to measure perceptions that racism
against African Americans exists in health care. The measure was chosen to assess perceptions
of racism in health care regardless of participants’ personal experiences with such
discrimination, which was assessed by the previously mentioned measures. Participants were
asked to indicate the extent to which they agree with four statements about racial discrimination
in health care settings (strongly disagree, disagree, neither disagree nor agree, agree, strongly
agree) (LaVeist, Nickerson, Bowie, 2000). Psychometrics data could not be found on this
instrument.

**Expected Quality of Care**

*Perceptions of problems in health care: Doctor-Patient Relationships subcale*
In order to assess respondents expected quality of care, a modified version of the 4 item Doctor-Patient Relationship subscale of the Questionnaire on Stress in Patients with Diabetes was used, alpha=.80 (Herschbach, Duran, Waadt, Zettler, Amm, & Marten-Mitag, 1997). The original scale assessed whether each of the following is a problem for the participant: different doctors give you different information regarding your diabetes; you feel insufficiently informed about your diabetes; doctors do not spend enough time with you; and your doctor does not treat your diabetes in the best possible way. This measure was modified slightly to reflect overall health as opposed to Diabetes only.

**Social Support**

**The Social Support Questionnaire**

A shortened and modified version of The Social Support Questionnaire (SSQ) was used to measure social support (Sarason, Levine, Basham, & Sarason, 1983). The SSQ measures perceived number of social supports, whether the social support is a family member or friend, and satisfaction with social support. This measure was modified to specifically ask about social support as it relates to health care decisions and to remove the question that asks about satisfaction with social support. These items were removed because they did not specifically address the needs of this study.

**Socio-demographic variables**

The questionnaire was used to collect self-reported data on race, ethnicity, date of birth, highest level of education completed, household income, employment status, insurance status, and marital status.
Utilization of healthcare services was measured by collecting information on mammogram screenings, prostate screenings, colo-rectal screenings, well visits, and sick visits. Respondents indicated if they have ever had the screening or visit, and how recent the last screening or visit was. Data on colo-rectal screenings were included in the preventative health care data. Prostate screenings were not included in the results due to varying data on the recommended age for the screening.

**Procedure**

In order to recruit participants, solicitations (See Appendix B for recruitment message) were sent out via social media (Facebook and Twitter) and to the email addresses of those the researcher is familiar with. A recruitment table was also be set up within Salem Baptist Church to recruit participants (See Appendix C for letter of support) that may not have access to a computer. These participants were provided with a paper questionnaire, others were provided with a link directing participants to complete an online questionnaire regarding their experiences within the health care system.

Consistent with The National Louis University Institutional Review Board policies, only participants who indicate their interest in the study by consenting to the online questionnaire electronically or signing a hard copy consent form were able to enroll in the study. The questionnaire was not presented until after informed consent had been received on paper (see Appendix D for informed consent) or electronically (see Appendix E for electronic informed consent).

There was also an email account and voice message account set up to take any questions participants had about the study. There was no financial compensation for participating in the
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study however participants were made aware of the potential impact this study may have on the overall body of research on the topic.

Results

Scale Reliability

A reliability analysis was run on the discrimination, quality of care, and social support scales. The discrimination scale consisted of 18 items ($\alpha = .82$). Based on the analysis the scale is fairly reliable as the inter-item statistics were consistent with the overall scale statistics. The quality of care scale consisted of 4 items ($\alpha = .63$). Based on this analysis question number twenty-one was deleted, this increased $\alpha = .76$. The social support scale consisted of 5 items ($\alpha = .89$), based on the analysis the scale was reliable.

Descriptives

The sample included 104 participants 99 of whom identified as Black or African American and 5 that identified as Caucasian. Seventy-seven percent of respondents were female while 23% were male. Ages ranged from 21 years old to 77 years old, with 50% of participants being over the age of 45 years old. Marital status and educational attainment varied with 29% of participants being single and never married; 35% married; 6% divorced; and 22% living as married. More than half of the sample (58%) had at minimum completed a graduate degree, while 14% had a four year college degree, 25% had completed some college and 3% only completing high school as seen in Table 1. The median income of respondents was in the range of $50,001 and $75,000 and with 77% working full time and 85% with insurance coverage.
Education of Respondents

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<th>Frequency</th>
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<th>Valid Percent</th>
<th>Cumulative Percent</th>
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<td>3.5</td>
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<td>13-15 years (some college)</td>
<td>21</td>
<td>19.6</td>
<td>24.7</td>
<td>28.2</td>
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<td>16 years (completed college)</td>
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<td>11.2</td>
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<td>45.8</td>
<td>57.6</td>
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<td>79.4</td>
<td>100.0</td>
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</tr>
</tbody>
</table>

**Research Question 1: Do African American men and women differ in their perceptions of discrimination, social support, and expected quality of care? If so, do these differences impact their use of preventative health care services?**

Analyses was run to determine if there was difference in reported levels of social support, experience with/perception of discrimination, and quality of care between the two genders. Total scores were computed for each measure and means compared by gender (Table 2). Independent samples T-tests were conducted to test the significance of these findings, and showed that the difference in means was not significant for any of the variables tested. Social Support, t(1.571)=99, p=.355, Discrimination t(298)=99, p=.187, and Quality of health care t=(.747)=99, p=.486.
Table 2
Comparison of Independent Variable Means by Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Discrimination Total</th>
<th>Quality Total</th>
<th>SocialSupport TotalScale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P=.187</td>
<td>P=.486</td>
<td>P=.355</td>
</tr>
<tr>
<td>Male</td>
<td>Mean</td>
<td>28.7647</td>
<td>12.5294</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Std. Deviation</td>
<td>4.54876</td>
<td>1.62472</td>
</tr>
<tr>
<td>Female</td>
<td>Mean</td>
<td>28.2353</td>
<td>12.9265</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>77</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>Std. Deviation</td>
<td>6.93922</td>
<td>2.03195</td>
</tr>
<tr>
<td>Total</td>
<td>Mean</td>
<td>28.3412</td>
<td>12.8471</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>99</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td>Std. Deviation</td>
<td>6.51108</td>
<td>1.95488</td>
</tr>
</tbody>
</table>

A correlation was then run between the three total sum scores to determine if a relationship existed. The relationship between social support and quality was found to be significant but fairly week \( (r = .426, n = 99, p < .01) \) while the relationship between quality and discrimination was significant and fairly strong \( (r = -.698, n = 99, p < .01) \). This indicates that the more social support respondents had the higher they rated the quality of health care they would receive, and the more discrimination they perceived the lesser the quality of health care they reported.
Research Question 2: Do African Americans’ perceptions of discrimination, social support and expected quality of care impact their use of preventative health care services.

Quantitative analysis on the impact of perception of discrimination on the quality of health care services.

The relationship between perceptions of discrimination and perceived quality of health care was analyzed by using a regression analysis. A significant model emerged, p< .005 (p = .003). The model explains 57% of the variance in perceived quality of health care (R² = .596). The model shows that even when controlling for other key descriptives such as gender and education, the largest predictor of how one rated their quality of health care was their perception of discrimination, (β = -.53). Table 3 gives information about regression coefficients for the predictor variables entered into the model. Results of this analysis display that the higher your perception of discrimination the lower the perception of your quality of health care.

Table 3

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>SocialSupportTotalScale</td>
<td>0.140</td>
<td>0.096</td>
<td>0.213</td>
<td>0.179</td>
</tr>
<tr>
<td>discriminationtotal</td>
<td>-0.403</td>
<td>0.124</td>
<td>-0.534</td>
<td>0.003</td>
</tr>
<tr>
<td>Gender</td>
<td>-1.145</td>
<td>1.142</td>
<td>-0.154</td>
<td>0.325</td>
</tr>
<tr>
<td>school33</td>
<td>-0.67</td>
<td>0.421</td>
<td>-0.024</td>
<td>0.875</td>
</tr>
</tbody>
</table>

R² = .596
AA Health Care Utilization

Quantitative analysis on the impact of perception of discrimination on the use of health care services.

The relationship between discrimination and the amount of time since the last preventative exam and acute exam was analyzed by using a regression analysis. A significant model emerged within both regressions with discrimination explaining between 41% and 47% of the variance in the length of time since the last exam ($R^2 = .471$, $p<.05$; $R^2 = .413$, $p<.05$). The model shows that even when controlling for other descriptives the largest predictor in the length of time since the last exam was their perception of discrimination, ($\beta = .419$; $\beta = .419$). Tables 4 and 5 give information about regression coefficients for the predictor variables entered into the model. Results of this analysis display that the higher your perception of discrimination the higher the amount of time since your last wellness or acute exam.

Table 4
Preventative Exam Regression Model

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>$\beta$</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>SocialSupportTotalScale</td>
<td>-0.004</td>
<td>0.048</td>
<td>-0.119</td>
<td>0.056</td>
</tr>
<tr>
<td>discriminationtotal</td>
<td>0.032</td>
<td>0.066</td>
<td>0.419</td>
<td>0.035</td>
</tr>
<tr>
<td>qualitytotal</td>
<td>-0.010</td>
<td>0.086</td>
<td>-0.027</td>
<td>0.635</td>
</tr>
<tr>
<td>DOB</td>
<td>-0.030</td>
<td>0.015</td>
<td>-0.258</td>
<td>0.043</td>
</tr>
</tbody>
</table>

$R^2 = .471$
Quantitative analysis on the impact of perception of social support on the length of time since the last mammography.

While not significant in this model, a relationship between social support and utilization appears to be present from the correlation analysis. To further investigate the relationship between social support and utilization of health care services, a regression analysis was run to determine if a person’s social support score was related to the last time they received a mammography screening.

Only female cases were selected and only women over the age of 45 were included in this analysis since mammograms are only recommended yearly for women over 45 years of age. According to the regression analysis only the social support total was a significant predictor of mammography utilization in the cases selected, with $p = .040$. The model accounts for 58% of the variance within the variable breast screening ($R^2 = .578$), with $\beta = -.483$. The negative relationship to mammography utilization indicates that the higher the social support total the shorter the amount of time since the last mammogram was received. The results of this regression are shown below in Table 6.
Table 6

Mammography Regression Model

<table>
<thead>
<tr>
<th>Model</th>
<th>B</th>
<th>Std. Error</th>
<th>Beta</th>
<th>t</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Constant)</td>
<td>8.943</td>
<td>1.770</td>
<td></td>
<td>5.052</td>
<td>.000</td>
</tr>
<tr>
<td>SocialSupporttotal</td>
<td>-.114</td>
<td>.052</td>
<td>-.483</td>
<td>-2.197</td>
<td>.040</td>
</tr>
<tr>
<td>Discriminationtotal</td>
<td>-.066</td>
<td>.056</td>
<td>-.251</td>
<td>-1.194</td>
<td>.247</td>
</tr>
<tr>
<td>qualitytotal</td>
<td>-.044</td>
<td>.085</td>
<td>-.127</td>
<td>-.518</td>
<td>.611</td>
</tr>
</tbody>
</table>

$R^2 = .578$

Discussion

The study examined the relationship between perceptions of discrimination, social support, quality of health care received, and utilization of health care services. The results indicated that significant relationships existed between discrimination and quality of health care as well as social support and utilization of health care. From the results one can conclude that the more discrimination one perceives, the lower quality of health care they are to expect, and therefore they are less likely to utilize services. The study also found that younger African American’s utilized health care services more frequently than older African American’s. Aligned with the results of the study this may be attributed to higher perceptions of discrimination. One variable that impacted this process for women was the addition of social support. According to the data, even in the presence of discrimination, the right social support is enough to influence more frequent usage of preventative health care services in women. This finding is consistent with my thesis results although the social support measure was changed (Powell, 2015). This model, along with Andersen’s model, Rosenstock’s health belief model, and Young’s choice making
AA Health Care Utilization model similarly predicted that social support would be a factor in one’s choice to utilize health care services.

The hypotheses that perception of discrimination influence perceived quality of health care and perceptions of discrimination influence utilization of health care services were supported and are aligned with literature on this topic, King County Ethnicity and Health Survey (2001). However, the conclusion that social support is a strong enough influence to lessen the impact of discrimination was an unexpected finding and contrary to. Previously referenced studies such as The Boston Social Networks Study (1973) and The North Carolina Outpatient Clinic Study (1989) showed that social support either had no impact on utilization rates or even acted as a deterrent if it came from family as opposed to friends, however both of these studies utilized different measures of social support. The significance of social support in this study may be attributed to the interconnectedness of respondents or a shift in the role of support in 2016 vs. 1989 and 1973 when the previous studies were conducted. The fact that the sample consisted of regular church attendees may have also contributed to social support being such a strong buffer to discrimination. Study participants are members of a church that regularly discusses the benefits of preventative health care screenings and encourages members to take charge of their health.

Limitations of the Study

A number of limitations existed within this study. Participants were drawn from a convenience sample, and this may have influenced results. However, the sample consisted of majority middle class African American’s who had the means to seek health care services. The fact that their perception of discrimination was still the most influential factor in the decision to utilize health care services adds strength to the study. An additional limitation was a relatively
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small sample size, including the disproportionately low number of male participants; this may have affected the power of the study and its ability to be generalized to the larger African American population.

In order to garner more details behind the actual motivators and distracters to utilizing health care, interviews could have been used in this study. For example, detailed information regarding the type of social support respondents noted having would have been helpful in determining whether or not my results matched that of previous studies. In the future, a qualitative component should be added to address this issue.

**Future Directions for Research**

We know that a variety of factors influence African Americans’ choice to utilize health care services. As displayed in Figure 3, cultural mistrust and perceived barriers directly lead to underutilization of health care services. The literature will benefit from an investigation in the ways that African American’s identities and internalization of discrimination influence health care choice and access, allowing practitioners to develop more effective culturally tailored interventions. Other examinations into African American’s perceptions of self-worth and internal vs. external loci of control may aide in uncovering previously unknown barriers to utilization of health care services. Future research should also test the reliability and validity of the discrimination scale utilized. Further examination into whether or not the outcomes of the discrimination scale can be applied to the general African American population is necessary. The use of social support as a catalyst to utilization of health care services should also be thoroughly examined. Because such conflicting data exist on the topic, further analysis is needed to truly
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tease out which types of social support are the most influential and the best way to structure that support.

Implications for Policy or Practice

Results of this study lend to the idea that the larger systematic issue around discrimination needs to specifically be addressed in the health care setting. Programs that specifically target and reach out to African Americans and encourage them to seek health care must be implemented to combat the current feeling of uneasiness that African American’s have as it relates to their health care experience. Shifts towards a population-health based system like the recent Medicaid changes, going from a fee-for-service to a capitation system encourage the use of preventative health and reward providers for keeping patients healthy. This shift in payment also opens creates a new need for community-based health educators and care coordinators. Medical practices will need to be held accountable for being proactive in addressing any barriers to utilizing health care, including their personal biases. The health care system would greatly benefit from the addition of cultural competency and race relations to the training and curriculum of our health care providers.
References


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Appendices

Appendix A

Questionnaire

HEALTH CARE UTILIZATION
Thank you for helping investigators at National Louis University by completing this survey. Your responses will be kept confidential, and your input is important to us.

- Please take the time to read each question carefully and mark the box that best represents your answer.

- Please do not hesitate to skip any questions that make you feel uncomfortable.
DEMOGRAPHICS

Please respond to the following demographic questions to the best of your ability.

1. **In what year were you born?** (enter four digit birth year; for example: 1976)

   _____ _____ _____ _____

   *(Year)*

2. **What is your gender?**

   □ Male  □ Female

3. **Which of the following best describes you?**

   □ Hispanic or Latino
   □ Not Hispanic or Latino
   □ Don’t know

4. **Which of the following races best describes you?** (Please select all that apply.)

   □ American Indian or Alaska Native
   □ Asian
   □ Black or African American
   □ Native Hawaiian or Pacific Islander
   □ White or Caucasian
   □ Other, please specify: ___________________________________________________

LIFESTYLE AND HEALTH BEHAVIORS
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The following questions are about lifestyle and health behaviors. Please answer to the best of your ability.

5. When was the last time you visited the doctor for these preventive services or health screenings?

<table>
<thead>
<tr>
<th>Service</th>
<th>Less than 1 year ago</th>
<th>1-2 years ago</th>
<th>3-4 years ago</th>
<th>5 or more years ago</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Colon/Rectal Cancer Screen</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b) Breast Cancer Screening (women only)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c) Prostate Screening (men only)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d) Wellness Exam</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>e) Sick Visit</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

SOCIAL SUPPORT
The following questions ask about people in your environment who provide you with help or support. Each question has two parts. For the first part, list all the people you know, excluding yourself, whom you can count on for help or support in the manner described. Give the person’s initials and their relationship to you (Example: T.N. (brother)).

If you have no support for a question select the option “No one.” Do not list more than 9 people for one question.

EXAMPLE
Who do you know whom you could trust with information that could get you in trouble?

No one 1) T. N. (brother) 4) 7)
2) B. P. (sister) 5) 8)
3) S.R. (friend) 6) 9)

6. Whom can you really count on to listen to you when you need to talk about important health matters?
### AA Health Care Utilization

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>4</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>

7. Whom do you feel would help you if you had a serious health concern?

<table>
<thead>
<tr>
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<th>1</th>
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<tr>
<td></td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>

8. Whom do you trust for sound health advice?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>4</th>
<th>7</th>
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<tbody>
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<td>5</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>

9. Whom can you count on to tell you, in a thoughtful manner, that you need to improve your health?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>4</th>
<th>7</th>
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<tr>
<td></td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>

10. Whom can you really count on to support you in major decisions that you make regarding your health?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>4</th>
<th>7</th>
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<tbody>
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<td></td>
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</tr>
<tr>
<td></td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>
Discrimination

In your day-to-day life, how often do any of the following things happen to you because of your race?

11. You are treated with less courtesy or respect than other people are.
   - □ At least once a week
   - □ A few times a month
   - □ A few times a year
   - □ Less than once a year
   - □ Never

12. You receive poorer service than other people at restaurants or stores.
   - □ At least once a week
   - □ A few times a month
   - □ A few times a year
   - □ Less than once a year
   - □ Never

13. People act as if they think you are not smart.
   - □ At least once a week
   - □ A few times a month
   - □ A few times a year
   - □ Less than once a year
   - □ Never

14. People act as if they are afraid of you.
   - □ At least once a week
   - □ A few times a month
   - □ A few times a year
   - □ Less than once a year
   - □ Never

15. You are threatened or harassed.
   - □ At least once a week
   - □ A few times a month
   - □ A few times a year
   - □ Less than once a year
   - □ Never

16. Have you ever experienced discrimination, been prevented from doing something, or been hassled or made to feel inferior in any of the following situations because of your race, ethnicity, or color?
   a) At school? □ Yes □ No
   b) Getting hired or getting a job? □ Yes □ No
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c) At work? □ Yes □ No
d) Getting housing? □ Yes □ No
e) Getting medical care? □ Yes □ No
f) Getting service in a store or restaurant? □ Yes □ No
g) Getting credit, bank loans, or a mortgage? □ Yes □ No
h) On the street or in a public setting? □ Yes □ No
i) From the police or in the courts? □ Yes □ No

Discrimination in Health Care

17. Doctors treat African American and White people the same.
   □ Strongly disagree
   □ Disagree
   □ Neither disagree or agree
   □ Agree
   □ Strongly agree

18. Racial discrimination in a doctor’s office is common.
   □ Strongly disagree
   □ Disagree
   □ Neither disagree or agree
   □ Agree
   □ Strongly agree

19. In most hospitals, African Americans and Whites receive the same kind of care.
   □ Strongly disagree
   □ Disagree
   □ Neither disagree or agree
   □ Agree
   □ Strongly agree

20. African Americans can receive the care they want as equally as White people can.
   □ Strongly disagree
   □ Disagree
   □ Neither disagree or agree
   □ Agree
   □ Strongly agree

Quality of Care

21. Different doctors give you different information regarding your health conditions.
   □ Strongly disagree
   □ Disagree
   □ Neither disagree or agree
   □ Agree
   □ Strongly agree
22. **You feel informed about your health from your doctor.**
- □ Strongly disagree
- □ Disagree
- □ Neither disagree or agree
- □ Agree
- □ Strongly agree

23. **Doctors do not spend enough time with you.**
- □ Strongly disagree
- □ Disagree
- □ Neither disagree or agree
- □ Agree
- □ Strongly agree

24. **Your doctor does not treat your health concerns in the best possible way.**
- □ Strongly disagree
- □ Disagree
- □ Neither disagree or agree
- □ Agree
- □ Strongly agree

**Background Information**

25. **What is your current marital status?**
- □ Married
- □ Living as married
- □ Separated
- □ Divorced or Widowed
- □ Single, never married

26. **How many years of school did you complete?**
- □ 6 years (grade school)
- □ 7-9 years (junior high/middle school)
- □ 10-12 years (high school)
- □ Technical training (beyond high school)
- □ 13-15 years (some college)
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☐ 16 years (completed college)

☐ More than 16 years (graduate or professional degree)

27. Which of the following best describes your current employment status? (Check only one box)

☐ Work full time (35+ hours a week at one or more jobs)
☐ Work part-time
☐ Retired
☐ Homemaker
☐ Self-Employed
☐ Student
☐ Out of work for less than 1 year
☐ Out of work for more than 1 year
☐ Unable to work

28. Have you been without health insurance for any part of the past 12 months?

☐ Yes
☐ No

29. What is your annual gross (before taxes) household income from all sources?

☐ Less than $10,000
☐ Between $10,001 and $15,000
☐ Between $15,001 and $20,000
☐ Between $20,001 and $25,000
☐ Between $25,001 and $35,000
☐ Between $35,001 and $50,000
☐ Between $50,001 and $75,000
☐ More than $75,000

30. How would you rate your overall health?

☐ Excellent
☐ Good
☐ Fair
☐ Poor

31. How would you rate your utilization of healthcare?

☐ Excellent
☐ Good
☐ Fair
32. What is the biggest barrier to you utilizing health care services?
_________________________________________________________________________

33. Has discrimination ever impacted your decision to access medical care? Please explain?
_________________________________________________________________________

34. Have family or friends ever impacted your decision to access medical care? Please explain?
_________________________________________________________________________

35. Has the quality of care you expect to receive at a doctor’s office ever impacted your decision to access medical care? Please explain?
_________________________________________________________________________
ENDING STATEMENT

Thank you very much for participating in this survey. Your time and effort is greatly appreciated, and your input is very important to us.

Please do not hesitate to call us if you have any questions. A member of the team can be reached at (708) 320-1335.

We would also appreciate any comments or suggestions regarding this questionnaire and/or study process.

Comments or Suggestions

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
Hi,

My name is Brittany Powell and I am a doctoral candidate in Community Psychology at National Louis University. As part of my studies I have developed a survey on Healthcare Utilization. I am asking for YOUR participation in completing the survey. The purpose of the study is to examine how African Americans’ perceptions of discrimination, social support, and quality of care affect their utilization of preventative health care services.

Below is the link that will take you to the survey, which may take about 15 minutes of your time. Your participation in this research is voluntary, and you may choose not to participate by not following the link to the survey. Once you begin the survey you may withdraw participation at any time. All information collected in this survey will remain confidential. I hope that you are willing to reply to this online survey.

If you choose to participate in this research, please click on the following link:  https://www.surveymonkey.com/r/?sm=oDDduJsaAe4rlPzAQVivGQ%3d%3d

The Project has been reviewed and approved by the National Louis University Institutional Research Review Board (IRRB). If you have questions about this study, please contact Brittany Powell by phone at (708) 320-1335 or email at, bpowell3@my.nl.edu.
Letter of Support
INFORMED CONSENT

You are being asked to participate in a research study conducted by Brittany Powell, a doctoral candidate in Community Psychology at National Louis University, Chicago, Illinois. The study is entitled African Americans and Health Care Utilization. The purpose of the study is to examine how African Americans’ perceptions of discrimination, social support, and quality of care affect their utilization of preventative health care services.

With your consent, you will complete a questionnaire that should take approximately 15 minutes. You will not receive a copy of your answers to this questionnaire.

Your participation is voluntary and you may discontinue your participation at any time without penalty. Your identity will be kept confidential by the researcher and will not be attached to the data. Only the researcher and her faculty supervisor will have access to all records. Your participation in this study does not involve any physical or emotional risk to you beyond that of talking about these topics in everyday life. While you are likely to not have any direct benefit from being in this research study other than having your voice heard, your taking part in this study may contribute to the general body of research on the topic.

While the results of this study may be published or otherwise reported to scientific bodies, your identity will in no way be revealed.

In the event you have questions or require additional information you may contact the researcher: Brittany Powell, National Louis University, 122 South Michigan Avenue, Chicago, Illinois 60603; 708-320-1335; bpowell3@my.nl.edu.

If you have any concerns or questions before or during participation that you feel have not been addressed by the researcher, you may contact Suzette Fromm Reed, 122 South Michigan Avenue, Chicago, Illinois 60603; Suzette.frommreed@nl.edu, 630-874-4257 or the chair of NLU’s Institutional Research Review Board:

Shaunti Knauth, National Louis University, 122 South Michigan Avenue, Chicago, Illinois 60603; 312-261-3526; email: shaunti.knauth@nl.edu.

Participant Name (Print)

_____________________________________

Participant Signature                        Date

_____________________________________

ELECTRONIC INFORMED CONSENT

You are being asked to participate in a research study conducted by Brittany Powell, doctoral candidate in Community Psychology at National Louis University, Chicago, Illinois. The study is entitled African Americans and Health Care Utilization. The purpose of the study is to examine how African Americans’ perceptions of discrimination, social support, and quality of care affect their utilization of preventative health care services.

With your consent, you will complete a questionnaire that should take approximately 15 minutes. You will not receive a copy of your answers to this questionnaire.

Your participation is voluntary and you may discontinue your participation at any time without penalty. Your identity will be kept confidential by the researcher and will not be attached to the data. Only the researcher and her faculty supervisor will have access to all records. Your participation in this study does not involve any physical or emotional risk to you beyond that of talking about these topics in everyday life. While you are likely to not have any direct benefit from being in this research study other than having your voice heard, your taking part in this study may contribute to the general body of research on the topic.

While the results of this study may be published or otherwise reported to scientific bodies, your identity will in no way be revealed.

In the event you have questions or require additional information you may contact the researcher: Brittany Powell, National Louis University, 122 South Michigan Avenue, Chicago, Illinois 60603; 708-320-1335; bpowell3@my.nl.edu.

If you have any concerns or questions before or during participation that you feel have not been addressed by the researcher, you may contact Suzette Fromm Reed, 122 South Michigan Avenue, Chicago, Illinois 60603; Suzette.frommreed@nl.edu, 630-874-4257 or the chair of NLU’s Institutional Research Review Board:

Shaunti Knauth, National Louis University, 122 South Michigan Avenue, Chicago, Illinois 60603; 312-261-3526; email: shaunti.knauth@nl.edu.

ELECTRONIC CONSENT: Please select your choice below.

Clicking on the "agree" button below indicates that:

• you have read the above information
• you voluntarily agree to participate
• you are at least 18 years of age
If you do not wish to participate in the research study, please decline participation by clicking on the "disagree" button.

*1. Informed Consent

☐ agree

☐ disagree