# Walden University

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Walden University
2023

Abstract

# The Experience of African American Adults with Low Health Literacy When Accessing Healthcare

By

Lorraine E. Green

MA, LaSalle University, 2013

BS, LaSalle University, 2008

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

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# Abstract

Low health literacy (HL) among low socioeconomic status (SES) African American adult patients is an ongoing health problem that has increased since the 1990s. Improving HL among low SES African American adults may improve their overall health and decrease the high rates of low HL. The high rates of low HL translate into billions of dollars in healthcare costs annually. Medicare and Medicaid absorb a significant amount of the cost, so improving HL among this population could decrease healthcare costs to the U.S. economy. The theoretical framework for this basic qualitative study was Pender's health promotion model. Implementing strategies aligned with positive cognitive health-motivating behaviors could increase this marginalized population's HL levels. A semi structured, face-to-face interview design was used to explore the experiences of 10 low SES low HL African American adults when navigating the healthcare system.. The analysis of responses to the interview questions led to code and theme development, potentially leading to sustained interventions, influencing improved HL, and promoting positive health behaviors and outcomes. Two themes emerged from the results of this study. The first theme was doctors/healthcare providers lacked the communication skills to help low SES African American adults improve health outcomes. The second theme was doctors'/healthcare providers' deficient interactions with low SES African American adults sustained low HL. Positive social change may be realized for this marginalized group nationwide by developing effective interventions to increase HL levels.

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# Dedication

I dedicate my dissertation to my family. A special feeling of gratitude to my parents. Earline and Joseph Green and my maternal grandparents Mae and Henry Jamieson, who instilled confidence with their words of encouragement and support during my formative years, which determined my future. My sister Loretta never allowed me to doubt my abilities and always reminded me to maintain tenacity. My daughter Kim, granddaughter Shannon, grandson-in-law Reno, and grandson Kareem were always there and were exceptional and never left my side. My other siblings, sister Laverne, and brothers Joseph and Spencer, often reminded me of how proud they were of me.

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# Chapter 1: Introduction to the Study

Low health literacy (HL) is an ongoing harmful health problem that affects low socioeconomic status (SES) African American adults at higher rates than all other ethnic/racial groups, leading to premature morbidity and mortality. Ali et al. (2018), Kajanova and Rimnacova (2019), and Noonan et al. (2016) determined low HL levels occurred more in low SES African American adults. Understanding why low HL continues to occur at higher rates among low SES African American adults could provide insight that may allow for avoiding poor health behavior, manifesting as low HL among the low SES African American adult patient population.

Kajanova and Rimnacova (2019) found that low HL is associated with nonadherence to medication regimens and difficulty following and understanding the healthcare professional's advice and instructions. Researchers stated these behaviors are found disproportionately among low SES African American adults, given low SES African American adults' HL levels are lower than all other ethnic/racial groups in the United States. Additionally, when low SES African American adult patients determine medication is too expensive, they may not have their prescriptions filled due to a lack of funds. Preventative health screenings are not a priority among low SES African American adults. The shortage of preventive healthcare service facilities in communities of African American adults with low SES and their lack of transportation does not encourage the low SES low HL African American adults to seek preventative healthcare screenings (Cole et al., 2017; Han et al., 2019; Kobayashi & Smith, 2016).

Kumar et al. (2017) suggested the increased cost of healthcare annually to the U.S. economy stems partly from the health inequities and disparities found among low HL African American adults of low SES. Noonan et al. (2016) stated the differences in the healthcare experienced by low SES African American adults result from their low HL levels, which may arise from consistent, continuous decades of systemic racism, thus contributing to low SES perpetuating low HL. Han et al. (2019) and Rikard et al. (2016) agreed that low HL is prevalent among low SES African American adults.

The World Health Organization (WHO) definition of HL is the cognitive ability to understand the importance and maintenance of good health and the motivation to engage in health-benefiting behaviors (Trezona et al., 2018).

Baciu et al. (2017) conducted a study that determined systemic racism has created the health inequities and disparities the United States has witnessed concerning providing healthcare services to low SES African American adults with low HL levels. Researchers determined that systemic racism's implicit tenets have influenced all aspects of healthcare services relative to the African American adult and are determinants in the inequitable provision of healthcare services. According to Noonan et al. (2016), inequalities have informed disparities and perpetuated cognitive decline resulting from continued imbalances informed by systemic racism. Hence, systemic racism contributes to cognitive decline and can result in low SES and low HL African Americans disregarding crucial healthcare needs. The influence of cognitive decline on self-efficacy and agency could mitigate motivation that aligns with positive health behaviors and diminish the potential for sustained optimistic health beliefs that lead to positive health outcomes.

Studies have shown that African American adults have consistently low HL across acute and chronic illnesses. The continuing inequities in healthcare for low HL African American adults are ever-present and informed by the low SES of this marginalized population (Carnethon et al., 2017; Cunningham et al., 2017; Laster et al., 2018; Weeks, 2012). Low HL among low SES African American adults is a lack of subjective and objective comprehension of the healthcare professional's healthcare instructions/information (Noonan et al., 2016). Consistent findings in the literature determined that low SES African American adults demonstrate low HL across the entire healthcare trajectory. Social determinants may significantly drive low HL among low SES African American adults. Noonan et al. (2016) explained social determinates as inadequacies relative to healthcare in the political and social structures responsible for providing and determining what is fair and what constitutes an equal distribution of healthcare services.

The literature has been explicit regarding low HL as an outcome of low SES among African American adults, which stemmed from decades of structural inequality (Baciu, 2017). I captured the subjective explanations of 10 participants's experiences when navigating the healthcare system through an exchange of dialog using an interview format. I gained a personal understanding of their perspectives and what guides the healthcare behaviors of low SES African American adults, thereby allowing for the surfacing of what processes might determine health literacy among the low SES African American adult patient population.

This basic qualitative study was needed to examine, address, and understand the damaging determinants of low HL perpetuated by low SES. Researchers suggested that an oppressive social structure has preserved these determinants, thus informing ongoing low HL that maintains health disparities and fosters the inequality in healthcare the African American adult patient receives (Noonan et al., 2018). In addition, low SES determinates coupled with the risk factor of an unjust social system could lead to a decrease in the cognitive motivations that inform health matters concerning improved self-efficacy and agency (Howard et al., 2019; Noonan et al., 2016). However, Pender's health promotion model (Pender, 2011) provided a theoretical framework to promote interventions and increase HL.

Muvuka et al. (2020) concluded that one group of Americans' disproportionate rate of poor health affects the overall health of their community and environment. Improving community health leads to positive social change, which is also cost-effective (Agarwal et al., 2015; Minnesota Health Literacy Partnership., 2017; Rasu et al., 2015; Vernon et al., 2007). The findings from my study could contribute to developing an intervention that improves health behaviors and sustains an increased HL level. In addition, increased HL levels can translate into improved health behaviors and health outcomes in low SES, low HL African American adults. Increased HL levels among low SES, low HL African American adult patients will contribute to positive social change.

Social change is not tangential to improving HL, reducing disproportionate health inequities and disparities affecting the low SES African American adult population.

This chapter provides background information concerning what may constitute the ongoing low HL among low SES African American adults. It confirms the need for this study based on the literature review. This chapter includes the problem statement, as evidenced in the literature, the purpose statement, and the research question. The succinct description of the theoretical framework included in this chapter allows for an understanding of the cohesiveness this framework has provided, which is one of the foundational aspects of qualitative research. The nature of the study in this chapter provides a concise, comprehensive rationalization for the chosen design and methodology relative to the phenomenon of interest. The definitions included in this chapter give the readers an understanding of the terms used in the study, which the reader does not commonly use. Chapter 1 also includes assumptions, scope and delimitations, limitations, and significance, all relevant to this study. Chapter 1 presents a thorough overview of the study, allowing for an appreciation of the theoretical framework and methodology choice.

## Background

The preponderance of the literature concerning low HL among the African American adult population discussed correlations between low SES and low HL, race/ethnicity, and the influence of low SES on the HL levels of African American adult patients. The literature emphasized how race, poverty, and low education, perpetuated by years of structural racism, might have impacted the HL levels of African American adult patients (Baciu, 2017; Noonan et al., 2016). These significant social determinants dictate bad health outcomes relative to African American adults. Health disparities, which determine the burden of an illness, have affected African American adults more than all other ethnic majorities or minorities in the United States. Insufficient HL has predisposed African American adult patients to years of unequal access to healthcare services (Howard et al., 2019; Noonan et al., 2016). Health inequities are social determinants of the unjust, unnecessary, and purposeful unfair treatment of an ethnic minority, usually based on race and SES. According to Baciu et al. (2017) and Noonan et al. (2018), the ruling society's ideology that their interests are superior and have priority has encouraged many of the unfair negative aspects of social determinants, which influenced the health inequalities experienced by the low SES African American adult.

Kobayashi and Smith (2016) found that one-third of Americans have low HL. However, low HL disproportionately affects low SES African American adults. The literature supports an association of low HL with older age, race, inadequate education, and low income, further explaining the determinants of low HL. When these social determinates are evident, the efforts of the economically, socially, and educationally impoverished African American adults seeking health prevention screenings or healthcare services are compromised.

Howard et al. (2019) and Noonan et al. (2016) found that African American adults with low SES may have experienced implicit and explicit biases in the healthcare professional health clinicians provided. Kobayashi and Smith (2016) suggested maintaining positive communication between the patient and healthcare professionals is essential. These guidelines may mitigate the disparities and inequities experienced by

African American adult patients, which might be perpetuated by low SES, leading to low HL across the healthcare continuum. The increased use of emergency rooms for health conditions usually addressed during a primary care physician's office visit has seen an overwhelming increase among low SES African American adult patients with low HL.

Kutner et al. (2006) found that African American adults are affected disproportionately by strokes, heart attacks, and kidney disease, which are outcomes of uncontrolled high blood pressure due to low HL. Studies have shown that one-fourth of African American adults have high blood pressure at one-half times higher rates than White Americans. The rate of high blood pressure among African American adults is 25% higher than among Hispanic American adults (Carrataia & Maxwell, 2020). Asian Americans are 5% of the U.S. population, yet hypertension among this ethnic minority is 42.8%, although this is lower than the African American adult's prevalence of hypertension at 58.0%. However, the Hispanic/Latino prevalence of hypertension is 16 percentage points lower at 42.4% than the African American adult. The non-Hispanic White American's hypertension prevalence is lower than the three ethnic minorities at 37.5% (Gordon et al., 2019).

Uwaoma and Reed (2006) found African American adult men have a 100% higher mortality rate from strokes, and African American women had a 50% higher mortality rate from strokes than their White counterparts. Carratais and Maxwell (2020) also noted stroke as the leading cause of death among Hispanic American adults. Yet, the life expectancy of the Hispanic American adult is 81.9 years, 10.9 years longer than the African American adult male and 4.6 years longer than the White American adult male.

Studies have shown mortality rates among Asian Americans are significantly higher among South Asians than among Chinese adults (Gordon et al., 2019). Additionally, Baciu et al. (2017) noted that the disease burden of these illnesses had not signaled a need for an improvement in the quality of care delivered by healthcare professionals to African American adults. Noonan et al. (2016) similarly believed that low SES among African American adults is associated with tremendously poor health outcomes, lack of access to quality healthcare, and early death. Baciu et al. (2017) and Noonan et al. (2016) argued that low SES leads to inadequate HL, thus negatively affecting acute and chronic health outcomes. Also, the inappropriate healthcare system's past unethical practices involving African American adults have led to mistrust of the healthcare system on an unratified scale. This mistrust of the healthcare system lends itself to low HL and a belief among low SES African American adults that healthcare professionals may not view the healthcare of African American adults as a priority.

Studies have shown that low HL among African American adults leads to higher rates of premature morbidity and mortality (Ali et al., 2018; Cunningham et al., 2017; Laster et al., 2018). These adverse health outcomes are perpetuated by low HL, thus leading to inadequate healthcare behaviors and excessive increases in the cost of healthcare to the U.S. economy. Low HL levels have cost the U.S. economy billions of dollars annually (Agarwal et al., 2015; Minnesota Health Literacy, 2017; Rasu et al., 2015).

The HL level imbalance between African American adults and White Americans' higher HL proficiency suggests underlying factors affecting HL proficiency among

African American adults. The underlying element of an unstainable educational intervention has diminished the elevation of HL among low SES, low HL African American adults. In addition, a comprehensive needs assessment of older African American adults may also help provide insight into increasing their compliance with medical regimens (Bazargan et al., 2017).

There was a knowledge gap relative to what the low SES low HL African American adults have perceived as barriers to their healthcare when navigating the healthcare system. The ongoing inadequate HL levels among low SES African American adults justified the need to study their perceived barriers to healthcare. This population of low SES, low HL African American adults lacked a basic understanding of healthcare information/instruction, had inadequate communication with healthcare professionals, and has shown ineffectual healthcare system navigation.

When the healthcare professional understands the perceived barriers to healthcare from the perspective of the low SES African American adult, a pathway will be developed, leading to open dialog between the patient and the healthcare provider. An open dialogue establishes the potential for ongoing quality communication built upon the information obtained that addresses the unique collective needs and perspectives of the low SES African American adult. The African American adult's low SES relationship to low HL has not changed across studies. As the levels of low SES increased among the African American adult patient population, there are increased rates of low HL among the African American adult patient population. Low SES (low education, low income, inadequate housing/environments) African American adults have consistently experienced low HL when navigating the healthcare system (Han et al., 2019; Kutner et al., 2006; Uwaoma & Reed, 2013). However, Howard et al. (2019) showed that epigenetic factors may have determined low HL levels even when low SES is not a determinant.

In this study, I aimed to understand the experiences of African American adults with low SES and low HL and develop interventions that promoted sustained positive health behaviors predicated on increased HL levels. This study led to potential interventions using Pender's HPM theoretical framework, which could motivate low SES and low HL African American adults to adopt behaviors consistent with self-efficacy and agency. Health-promoting interventions could substantially improve the overall health and quality of life (QOL) for low SES and low HL African American adults. Researchers attest improving HL will decrease healthcare costs for the U.S. economy, and enhancing HL has a direct positive impact on Medicare and Medicaid costs (Agarwal et al., 2015).

Researchers have also found that health improvement indirectly improves an individual's financial status (Howard et al., 2019; Kajanova & Rimnacova, 2019). Healthy individuals are usually able to remain employed until they retire. However, individuals who develop an acute illness or remain chronically ill due to poor HL tend to stay unemployed for extended periods. Given the African American adult's low SES and low HL, a study could determine the steps needed to improve their HL level. The low SES of the African American adult may be immutable. However, their low HL is mutable, thus allowing for an increase in their HL. Therefore, this study was essential in developing interventions that sustained improved HL of the low SES low HL African American adults.

I determined that conducting this study was critical to mitigate the ongoing proliferation of low HL among low SES African American adults. Low SES may be an immutable factor in real time. Therefore, this study was necessary to help improve low HL among the African American adult patient population, notwithstanding their low SES. The need for guidance concerning developing sustainable educational interventions to increase the HL of the African American adult patient population is essential. The mutable factors that drive low HL (perceived barriers to healthcare, decline in the cognitive motivations determining self-efficacy, agency, and contextual worldviews) will continue to increase if left unaddressed.

## Problem Statement

Researchers found only 2% of African Americans have proficient HL compared to 14% of White Americans (Ali et al., 2018). This imbalance in proficient HL among African American adults compared to White American adults suggested underlying perceptions among African American adults of perceived barriers when navigating the healthcare system, thus perpetuating low HL. These perceptions could mitigate the expected benefits of an intervention to increase low HL levels of the low SES African American adult. Proficient HL is how individuals correctly follow, understand, and gather healthcare information (Clouston et al., 2017).

Difficulty navigating the healthcare system and following basic instructions are associated with low HL. Studies have shown that African American adults with low HL had disproportionately higher mortality and morbidity rates (Carnethon et al., 2017). African Americans are 13% of the United States population. Yet, they experienced the most increased premature morbidity and mortality and the highest mortality rates attributed to low HL for all ethnic groups (Cunningham et al., 2017; Laster et al., 2018). Yen and Leasure (2019) noted that studies had not provided conclusive evidence that the experiences of low SES African American adults navigating the healthcare system had improved after an educational intervention. Individuals must demonstrate comprehension, understand written health care instructions and numeracy, and have the aptitude to correctly calculate and work with numbers (Weekes, 2012). Researchers have designed educational interventions to address low HL. Yet, the literature has not been explicit concerning the long-term positive effects on HL after an educational intervention. Yen and Leasure (2019) determined that Teach Back is a universal HL method endorsed by American governmental agencies as a technique used to verify a patient's understanding of their healthcare information. This technique instructs patients to repeat the healthcare information given to them by the healthcare professional. Early assessment of the patient's HL level using Teach Back during the admission/consent process could improve HL levels during communication between the patient and the healthcare professional. However, using Teach Back methods to determine adequate HL long-term has been inadequate. It only clarifies the patient's understanding of healthcare information in real time and is not a panacea.

Bazargan et al. (2017) suggested a comprehensive assessment of the needs of the older low SES African American adults concerning their medical regimens allowed for an increase in compliance and elevated levels of HL for this subgroup of the African American adult population. These collective findings further justify conducting a study to close the gap in knowledge relative to the perceived barriers experienced among low SES African American adults who feel they have low HL when navigating the healthcare system.

Capturing the experiences of 10 low SES low HL African American adults using a basic qualitative design methodology may provide an understanding of the relationship between perceived barriers to healthcare and low HL among low SES African American adults. Low HL costs the United States between $106-236 billion annually (Agarwal et al., 2015; Minnesota Health Literacy, 2017; Rasu et al., 2015). Low HL continues to increase among all groups but at higher disproportionate rates among African American adults (Ali et al., 2018; Noonan et al., 2016).

## Purpose of the Study

In this study, I aimed to understand the experiences and barriers to healthcare perceived by low SES African American adults who have shown low HL due to their lack of understanding of basic healthcare instructions and information when communicating with healthcare professionals and navigating the healthcare system.

I aimed to increase the HL of the low SES African American adult and to clearly understand the barriers impacting the low SES African American adult’s ability to navigate the healthcare system. Themes from interviews provided a sense of the low SES, low HL African American adult’s perceived barriers to healthcare, allowing for the development of interventions exclusive to the needs of the low SES, low HL African American adult.

The transformative paradigm was chosen for this study to address the social determinants affecting low SES low HL African American adult patients. This paradigm lends itself to actions focused on mitigating social determinants perpetuating low HL among low SES African American adults. The ethical belief of the transformative paradigm reflects the principles guiding my thoughts and opinions relative to how society should provide for and treat marginalized or underserved individuals (Kivunja, 2017; Romm, 2015). The transformative paradigm is aligned with this study's concern for social justice relative to healthcare and gives voice to those less powerful in society (Kivunja, 2017).

Low HL among low SES African American adults is an ongoing phenomenon. It has generated an interest in how researchers could begin mitigating this existential threat to a continual increase in the low HL rates among low SES African American adults. Low HL among low SES African American adults needs modification to realize an overall improvement in QOL relative to the disease burdens and health inequities plaguing the low SES African American low HL adult patient population. Educational interventions developed with an appreciation for the cultural aspects unique to the African American patient population will sustain the expected increases in HL as an outcome of these educational interventions and relieve the high healthcare costs to the U.S. economy related to low HL.

## Research Question

RQ: What is the experience of low SES African American adults who self-report low health literacy when navigating the healthcare system?

## Theoretical Framework for the Study

This study's theoretical framework is based on Pender's HPM. The social cognitive theory is one of the theoretical roots upon which Pender's HPM builds the foundation of her theoretical framework (Pender, 2011). The social cognitive theory allows for an appreciation of the influence of cognition relative to healthcare behaviors, thus guiding positive healthcare via cognitive motivations. These cognitive motivations stimulate and promote positive health behaviors and outcomes and control an individual's external environment using Pender's HPM's cognitive motivation theoretical framework as a guide. Pender's HPM was initially introduced in nursing literature in 1982 and was revised in 1996 to show the relevance of the theoretical propositions presented, which could positively influence health behaviors(Pender, 2011).

Seven of the 14 theoretical propositions of Pender's HPM are pertinent to this basic qualitative research study. They include (a) past behaviors, inherited or acquired characteristics, influenced health beliefs that may adversely affect health-promoting behavior; (b) perceived barriers are determinants to self-efficacy and agency concerning responsible health behaviors; (c) perceptions of self-agency translated into cognitive motivations guiding improved health behaviors; (d) increased self-efficacy will decrease perceived barriers to effectual health behaviors; (e) patient support systems that include family, friends, and healthcare providers who expect responsible healthcare behaviors to take place will witness an occurrence of improved health behaviors; (f) support systems and external environments can increase or decrease the pledge to engage in health benefiting behaviors; and (g) an obligation to improving health has shown long-term effects (Pender, 2011).

Heydari and Khorashadizadeh (2014) and Majlessi et al. (2019) found that Pender's HPM theoretical framework explains behaviors congruent with decreasing barriers to health care, thus increasing HL and minimizing the adverse health outcomes associated with low HL. Pender's HPM identifies negative health behaviors driven by low HL. Pender's model also addressed salient barriers that low SES African American Adults with low HL perceived as ongoing. Pender's HPM provided a structure that allowed for changes in health behaviors that may improve HL simultaneously and spontaneously. Pender's HPM attests to the importance of a holistic approach to overall health, as shown in the relevance attributed to the importance of the patient's environment, which includes situational factors that help guide patient behaviors. Pender's HPM interventions have consistently demonstrated positive health outcomes, and Pender's HPM is a model and an intervention.

Chapter 2 presents information on how Pender's theoretical framework allows for the contextual factors essential in the design of the HPM. When the patient's environment and healthcare behaviors were made relevant during communication with the healthcare providers using the guidelines of Pender's HPM, it promoted the mitigation of adverse health behaviors and beliefs, which surfaced during the interactions between the healthcare provider and the patient.

Pender’s HPM (2011) guided the selection of interventions that promoted healthy lifestyles and improved health behaviors. For example, perceived barriers to health among low SES, low HL African American adults are minimal when using Pender’s behavioral model’s educational intervention component based on the theoretical framework root concerning self-efficacy and agency (Pender, 2011). This intervention encouraged cognitive motivation by reflecting on the benefits and advantages of improving health behaviors and evaluating the barriers that impede successful health behaviors. Self-care behavioral health education is an intervention based on Pender’s HPM’s self-care questionnaire (Khodaveisi et al., 2017; Majlessi et al., 2019). Hence, Pender’s models guided the selection of health promoting interventions, and the intervention selected depended on the adverse health behavior in question. Therefore, healthcare behaviors predicated on low HL might show an improvement. Pender’s HPM foundation is a step-by-step structural construct that guides improved self-health behaviors (Khodaveisi et al., 2017). Pender’s HPM (2011) knowledge of perceived health benefits aims to motivate positive health behaviors while elevating HL levels. As previously mentioned, Pender’s HPM guides the healthcare professional’s health promotion intervention selection, thus allowing for synergy between the model and the intervention, thereby leading to positive health outcomes. Pender’s HPM’s interpersonal norms attest to the influence of the healthcare professional and how these interactions may increase an individual’s ability to navigate their healthcare system. Khodaveisi et al. (2017) explained patient support as the encouragement patients receive from family, friends, and healthcare professionals. These support systems are essential to promoting positive health behaviors and health outcomes.

## Nature of the Study

I used a basic qualitative design and a narrative inquiry methodology for this study. Narrative inquiry in this study provided a format in which the phenomenon's understanding is through semi structured interviews. The 10 participants in the study were allowed to express their feelings and explain their experiences relative to their healthcare encounters. These narrative inquiries were unencumbered by preconceived notions that questions or inquiries have a correct response or answer (see Wolgemuth & Agosto, 2019).

Low SES African American adults with low HL were abundant across research studies. The literature focused on how chronic illness, acute illnesses, inequities, and disparities disproportionately impacted this population and perpetuated healthcare behaviors that led to poor health outcomes. Wolgemuth and Agosto (2019) stated that narrative inquiry provided subjective context, allowing for an appreciation of the participant's cognitive processes and giving insight into their personality, culture, and experiences.

The basic qualitative approach is well suited to explore perceived challenges and barriers the low SES low HL African American adults perceived as obstacles or external challenges that made it demanding to navigate the healthcare system (see Percy, 2015). Percy (2015) explained that when marginalized low SES low HL African American adults interacted with the healthcare system, they subjectively expressed difficulty or objectively demonstrated problems navigating the healthcare system. The low SES, low HL African American adult patient may also have trouble making and keeping appointments, arranging medical screenings, and following medical information/instructions. The basic qualitative approach allows for a broad understanding and exploration of health determinants. The knowledge gained from a basic qualitative inquiry of the low SES low HL African American adults' healthcare experiences might lead to improved health behaviors, increased HL, and the development of interventions unique to the needs of low SES, low HL African American adults (see Percy, 2015; Wolgemuth & Agosto, 2019)

I captured the subjective experiences of 10 purposeful selected low SES low HL African American adults navigating the healthcare system using a semi structured interview question method, which allowed for code development of the data. An inductive open coding analysis approach determined theme development.

## Definitions

*Health disparities*: A health difference intricately linked with social, economic, and environmental disadvantage. Any imbalances in the health burdens of a particular group (Noonan et al., 2016).

*Health inequities*: Systematic unfair differences in healthcare provision to one group based on race, age, or gender (Baciu et al., 2017).

*Healthcare provider/professional*: Qualified licensed professionals (clinicians, nurses, physicians) who provide medical care (Norton et al., 2016).

*Social Desirability*: A study participant answers survey or interview questions based on what they believe the interviewer/researcher wants to hear instead of what the participant honestly thinks or feels (Latkin et al., 2017).

*Socioeconomic status (SES)*: The higher an individual's educational level coupled with one's annual income above federal poverty guidelines is commensurate with being in a higher socioeconomic status (Amandeo & Scott, 2020; Curtis et al., 2012; Stewart et al., 2014).

*Structural inequities*: These are systemic societal practices of unequal access to social and political goods and services based on race, gender, and sexual orientation (Baciu et al., 2017).

## Assumptions

My initial assumption is that the study participants in this study will appreciate the benefits of improved HL. The second assumption was that the participants in this study would give honest answers and would not give answers because they thought those answers were socially acceptable or desirable (Latkin et al., 2017). My third assumption was that the participants would not feel embarrassed and would be comfortable revealing their lack of knowledge concerning their health issues. My fourth assumption is that the family members, friends, and healthcare providers will support the participant's participation in my study.

## Scope and Delimitations

Low HL disproportionately affects African American adults more than all other ethnic/racial groups in the United States (Ali et al., 2018). The low SES of African

American adults has been relegated to a place in American society that has labeled them as marginalized (Howard et al., 2019; Noonan et al., 2016). Low HL is not unique to African American adults, but low HL is highest among African American adults (Ali et al., 2018; Howard et al., 2019; Noonan et al., 2016).

I chose Pender's HPM as my theoretical framework, given this is a behavioral promotion model with theoretical propositions that address concepts related to health promotion. Also, using the step-by-step stages of behavior change that Pender has endorsed *(pre-contemplating, contemplation, preparation, action, and maintenance)* may enhance positive health promotion in a step-by-step manner. I mentioned the critical race theory (CRT) to provide context to the ongoing low SES of the African American adult, perpetuating the continuous high low HL rates among the African American adult population. Given my study addresses the experiences of low HL African American adults accessing healthcare, the potential for transferability to other ethnic populations may be possible if the construct of SES predicts low HL in ethnic populations other than the African American adult population.

## Limitations

One potential limitation of this study is social desirability. Study participants may harbor a conscious or unconscious desire to appear knowledgeable concerning their healthcare regimen. Therefore, I worded questions clearly to avoid causing the participant embarrassment, thus leading to incorrect responses by a participant trying to avoid disclosing sensitive, personal, or embarrassing information (see Latkin et al., 2017). Including an HL subjective screening tool (narrative inquiry) instead of an objective screening tool (assessment of reading comprehension and numeracy) minimized the stigma and embarrassment of the Short Test of Functional Health Literacy in Adults. Given that embarrassment may occur among low SES, low HL African American adults when they must demonstrate proficient HL skills objectively. The potential for participant embarrassment and stigmatization relative to low HL may not be avoidable and is a potential reality.

A second limitation of this study was the possibility of a conflict of interest, given my 30-year career as a healthcare provider and patient advocate. I allowed for potential biases concerning understanding and the subjective perspectives of the low SES low HL African American adult patient. The potential conflict of interest could present an ethical concern, threatening the credibility value associated with trustworthiness. Therefore, given the likelihood of an unintended allegiance between the participant and the researcher/interviewer, the measures taken to address this conflict of interest limitation used reflexivity and memos to reflect upon the cognitive biases psychologically embedded in conflicts of interest.

## Significance

This study may explain why low SES African American adults consistently experience disproportionate rates of low HL when navigating the healthcare system and interacting with healthcare professionals. The results afforded the scholar-practitioner knowledge that will build a framework of understanding and assist in developing interventions unique to mitigating the perceptions of this population that do not align with positive health outcomes. African American adult patients of low SES demonstrating below basic HL experience inadequate healthcare services, resulting in deficient healthcare (Clouston et al., 2017). This basic qualitative research study enhanced understanding of the low SES low HL African American adults' experiences with the ongoing phenomenon of low HL and difficulty navigating the healthcare system. The results will provide healthcare professionals and administrators with insight into the culture and worldview of this population. Researchers/interviewers could develop interventions based on data gathered from study participants that may help mitigate negative health behaviors and inadequate communication between low SES African American adults and healthcare providers.

An increase in HL could also decrease healthcare costs to the U.S. economy. When a patient's HL level increases, these patients may be motivated to seek and maintain preventative healthcare and establish behaviors that inform compliance with medical instructions and medication regimens (Clouston et al., 2017). The findings from this study could contribute to developing an intervention to improve health behaviors and health outcomes for low SES African American adults and thereby contribute to positive social change by reducing health inequities and elevating HL.

## Summary

In conclusion, despite interventions designed to mitigate low HL among African American adults, this population continues to experience the highest levels of low HL in the United States compared to all other groups. Low HL has cost the U.S. economy billions of dollars annually. Perhaps if the healthcare professional demonstrated increased consideration for cultural and worldview ideologies, this might also improve the HL of the low SES African American adult patient.

Combining teach back interventions and Pender's HPM and addressing the cognitive damage from unjust treatment could increase HL levels and the sustainability of the healthcare knowledge gained. Thus, effective communication between healthcare professionals and patients promotes positive behavioral change.

Chapter 2 reviews the most recent literature on low HL among low SES African American adults and older relevant sources to provide consistency concerning a timeline that shows the ongoing low HL among African American adults. The literature search conducted in Chapter 2 allowed me access to studies that emphasize the problem statement, the purpose of the study, and the significance, which determined the research question.

# Chapter 2: Literature Review

The problem I addressed in this basic qualitative research study was the increase in low HL among African American adults at disproportionately higher rates than all other American groups (see Ali et al., 2018). Low SES and low HL among African American adults predict poor health outcomes. Studies have shown years of racial injustice contribute substantially to low HL, leading to disproportionate previsions in healthcare, thereby perpetuating increases in morbidity and mortality rates among African American adults (Carnethon et al., 2017). Carnethon et al. (2017) and Noonan (2016) stated that low HL significantly influences morbidity rates among African American adults. Health inequities resulting from systemic structural racism are an underlying determinant of low HL among low SES African American adults.

McBride and Koehly (2017) noted biophysical factors encompassing genetics might also potentially influence HL. Researchers have shown genetic processes involving epigenetic DNA gene expression may occur with continuous abuse of an individual's humanity and affect aspects of cognitive processes relevant to HL that will determine an individual's health behaviors for generations of future offspring (McBride & Koehly, 2017; Noonan et al., 2016). Adverse effects on cognition lead to low self-efficacy that predicts inadequate motivation, which is relevant to poor health behaviors dictated by low HL (Juvigny-Canal et al., 2020; Noonan et al., 2016).

Additionally, low HL contributes to the excessive financial burdens on the U.S. economy concerning healthcare. The cost of low HL to the U. S. economy is an avoidable excessive expenditure. An increase in the African American population's HL alone could save the United States millions of dollars annually. Low health literacy has hurt the U.S. economy and costs between $106 to $ 236 billion annually (see Agarwal et al., 2015; Minnesota Health Literacy, 2017; Rasu et al., 2015).

I aimed to understand the experiences and barriers to healthcare perceived by low SES African American adults who have shown low HL due to their lack of understanding of basic healthcare instructions and information when communicating with healthcare professionals and navigating the healthcare system. In this basic qualitative research study, I sought to understand the experiences and barriers to healthcare perceived by low SES African American adults who have consistently shown low HL. Understanding factors contributing to continued low HL among low SES African American adults when navigating the healthcare system might lead to developing interventions to improve low HL, health behaviors, and outcomes and establishing an educational intervention with the potential for long-term positive effects on HL. Additionally, an increase in the low HL of the low SES African American adult will decrease the financial burden low HL has placed on the U.S. economy (McBride & Koehly, 2017; Yen & Leisure, 2019). Therefore, one of the objectives of this study was to gain an awareness of obvious and insidious elements regarding social structures, policies, and biophysical and environmental factors, which have negatively influenced cognitive processes. The cognitively informed aspects of HL guide low SES African American adults’ health behaviors. Additionally, older African American adults contribute substantially to the disproportionate rates of low HL among African Americans. A thorough assessment of the cognitive needs of the older African American adult (65 years and older) relative to their medical regimens may allow for an increase in compliance and an increase in this subgroup of African American adult's HL levels (see Anthony et al., 2007; Chesser et al., 2016; Cole et al., 2017; Speros, 2009).

The proliferation of low subjective and objective HL among low SES African American adults and the excessive reports of poor health outcomes have led those in the healthcare community to conclude that an immediate solution or an understanding of the factors that drive this behavior is warranted. When healthcare professionals have access to information explaining a patient's health behaviors, the negative aspects of those behaviors could be eliminated or mitigated.

The importance of HL emerged in literature during the 1990s. Articles covered patient knowledge or lack of knowledge concerning healthcare regimes (navigating the healthcare system, medication adherence, appointments, health screenings, and understanding healthcare information/instructions). The interest in HL among healthcare providers grew as the prevalence of low HL increased (Kalichman et al., 1999; Roter et al., 1998). Concern grew among healthcare professionals when inadequate HL began to influence health outcomes at alarming rates negatively (DeWait et al., 2004; Kalichman et al., 1999; Wallace, 2010). Wallace (2010) found that low HL was higher among the elderly and racial/ethnic minorities than in the majority. Researchers also understood low self-efficacy informed low HL, low participation in healthcare decisions, and lack of agency. However, the overarching factor of low HL is low SES. Low SES presents significant barriers to equitable healthcare concerning the lack of health insurance coverage, inadequate, unreliable, or unavailable transportation to medical appointments, unemployment, and poverty, as determined by federal poverty guidelines (Amadeo & Scott, 2020).

Understanding how low SES African American adults perceive issues surrounding their healthcare may explain why low HL among African Americans has continued regardless of the educational interventions designed to increase their HL. Low SES African American adults with low HL have been an ongoing phenomenon. African American adult patients living below federal poverty guidelines have not shown sustained improvement in HL levels after interventions designed to elevate HL levels were implemented (Carnethon et al., 2017; McBride & Koehly, 2017; Wallace, 2010; Yen & Leasure, 2019). Studies have shown that African American adults had disproportionately lower rates of HL than all other groups (Ali et al., 2018; Noonan et al., 2016). Interventions designed to measure HL among low SES African American adults have shown deficits in comprehension and numeracy (Weekes, 2012), which are critical for adequate and proficient HL.

Perceived barriers informed the low SES and low HL African American adults' objective and subjective healthcare challenges. Acknowledging these perceived challenges during patient and healthcare provider communication may help the healthcare professional understand any underlying factors determining low HL among African American adults. I sought to understand the cognitive processes influencing low HL among low SES African American adults. The goal was to understand how cognitive processes dictate self-health motivation and potentially sustain positive health behaviors and outcomes.

In this chapter, I present a literature search strategy detailing obtaining literature relevant to the phenomenon of interest. I introduce a comprehensive narrative of Pender's theoretical framework, which adheres to the tenets that allow for the development of self-efficacy and agency concerning self-health behaviors in low SES, low HL African American adults. The literature review in this chapter addresses the determinants attributed to low HL among low SES African American adults. In the summary and conclusion at the end of this chapter, I culminated the factors I determined to provide insight into this ongoing phenomenon and the possible development of interventions to help improve the HL of the low SES African American adult population.

## Literature Search Strategy

The articles described here relate to low HL among low SES African American adults. The databases searched were from the Walden University Library. The selected databases included ProQuest Health & Medical Collection, ProQuest Nursing & Allied Health Source, PsycArticles, PsycINFO, PubMed, Education Source, Eric, Sage Journals, CINAHL & Medline Combined Search, CINAHL and MEDLINE, Education Source, and Google Scholar. Listed are the keywords used to compile my peer-reviewed literature: *Afro-American, ethnic minority, Blacks, Black Americans, African American, race and ethnic, ethnic identity, low health literacy, health knowledge, literacy, health behaviors, wellness behavior, health care, health education, health services, health disparities, health communication, health promotion,* and *health attitudes.*

The literature reviewed for this study included psychological literature, social science literature sources, and literature from governmental agencies, including the

National Institute of Health (NIH), The World Health Organization (WHO), the Center for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), and Health and Human Services (HHS). The governmental sources provided an additional understanding of the potential relationships between low SES and low HL.

The literature reviewed for low HL of low SES African American adults did not provide data that showed a sustained improvement in elevating low HL levels of low SES African American adults after implementing educational interventions. The data from sources over 5 years was consistent with the data that was 5 years old or less, which noted that the same factors were driving this ongoing phenomenon of low HL among low SES African American adults. Constructs, which were determinants of continued low HL among low SES African American adults in articles older than 5 years, were the same constructs noted in articles less than 5 years old. A thorough review of the factors from more senior literature sources has clarified that the low SES African American adult health, health behaviors, and health outcomes stem from the same constructs that dictated low HL for the past 10 years. Therefore, for this study, a literature source before 2015 does not negate the significance nor the importance of evidence a literature source before 2015 may provide. The addition of older literature offers data that has supported and provided a clear timeline of this ongoing phenomenon and the perceived barriers and challenges that may have prohibited improvement in the HL of this population.

The search criteria, theoretical framework, and methodology supported the qualitative research question. The articles I explored addressed the social determinants influencing continued low HL among African American adults with low SES. Data have shown low SES maintained low HL among low SES African American adults. This study also aimed to explain how low HL might burden the U.S. economy (see Agarwal et al., 2015; Minnesota Health Literacy, 2017; Rasu et al., 2015; Vernon et al., 2007).

Clouston et al. (2021), McBride and Koehly (2017), and Noonan et al. (2016) explained explicit and implicit systemic racism might potentially inflict harm on this group's cognition and negatively affect self-efficacy and agency, which minimizes positive health behaviors and QOL. I have considered the genetic factors relative to health for this study, given the groundbreaking discovery that genetic factors could influence health behaviors (see Cunningham et al., 2017; Howard et al., 2019; Langie et al., 2019; McBride & Kochly, 2017; Rikard et al., 2016).

Researchers explored health behaviors of low SES and low HL African American adults to understand and appreciate contextual factors, which are valuable essential aspects when elucidating this ongoing phenomenon (Ali et al., 2018). Studies have shown older low SES, low HL African American adults and younger low SES, low HL African American adults have the same negative experiences (Melhado et al., 2011). Although the older low SES low HL African American adults (65 years or older) cognitive decline might predispose them to adverse health behaviors that exceed those of younger low SES low HL African American adults (Mayo-Gamble and Mouton, 2018).

## Theoretical Foundation

The theoretical approach I used is based on Pender's HPM. Pender's HPM was introduced in the nursing literature in 1982 and was revised in 1996 to bring to light the theoretical propositions that could positively influence health behaviors (Pender, 2011).

Pender’s theoretical proposition, which attests to “ personally valued benefits” (Pender, 2011, p.5), aligns with the assumption that ineffective healthcare provision will not continue among African American adults when Pender’s “ health promoting behavior” (Pender, 2011, p.5) theoretical proposition is implemented. This theoretical proposition determines health behaviors, which centers on the importance of personal health gains. When applied, these tenets can guide the African American adult patient toward adopting positive health behaviors based on the theoretical proposition that valuable personal benefits are associated with maintaining good health. Thus, the ineffective healthcare received due to low HL should not occur. Adopting health behaviors based on the theoretical proposition that positive health behaviors will render health gains may eliminate or mitigate the potential for ineffective healthcare from healthcare providers. When African American adult patients show that they appreciate and value good health, it will pave the way for enhanced healthcare communication between the healthcare provider and the adult patient (Kobayashi & Smith, 2016).

The assumption that African American adults' healthcare will meet the highest standards possible based on fair, equitable criteria aligned with Pender’s HPM theoretical proposition that supports when perceived barriers are constrained, this will lead to a commitment to actions. These barriers concern the African American adult’s challenges when navigating the healthcare system or barriers concerning actions not taken against the basis of some healthcare providers (see Baciu et al., 2017; Noonan et al., 2016). Both are adversities concerning standards the healthcare provider must be aware of, which concerns the healthcare of the African American patient in this study and the barriers the low SES low HL African American adult is expected to overcome when following Pender’s HPM theoretical proposition. Addressing these barriers using strategies based on Pender’s HPM theoretical proposition concerning perceived barriers constraining commitment to action, the assumption of quality and sufficient healthcare predicated on just and fair criteria will be realized. Quality healthcare will lend itself to just and equitable treatment of the African American adult patient. However, these barriers can be constraints concerning providing effective, sufficient healthcare (Heydari & Khorashadizadeh, 2014; Pender,2011).

Pender’s HPM (2011) is determinative, promoting self-efficacy and agency. The low SES, low HL African American adult population could benefit from interventions implemented based on the theoretical concepts that Pender’s HPM attests. Low SES is an immutable factor. The benefit of Pender’s HPM theoretical proposition is that Pender’s model may circumvent the low SES of the African American adult and potentially use an applicable theoretical framework to improve low HL among low SES African American adults (Pender, 2011). Pender’s theoretical propositions are primarily psychologically driven, not physiologically determined. Therefore, factors dependent upon external environmental causes that dictate low SES (e.g., unreliable transportation to medical appointments) may not impact health behaviors and outcomes that generally consider low SES when determining a successful health behavior outcome. Pender’s HPM theoretical proposition is a health promoting intervention applied to the appropriate psychologically and cognitively driven health behaviors (Heydari & Khorashadizadeh, 2014; Majlessi et al., 2019).

The HPM theoretical propositions concerning self-efficacy will support the assumption that low HL perpetuates inadequate self-efficacy and can be comprehensively understood or applied to the different cognitive renderings unique to the human experience (Pender, 2011). According to Pender's (2011) HPM, "self-efficacy increases commitment to action concerning positive health behaviors" while "self-efficacy decreases perceived barriers to a specific health behavior " (p. 4). Pender posited that "positive outcomes of a health behavior will enhance self-efficacy" (Pender, 2011, p.4). According to Pender, HPM's tenets acknowledged the environment's influence on the African American adult's HL level as an independent risk factor for poor health behaviors and outcomes. The environmental context determines which of Pender's HPM concepts significantly impacts the low SES African American adult's HL level.

The African American adult population has experienced low HL levels at rates that exceed the low HL rates of all other ethnic groups throughout the United States (Ali et al., 2018). Interventions addressing the unique needs of the African American adult population are necessary if an increase in HL levels is the goal sought for this group. Pender explained behaviors congruent with decreasing subjective and objective barriers to health care, which may enhance HL and minimize adverse health outcomes associated with low HL, are based on the use of theoretical propositions, which align with a specific obstacle, barrier, or challenge (Heydari & Khorashadizadeh, 2014; Majlessi et al., 2019). Pender's HPM identifies adverse health behaviors driven by low HL. Pender's model also addressed salient factors relative to barriers that low SES African American Adults with low HL may have perceived as commonplace (Pender, 2011). A structured framework allows for health behaviors reflective of improved HL. Pender's HPM attests to the importance of a holistic approach to overall health, as shown in the relevance attributed to the importance of the patient's environment, which is a situational factor guiding patient behaviors. However, Pender's HPM theoretical proposition concerning situational factors relative to a holistic approach states that situational influences in the external environment may increase or decrease health promoting behaviors.

Researchers have found Pender's HPM interventions consistently demonstrated positive health outcomes (Heydari & Khorashadizadeh, 2014; Majlessi et al., 2019). Also, Pender's HPM is a model and an intervention, and the model guides the selection of interventions that promote healthy lifestyles, leading to improvements in health behaviors. For example, Pender (2011) found that perceived barriers to health, a behavioral model component of Pender's HPM theoretical proposition, may be minimized by an educational intervention. Pender's educational interventions encourage cognitive processes to reflect on the benefits and advantages of improving health behavior and evaluate barriers that impede successful health behavior. Healthcare providers who use Pender's HPM to develop an educational intervention will realize successful health outcomes relative to HL and healthcare behaviors (Heydari & Khorashadizadeh, 2014; Majlessi et al., 2019).

Self-care behavioral health education is an intervention based on Pender's HPM's self-care questionnaire (Khodaveisi et al., 2017; Majlessi et al., 2019). Pender's models guide health promoting interventions, and the intervention used depends on the adverse health behavior in question. However, Pender's interventions are modifiable, and one intervention may apply to more than one or two damaging health behaviors (Pender, 2011). Healthcare behaviors predicated on low HL may improve when guided by Pender's HPM. Hence, Pender's HPM foundation is a step-by-step structural construct guide that seeks to enhance HL and health behaviors using self-health interventions, allowing for exploration and self-prospective of perceived barriers to health promoting behaviors and lifestyles (Khodaveisi et al., 2017). Pender's HPM's knowledge of perceived health benefits can motivate health behaviors while elevating HL levels. Pender's HPM guides the healthcare professional's health promotion intervention selection, thus allowing for synergy between the model and the intervention, thereby leading to positive health outcomes (see Khodaveisi et al., 2017; Pender, 2011

Pender's HPM's interpersonal norms attest to the influence of the healthcare professional and how these interactions may increase an individual's ability to navigate their healthcare system. Thus, patient support is an encouragement the patient receives from family, friends, and healthcare professionals and is a motivating factor in demonstrating consistent positive health behaviors (Khodaveisi et al., 2017).

The low SES, low HL African American adult patient's history of ongoing low HL has not improved in 24 years (Kalichman et al., 1999; Roter et al., 1998). Understanding how to enhance the HL of African American adults has been challenging. Pender's HPM allows for and elucidates the barriers and determinants to health behaviors that may explain this ongoing phenomenon among low SES and low HL African American adults or improve their HL through interventions (Khodaveisi et al., 2017).

Pender’s HPM focuses on individuals holistically, affording the researcher/interviewer a broad scope. Pender’s HPM will provide the researcher/interviewer and the African American adult with theoretical propositions, informing them on developing health promoting skills. Based on individual needs, a step-by-step process will mitigate the potential to overwhelm an individual and create a situation that could become counterproductive (see Khodaveisi et al., 2017; Pender, 2011). Pender (2011) suggests that goal-directed behavioral health concepts have guided tenets that may manifest as positive health behaviors and outcomes with increased HL, given the essential concepts of Pender’s HPM and theoretical propositions geared toward health promotion. Hence, low HL found among low SES African American adults has the probability of showing a significant increase in HL levels by engaging in Pender’s HPM Theory.

Pender’s HPM allows the low SES, low HL African American adult patient insight into barriers relevant to poor health behaviors, which do not align with a healthy lifestyle. The tenets guiding Pender’s HPM are congruent with what the low SES low HL African American adult patient needs cognitively, relative to self-efficacy, agency, and motivation to increase their HL levels. Pender’s HPM theoretical propositions are thought-provoking and a comprehensive selection of Pender’s theoretical HPM concepts (see Khodaveisi et al., 2017; Pender, 2011). I must strive to understand the barriers unique to the low SES, low HL African American adults who struggle to navigate the healthcare system.

Pender’s HPM has four behavioral model components. The first model component, “characteristics and experiences” (Pender, 2011, p. 4), aligns with the research question, and the first model component of Pender’s HPM appreciates health behaviors influenced by experiences. Hence, these experiences shaped and determined the behaviors of this study’s low SES low HL African American adults.

## Literature Review Related to Key Variables and/or Concepts

### Low Health Literacy in the United States Economy

There is an inverse relationship between low HL, utilization, and expenditure relative to healthcare in the United States. Roter et al. (1998) conducted a study that showed their findings align with recent literature attesting to the low HL among low SES ethnic minorities attributed to higher healthcare costs. Healthcare service use is at higher rates among low SES, low HL African American adults, and these increased rates predict higher healthcare expenditures for the U.S. economy. The Minnesota Health Literacy Partnership (2017) found that low HL healthcare costs are 40% higher than individuals with adequate or proficient HL. When HL levels increased, the savings in healthcare costs provided the United States with an economic income source that could provide coverage for millions of uninsured Americans (Vernon et al., 2007). Rasu et al. (2015) agreed with Vernon et al. (2007), who have shown low SES and low HL as precursors to the excessive spending incurred in providing healthcare to individuals with low SES and low HL. Agarwal et al. (2015) supported the findings of Rasu et al. and Vernon et al. that low HL had created an extreme financial burden on the U.S. economy.

Concern about the increased healthcare expenditure and its relationship to low HL has been consistent throughout the literature. Therefore, identifying risk factors that perpetuate low HL could mitigate the rising healthcare costs associated with low HL, thereby decreasing the financial healthcare burdens to the U.S. economy. Understanding behavioral health risks associated with low HL allows clarity concerning the increased financial obligations to the U.S. economy perpetuated by low HL, a significant factor healthcare providers must address (see Agarwal et al., 2015; Rasu et al., 2015). Agarwal et al. (2015), Rasu et al. (2015), and Vernon et al. (2007) identified three key factors that may be responsible for low HL, and they included advanced age, low SES, and being African American.

According to Agarwal et al. (2015), the financial impact of low HL on the U.S. economy might be mutable. A large portion of this economic burden to the U.S. economy stems from inappropriate emergency department visits. When healthcare providers communicated with low HL patients and explained which health behaviors were positive, this led to positive, cost-effective health outcomes. Researchers found patients with low HL often substitute a physician's visit for an emergency room visit at the behest of physicians who become frustrated with their inability to communicate instructions clearly over the telephone to patients with low HL. Therefore, inappropriate healthcare services and unnecessary medical costs are the outcomes. Healthcare providers were encouraged to adopt behaviors consistent with health promotion models that supported a holistic approach or addressed those risk factors that may place their patients at a disadvantage if they fit into a specific demographic group. For example, the African American adult has endured decades of health inequities and disparities that could place this group at high risk for low HL, adverse health outcomes, and poor health behaviors (Howard et al., 2017; Noonan et al., 2016). These negative health-related factors contributed to avoidable increased healthcare costs to the U.S. economy (see Howard et al., 2017).

Mitigating low HL among the African American adult population alone may save the U.S. economy enough to finance positive health initiatives and increase HL levels among underserved, marginalized African American adults (see Vernon et al., 2007; Agarwal et al., 2015). Low HL's substantial financial impact on the U.S. economy totaled billions annually (Vernon et al., 2007). Low HL increased healthcare costs significantly in the United States and has allowed for approximate financial healthcare costs ranging between $106 to $238 billion annually in healthcare expenditures. This unnecessary expenditure results from poor health outcomes induced by low HL (Agarwal et al., 2015).

Medicare and Medicaid satisfied many of the costs incurred due to low HL (Agarwal et al., 2015). Researchers suggested three health behaviors are incongruent with responsible self-health and are determinants of low HL. These include improper prescription use, ill-chosen visits to the physician’s office, and inappropriate emergency room visits, contributing to increased annual healthcare costs (Rasu et al., 2015).

Low HL lends itself to an increase in illnesses, acute and chronic. That necessitates increased prescription use and frequent visits to the doctor’s office and the emergency room. The inappropriate use of healthcare services has increased the costs of prescription medications, doctors’ office visits, and emergency room visits (Rasu et al., 2015). Rasu et al. found studies have shown that low SES low HL African American adult patients' inappropriate dependence on prescription medications as a panacea for health lends itself to incorrect prescription use, serving as a replacement for preventative health care.

Preventative healthcare behaviors mitigate the potential for poor health outcomes and decrease the cost associated with the increased use of prescription medications. The inconsistent use and reliance on prescription medications to provide positive health outcomes are counterproductive. Health behaviors predicated on health prevention relative to health screenings and annual medical check-ups alleviated an inappropriate dependence on prescription medications (Rasu et al., 2015). Positive health maintenance behaviors decreased the need for prescribed medications and excessive improper use of healthcare facilities or services, reducing healthcare costs to the U.S. economy. Physician and emergency room visits contributed substantially to increased healthcare costs in the U.S. economy. Low SES, low HL African Americans increased dependence on the emergency room, and unnecessary physician office visits are reflections of their inability to make responsible healthcare choices and decisions (see Rasu et al., 2015).

Lack of self-efficacy and agency, which inform irresponsible healthcare choices and decisions stemming from low HL, is seen predominantly among SES-deprived African American adults and has contributed to the high healthcare costs to the U.S. economy. Studies by Agarwal et al. (2015), Rasu et al. (2015), and Vernon et al. (2007) have shown that low SES, advanced age, unemployment, and being a member of an ethnic minority are associated with reported rates of increased inappropriate physician and emergency room visits.

Rasu et al. (2015) and Vernon et al. (2007) agreed that the United States' economic burdens are lower when HL levels are higher. Therefore, interventions designed to improve low HL among African American adults should be seriously considered. Eliminating or considerably increasing low HL levels among African American adults of low SES will require educational, political, and social structural system reforms. The cost of systemic system reforms measured against the savings to the U.S. economy from an increase in HL may provide an incentive for system reforms, given the cost of low HL to the U.S. economy may far outweigh the costs of reforms to the educational political, and social structural system (Agarwal et al., 2015). Reforms concerning educational, political, and social structural systems must involve the equal distribution of all goods and services, consistent with a favorable QOL for all underserved minorities (HHS Action Plan, 2015; Vernon et al., 2007).

Agarwal et al. (2015) acknowledged that low HL is time-consuming, labor-intensive, and a contributing factor to the negative economic impact on the U.S. economy, perpetuated by healthcare behaviors unique to low SES low HL individuals. Low HL is an overarching construct that maintains the increased healthcare cost burden on the U.S. economy. Given low SES, African American adults have disproportionately higher rates of low HL (Ali et al., 2018). An intervention that sustains knowledge and has shown increased HL levels among this population will be worth the economic investment. Appreciating this population's cultural, contextual, and cognitive processes will support an intervention amiable to the low SES, low HL African American adult.

Low HL and health inequities have led to premature death, costing the U.S. economy 1.24 trillion dollars between 2003 and 2006 (HHS Action Plan, 2015).

## Health Literacy and Systemic Social Structured Racism

Health inequalities stemming from racial and social factors have affected African American adults across their life span, allowing for premature mortality and adverse chronic health outcomes. Low HL among low SES African American adults has a psychological component maintained by four hundred years of systemic social and structural racism, which allowed for disproportionate low HL. Muvuka et al. (2020) contended that this is an outcome of the unjustified treatment of African American adults by robust social structures that govern society. The World Health Organization (n.d.), as cited in Health and Human Services Action Plan to Reduce Racial and Ethnic Health Disparities (2015), has determined that social determinants relative to the environment, age, income, and race contribute to and are central determinates in an individual's health and well-being. Providing quality healthcare services to African American adults has been marred by inequality and disparities based on race, thereby preserving low HL (Baciu et al., 2017).

Muvuka et al. (2020) contend that discriminatory treatment of African American adults for over four hundred years has systematically limited their access to healthcare resources relative to self-health, obtaining health information, and understanding healthcare instructions. Baciu et al. (2017) and Noonan et al. (2016) argued that four hundred years of racial discrimination have negatively affected the cognitive processes that governed motivations concerning self-efficacy and agency, thereby lessening the incentive to increase low HL levels. Studies have shown limited educational opportunities, racism, mistrust of the healthcare system, and culturally insensitive healthcare providers have created barriers to African American adults navigating the healthcare system, further influencing low HL among African American adults. Systemic social and structural racism concerning unequal access to education is a significant independent determinant of health, leading to low HL(Baciu et al., 2017). Noonan et al. (2016) have determined that the African American adult's history of disproportionately higher rates of low HL, poor health outcomes, and difficulty navigating the healthcare system reflects the years of structural racism and discrimination against this marginalized ethnic group. These factors have diminished cognitive motivation relative to positive health behavior. The transport of thousands of enslaved people could be considered the beginning of a blatant disregard for the health of African American adults.

Studies suggested that the reported physical and social conditions were deleterious to African American adults' health during slavery and for generations (Noonan et al., 2016). Noonan et al. (2016) determined that these behaviors have demonstrated that the health, well-being, and QOL of this ethnic group were not a priority of those who decided the social structures of the United States at the time. The physical, social, and mental abuse inflicted upon the African American's ancestors during slavery has negatively affected the African American adults today relative to their low HL levels and increased rates of adverse health behaviors and health outcomes. Noonan et al. (2016) noted that continued and consistent inequity in healthcare services does not encourage the cognitive processes that align with positive health behaviors. Health inequities and disparities are outcomes of low HL. Since the end of slavery, African Americans have been subjected to disproportionate maltreatment compared to White Americans and continued systematic discrimination concerning healthcare services.

To mitigate health inequities and disparities of African Americans perpetuated by low HL, healthcare professionals must first acknowledge that inequities and disparities exist. Baciu et al. (2017) and Noonan et al. (2016) agreed that implicit and explicit biases contribute to health inequities and disparities. However, Baciu et al. (2017) attributed adverse healthcare to healthcare provider bias and racism in healthcare provision to African American adults as inadvertent concerning the inequities in healthcare provided to African Americans. Most healthcare professionals do not realize they harbor racial biases, racist behaviors, and ideologies that drive inequities in providing healthcare to low SES African American adults, thus leading to health disparities, unfairness, and low HL. Correcting inequities and disparities concerning healthcare will depend upon changes made to social structures through equal opportunities relative to education, income equality, and housing. Healthcare professionals must communicate the importance of these changes to the healthcare governing bodies to diminish disproportionate low HL among African American adults (Kajanova & Rimnacova, 2019). Healthcare professionals may also benefit from an intervention that explains how racial biases are determined.

## Racial Biases and Healthcare

Bacui et al. (2017) noted that racism has penetrated the social fabric of American culture concerning all aspects fundamental to social well-being, from which healthcare has not been exempt. Racial bias is discrimination, with implicit and explicit biases expressed consciously, subconsciously, overtly, and inadvertently. Bacui et al. (2017) explained that biases might manifest as psychological/cognitive awareness-explicit or unawareness-implicit. Therefore, the healthcare service an African American adult patient receives from White healthcare professionals with prejudice may be systematically different and worse than White patients. In addition, researchers discovered that implicit racial biases might manifest unconsciously when healthcare professionals treat patients under minimal time constraints. Hence, African American adult patients may likely receive worse care (Bacui et al., 2017).

Implicit or explicit racial biases are detrimental to the patient’s healthcare and adversely affect health outcomes. Patients who receive healthcare in an environment mired in the racial prejudices of healthcare professionals are subject to ineffectual health outcomes (see Baciu et al., 2017). Baciu et al. (2017) suggested that the racial biases experienced by African American adult patients by White healthcare professionals stem from the healthcare professionals' preconceived negative beliefs about African American patients in general. Baciu et al. (2017) agreed with Noonan et al. (2016) and argued that racial biases cause health inequities and influence health disparities. The percentage of an illness’s effect on African American adults determines this population’s health disparities. Also, studies have shown racial biases lead to substandard healthcare, informed poor health outcomes, and maintained low HL levels among low SES African American adults. When an African American adult patient receives healthcare from a healthcare professional whose practice is negatively biased against African American patients, conscious or unconscious, the patient experiences negative cognitive processes (Noonan et al., 2016). Baciu et al. (2017), McBride and Kochly (2015), and Noonan et al. (2016) agreed that perceived discrimination of the low SES African American adult concerning healthcare informs low HL given this patient population may feel intimidated when communicating with healthcare providers if they believe they are racially biased. Stewart et al. (2015) concluded that these perceptions prevent African American adult patients from asking essential questions relevant to their healthcare. Asking questions is crucial to improving the low HL of African American adult patients. Not asking questions challenges communication between patients and healthcare providers, thus contributing to and maintaining low HL.

Inadequate healthcare exposure may create an ongoing physiological and stressful psychological environment. African American adult patients exposed to or experiencing substandard healthcare may have genetic responses that are biochemical processes that influence cognition, dictating negative health behaviors that could become permanent if denied the benefits of an intervention (McBride & Kochly, 2015; Noonan et al., 2016). Studies have shown the ongoing inequities among low SES and low HL African American adult patients partly stem from systemic structural racism leading to deleterious health outcomes (Howard et al., 2019). The continuous negative feedback associated with systemic structural racism's implication that African Americans' health is not a priority can genetically influence the cognitive processes that govern motivations relevant to self-health (Noonan et al., 2015). An individual's cognitive incentives are adversely affected by structural racism and unjust, unfair treatment, and their ability to cognitively process behaviors that demonstrate proficient HL levels diminishes (Howard et al., 2019). Cognitive processes are the key elements that guide behaviors and thoughts. Cognition determines HL, health behaviors, and benefits from an intervention to sustain elevated HL levels. Understanding that cognitive processes relative to health may have been negatively affected by continuous negative experiences in the past or the present when exploring an intervention to improve low SES African American adults' low HL level is essential to the success of an intervention.

## Epigenetics Influence on Health Behaviors

Epigenetics is an emerging field in studying this molecular mechanism's influence on phenotype plasticity via DNA relative to health behaviors (Gowland, 2015) and potentially influencing health outcomes. Researchers contend that the inheritance of poor health across generations may occur in response to stressors and harmful environmental factors that stimulate a chemical reaction, thus promoting an epigenetic process. Epigenetic processes are fundamentally genetic. The continued psychological, physiological, and adverse environmental factors allow this epigenetic process to occur (Howard et al., 2019). For example, the stress of structural racism lends itself to the psychological stressors of racism (Noonan et al., 2016) experienced by African American adults in society.

## Genetic-Epigenetic Processes Affect Health Literacy

Environmental factors influence epigenetic biochemical processes governing cognition concerning HL. Epigenetic processes respond to adverse environmental factors, transmitting poor health behaviors across generations (Howard et al., 2019). Hence, an epigenetic response from stressful environmental factors will be passed on to future generations. These epigenetic processes stem from adverse psychosocial and physiological experiences of stress-related environments, which inform negative health behaviors (Cunningham et al., 2017). Rikard et al. (2016) determined that African American adults' disproportionate higher rates of low HL resulted from this population's low SES (low education, low income, unemployment) compared to White Americans' higher levels of SES. When the researchers contrasted the African Americans with the same demographics as White American adults relative to SES (income, employment, education, age, gender), African Americans had lower HL scores. These findings aligned with the scientific studies of epigenetic processes related to health behaviors and outcomes influenced by adverse environmental factors.

McBride & Kochly et al. (2017) and Noonan et al. (2016) explained that the physiological chemical processes influenced by psychological factors swayed by the environment dictated health behaviors and outcomes. This chemical process is an epigenetic biochemical process that affects DNA's ability to control gene expressions relevant to health behaviors and inform health outcomes. The cognitive processes that stimulate motivations, which determine increases or decreases in HL levels, are regulated primarily by a chemical process, which influences health behaviors. Hence, McBride & Kochly (2017) suggested that harmful psychological, physiological, and environmental factors may genetically determine poor health outcomes among low SES and low HL African American adults. Genes expressed epigenetically can be passed to subsequent generations. McBride & Kochly (2017) suggested that adverse health outcomes among low SES low HL African American adults were an epigenetic response that affected their cognitive motivation relative to HL, health behavior, and health outcomes. Therefore, low HL could likely manifest as years of structural racism that may have damaged DNA's gene expression. Damage to DNA expressions allows epigenetic processes that inform negative health behaviors, hindering positive cognitive health motivations and thus perpetuating low HL and poor health outcomes.

Noonan et al. (2016) stated that the psychological and pathological effects of stress experienced by African American adults who have undergone years of structural racism led to pathological and psychologically developed illnesses. The inability to cope with stressful psychological and physiological life events manifests as biochemical epigenetically processed negative health behavior.

McBride & Kochly (2017) concluded that adverse health behaviors influenced by biochemical processes are DNA gene expressions determined by negative environmental, psychological, and psychological factors. Genetics are inherited pre-determined physiological and psychological factors present at birth. Epigenetic chemical processes respond to adverse psychological, physiological, and environmental factors that affect behaviors and are mutable thought processes. However, the genetic DNA gene expressions present at birth are immutable.

Bacui et al. (2017), McBride and Kochly (2017), and Noonan et al. (2016) agreed and concluded that factors informing many negative health behaviors influenced by low HL might be outcomes of epigenetic processes. Therefore, the disproportionately high rates of adverse health behaviors among African American adults might be due to epigenetic processes stemming from chemical interactions that inform DNA gene expressions. These chemical processes lead to negative psychological and physiological input influenced by the hostile environment the African American adult has been exposed to continuously over generations. These adverse environmental factors affect cognitive processes that allow for habits incongruent with positive health behaviors.

McBride & Kochly (2017) determined that after continuous damaging environmental exposures, the epigenetic chemical process prompted chemical processes and impacted health—constant negative environmental factors influenced epigenetically processed gene expressions. Hence, external (environmental) factors that chemically alter gene expressions for poor health behaviors are epigenetic chemical responses fostering low HL. However, health-promoting interventions can alter negative health behaviors. Therefore, these epigenetic chemical processes vary gene expressions and are modifiable when interventions change individuals' negative health behaviors.

McBride and Kochly (2017 stated that epigenetics are processed chemical gene expressions, which are environmentally induced outcomes of negative social structures and years of psychological or physiological stress that transmit damaged DNA instructions. However, interventions adapted to a positive cognitive-related pathway may provide positive, sustainable motivations toward self-efficacy and agency, allowing for positive health behaviors, health outcomes, and improved HL.

Understanding the genetic elements (epigenetic processes) that chemically influence cognitive changes based on environmental factors may provide additional understanding of ongoing low HL among low SES African American adults (see

McBride & Kochly, 2017). As previously mentioned, inequities, disparities, and poor health in low SES African American adults are higher than in all other groups (Ali et al., 2018). Genetic factors may provide an additional element to consider when understanding this phenomenon. Conceivably, epigenetics may explain the African American adult's difficult experiences and challenges concerning maintaining adequate HL levels, health behaviors, and health outcomes (Noonan et al., 2016).

The negative environmental factor of low SES compounds the African American adults' predisposition to disproportionate levels of low HL, further perpetuating inequitable healthcare and higher healthcare disparities. Howard et al. (2019), McBride and Kochly (2017), and Noonan et al. (2016) have shown data provided additional assurance that low HL among African American adults may be from the past as well as present ongoing negative environmental factors. Weitzman (2012) stated that healthcare professionals must consider environmental factors the patient may perceive as challenging or barriers when navigating the healthcare system. Interventions designed to increase low HL must consider the influence of unique contextual circumstances or situations on health behaviors. For example, an older African American patient may harbor mistrust toward healthcare providers due to past inequities. This lack of trust can compromise communication between the patient and the healthcare provider, adversely impacting HL.

## Environmental Epigenetics

McBride and Kochly (2017) explained that adverse environmental factors stimulated physiological chemical processes that inform epigenetic processes, affecting

DNA transcriptions that govern health behaviors. Therefore, future interventions geared toward integrating theoretical innovations focusing on a supportive environment may promote positive epigenetic processes, thus promoting positive, sustainable healthcare behaviors, positive health outcomes, and increased HL levels. Hence, aligning interventions with the theoretical framework translates into positive cognitive motivation.

An epigenetic chemical process can restrict DNA transcription and prevent expression [methylation], thus turning off gene expression. When DNA transcription is turned on [demethylation], this is equivalent to reading the expression. Hence, the epigenetic processes are akin to turning on gene expressions after exposure to adverse environmental factors (McBride & Kochly, 2017). McBride and Kochly (2017) found that the negative sway on health from an environmental factor affecting gene expression can be modified. The epigenetic processes that dictate undesirable health behaviors result from a methyl chemical compound governing gene expression unique to health. Researchers have shown that this compound is in an individual’s saliva (Langie et al., 2017). Muller et al. (2017) explained that experiencing ongoing trauma, coupled with the negative psychological and physiological factors associated with low SES, could potentially affect and change biological processes that determine health behaviors, beginning at the molecular level, hence, an epigenetic process.

Epigenetically influenced low HL is associated with adverse environmental factors perpetuating low HL, damaging health behaviors, and influencing poor health outcomes. The effects of epigenetic processes relative to health are transgenerational. Muller et al. (2017) argued that marginalized groups, low SES groups, and individuals who have experienced trauma during their formative years are predisposed to epigenetic process changes informed by negative external environmental factors. Therefore, when an individual's psychological development is compromised, they may experience poor health outcomes, demonstrate poor health behavior, and have low HL that is epigenetically determined. Consequently, the disadvantages experienced by African American adults relative to an unjust social structure and systemic racism lead to low HL, contributing to health inequities, poor health, and illness via an epigenetic process. Cavalli and Heard (2019) and McBride and Kochly (2017) concurred with Muller et al. (2017) that epigenetic changes had a lasting inheritance effect. Each succeeding generation could inherit the chemical process that induces an epigenetic process relative to health behaviors in a progeny. However, researchers have determined that epigenetic chemical processes were more amiable to reversal than DNA mutations. Epigenetic responses allowed a targeted approach to moderating negative health issues and improving HL.

According to Howard et al. (2017) and Noonan et al. (2016), the daily damages caused by structural social racism are harmful environmental exposures determined by exclusion, prejudice, and discrimination, manifested as health inequities and disparities. The detrimental effects of structural racism on health diminished positive health behaviors through an epigenetic process that thwarts the genetic systems that inform positive HL, health outcomes, and health behaviors. African American adults have experienced less priority associated with their health for four hundred years due to continued structural racism. A psychological withdrawal from positive health concepts and constructs leads to adverse health outcomes. An epigenetic process diminishes positive concepts and constructs in a hostile psychological or physiological environment. The complexities associated with epigenetic processes related to health, health outcomes, and HL are profound. Langie et al. (2017) suggested that researchers should concentrate on the chemical compound methyl when focusing on genetic and epigenetic processes relative to health. Methyl is the best-understood chemical process associated with epigenetics and its relationship to health. A low level of methyl may indicate epigenetically informed negative health behaviors, health outcomes, and low HL.

## Low Socioeconomic Status and Low Health Literacy

The ongoing disproportionate rates of low HL among African American adults captured the interest of the healthcare community during the late 1990s. Researchers began to seek explanations for the factors contributing to this ongoing phenomenon. Roter et al. (1998) explained that researchers had frequently found low HL among low SES African American adults. The differences in social factors, such as low SES, leading to a lack of access to healthcare and low HL, existed along ethnic and racial lines. HHS Action Plan (2015) study was in line with prior studies noting that African American adults of low SES have disproportionately higher rates of low HL across all illnesses. Low HL predicated on low SES leads to poor health outcomes among low SES patient populations. Studies have shown that low SES African American adults have disproportionately lower HL rates than all other ethnic groups (Ali et al., 2018; HHS Action Plan, 2015; Noonan et al., 2016; Roter et al., 1998).

Data have shown the healthcare received by African American adults is poor compared to White Americans. Thus, governmental agencies determining policies germane to equitable healthcare launched an investigation of these data reports. The AHRQ action plan, cited in the HHS Action Plan (2015), found that African American adults received poorer healthcare than White Americans, relative to all aspects determining quality healthcare treatment, including preventative screening information and acute or chronic illness treatment. Roter et al. (1998) acknowledged that low HL caused poor health and increased hospitalizations for this patient population. In a similar report from a study conducted by HHS Action Plan (2015), African American adults experience preventable hospitalizations at rates double those of White Americans. Inequity relative to the provision of healthcare services and information regarding the necessity for medical-related screenings, for instance, colorectal rectal cancer screenings, have been attributed to inadequate communication between low SES low HL African American adult patients and healthcare providers, a common occurrence across the health spectrum (Cole et al., 2017).

Cole et al. (2017) argued that when quality communication between healthcare providers and African American adults occurs, a thorough assessment of the patients' health knowledge occurs, thus allowing for enhanced awareness of a patient's HL level. Roter et al. (1998) noted that healthcare providers experienced inadequacy when recognizing patients with low HL. Therefore, a dialogue with patients discussing and explaining treatment instead of a biomedical monologue is best.

The unmodifiable factor of belonging to an ethnic minority group, coupled with low SES (low income and low education), places African American adult patients at a substantially higher risk of receiving a lower standard of healthcare service. Cole et al. (2019), Curtis et al. (2012), and Noonan et al. (2016) discovered that African American adults with low SES low HL encounter barriers associated with inadequate healthcare services due to a lack of health insurance, discrimination in the provision of healthcare, and their lack of trust of their healthcare providers. This lack of confidence stems from past inequities in healthcare provision and years of structural racism. As previously mentioned, Muvuka et al. (2020) agreed that mistrust contributes to low HL and interferes with communication between the patient and the healthcare provider, which is critical to the patient's understanding of medical regimens. Health outcomes are improved among African American adult patients when their healthcare providers demonstrate respect for and a sense of their cultural experiences and the contextual factors unique to the African American adult population. Howard et al. (2019) contended that understanding African Americans' culture and the contextual factors individual to this group has led to positive health outcomes.

Low SES low HL African American adults experience a perpetual flux of nonproductive health behaviors fostered by their low HL that low SES has perpetuated. Mayberry et al. (2016) suggested the relationship between low SES and low HL informed adverse health outcomes regardless of the environment, either meso level (hospital, physician office, and healthcare clinic) or micro (at home with care given by family members). Careful consideration of the family member's ability to provide healthcare to their family member is essential. When family members are the caregivers for a family member with an acute or chronic illness, and the patient lacks health knowledge concerning adherence to their medical regimen, this negatively influences the caregiver. Allowing them to become frustrated with the patient's lack of healthcare knowledge, and the family member's caregivers may provide inadequate healthcare.

In the United States, individualistic healthcare is the common practice instead of the collective healthcare practice seen in other cultures. However, among African Americans, a form of joint healthcare can be appreciated, given it is common for elderly ill family members to be taken care of at home. Yet, regardless of the good intentions of the family member providing care, it may not always be optimal ( see Mayberry et al., 2016). Mayberry et al. (2016) noted that low SES African American adults are likely to depend on low SES adult children for their healthcare. The burdens that accompany this responsibility may manifest as obstructive and inadequate healthcare provision. This relationship could potentially become harmful when the family member's caregiver and an ill family member both are experiencing the challenges associated with low SES and low HL, which may lead to stress and depression, further exacerbating low HL and lack an understanding of the dynamics that influenced positive healthcare, which does not allow for an appreciation of positive, supportive healthcare behaviors that contributes to increased HL.

Jager et al. (2019) found that understanding the relationships between family caregivers and ill family members provided support, which leads to motivational aspects associated with positive health outcomes. Determining the extent to which family caregivers prove valuable to the patient’s future well-being and lead to positive health outcomes can be identified by assessing the responses of the patient and caregiver throughout care. When healthcare providers communicate with patients and family caregivers using an open-ended dialog, they demonstrate their support for family members and caregivers. Healthcare providers’ support of family caregivers and ill family members will promote an improved understanding of an illness, increase medication adherence, and motivate the caregiver and patient to follow the recommended health regimen.

Authors across studies researching illness and diseases determined collectively that low SES low HL ethnic minorities have disproportionately experienced higher health disparities. Researchers contend that African American adults face increased health inequities (Jager et al., 2019). Jager et al. (2019) agreed with the literature, which showed that low HL impacts low SES African American populations at higher rates than members of the White majority population in the United States, leading to increased health disparities among this underserved population. Thus, low SES and low HL African American adults are predisposed to poor health outcomes. Healthcare professionals must mitigate mutable factors’ adverse effects (negative health behaviors). The biases informed by immutable (race/ethnicity) factors are unchangeable factors that may dictate adverse healthcare toward low SES low HL African American adult patients from healthcare professionals who harbor biases regarding ethnic minorities.

## Low SES

Poverty has negatively influenced the African American population for sixteen generations (four generations equal one hundred years), which has impacted HL. Low SES predicts poor health outcomes relative to physical and mental health. Kajanova and Rimnacova (2019) noted that individuals who reported low income lacked responsible healthcare behavior and demonstrated a cavalier approach to their health maintenance. Adherence to medical instructions was treated like an inconvenience and only followed after determining if the prescribed medications were affordable, and the doctor's advice and recommendations were credible.

Kajanova and Rimnacova (2019) concluded that low HL is higher among low-income African American adults than among most Americans. Health behaviors predicated on low HL allowed an approach to healthcare incongruent with responsible self-health. Low income, low HL African American adult patients with a casual attitude toward personal matters have shown a lack of interest in preventive health screens. These patients opt to forgo health screenings despite offering free preventive health screenings. Individuals living above the poverty level tend to comply more with their healthcare regimes, such as following instructions, taking medications as prescribed, and following physicians' advice. Howard et al. (2019) suggested that financially secure individuals have health insurance coverage for annual health screening. These individuals are financially able to purchase prescribed medications and can buy quality foods. Hence, Kajanova & Riminacova (2019) determined that higher incomes predicted positive health outcomes and low incomes lead to poor health outcomes. Low SES may lead to abusive health habits, such as smoking, excessive drinking of alcohol, illicit substance use or abuse, and frequent exposure to unhealthy environmental elements (secondhand smoke). Healthcare providers are responsible for communicating to the low SES African American adult patient the importance of following medical instructions and answering their questions about health matters they do not understand. It behooves the healthcare provider to create an atmosphere free of subjective or objective intimidation.

Williams and Mofya (2016) found that low-income perpetuated behaviors not aligned with positive health outcomes, and low-income individuals lack the motivation to exercise, predisposing them to obesity. Low-income African American adults regularly consume fast foods as their primary dietary intake. Hence, sedentary living and a core fast-food diet create obesity. Howard et al. (2019) determined that African American adults' higher risk for obesity relative to a fast-food diet and lack of exercise predisposed them to diabetes, hypertension, and heart disease. Thus, this cycle perpetuated poor health outcomes induced by negative health behaviors influenced by low HL, which low income enabled.

Many cities throughout the United States have underserved, marginalized individuals in neighborhoods identified as "food deserts" (Howard et al., 2019, p. 7). Carnethon et al**.** (2017) agreed with Howard et al. (2019) and Williams and Mofya (2016) that a lack of assessable quality food resources in a community populated with low income African American adults determines poor health outcomes and an increased rate of health disparities. These disparities include diabetes, obesity, and atherosclerotic cardiovascular disease. Researchers determined that low SES and low HL allowed health disparities to continue (Howard et al., 2019).

Income determines the extent of an individual’s access to quality healthcare, education, and decent housing in a healthy community. Carnethon et al. (2017) noted that SES factors are critical to good health, positive health outcomes, and determining proficient or adequate HL. Insufficient income significantly impacts the HL of African American adults. Hence, low HL affords this population poor health outcomes attributed to low income.

Berry (2020) stated that the coronavirus outbreak in 2020 has caused new concerns among advocates for equitable healthcare. Low-income African American adults are vulnerable and marginalized, placing them at higher risk for contracting this disease. In addition, low-income African American adults are harbingers of illnesses that make them vulnerable to opportunistic infections.

The lack of wealth accumulation has caused low income among African Americans, thus affecting healthcare quality, increasing the burden of illness, and contributing to the highest low-income rates for all ethnic minorities (Han et al., 2019). Han et al. (2019) have agreed that addressing the negative aspects of a low-income relationship to acute or chronic illnesses in this population must also be approached from a historical, cultural, and contextual standpoint.

Sayah et al. (2015) and Stewart et al. (2015) noted low SES low HL worsens chronic illnesses because low SES low HL African American adults tend to avoid reading healthcare information/instructions. Therefore, they lack a basic understanding of healthcare information/instruction and are embarrassed by poor reading comprehension and numeracy skills. Consequently, this marginalized population does not seek help, further diminishing their health status given their poor understanding of healthcare information and refusal to admit difficulties with HL to healthcare providers and supporters.

Han et al. (2019) and Sayah et al. (2015) agreed that sensitivity to the needs of low income African American adults is when attention to contextual, cultural, and historical aspects unique to this population is included in the communication between the healthcare provider and the African American adult patient and included in the intervention design. This approach enhanced the sustainability of knowledge gained from an educational intervention. Additionally, when an in-depth evaluation of needs has been considered, including contextual, cultural, and historical factors informing an intervention design, inequities and disparities concerning healthcare are minimized.

According to Sayah et al. (2015), the disproportionate burden of chronic illnesses among African American adults results from low income and its perpetuation of low HL. Sayah et al. (2015) agreed with the resources included in this study that a higher proportion of African American adults of low income (incomes below the federal poverty level) experienced low HL with rates exceeding those of all other ethnic groups. It is common to discover low HL among low income African American adults. Therefore, it is unsurprising that mortality rates are higher among this population than among White Americans when correlated with low income and mortality (Noonan et al., 2016).

Howard et al. (2019) contended, and Norton et al. (2016) suggested that low income predisposes African American adults to increased levels of inadequate health and mortality rates compared to White Americans. Low SES low HL African American adults face ongoing challenges associated with the absence of health insurance, poor housing, and a shortage of quality supermarkets that provide high-quality food products. Supermarkets in low SES predominantly African American communities are scarce. Hence, there is the potential for poor dietary habits because fast foods are the primary food source in these communities. The insufficient availability of foods with nutritional value further exposes this vulnerable population to poor health (Norton et al., 2016).

Norton et al. (2016) suggested that low HL may not be as challenging a barrier to healthcare for African American adults as low income. Low health literate African American adults with sufficient health insurance and an income above federal poverty levels tend to receive more equitable healthcare relative to all aspects that determine health equity. Curtis et al. (2012) agreed that low HL was much easier to address using evidence-based interventions than meeting the challenges of an inadequate income. Low income is one of the primary determinants of poor health, and poverty predicts a lack of basic human needs, such as clean water, proper nutrition, adequate healthcare, sufficient clothing, and healthy environments. African American adults are the poorest ethnic group in the United States. The median income of African American adults has been the lowest of all ethnic groups for five decades (Noonan et al., 2016).

Noonan et al. (2016) found that low income correlates with adverse health behaviors, health outcomes, and increased morbidity and mortality, which informs low

HL. The African American adult's burden of chronic illnesses such as diabetes, heart disease, depression, and hypertension exceeds those of other ethnic groups. Low-income African American adults' mental health is fragile, given poverty exposes them to disproportionately high levels of racism and discrimination, thus further impacting their mental state affected by low income.

Howard et al. (2019) suggested there are racist and discriminatory behaviors among healthcare providers when prescribing pain medications. Studies have shown that healthcare providers prescribe less pain medication for African American adults than White Americans with the same disease symptoms. Howard et al. (2019) found that prescribing insufficient pain medication to ethnic minorities was perpetuated by the low HL of this marginalized group.

Howard et al. (2019) suggested encouraging the healthcare community to promote culturally competent healthcare professionals' initiatives. Experiencing_healthcare provided by diverse, culturally competent practitioners promotes an interactive approach, mitigating many negative aspects of low HL among African American adult patients.

Howard et al. (2019) stated that low income does not encourage cognitive, motivational processes that moderate low HL. Low income begets low education and no health insurance. Hence, low income does not contribute positively to factors governing proficient HL or adequate healthcare. The congruency of low income and low education informed low HL and negatively impacted healthcare behaviors related to reading comprehension and numeracy. These skills are pertinent to positive health outcomes and behaviors and are the established beliefs in the healthcare community as to what constitutes proficient HL.

## Low HL

Low HL is a modifiable construct that could benefit from an intervention that appreciates cultural, contextual, and historical factors unique to the African American adult. Brittain et al. (2016) noted that low HL has an adverse effect on many illnesses. African American adults are disproportionately affected by low HL at rates higher than all ethnic groups and across all diseases. Sustainable interventions will promote improved health behaviors and allow for positive health outcomes.

Brittain et al. (2016) posit that researchers must consider the theoretical framework to achieve favorable health outcomes. A combination of Pender's theoretical propositions addressed the barriers and challenges that plagued the African American adult concerning low HL. Lack of trust in healthcare providers and low SES are components that I found to contribute significantly to existing low HL among the African American adult population. Researchers established low HL perpetuated by any construct was higher among African American adults. Therefore, a comprehensive assessment of the most successful interventions to improve low HL among African American adults and adding a theoretical framework may allow for a sustainable elevation in HL levels among the African American adult low SES population.

Health Literacy is foundational to understanding essential aspects of healthcare, health information, navigation of the health system, and health behaviors. Low HL is tantamount to insufficient knowledge of responsible health behaviors, including preventive health screenings and annual medical physician visits (Brittain et al., 2016). Low HL lends itself to poor health outcomes and inadequate healthcare behaviors. Written instructions place African American adults with low HL consistently at a disadvantage concerning understanding healthcare instructions/information and navigating the healthcare system (Brittain et al., 2016).

Brittain et al. (2016) acknowledged that proficient HL reduced health disparities and inequities among African American adults. Proficient HL allowed for self-advocacy and the promotion of positive self-health. The African American adult obtained adequate levels of HL using interventions based on theoretical frameworks that followed a step-by-step process, improving one aspect of low HL at a time. The healthcare provider must first meet the needs of the African American adult patient to elevate HL levels. What has been considered quality communication between the patient and the healthcare provider has revealed that African American adults with low HL may take their medications as prescribed but do not understand why they are taking a particular medicine. The side effects and how to take a medication, including with or without food, and not drive after taking a specific drug should be explained clearly by the healthcare provider to the low HL patient. Hence, the healthcare provider must make a concerted effort to communicate effectively, providing clear essential instructions to the low HL African American adult patient about their medication regimen. However, overwhelming patients with too much information at once to improve their HL could be counterproductive. Researchers have suggested low HL among African American adult patients will improve when the most relevant healthcare information is in the order of importance (Eneanya et al., 2018).

Comprehension of healthcare information is enhanced when the healthcare provider's communication exchanges are culturally, contextually considerate, and historically informed (see Brittan et al., 2016). Ali et al. (2018), Brittan et al. (2016), and Eneanya et al. (2018) found that the use of pictures, videos, and repeating instructions/information during subsequent medical visits increased the patient's comprehension of the healthcare information/instructions presented when healthcare providers communicated effectively with patients the health knowledge gained allowed for improved HL, health behaviors, and outcomes that were lasting.

Benes and Alperin (2019) found that more than 50% of African American adults were at basic or below required HL compared to 28% of White Americans at basic or below adequate HL levels. One of the dominant subjective barriers to HL among African American adults is mistrust (Ali et al.,2018; Brittain et al., 2016), negatively impacting communication between patients and healthcare providers. Increased gains in HL involve healthcare providers through productive communication.

Low HL among African American adults has a detrimental effect on crucial aspects of health over the life span. When health promotion is challenged by low HL, to the extent that health behavior is compromised, this will jeopardize overall health (McDaid, 2016). Han et al. (2019) suggested that African American adults with low HL lack the communication skills to inform healthcare providers of their most immediate healthcare needs. As a result, they do not understand the necessity of medical treatments recommended by their healthcare providers. When healthcare providers begin designing an educational intervention to increase low HL among African American adults' consideration of culture and context is vital. The cultural and contextual factors unique to African American adult patients affect their HL significantly. If healthcare providers do not consider these social determinants, the low SES low HL African American adult patient will not realize the benefits of interventions to improve their low HL. The healthcare provider must tailor successful interventions to enhance the HL of the African American adult, which should include aspects related to cultural, contextual, and historical needs.

Backonja et al. (2016), Han et al. (2019), and Pender (2011) proposed that for the low SES, low HL African American patient population, Pender's HPM interventions may capture the fundamental elements that are key to improved HL. Low HL is modifiable when interventions focus on protocols that discourage biases and are culturally sensitive (Pender, 2011). The stages of the change model led to a process that could improve HL when the patient has completed each step of the model. A culturally appropriate, unbiased approach to the African American adult's challenges with low HL can positively impact HL levels. Comprehensive interventions improving HL among African American adults may allay poor health outcomes and encourage positive healthcare behaviors.

Healthcare providers' social contextual patient-centered approach will improve HL among African American adults. Ayotte and Kressin (2010) agreed that when the social construct of positive social support from family, friends, or healthcare providers all have a role in an individual's healthcare, the benefits positively affect HL and improve health outcomes by promoting positive health behaviors. Social support from family and friends allows for an enhanced understanding of healthcare issues. Matters concerning healthcare brought forth during communication between the African American adult and the healthcare provider are less intimidating when family members or friends support the patient. The clarity brought to an illness or medical situation by a family member, or friends will decrease the likelihood of patient intimidation from healthcare providers. Literacy increases when social support is positive. The positive social environment encourages and promotes health screening (advertising by the local pharmacy, health initiative church programs), adherence to medication regimens, and family or friends accompanying patients to medical appointments.

Healthcare providers must develop the ability to identify patients with low HL in clinical settings, which may help mitigate poor health outcomes. Stewart et al. (2015) reported low HL as an independent predictor of poor health outcomes. Researchers contended that African American adults who self-reported their overall physical health as inferior had experienced high stress levels and manifested low HL relative to medication adherence, navigating the healthcare system, and understanding healthcare information/instructions. Using plain language and teach back methods are universal evidence-based interventions that immediately increase HL in real time.

The lack of studies on HL that includes the African American adult’s perceptions of their healthcare services has placed low HL African American adults, who could benefit from an intervention designed to address their unique healthcare needs, at a disadvantage. Weekes (2012) allowed that race was one of the determinant factors of low HL among African American adults. The paucity of studies reviewing HL levels among

African American adults has shown that proficient HL levels correlated with positive health behaviors and outcomes. When low HL African American adults understand their disease process and comprehend medical instructions/information, they enhance self-efficacy and mitigate potential health disparities.

Ineffective communication/interactions between healthcare providers and African American adult patients negatively impacted their understanding of healthcare information and informed poor health behaviors (Miller et al., 2018). Ali et al. (2018) and Miller et al. (2018) stated that this patient population might not understand crucial healthcare information, given their HL levels have been lower than all other ethnic groups across studies. According to Ali et al. (2018) and Miller et al. (2018), negative health-related factors translate into health disparities. Key factors relative to harmful health behaviors, which determine processes leading to health disparities, are avoided with effective communication, leading to positive health behaviors and outcomes.

Health literacy is multifactorial, and the components involved are needed to sustain increased levels of HL. Rosario et al. (2017) appreciated that three critical elements determined adequate HL: The first, for example, is functional HL, this pill will lower your high blood pressure. The second is critical HL, which renders the patient capable of and responsible for proper healthcare behaviors that promote wellness. For instance, diabetic patients monitor their blood glucose levels daily and make necessary dietary oral or insulin medication adjustments as instructed by their physician. Last, interactive HL is akin to patients benefiting from communication between them and their healthcare provider. The patient demonstrates health behaviors aligned with positive health outcomes, given the information/instructions shared are understood and followed by the patient. Effective communication between the patient and the healthcare provider will allow the patient to appreciate the benefits of health information/instruction.

An evolutionary process has occurred concerning HL. The initial focus in the dawn of studies engaged in understanding HL and how it relates to or affects health, health behaviors, and health outcomes and were primarily discussions of comprehension of healthcare instructions/information and numeracy (see Roter et al., 1999 and Kalichman et al., 1998). However, Miller et al. (2018) concluded HL has evolved to include health knowledge, allowing for the most beneficial use of healthcare services accessible to the patient. For example, recently insured individuals of low SES and low HL may find having health insurance for the first time challenging relative to understanding their coverage.

Improving HL requires an appreciation for interventions driven by education models with interventional techniques based on an individual's culture (see Pender, 2011). Rosario et al. (2017) have proposed that HL may not always require interventions or frameworks to establish a sustainable, adequate HL foundation. The social-cultural aspects of one's environment could likely shape the African American adult patient's HL levels. Sorensen and colleagues cited in Rosario et al. (2017) have based this on interpersonal, social, and environmental factors. However, HL is usually explained with its relevance to health outcomes as an overarching determinant. Rosario et al. (2017) have noted that the HL levels of the African American adult population, based on their research findings, determined that adequate HL levels result when the critical components for proficient HL are functional and interactive.

Health programs sponsored by churches have long been considered the gold standard of community health promotion initiatives by promoting positive health behaviors in low SES African American communities (see Pullins et al., 2018). Pullins et al. (2018) appreciated that the improvements in HL among African American adults, such as positive health behaviors and improved health outcomes, were realized through health-based church programs. A positive effect on HL and health promotion occurs when church leaders promote positive health initiatives. These initiatives have increased HL, awareness of preventive health screenings, and improved health behaviors. Conversely, when church leaders' health behaviors are inadequate, these behaviors have a negative impact when witnessed by church members. Therefore, health-based initiatives in African American churches have sought to improve HL among church leaders, which mitigated the health disparities that plague low SES, low HL African American adults in the community by stressing the importance of positive health behaviors of church leaders.

Church leaders must demonstrate responsible behaviors, such as regular physical activity and a healthy diet. Focusing on and participating in healthy behaviors increased HL and proficient HL levels and informed healthy behaviors. An inverse relationship exists between improved HL levels and health disparities (see Pullins et al., 2018).

Low SES low HL African American adults have benefitted from community health programs promoting health services, which minimize poor health outcomes from acute or chronic illnesses. Zonderman et al. (2014) and Pullins et al. (2018) shared similar views concerning community involvement in improving health disparities among low SES and low HL African American adults. Researchers noted that increased HL mitigates health disparities and improves the healthcare-related partnership between the healthcare provider and the African American patient. This collaboration enhanced the health and HL of the community. Building these partnerships is crucial for increasing low HL and diminishing health disparities among low SES African American adults. The development of ethnically and culturally sensitive health incentive programs focusing on diseases most prevalent among low SES low HL African American adult populations (obesity, depression, cardiovascular disease, hypertension, and diabetes mellites) will serve to increase this population's HL and thereby lower the disproportionate rates of morbidity, mortality, health disparities, and poor health outcomes. Low SES low HL African American adults who receive healthcare information from community healthcare church workers are likely to retain the information. Community healthcare church workers are culturally and contextually sensitive to the community's healthcare needs and are familiar with the contextual aspects of the community.

Zonderman et al.'s (2014) idea of community involvement with church groups aligns with Pullins et al. (2018), who contended that church leaders who are mindful of the benefits that positive health behaviors may provide could potentially persuade their church members to begin practicing positive health behaviors. This improved healthcare behavior includes following up with doctor appointments and seeking guidance from community health laypersons when they have trouble understanding issues related to their healthcare. Understanding healthcare issues explained by a community healthcare layperson or an interdisciplinary team member will increase the HL level.

Health literacy is understanding the amalgamation of health behaviors, skills, support systems, and cognitive motivations that determine responsible healthcare (Healthy People, 2020). Healthy People (2020) explained that adequate HL promoted responsible healthcare behaviors for individuals and their families. Healthy People agreed with previous studies in the literature that the complex demands of the healthcare system might prove challenging to patients with inadequate HL levels relative to navigating the healthcare system, reading comprehension, and numeracy.

Healthy People (2020) concluded that healthcare organizations focusing on prioritizing the health of their consumers have the task of implementing interventions that promote HL amiable to the patient population's culture and contextual environments, both psychologically and physiologically. Low HL negatively impacts the functional skills vital to positive health outcomes, reading comprehension, numeracy, and effective communication with healthcare providers. Wallace (2010) agreed that when these skills are inadequate, communication between the healthcare provider and the African American adult patient is insufficient. As a result, the healthcare professionals will not meet the patient's needs regarding everyday healthcare issues.

Poor or inadequate communication between patients and their healthcare providers leads to adverse health outcomes, frequently leading to hospitalization (Healthy People, 2020). McCleary-Jones et al. (2013) conducted a study that aligns with previous studies found in the literature that reflected on how increased rates of hospitalizations and infrequent use of preventative healthcare services have played a key role in adverse health outcomes and behaviors. Barriers to increasing HL levels are minimal when researchers use the qualitative method to understand the perspectives of the underserved African American population. Healthy People (2020) has shown that cultural beliefs may pose a barrier between patients and healthcare providers. The patient may find it challenging to follow healthcare instructions that are not in line with cultural beliefs or practices. For example, food choices are incompatible with a medically healthy diet (less or no salt for patients with high blood pressure, preparing more baked foods instead of fried foods).

Wallace (2010) and Healthy People (2020) have argued that HL functionality should lead to appropriate actions relative to self-healthcare. This action may involve following medication instructions, adhering to medication regimens, understanding the benefits of medication adherence, and keeping medical appointments, thus leading to positive health outcomes. The cognitive analytical process addresses HL's critical aspects. WHO, as cited in Wallace, 2010 has found psychosocial and emotional factors influence HL. Proficient HL are those functional, active, and critical skills relative to health, governing health outcomes during an acute illness or maintaining health for chronic disease. One of the constructs put forth by researchers stated that critical HL skills are essential to making an informed choice/decision relative to self-health. The crucial skills of HL are cognitively motivated health behaviors that can minimize exacerbations of chronic illnesses and mitigate acute diseases.

Noonan et al. (2016) offered that low HL is influenced by poverty, education, age, and race/ethnicity. However, studies have shown low SES African American adults have lower HL levels than low-SES White Americans living below the poverty level. Enhanced communication between the healthcare provider and patients may allow for culturally developed specific interventions in which the healthcare provider encourages the patient to explain their understanding of an illness. Williams (2017) described the importance of considering and understanding contextual factors, which serve as a structural foundation for the low SES low HL African American adult's environment. Structural factors are environmental aspects that guide an intervention's development, implementation, and optimization. Wallace (2010) argued that interventions must align with the patient's literacy level, and consideration must be shown for the cultural and contextual aspects. In addition, interventions to increase HL levels among African American adults must be multifactorial, given that more than one factor plays a role in low HL levels among African American adults.

African American Adults' high rates of low HL correlated with their high rates of health inequities. The literature has suggested that African American adults experienced discrimination when interacting with the healthcare system. Noonan et al. (2016) stated that inequalities reported throughout the literature relative to the African American's provision of healthcare services might stem from the healthcare provider's cognitive predisposition to implicit or explicit biases or conscious or unconscious discrimination when providing healthcare to the African American patient. Williams (2017) determined these biases allowed the healthcare experiences of the African American adult patient to become further complicated by low HL perpetuated by inadequate communication prejudiced by implicit or explicit biases.

Productive communication between the healthcare provider and the patient provides the healthcare provider with insight into the cultural and contextual factors that negatively contribute to health behaviors or barriers that predict adverse health outcomes among low SES and low HL African American adults (see Noonan et al., 2016). Noonan et al. (2016) stated that when healthcare providers consider cultural and contextual factors, the biases of the provider will translate into understanding by the healthcare professionals. This understanding indicates that the low SES low HL African American adult patient may be experiencing challenges contributing to low HL. For example, lack of social support, transportation to medical appointments, no insurance, and unemployment exaggerate low HL. Health insurance has the most significant impact on HL, more than all the previously mentioned factors explaining low SES impact on low HL. Wallace (2010) determined healthcare providers should consider implementing a multidisciplinary approach in the short term. Then, focus on sustaining interventions that may increase low HL levels, improve patient safety, and decrease health disparities, inequities, and healthcare costs in the long term.

## Low SES Low HL and Older African American Adults

Older African American adult patients have found navigating the healthcare system a vexing experience relative to understanding their healthcare regimens and medications (see Barzargan et al., 2017). Barzargan et al. (2017) have shown that older African American adults are disproportionately affected by comorbidities compared to older White Americans. These conditions require polypharmacy treatment (no less than five medications). Hence, lack of knowledge has placed older African American adults at a more significant disadvantage when understanding medication instructions/information. Melhado et al. (2011) explained that more senior (65 years and older) African American adults' adverse experiences navigating the healthcare system were not unique. Low SES impact on low HL also adversely affects younger (18 to 64) African American adults. However, Chesser et al. (2016) and Barzargan et al. (2017) elaborated that older African American adults with low SES and low HL may likely have the burden of cognitive decline. This cognitive decline among low SES, low HL older African American adults is immutable, challenging them to understand and navigate the healthcare system. Barzargan et al. (2017) explained low HL among older African American adults is analogous to a lack of knowledge regarding medication regimens.

Barzargan et al. (2017) were not as explicit in their study as Chesser et al. (2016), given Chesser et al. determined that older African American adults' difficulties navigating the healthcare system resulted from their cognitive decline and the impact of low SES, low HL, and being an older African American manifested as poor health outcomes and health disparity. Melhado et al. (2011) further explained that older African American adults with low SES and low HL are agreeable to healthcare providers who offer explanations concerning health, medications, and expected health outcomes in a culturally appropriate, respectful manner.

Older African American adults have based medical advice on how well the healthcare provider communicated health information. For instance, has the healthcare provider assessed the patient's understanding of medication instructions? Barzargan et al. (2017) and Melhado et al. (2011) have agreed that evaluating older African American adults' knowledge of medication issues is imperative. Many older African American adults have co-morbidities that require medication regimens consistent with polypharmacy treatment. Barzargan et al. (2017) and Mayo-Gamble et al. (2018) agreed with Melhado et al. (2011) explanation that cognitive decline of the older African American adult manifested as a lack of disease-related knowledge concerning understanding the purpose of medications for a given illness, and the side effects of prescribed medications with a polypharmacy medication regimen.

## Summary and Conclusions

### Summary

Studies have repeatedly found that low SES profoundly impacts low HL among African American adults. The social structural aspects that informed their HL are their environments, interactions with healthcare providers, peers, support systems, and SES. Low SES includes low income below federal poverty guidelines, low education, less than a 12th-grade education, inadequate housing, and poor communities (living in a food desert).

Poverty does not afford patients access to quality healthcare. Therefore, meeting the healthcare needs of many low SES African American adults is challenging. In addition, relative to an inability to acquire transportation to medical appointments, low SES African American adults are financially unable to purchase prescriptions and cannot afford health insurance. Thus, these factors present barriers to adequate HL. Therefore, poverty informs low HL, given poverty allows for health behaviors incompatible with self-efficacy and agency, further perpetuating poor health outcomes.

Continuously missing medical appointments for the above reasons is akin to low HL perpetuated by low SES. Poverty diminishes the motivations of African American adults to seek ways of engaging in responsible health behaviors. However, when low SES, low HL African American adults are cognitively motivated by critical HL, they may call their healthcare providers to explain their financial situations. Involvement of support systems (family and friends) for transportation to appointments and applying for medical assistance indicates that the low SES low HL African American adult patient is cognitively motivated to gather information and seek ways to access healthcare services. Critical HL skills may prove beneficial to low SES African American adults. Low SES African American adult patients who developed essential HL skills enhanced their communication with healthcare providers. Thus, the healthcare provider can explore the patient's availability of short-term options to provide immediate satisfaction with healthcare needs. The healthcare provider's concern is essential in promoting HL among underserved, marginalized individuals, and this form of communication might increase HL levels.

Genetic research has given the healthcare community a different perspective to explain the high rates of low HL among African American adults. Researchers suggested negative environmental factors have affected health behaviors, health outcomes, and HL relative to the physiological, psychological, and environmental factors that motivated negative cognitive health behaviors via DNA gene expression.

## Conclusions

Interventions needed to address low HL among low SES African American adults are apparent. Communication between healthcare providers and patients relative to what the patient deems vital to good health before an intervention is critical to successful health outcomes. The African American adult population has unique needs. Therefore, using the theoretical framework that has been proven successful and applying those tenets unique to the low SES low HL African American adults might provide healthcare professionals with sustainable interventions. Pender’s HPM of perceived barriers to healthcare could increase the low SES African American adults’ HL levels and provide an understanding of how to sustain positive health behaviors and increase HL in the future. When patients know what psychological factors dictated their negative health behaviors, they may be more amiable to behavior modifications, leading to higher HL levels.

Pender’s HPM is congruent with critical HL. Patients are cognitively motivated to seek methods or engage in health behaviors consistent with health promotion. Communication between a trusted healthcare professional and the African American adult patient using the behavior modification model from Pender’s HPM may provide a sustainable intervention. This model’s components center on the patient’s understanding of how crucial positive health behaviors are to overall well-being. This model is a step-by-step approach; the patient is not overwhelmed with too many changes. Intervention sustainability promotes behavioral health change one step at a time.

The basic qualitative research methodology will explore this population's perceived barriers and subjective experiences revealed during the interview-narrative format design, which will fill the knowledge gap relative to perceived barriers and influences concerning low HL. The interview narrative format is unique to a basic qualitative research methodology and, coupled with the theoretical framework of Pender's HPM, serves as a guide to Pender's HPM's interventions, which will be most beneficial to an improvement in the low HL of the African American adult perpetuated by low SES.

In Chapter 3, the basic qualitative research design will explore the subjective experiences that determined the literature gap relative to 10 low SES low HL African American adults concerning perceived barriers to healthcare when navigating the healthcare system. The basic qualitative research design's exploratory face-to-face interview approach and data analysis provided insight into how the methodological approach allowed for an understanding of the literature gap.

# Chapter 3: Research Method

In this basic qualitative research study, I aimed to understand and explore the subjective experiences and barriers to healthcare perceived by low SES African American adults who have consistently shown low HL. Potential barriers when seeking healthcare services may occur during an individual's healthcare trajectory (see Ali et al., 2018). However, individuals with proficient HL mitigate or can eliminate barriers when navigating the healthcare system (Ali et al., 2018). Barriers to healthcare are omnipresent. However, barriers to healthcare in individuals with low HL manifested as adverse health behaviors and outcomes (Ali et al., 2018). For the low SES African American adult, obstacles to healthcare have led to high rates of low HL among this population. Exploring the experiences of low SES African American adults navigating the healthcare system may explain why this ethnic minority has higher rates of low HL than all other groups in the United States (Ali et al., 2018).

I used a basic qualitative research design, which allowed for an exploratory approach to the experiences of the low SES, low HL African American adult when navigating the healthcare system. In this basic qualitative research study, I explored perceived barriers to healthcare as expressed by this ethnic group. The basic qualitative research methodology contributed to appreciating the experiences of low SES, low HL African American adults navigating the healthcare system. I reported the low SES African American adult's subjective and objective experiences and how they have perceived and interpreted these experiences (see Worthington, 2013), which are not amiable to statistical measurements. Using a quantitative statistical research design method would not have satisfied the qualitative research methodology’s subjective nuances articulated through data redundancy or saturation (see Lopez & Whitehead, 2012; Percy et al., 2015). Therefore, the participants in this study shared their experiences in an interview-narrative format. The basic qualitative interview-narrative design provides valuable subjective knowledge relative to understanding, experiences, interpretations, and context determined by settings or environments (Worthington, 2013). Thus, healthcare providers gained insight into the low SES African American adult worldview in a dialog exchange (see Wohlgemuth & Agosto, 2019). However, a quantitative research study defines objective, verifiable facts or numeracy congruent with a quantitative research study (see Creswell, 2018, pp. 166-174). Therefore, seeking the perceived subjective experiences low SES low HL African American adults may encounter when navigating the healthcare system will align with a basic qualitative research methodology (Percy et al., 2015; Worthington, 2013).

In this chapter, I review the critical aspects of this study. The design used was a semi structured interview question format, which captured the external experiences of the low SES, low HL African American adult navigating the healthcare system. This study’s basic qualitative research methodology fits with a subjective narrative format. Also, my role in the research process as an instrument was acknowledged using reflexivity, which mitigated the potential for researcher bias relative to the research process and data analysis.

I address the selection of the sample participants in the methodology section. I chose purposeful sampling for this qualitative research study because dissimilar sampling did not align with the problem, purpose, or research question. Using purposeful sampling allowed me to select participants who had experiences that allowed for the capture of rich information needed to answer the research question and explore the phenomenon of interest.

I used predetermined questions in the selection criteria that the participants self-reported concerning race, age, SES, and mental health history. The sample size is crucial in qualitative research (Lopez and White, 2012; Creswell, (2018); however, there was no predetermined sample size. Saturation determined the sample size, which manifests as redundant (Creswell, 2018). Therefore, reaching saturation or redundant data was essential in determining the sample size for this basic qualitative research study. Scope and topic also determine sample size. When the scope and topic are narrow, the sample size is smaller than a broad scope and topic, which requires a larger sample size (Determining Sample Size, 2000).

As the researcher, I developed an interviewing instrument, and the questions were reflective of peer-reviewed literature, which explored low HL among low SES African American adults. Unfortunately, a tool does not exist in the literature studying experiences and perceived barriers among low SES low HL African American adults.

Before the main study, there was a pilot study to ascertain if there were any confusing, offensive, or embarrassing questions. The pilot study established neutrality by eliminating researcher bias. A purposeful participant sample of low SES, low HL African American adults was selected to answer the research question developed from literature studies conducted between 1998 and 2021.

I collected data to answer the research question during the semi structured interviews of purposefully selected sample participants. Data collection lasted 30-60 minutes unless the participant's responses required additional time. One participant required extra time and continued with the interview after 60 minutes. I did not interrupt the participant, and the interview lasted 90 minutes. Once data saturation occurred, I conducted four more interviews, allowing for data saturation's confirmability. All participants received a financial incentive for their participation in the study.

As the researcher/interviewer, I recruited potential participants using flyers, face-to-face interactions, and assistance from family, friends, and community leaders who helped identify 12 individuals who met the inclusion criteria. I manually coded the data collected from the semi structured interviews. I used two forms of coding to determine subjective experiences. Theme development resulted from the culmination of parallel code development.

Trustworthiness overlaps four values germane to qualitative research: credibility, transferability, dependability, and confirmability (Connelly, 2016). These values determined the overall reliability of the study by establishing saturation, feedback relative to member checking, and researcher reflexivity. Additionally, probing questions led to rich, in-depth responses.

The ethical review occurred before data collection and after the institutional review board (IRB) Form A was completed. IRB Form A generated the documents concerning the guidelines for human subjects in qualitative research. The care and planning involving humans are crucial aspects of ethical research.

Qualitative research studies provide pathways to understanding phenomena that cannot be quantified but follow a scientific discipline (Worthington, 2013). This basic qualitative research study accomplished this goal by using this population's collective worldviews, experiences, and perspectives, and with the inclusion of Pender’s HPM, potentially establish and develop sustainable interventions relative to the improvement in the HL of low SES African American adults.

## Research Design and Rationale

The following research question was a guide for my study:

What is the experience of low SES African American adults who self-report low HL navigating the healthcare system?

I used a face-to-face, semi structured interview qualitative research design. A basic methodology explored this ongoing phenomenon of low HL among low SES African American adults, which allowed for an appreciation of context and development of themes, guiding the advancement of health-promoting interventions for this ethnic group. Face-to-face, semi structured interviews were assumed to be the best method. Remote interviews using Zoom were not amenable to this purposefully selected participant sample. Given their low SES, it was possible they could not afford the technology which allowed remote interviews. Therefore, I let each interviewee wear an N95 mask and maintain social distancing. Mask requirements and social distancing were addressed during the informed consent process, clarifying the strategies implemented to maintain safety during the pilot and main studies. Semi structured interviews and basic qualitative research methodology tenets captured the cultural context and worldviews.

They elucidated many of the low SES, low HL African American adults’ perceived barriers to healthcare.

Researchers began to study the ongoing phenomenon of low HL among low SES African American adult patients in 1998 using a qualitative methodology (Roter et al., 1998) and have continued to the present day. Yet, an imbalance between HL rates of low SES African American adult patients and the majority populations in the United States, which the literature has shown, remains. Hence, African American adults continued to experience the highest rates of low HL compared to other groups in the United States (Ali et al., 2018).

Using this basic qualitative design data collection method, I sought to gather information from sample participants about their worldviews and personal experiences concerning matters related to healthcare. The core of a basic qualitative research design is the external experiences of an individual instead of the internal psychological experiences germane to the phenomenology investigative approach (Percy et al., 2015; Worthington, 2013). I used the basic qualitative approach to explore subjective opinions, beliefs, and experiences (see Percy et al., 2015; Worthington, 2013) of the low SES and low HL African American adult patients navigating the healthcare system.

## Role of the Researcher

I mitigated biases using reflexivity, acknowledging my role in the research process. Reflexivity examines a researcher’s prior experiences, assumptions, and beliefs that impacted the research process (see Creswell & Creswell, 2018). Also, while allowing for participant flexibility, I remained cognizant of my biases by maintaining the focus of the interview on the perspectives of the participants in the form of bracketing, keeping an open mind concerning the views of the sample participant (see Barrett & Twycross, 2018; Crawford & Lynn, 2016). I avoided leading questions and non-verbal gestures, which could potentially have influenced the participant's responses (see Barrett & Twycross, 2018).

I addressed research bias using reflexivity before the interview during data collection and analysis. Ongoing reflexivity throughout the interviewing process lessens the potential for researcher/interviewer biased interpretations of the phenomenon of interest (Crawford & Lynn, 2016). The continuing reflection on my biases during each interview moderated the potential to compromise the data. I was mindful of how my role and preferences influenced data analysis (see Crawford & Lynn, 2016). Bracketing augmented my cognition relative to keeping an open mind during the interviews, data collection, and analytic processes (Tufford & Newman, 2010). Bracketing ensured that data analysis predominantly reflected the sample participant's perceptions and was crucial. Bracketing facilitates trustworthiness, validity, and reliability (Creswell, 2018). Bracketing created an additional safeguard against researcher/interviewer bias. Hence, reflexivity, memos, and bracketing during data collection and analysis helped me reveal any presuppositions I held and minimized their occurrences (see Crawford & Knight, 2012; Creswell, 2018). When conducting this basic qualitative study using face-to-face interviewing, I maintained reflexivity, a crucial aspect of qualitative research studies.

As a healthcare provider and an African American adult, I brought my experiences, knowledge, cultural understanding, assumptions, and biases to this study.

My 30 years of employment as a registered nurse for two large teaching hospitals in the United States, as a staff nurse, nursing director for a hospital-based skilled nursing facility, and a clinical nurse liaison, respectively, impacted how I related to the sample participants of this study. Given my years of employment as a healthcare provider, the biases I brought to the study demanded that I make a concerted effort to remain objective. Researcher objectivity significantly diminished my biases concerning interpreting the findings relative to the research question.

However, my sensitivity to the cultural aspects unique to the interviewee benefited the overall quality of this research (see Lopes & Whitehead, 2012; Stenfors & Bennett, 2020). Shared cultural factors with the interviewees enhanced my appreciation for the cultural nuances that determined certain healthcare behaviors and beliefs that influenced the health outcomes of the low SES low HL African American adult patient. Reflexivity remained an ongoing conscious process throughout the interviewing process, allowing for comprehension of established worldviews and experiences. I always remained mindful of the degree of contact between myself and the sample participants and how my background and experiences may have influenced data analysis (see Busetto et al., 2020).

I completed this study expecting the views, codes, and theme development to be exclusively those of the sample participants. Through reflection, I used a transformative approach, which allowed for an understanding of the need to raise the consciousness of governing societies to confront the oppression of marginalized groups concerning health inequities and disparities relative to their experiences with healthcare provision (see

Caswell & Caswell, 2018). As previously mentioned, reflexivity or memos during data collection (Mecca et al., 2015) disclosed my potential for a conflict of interest.

## Methodology

### Participant Selection Logic

Purposeful sampling was used, and the sample participants met the criteria aligned with the research question (see Lopez and Whitehead, 2012). The selected purposeful sample participants shared similar demographics. These participants' experiences provided the in-depth, rich information I sought (see Lopez & Whitehead, 2012). If the characteristics of this sample were dissimilar, the data collection results would not be in alignment with the purpose, problem, or research question. Purposeful sampling supported a basic qualitative research method seeking in-depth, rich, detailed information about a phenomenon.

The participation selection criteria I developed required potential participants to meet the following conditions:

- Self-identify as African American.
- Be 18 years old or older.
- Self-report an annual income below the federal poverty guideline
- Speak English as their first language.
- Not having a current diagnosis or documented history of mental illness nor receiving treatment for any condition that qualifies under the guidelines of a mental disorder.

Potential participants who meet these criteria were selected for my study. Researchers contended low SES African American adults are more susceptible to higher rates of low HL than all other ethnic groups in the United States (Ali et al., 2018; Wallace, 2012).

Studies have shown ongoing inequities and disparities in healthcare provision to low SES low HL African American adults (Wolgemuth & Agosto, 2019). Therefore, the basic qualitative research method was well suited to capture in-depth, rich information, explaining the low SES low HL African American adult's subjective experiences when interacting with healthcare providers and navigating the healthcare system. In addition, the basic qualitative research method allowed for the counternarratives of the low SES African American adults concerning experiences perpetuating their low HL.

The sample size is a crucial aspect of a qualitative research study. However, qualitative research studies do not attest to predetermined sample sizes (Lopez and Whitehead, 2012). The richness of data from in-depth interviews dictates sample size in qualitative research studies and is a decision made by the researcher/interviewer. Lopez and Whitehead (2012) agreed that a rich, detailed, in-depth exploration of the sample participants' experiences relative to the phenomenon of interest allowed for a smaller sample size. The traditional range for participants in a basic qualitative study is between eight and 12 or until saturation (Creswell & Creswell, 2018). However, this number is subject to change and may increase or decrease the number of participants. Qualitative researchers disagree with the number of participants required for a qualitative research study. Creswell and Creswell (2018) recommended three to five participants for case studies, 10 for phenomenological research, and 15 to 20 for grounded theory studies.

Morse (1995), as cited in Lopez and Whitehead (2012), suggested six participants for a phenomenological study and 30 to 50 participants for ethnographic research, however, I recruited 12 participants.

Scope and topic also determined sample size, and narrow scopes and topics aligned with smaller sample sizes. Broad scopes require more data collection, requiring a larger sample size (Determining Sample Size, 2000). Additionally, vague topics or data are congruent with larger sample sizes. Hence, the scope and subject of this study determined the sampling size. The scope of this study was narrow and explored a purposeful sample of low SES, low HL African American adults' experiences involving issues concerning healthcare. The topic is clear and evident, given clinical researchers began to study this phenomenon in the 1990s (Kalichman et al., 1999; Roter et al., 1998), seeking to understand what processes have allowed continuous low HL rates among the African American adult population. Eight to 12 participants created the small sample size appropriate for this study. The study's scope, topic, and purposeful sampling correlated with the small sample size used for this basic qualitative research study (Lopez & Whitehead, 2012). Purposeful sampling using a small sample size captured the in-depth expressions and rich details relevant to the healthcare experiences of this study's sample participants by thoroughly exploring the experiences associated with this phenomenon (Lopez & Whitehead, 2012). When the data of a study are rich in quality, useability increases, which justifies fewer participants needed to reach saturation (Determining Sample Size, 2000). I also determined this study's sampling size based on the research study's scope and topic. I asked all questions in a respectful, appropriate manner.

During the recruitment phase, I informed the participants that this research study was exploratory and that personal benefits from their participation would not occur. Therefore, I avoided any implication which led to the misconception that personal benefits would be an outcome of this study, which otherwise would not have happened had it not been for this study (UCLA Research Administration, 2021).

Ethical concerns were vital during the recruitment phase of participant sampling. Ethical considerations were determined and addressed by Walden University's IRB. This population was categorized according to the standards for vulnerable people because they were a low SES marginalized group. Walden University's IRB provided specific considerations for the sample participants of this study (UCLA Research Administration, 2021; Walden Transcripts, 2019).

After data collection, I gave each participant a debriefing statement discussing the study's goal (Microsoft Word-Debriefing, 2018). All the participants ascertained that I thoroughly addressed all aspects during the interview and had not overlooked or inappropriately presented data the participant determined as significant (Krogh et al., 2016). Once each participant had been interviewed and the debriefing completed, the findings provided insight into whether or not the need to modify the research question was warranted. Based on the participant's responses to the debriefing, the research question did not require modification to the research questions. Also, follow-up interviews to explore emerging questions concerning strengths or weaknesses relative to the research questions or interview questions will not be possible. This study only interviewed the participant once (McMahon & Winch, 2018).

In addition to the scope and topic, data saturation also determined the sample size for this study. The degree to which the emerging data became repetitive or redundant heralds data saturation (Lopez & Whitehead, 2012; Hennink et al., 2017; Sebele-Mpofu, 2020). The relationship between sample size and data saturation in this qualitative study was dependent upon the quality (richness) and the quantity (depth/thickness) of developing data (Fusch & Ness, 2015). Data saturation reflected an assumption I made regarding this study. Accepting data saturation with eight to twelve-participant interviews is an acceptable methodology for qualitative research studies where sample sizes as small as six have reached saturation (Hennink et al., 2017; Lopez & Whitehead, 2012). Small samples are good once repetitiveness and redundancy have emerged in quality, in-depth data (Hennink et al., 2017; Lopez & Whitehead, 2012Sebele-Mpofu, 2020). Researchers recommended interviewing two to three sample participants after saturation with small samples between six to twelve (Guest et al., 2006; Kuzel, 1992; & Morse, 2000, as cited in Sebele-Mpofu, 2020).

Choosing a small purposeful sample size of eight to twelve participants satisfied reliability relative to the parameters. A small homogeneous sample allowed me to gather in-depth, rich data and understand the phenomenon of interest (Guest et al., 2006; Kuzel, 1992; & Morse, 2000, as cited in Sebele-Mpofu, 2020). Since there are no definitive rules regarding sample size and saturation for qualitative studies, parameters guided this area (Hennink et al., 2017). These parameters were factors central to saturation. They included purpose, population, sampling strategy, data quality, and codes' repetitiveness and redundancy, which aligned with the research question. These parameters indicated that saturation is reliable using this sample size (Fusch & Ness, 2015; Hennink et al., 2017).

In addition, as stated previously, I used past researchers' qualitative study methodologies and conducted four additional interviews once saturation had occurred. Thus, with the redundancy or repetitiveness from other participant interviews, it was reasonable to assume data saturation (Lopes & Whitehead, 2012).

All the participants answered the same semi-structured interview questions, which informed data saturation with a small sample through methodological consistency (Fusch & Ness, 2017). The need for additional participants recruited using the community leader was not required. All the recruited participants were given a flyer with information about the study and a phone number to call for those interested in participating (Friedman et al., 2015).

## Instrumentation

A study exploring the experiences of low SES, low HL African American adults navigating the healthcare system did not exist. Therefore, I designed a data collection interviewing instrument (Appendix A). I used this interviewing instrument in an iterative data collection and analysis process concerning the phenomenon of interest. This instrument interpreted this phenomenon of interest as a subjectively expressed experience. (Crawford & Lynn, 2016; Busetto et al., 2020). A qualitative research study designed to explore the subjective experiences described as perceived barriers when navigating the healthcare system among African American adult patients required a data collection instrument that captured this population’s personal experiences when interacting with the healthcare system.

### Researcher-developed instrument

I produced an interview instrument that followed a semi structured, open-ended interview questioning protocol. The questions included in the data collection interview instrument were developed based on peer-reviewed literature articles (Ali et al., 2018; Anthony et al., 2007; Baciu et al., 2017; Backonja et al., 2016; Baskardoss, 2018; Bazargan et al., 2017; Brittain et al., 2016; Busetto et al., 2020; Chesser et al., 2017; Clouston et al., 2017; Cole et al., Curtis et al., 2012; Cunningham et al., 2017; Eneanya et al., 2018; Han et al., 2019; Jager et al., 2019; Kajanova, & Rimmnacova, 2019; Kalichman et al., 1999; Kobayashi, & Smith, 2016; Kumar et al., 2017; Kuter et al., 2006; Majlessi et al., 2019; Mayberry et al., 2016; Mayo-Gamble et al., 2018; Melhado, & Bushy, 2011; Pender, 2011; Rikard et al., 2016; Roter et al., 1998; Sayah et al., 2015; Short Test of Functional Health Literacy in Adults, n.d.; Speros, 2009; The National Academies Press, 2020; Trezona et al., 2018; Wallace, 2010; Weeks, 2012; Yen et al., 2017), which were the determinants that constituted the development of an appropriate interview instrument to answer the research question. An interviewing tool designed to capture the perceptions of this population concerning their healthcare experiences will lend itself to an enhanced exploration of the phenomenon of interest (Adosi, 2020; Cox, 2016). I produced an interviewing instrument that addressed the research question the tool was supposed to answer.

I conducted this qualitative research using an interview protocol that provided a clear perspective of the African American adult patient's subjective experiences. In addition, I developed an open-ended interview question instrument, which captured the participants' experiences based entirely on their points of view and produced an instrument that allowed for the development of questions and stimulated probing follow-up questions, thus gaining additional knowledge pertinent to the phenomenon of interest (Turner III, 2020).

The interviewing instrument and the questions I developed addressed determinant factors noted in the literature, which researchers and scientists suggested had perpetuated low HL (Keeley et al., 2013). In addition, Middleton (2020) argued that content validity would show a relationship between the interview question and the construct of low HL. The readers recognized the content validity of this study, given the thorough interview question guide's selection of items relevant to low HL (McBride & Kochly, 2017; Noonan et al., 2016). Bastos et al. (2014) argued that answering or explaining a research question during data analysis also determined content validity.

The phrasing of the interview questions captured any relevance SES, race, or genetics may have had on the ongoing phenomenon of low HL among African American adult patients (Keeley et al., 2013; Middleton, 2020). Questions relating to genetics delved into the patient's knowledge of their family's history of hereditary diseases or chronic illnesses involving maternal and paternal family members, for example, diabetes, cardiac disease, high blood pressure, or asthma. As previously stated, new developing science discovered hereditary factors that may affect an individual’s propensity toward low HL relative to those disease processes (McBride & Kochly, 2017).

Data saturation and factors that governed content validity determined data sufficiency, which is necessary to answer the research question (Stenfos et al., 2020). Consequently, the adequacy of the data collection interview instrument to answer the research question was met, given content validity items were congruent with the research question. The data collection instrument covered all aspects of the phenomena’s construct to answer the research question (Arroyo-Avila et al., 2020). The data collection process, the semi structured interview for data collection, and member-checking worked in tandem in this qualitative study, seeking an answer to the research question (Arroyo-Avila et al., 2020). The exploratory approach determined how this population perceived their experiences when interacting and navigating the healthcare system. Therefore, content validity and data saturation were essential and captured the experiences of the African American adults and answered the research question (Stenfors et al., 2020).

I used a data collection semi structured, face-to-face narrative interview format (Crawford & Lynn, 2016), which allowed the participants to describe their experiences navigating the healthcare system. I gained insight into the African American adult patients’ perspectives concerning their healthcare. The data collection design methodology for this qualitative research study elucidated this population’s experiences and made their experiences amenable to an exploratory research study design (Cox, 2016). I avoided the common error of writing confusing interview questions. The sample participants understood all the interview questions, and ambiguity did not occur. Hence, the sample participants did not become confused trying to understand what a question met. A pilot study eliminated discriminatory language (Chenail, 2011).

### Procedures for Pilot Study

A pilot study guided the developing research plan and clarified any unforeseen, confusing, or misunderstood interview questions. The pilot study provided preliminary information about how the interview instrument would perform during the main study (Cox, 2016; Ismail et al., 2018). The pilot study helped establish neutrality relative to the potential to influence participants' responses to interview questions (Chenail, 2011) by eliminating structurally biased interview questions. Solicitation for an answer to an interview question did not occur. The participants did not answer questions that led to responses that expressed agreement or disagreement (Cox, 2016).

The pilot study included two sample participants previously established as participants in the main research study. Janghorban et al. (2014), as cited in Ismail et al. (2018), argued that the advantage of using a small percentage of the participants for the pilot study would be beneficial, given this allowed to interact with the participants in a more relaxed manner during the main study. The pilot study was audio-recorded for 45 to 60 minutes (Ismail et al., 2018). I used the same interview/topic guide from the main study for the pilot study (Crawford & Lynn, 2016; Ismail et al., 2018; Malmqvist et al., 2019).

I conducted a pilot study before the main study to enrich trustworthiness, reliability, and validity. The pilot study did not identify inappropriate questions, enabling me to obtain quality data (Malmqvist et al., 2019; Ismail et al., 2018). During the pilot study, I remained cognizant of my researcher's role as an instrument, which allowed for an awareness of the potential for interviewer bias (Creswell & Creswell, 2018).

The pilot study provided crucial insights into aspects pertinent to the research question and determined the main study's credibility and dependability. The determination of the dependability and credibility of the main study was rooted in the insights that emerged from the pilot studies (Malmqvist et al., 2019). The interviewees for the pilot study understood their relationship to the main study. Their feedback about the instrument's methodology and interview techniques guided any decisions relative to making improvements, adjustments, or clarifications deemed needed for the main study (Malmqvist et al., 2019). The pilot study was well-planned and ensured high-quality research, which captured in-depth information to answer the research question (Malmqvist et al., 2019). I asked participants in the pilot study if they understood the interview questions and the ease with which they understood them. For example, I asked them if they felt comfortable answering the interview question immediately. Did they need to think about it because it was unclear, or did the participant find the question confusing? As previously mentioned, the responses from the participants would have allowed me to make the necessary adjustments to the interview instrument before the actual study began (Ismail et al., 2018). No adjustments were made to the main study after the completion of the pilot study.

I gathered information from participants using a face-to-face verbal interview design with questions from an interview guide prepared beforehand (Adosi, 2020). The interview question design distinguished my research from descriptive research, which describes a population phenomenon, or an observational study, which uses observations of individuals in their natural environments without researcher interaction (Cox, 2016). Nevertheless, I remained mindful of my dual role as an instrument when conducting this qualitative research study (Creswell & Creswell, 2018).

Before conducting interviews, I verified the details, ensuring the success of the discussions. For example, I confirmed the interview site, date, and time and assessed the audio recording equipment to guarantee high-quality voice tones (Crawford and Lynn, 2016).

### Procedures for Recruitment, Participation, and Data Collection

A purposeful participant sample of low SES African American adults answered questions generated by peer-reviewed literature research studies conducted between 1998 and 2021, which discussed how aspects of SES, ethnicity, and genetics might influence HL levels among African American adults (Keeley et al., 2013)

After approval from the Institutional Review Board (IRB) at Walden University, I began data collection. I used a topic/interview guide to ensure coverage of essential factors relative to the research question (Crawford & Lynn, 2016; Skea et al., 2017). However, before data collection began, I provided each participant recruited with a written explanation in a flyer describing the study. In addition, the participants receive a token financial incentive of $25.00 cash, addressed in the flyer, to show appreciation for their participation in the study. The cash incentive met the approval of Walden University’s IRB.

I gathered the data from interviews of purposefully selected sample participants who agreed to participate in the study and signed a consent form. I used direct data, consistent with the human-to-human exchange of dialog, recorded words, observable actions, or interactions of the sample participants during the face-to-face interview, as opposed to indirect data generated by someone other than the researcher or the participants (Sutton & Austin, 2018). As previously stated, I collected the data from each purposefully sampled participant who signed a consent form. I used a semi structured interview question face-to-face data collection design, audio recorded, and transcribed each interview verbatim before analysis (Barrett & Twycross, 2018; Sutton & Austin, 2015). Memos mitigated my biases and complemented the audio-recording data collection, given this allowed me to capture nuances during the interview, which concerned the environmental contexts and nonverbal cues. These memos were given the same secure priority as the face-to-face interviews and the audio recordings (Sutton & Austin, 2018). In the interest of time, I conducted face-to-face interview data collection sessions with each participant only once. Interviews lasted no longer than 60 minutes unless the sample participant provided additional rich, in-depth data, extending the discussion beyond the predetermined interview time.

I continued data collection from the participants until saturation in that information became repetitive and redundant. I relied on saturation to ensure quality, rigor, validity, and credibility (Sebele-Mpofu, 2020). When redundant, repetitive concepts emerged from the data, and no other codes, themes, insights, or information appeared, saturation occurred (Fusch & Ness, 2013; as cited in Sebele-Mpofu, 2020).

However, given the diverse explanations of qualitative researchers as to when saturation occurs, saturation was determined for this study once the participants had no new information to provide and their views were thoroughly known (Sebele-Mpofu, 2020).

This study sample used 10 participants, achieving saturation after six interviews, with final saturation after the eighth interview, given no new information emerged up to and including the eighth interview. I chose the face-to-face, semi structured interview design for data collection. It allowed me to ask questions that explicitly explored the phenomenon's critical aspects, which included the in-depth, rich data that resulted when participants expressed their personalities, perspectives, and experiences (Barrett & Twycross, 2018). I safeguarded participant data collection by obtaining approval from Walden's Ethnic Review Board and following their recommendations on protecting data collection of study participant interviews. All participants received information concerning how I safeguarded their data (Sutton & Austin, 2015).

I used recruitment tools, which included flyers, face-to-face interaction, and assistance from family members and friends, to help identify potential participants. However, if I had been unable to obtain a purposeful sample size of eight to twelve participants who met the inclusion criteria that led to data saturation, I would have considered using Rearchandme.com to recruit additional participants. Everyone recruited received a flyer explaining the study. During the recruitment process, I explained to all recruited participants that they might refuse, at any time, to continue the interview/study without fear of retribution (Namageyo-Funa., 2014; Rubin & Rubin., 2012; Webinar Transcripts, 2019). A token cash gift incentive of $25.00, the higher range of cash value

(Namageyo-Funa., 2014), was offered. I chose the higher degree of cash value to show the importance of the study, the level of appreciation, and the sample participant's value to the study. All 10 participants completed the interviewing/study process and signed a consent form.

I conducted face-to-face interviews with the study participants who had agreed to participate and met the inclusion criteria to answer the research question. Reflexivity during recruitment was a cognitive alert for me to avoid coercive or power-directed behaviors. Therefore, reflexivity (mental awareness) and bracketing (open-mindedness) for me were essential and allowed an appreciation of the potential to unknowingly demonstrate an influence on a participant's response to a study question. Additionally, bracketing mitigated an imbalance of power between the participant and the researcher, thus diminishing the participant's possibility of seeing the researcher in a dominant role (Creswell & Creswell, 2018).

Member checking assured accuracy relative to the participant's agreement with the interpretation of the data by the researcher/interviewer. Member checking lasted thirty minutes and took place before code development. I reviewed specific principal codes with participants and determined the findings' accuracy (see Creswell & Creswell, 2018).

Using the rich-thick descriptions of the findings made readers aware of the participants' experiences, which led to theme development. In addition, as previously mentioned, the bias I brought to the study was clarified by reflexivity, which is one of the core characteristics of qualitative research, determining validity.

I established the validity of this qualitative research by using reflexivity and bracking concerning background, life experiences, and how these findings affected the accuracy of data analysis. Reflexivity and bracketing established the accuracy of the conclusions and validity of this study (Creswell & Creswell, 2018).

The Purposeful sampling allowed for an appropriate selection of participants who met the inclusion criteria. I met with all recruited participants recommended by family, friends, and a community leader who had agreed to participate in the study. I maintained privacy for all participants in that all interviews took place in a private setting chosen by the participant, which would not allow others in an adjacent area to hear the interviewer and the interviewee (UCLA Research Administration, 2021). Purposeful sampling enabled me to capture the rich, thick, in-depth data sought during the interview to answer the research question. All participants were selected based on pre-selected criteria aligned with the research question (Lopez & Whitehead, 2012). I used a flyer and face-to-face interviews to recruit participants who met the inclusion criteria (Namageyo-Fuma et al., 2014).

Building trust involved meeting with the recruited participants and talking to them about the study based on the information presented in the flyer. I avoided misinterpreting the recruited participants’ feelings of being pressured (UCLA Research Administration, 2021). I introduced the consent form during the recruitment process. I explained and discussed the need for a consent form during the recruitment process, which mitigated the potential for overwhelming conceivable pressures that a participant might associate with signing the consent form.

The participant's HL and education level were considered during the face-to-face recruitment process, using careful word choices which did not intimidate the participants and provided participants with a clear understanding of the study's objectives. I discussed confidentiality with all the participants during the recruitment and the informed consent process. I discussed how the privacy methods de-identified them. I explained that de-identifying involves assigning them a number, and the only reference to their data would be an alphanumeric code. This alphanumeric code identification of sample participants protected their identity, which allowed their anonymity. Not assigning a name to the data did not minimize the impact of the data. The responses among all interviewees were consistent with their personal experiences from their perspectives (Rubin & Rubin, 2012; Namageyo-Fuma et al., 2014). I decided a priori to use vocabulary that did not exceed a sixth-grade level of education,

## Data Analysis Plan

The basic qualitative methodology using the face-to-face interview design acknowledged this sample population's experiences. Therefore, the basic qualitative data collection methodology was amiable to the research question, seeking information about the sample participants' experiences relative to the phenomenon of interest (Percy et al., 2015; Worthington, 2013). These experiences allowed for code development, culminating with themes, thus guiding the selection of interventions using Pender's theoretical framework. Codes and data are interdependent, providing an ongoing, insightful analysis (Mattimoe et al., 2021; Saldana, 2016), and I immersed myself in the analysis and data collection process, which allowed for precise coding and enhanced analysis of the data (Mattimoe et al., 2021).

Marginalized persons are relegated economically, socially, and politically to a second-class position due to discrimination (Law Insider, 2022). I focused on the perceived experiences of the marginalized African American adult patient when navigating the healthcare system. Manual coding of the data permitted accurate analysis of the data. Therefore, coding with the actual words, which in Vivo coding provided in-depth, rich information emerged and informed the study's trustworthiness (Saldana, 2016). As a novice researcher, I gained valuable knowledge, insight, and qualitative research skills by conducting this initial study using manual coding techniques. The literature stated that researchers have recommended Vivo Coding for small-scale research studies by novice researchers (Mattimoe et al., 2021).

The additional Value Coding method avoided limiting my perspectives concerning the theoretical framework (Saldana, 2016). Value Coding captured the experiences of the low SES, low HL African American adult patients when navigating the healthcare system based on their subjective beliefs. Value codes were appropriate for the basic qualitative study methodology. Value Coding provided insight into what guided motivation, agency, and low SES low HL African American patients' ideology relative to their perspectives when navigating the healthcare system. Value Coding explored the participants' culture, intrapersonal (healthcare system) and interpersonal (communication with healthcare providers) experiences, and values, thus enabling coding, categorization, and theme development (Saldana, 2016)

Once I determined which Values Code should apply to the participant's statement, it elucidated the expressions of the unique subjective experiences from the perspectives of the sample participants. In addition, using multiple coding methods enhanced the ability to recognize discrepant cases during the data collection. Finally, inquiries using various coding methods allowed new data-supported codes to emerge (Misiti, 2000; as cited in Houghton Mifflin Harcourt, 2021).

After data saturation, coding, categorization, and theme development, I determined discrepant cases in limitations relevant to this research study. Limitations of research studies allowed attention to the issues and events that future studies should address. The discrepancy addressed in this study provided additional insight into the phenomenon of interest positively.

## Issues of Trustworthiness

As noted, I am considered an instrument in this basic qualitative research study. For this reason, reflexivity determines trustworthiness (Chenail, 2011). Trustworthiness involves the overlapping values of credibility, transferability, dependability, and confirmability. Trustworthiness is analogous to "checks and balances" relative to determining the trustworthiness of a qualitative research study's findings. I established the first criterion, "credibility," as data saturation, member checks, and reflexivity. The redundancy of data collection information determined data saturation. Discussion of the data using member-checking with the sample participants to evaluate my interpretation of the participants' expressed perspectives concerning the phenomenon of interest helped to render my analysis accurate or inaccurate. Suppose the data analysis had been rejected as incorrect by the sample participant. I would have engaged in further discussions with the sample participants to elucidate all aspects of the analysis that did not reflect their perspectives, experiences, or views. However, I strived to avoid an inaccurate interpretation of the data by prolonged contact with the sample participants and used probing questions that allowed for rich, in-depth responses. Therefore, I established internal validity by including member-checking, data saturation, and prolonged contact (Amankwaa, 2016; Connelly, 2016; Nowell., 2017).

External validity, analogous to "transferability," was established when I applied the personal experiences of this study's participants to a different group. For example, low SES individuals and an ethnic group other than the African American adult patient could benefit from this study if the codes and themes from the same interview questions were similar. In addition, given rich, in-depth details of the study participants' experiences, navigating the healthcare system, and exchanging dialog during face-to-face interviews, the reader gained insight into the participants' experiences, which allowed transferability to other populations (Amankwaa, 2016).

This study's "dependability" is reflexivity. Reflexivity rendered reflections, which described unacknowledged emotions and values relevant to the phenomenon of interest (Amankwaa, 2016). A pilot study enhanced dependability and determined if any unforeseen areas of confusion or inappropriate language might cause the study participants to experience discomfort and confusion. Rectified interview question items resulting from the pilot study were not required before the main study was conducted.

“Confirmability” is another component of trustworthiness, built on the foundational constructs of analyzing raw data and reflexivity. I implemented member-checking with study participants to ascertain if an unrecognized instance of misinterpretation of a participant’s responses had occurred. My biases were mitigated, and an increased confirmability component of trustworthiness emerged. (Connelly, 2016; Amankwaa, 2016).

Before recruiting participants, conducting participant interviews, and collecting data, I initiated an ethical review process with Walden University’s Institutional Review Board (IRB). This ethical review process occurred after completing IRB’s Form A and generating the necessary documents from the IRB. These documents addressed Walden University’s IRB guidelines that aligned with data collection from human subjects for qualitative research (Research Ethics Review Process by IRB, n.d.).

In human research, the risk of something going wrong is significant. Therefore, the care and planning of research involving human subjects must be deliberate (Mandal et al., 2011). Unfortunately, human participants engaged in research during the early 1900s did not receive protection from established codes or standards concerning the ethical use of human subjects in research. Research involving human subjects before 1945 did not investigate the violations of humanity during research studies. The egregious violations of human subjects heralded the establishment of governing bodies globally, which promulgated ethical standards that determined guidelines for research using human subjects, which included The Nuremberg Code, 1946, The Declaration of Helsinki, 1964, with revisions in 1975, 1983, 1989, and 1996, and The Tuskegee Syphilis Study between 1932 to 1972 (Mandal et al., 2011).

The Tuskegee Syphilis Study led to the National Commission for Protecting Human Subjects of Biomedical and Behavioral Research formed in the United States. This commission was responsible for identifying the ethical principles determining research involving human subjects, biomedical or behavioral. These ethical principles led to drafting of an all-encompassing document guiding research ethics involving human subjects in the United States. The Belmont Report, published in 1979, summarized the ethical principles that guided research involving human subjects. There are three basic principles: Respect for Persons, informed consent, subject choice, what shall or shall not happen to them, information comprehension, and voluntariness. Beneficence, human subjects should not be harmed by research. The benefits must outweigh the risks. Justice, benefits, and risks have a fair distribution concerning the selection of human subjects (Mandal et al., 2011).

Walden University's IRB Form A document was submitted, addressed concerns, and sought ethical approval for this qualitative research study. Completing Form A allowed the IRB to guide ethical challenges relative to the final proposal. It also permitted the recruitment process to begin (Research Ethics Review Process by IRB, n.d.).

The recruitment of participants for this qualitative research study followed the requirements of the governing bodies that dictated the required ethics for human research. Informed consent is an ethical concern germane to all research studies involving humans.

This study followed the guidelines mandated by the ethics review process of Walden University's IRB. The Belmont Report's summation of fundamental ethical principles and guidelines informed this qualitative research study (Bayoumi & Hwang, 2002; Mandal et al., 2011).

I used the flyer to recruit potential participants for this study. I wrote the narrative of the flyer no higher than a sixth-grade level. All questions were asked and answered in a manner that did not allow the recruited individual to feel rushed or pressured into signing the consent form (Bayoumi & Hwang, 2002; Ladia et al., 2018. The consent form addressed potential risks to the participants, how I planned to protect participants' rights, and their right to withdraw from the study without consequences. The participants freely gave their informed consent. The information on the consent form was specific, informative, knowledgeable, and unambiguous. The comprehensive informed consent disclosed dependability and credibility, adding value to the research process (Celedonia et al., 2021). Compensation did not have an undue influence on this financially burdened population. The regulation guidelines relevant to this strategy followed Walden's IRB ethics review process (Celedonia et al., 2021; Ladia et al., 2018).

One ethical concern that could threaten the trustworthiness of this qualitative research study is a conflict of interest. Given a conflict of interest, I would have demonstrated an allegiance to the participants relative to the phenomenon of interest, thus abrogating my responsibility to mitigate bias by not recognizing my allegiance to the phenomenon of interest, thus perpetuating a conflict of interest. Therefore, reflexivity or memos during data collection (Mecca et al., 2015) disclosed any conflicts of interest.

However, researchers have determined that disclosure alone did not fully address a conflict of interest (Mecca et al., 2015). Therefore, for this qualitative research study, I maintained awareness of my interpretation of the participants' responses to semi structured interviews using reflexivity, memos, and bracketing throughout the data collection process. Consequently, I addressed repeated biases akin to recalcitrant conflicts of interest (Mecca et al., 2015).

Therefore, the potential for a conflict of interest was satisfied using reflexivity, memos, and bracketing. All the study participants are African American adults. As an African American adult conducting this qualitative research study, reflexivity, memos, and bracketing were essential throughout the data collection process. Remaining mindful of the potential for researcher bias allowed for a balanced perspective, thus avoiding unaware cognitive biases when interpreting answers to the interview questions relevant to the research question.

Confidentiality in qualitative research is ethically essential, and I maintained the confidentiality of all the sample participants. The readers of this study could not link the participants to the study (Weiss, 1994; as cited in Kaiser, 2009) via any form of data dissemination, written or lecture.  All the identifying characteristics had gone through de-identifying. The discussion of confidentiality was addressed during the informed consent process and again during data collection. Confidentiality is vital to establishing trust between the researcher/interviewer and the participant (Kaiser, 2009). As previously mentioned, I replaced the study participants’ names with an alphanumeric code. For example, participant John Doe will be DJ2, and participant Jane Doe will be JD4, and so forth. Qualitative research studies present inherent challenges for maintaining confidentiality. The rich, thick data sought captured unique features that can be attributed to a specific participant, thus threatening the confidentiality of the study participant in the future (Kaiser,2009).

Dissemination of data to academic journals and teaching hospitals is standard practice. However, disseminating data is ultimately the responsibility of the researcher/interviewer. When data for dissemination to an entity is requested and permission for use has not been established, the participant will be re-contacted to confirm permission to use their data (Kaiser, 2009). Although, for this study, I was the only person accessing the data. The data has remained in a locked, secured combination, accessed storage file cabinet on a UBS device (Lin, 2009). I will destroy the data at the end of five years (Lin, 2009).

As previously mentioned, the potential for a conflict of interest was satisfied using reflexivity. All the study participants are African American adults. As an African American adult researcher/interviewer, conducting this qualitative research study using reflexivity and memos has allowed self-reflection and a balanced perspective relative to seeking an answer to the research question.

## Summary

This qualitative research study explored the experiences of low SES, low HL African American adults navigating the healthcare system. This study followed a basic qualitative method using Pender’s HPM theoretical framework. The basic qualitative method explored how this population has interpreted their experiences, worldviews, and the meanings they have ascribed to their experiences. This basic qualitative research study gave the readers insight into how low SES and low HL African American adults have determined their experiences while navigating the healthcare system. These experiences have shaped their worldviews (Merriam, 2009, as cited in Worthington, n.d., Percy et al., 2015). Pender's HPM allowed an opportunity to assess interventions, which promoted and guided behaviors toward increased HL and responsible healthcare behaviors based on Pender's HPM step-by-step process (Merriam, 2009; cited in Worthington, 2013). The participants signed an informed consent, allowing data collection after Walden's IRB approved this basic qualitative research study. I began to analyze all the data manually.

I am a novice researcher/interviewer, so manual data analysis captured nuanced, overlooked data missed when using technical data analysis methods (Creswell & Creswell, 2018). In addition, reflectivity and memos ensured transparency, advancing this study's trustworthiness. In Chapter 4, I discussed the analysis of my findings.

# Chapter 4: Results

In this basic qualitative study, I explored the experiences of African American adults with low HL when accessing healthcare. The goal was to understand the ongoing low HL among the low SES African American adults and to develop interventions that would mitigate low HL among low SES African American adults using interventions created to address the unique needs of this ethnic minority. Therefore, the research question was "What is the experience of low SES African American adults who self-report low health literacy when navigating the healthcare system?" I recruited individuals from my former neighborhood who met the inclusion criteria outlined in Chapter 3. In addition, I solicited the help of friends and family members for names of individuals in the community who could contribute to the body of knowledge concerning low HL among African American adults. The individuals who expressed an interest in the study received a flyer explaining the details of the study (see Appendix C), which mentioned the informed consent. COVID-19 restrictions and concerns followed the present guidelines of the CDC for Philadelphia, PA., Wilmington, DE., and Columbia, MD. One participant was a resident of Columbia, MD., one was a resident of Wilmington, DE., and the remaining eight were residents of Philadelphia, PA.

The guidelines by the CDC in 2022 for COVID-19 restrictions recommend inquiries concerning possible exposure to COVID-19 involving travel to China or exposure to someone diagnosed with COVID-19 in the last 14 days (Centers for Disease Control and Prevention, 2022). I used these guidelines for the Philadelphia, Columbia, and Wilmington interviews. The participants in this study self-reported no exposure to

COVID-19 in the past 14 days and had received four COVID-19 vaccines. I received four COVID-19 vaccines and the additional booster vaccine. I maintained a social distancing of 6 feet during the ten face-to-face interviews.

Twelve Individuals met the inclusion criteria and agreed to participate in the study and sign the informed consent. However, two individuals withdrew before the study began. Therefore, 10 participants' face-to-face, semi structured, audio recorded interviews were conducted. I transcribed each interview verbatim and initially analyzed the data using open coding. The subsequent data analysis was for categories and emerging themes.

Chapter 4 includes a description of the pilot study process, demographics, and data collection of the 10 participants who agreed to participate. There was an analysis of the data, which described how the data evolved from open codes to themes. I discussed discrepant cases and trustworthiness concerning creditability, transferability, dependability, and confirmability values. Finally, this chapter closes with a summary of the findings answering the research question.

## Pilot Study

A pilot study helps foreshadow any complications with a study’s approach using a small number of participants before the main research study occurs (Cox, 2016; Ismail et al., 2018). Two participants who signed the informed consent to participate in the main research study provided feedback in a pilot study concerning any issues that could impact the main research study and warrant a change in the study’s process relative to data collection, interview questions, or interview instrument. Conducting this pilot study to identify obstacles before implementing the main research study helped to establish the validity of the study's processes. There were no changes to the research study indicated.

## Settings

My goal was to conduct all interviews at the local public library. The 10 study participants were allowed to select the time and location. Unfortunately, the public library was not always an option. Therefore, I modified the strategies to maintain confidentiality. Individuals who lived alone agreed to interviews in their homes. Individuals who did not live alone arranged for family members not to be home during the interviews so we could have privacy to conduct the interview. Thus, this provided both convenience for the study participants and a relaxed, familiar environment for those participants who could not commit to an interview at their local public library.

## Demographics

This study's participants are Philadelphia, PA., Wilmington, DE, and Columbia, MD, residents. Ten low SES African American adults shared their experiences relative to low HL when navigating the healthcare system. One participant was from Wilmington, DE, one was from Columbia, MD, and the remaining eight were from Philadelphia, PA. Each participant shared their subjective personal experiences from their perspectives. I maintained confidentiality by assigning each participant an alphanumeric code. All the participants were over 18 years old and responsible for their healthcare. Each participant has experienced navigating the healthcare system without the benefit of a supportive friend or relative. Table 1 provides the participant's alphanumeric code, age, gender, and SES.

**Table 1**

*Demographics*

| Participant | Gender | Age | Below annual FPG yes/no | At the annual FPG yes/no |
|---|---|---|---|---|
| CV1 | Female | 74 | yes | |
| BA2 | Male | 56 | yes | |
| WD3 | Female | 69 | | yes |
| BC4 | Male | 69 | | yes |
| GL5 | Male | 42 | yes | |
| CE6 | Female | 90 | | yes |
| MK7 | Female | 58 | yes | |
| MS8 | Male | 21 | yes | |
| CD9 | Female | 23 | yes | |
| MW10 | Male | 67 | | yes |

*Note*. FPG = Federal Poverty Guidelines.

## Data Collection

I began collecting data once I received approval from Walden University's IRB (02-20-20-0614590). I used purposeful sampling and recruited individuals from my former neighborhood. I solicited the assistance of friends, family members, and community leaders to help identify those individuals who met the inclusion criteria outlined in Chapter 3. For everyone recruited who expressed an interest in participating in the study, I gave them a consent form. The consent form provided the recruited individual with information addressing the study background, purpose, procedures, and interview questions. Also, the rights, benefits of the study, participant privacy, and confidentiality. Individuals who agreed to participate signed and dated the informed consent. Data from 10 low SES African American adults were collected using face-to-face semi structured interviews. Participants chose the date, time, and location for the interviews most compatible with their schedule. The participant interviews were conducted only once. The interviews lasted between 30-90 minutes. The interviews were consistent, given I asked each participant the same questions to allow the participant's responses to align with the same specific information. The semi structured interview questions explored the participant's subjective experiences when navigating the healthcare system and interacting with their healthcare providers. All interviews were audio-recorded, using the feature on my cell phone, with the participant's permission, thus allowing for the development of the written transcript. The participants understood they could stop the interview or withdraw from the study any time. None of the participants chose to withdraw from the study. A reflective statement in Chapter 3 discussed the potential for bias concerning any thoughts and feelings I had that may have influenced interpretations of the data.

## Data Analysis

In this basic qualitative study, I used semi structured, face-to-face interviews to explore the experiences of the low SES low HL African American adult when navigating the healthcare system. The research instrument was an interview guide in which the interview questions sought to understand the experiences of low SES, low HL African American adults while navigating the healthcare system. The interview was the first step in the data analysis process. However, before the interview process began, I reiterated to each participant that they could leave the study whenever they wanted without fear of repercussions. All 10 participants chose to remain in the study. I transcribed each interview using Microsoft Dictate and made the necessary corrections to all errors in the translation of the data dictation.

I read the transcriptions of each interview line by line four times. This process allowed for an analysis based on the study's theoretical framework and the literature, which guided the determination of the raw data selected and applied to open coding. The search for repeated words, phrases, and concepts answering the research question was an inductive process. I repeatedly listened to the audio recordings, comparing the tapes to the transcription of the error corrected data from Microsoft dictation of the participant's interview.

To actively begin the open coding process, I listened to each participant's audio recording while reading the transcripts with corrections, highlighting words, phrases, and concepts. All highlighted words, phrases, and concepts were on a separate note for display, allowing for an assessment of the relevance of words, phrases, and concepts to the research question and theoretical framework.

In vivo coding is an inductive coding of the data, allowing the participants to interpret their experiences concerning the phenomenon of interest in their own words, providing a deep understanding of their worldviews (Saldana, 2016). Thus, in vivo, coding did not result from understanding the phenomenon based on my practiced experiences. Also, values coding allows for a subjective expression of participants' experiences by coding the participants' (a) values, what the participant has determined as important; (b) attitudes, how the participant thinks about something; and (c) beliefs, accepting something is true based on the participant’s values, attitudes, personal experiences, opinions, and morals (Saldana, 2016).

After open coding was completed, 43 open codes emerged. See Tables 2-7 for examples of 23 open in vivo and values open codes with participants' identifiers and excerpts. After completing open coding, I began to code the data according to groups that shared characteristics or similarities to identify the category for each group (see Table 8).

I began the first step, open coding, with analysis of the data line by line, using colored notes and highlighting phrases, words, and concepts based on the research question, theoretical framework, and literature review. I then began axial coding, an activity that groups similar codes, which allowed for the emergence of five categories: communication, respect of persons, insurance issues, medical knowledge, and trust (Saldana, 2016). From the synthesis of the categories, two themes emerged. Theme 1, concerning communication/respect of persons, was ubiquitous throughout the study and was found to have relevance in each participant interview. Theme 2 presents how deficient interactions between healthcare providers and the low SES low HL African American adult mitigates improved HL among African American patients.

## Evidence of Trustworthiness

Credibility is one of the values determining the trustworthiness of a qualitative research study (Connelly, 2016). One aspect of credibility includes maintaining reflexivity. Reflexivity involves an awareness of how my experiences may impact the interpretations of the findings (Creswell, 2018). How my past or present experiences as a healthcare provider, as discussed in Chapter 3, could bias the understanding of the findings is essential knowledge. In vivo, coding helped minimize or eliminate any potential subjective interpretation of the findings I might have had. In vivo coding is the study participant’s language and voice (see Saldana, 2016). However, my sensitivity to the interviewee’s culture may have been beneficial in providing a deep, nuanced understanding of the participants' experiences. Member checking offered an evaluation of the data, allowing for credibility in that the participant can review their responses to interview questions designed to answer the research question (Amankwaa, 2016; Connelly, 2016; Nowell, 2017). Nine participants accepted my interpretations. Unfortunately, one participant was hospitalized for a severe illness and could not participate in member checking.

Data saturation is discussed in Chapter 3 as a value determining credibility. Saturation was reached after six interviews. I conducted four additional interviews to allow for unexpected findings. Saturation was maintained after the eighth interview. Two of the 10 participants interviewed, BC4 and WD3, had responses to some interview questions that were discrepant. These discrepancies are discussed further in the results of the study. Prolonged contact was accomplished by allowing the participants to explain their experiences navigating the healthcare system without interpretation. In addition, probing has allowed for an extension of the interview during the face-to-face semi structured interviews.

The transferability I discussed in Chapter 3 concerned the personal experiences of the low SES, low HL African American adults navigating the healthcare system. Transferability is not known currently. My results would need to be compared with the experiences of a different ethnic group of low SES low HL individuals to determine the similarity of corresponding code and theme emergence.

The dependability of this study is valid, given reflexivity is addressed. I conducted a pilot study to test the interview questions; no changes were requested during the pilot study.

To validate findings before theme development and inform confirmability, I consulted a colleague with a doctor of nursing practice degree for feedback concerning content validity relative to the research question and interview questions. My colleague agreed there was an alignment between the research question and interview questions. Confirmability is another value of trustworthiness. Confirmability assures readers of the study that my biases did not influence the interpretations of the participant's responses to the interview questions (Amankwaa, 2016; Connelly, 2016). In addition, member checking and reflexivity were implemented to safeguard against unrecognized biases.

## Results of the Study

Of 10 low SES, low HL African American adults' experiences navigating the healthcare system, eight reported a lack of communication and insufficient healthcare related interactions with their providers. Participants with discrepant responses did not report ineffective communication or unsatisfactory healthcare interactions with their providers. However, 80% of the participants described inadequate interactions with their healthcare provider, aligning with the literature.

Eighty percent of the participants disclosed excerpts supported by the literature concerning the lack of communication and interactions between the participants and the healthcare providers. Twenty percent of the participant excerpts discussed communication and interactions between the healthcare provider and the low SES low HL African American adult that did not align with the literature. The discrepancies were relative to interview Questions 2, 3, 4, 5, 7, and 8 (see Appendix A), which sought to capture participants' subjective experiences when communicating and interacting with their healthcare providers when navigating the healthcare system. Each participant had health insurance coverage. One participant had Affordable Health Care (Obama Care), five had Medicaid, and four had Medicare Part A & B.

I interviewed 10 participants using a basic qualitative research study method. The semi structured face-to-face interview was designed with eleven open-ended questions to help answer the research question: What is the experience of low SES African American adults who self-report low health literacy when navigating the healthcare system? This interview method provided an opportunity to capture in-depth, thorough responses to each question. This study’s findings were presented in a summary guided by the research question.

Each interview question supports and answers the research question. However, interview questions 2, 3, 4, 6, 7, 8, and 9 provided a subjective response concerning experiences, which were expressed in an in-depth, rich, thorough manner (see Appendix A). From an analysis of data from the interviews, two themes emerged.

Theme 1: Doctors/Healthcare Providers Lack the Communication Skills to Help Low SES African American Adults Improve Health Outcomes

The participants described their encounters with healthcare providers as lacking quality communication concerning the exchange of dialog between them and their healthcare providers. These inadequate exchanges led to participants' minimal understanding of their health problems, medical terminology, and instructions. Participants expressed a need to have the healthcare provider show more interest in their medical problems through an exchange of discourse, which triggered quality communication. For example, Participant CV1 expressed the frustration of not being given explanations concerning reasons for specific health procedures and decisions in the future. CV1 stated“ "You know it's hard, and I don't know the healthcare things. They always want to give Black People stuff. They always wanna give Black People medicine when you probably don’t even need it."

Participant BA2 shared, “I just don’t trust doctors. They treat us like Guinea pigs. They are experimenting on you.” BA2 continued to elaborate,

> Yeah, it was a situation where I was in my clinic, and they were doing a survey. It was six of us, and they gave three of us real pills and three fake pills. Those with fake pills were supposed to be so-called cured, like those who took the real pills. So, from there, I just stopped taking pills. I haven’t taken a pill since the '80s. I depend on herbs and my faith in God. They didn’t explain. They said placebo, whatever that stands for.
>
> Participant MK7 detailed,
>
> He didn’t fully answer my questions. It makes me want to, you know, get another doctor because I feel my doctor does the surface. He doesn’t dig deep. He doesn’t

> give me the answers to what I want to know. So ‘I’m going to seriously think about changing doctors. I don’t think he knows he gives me a lot of referrals, but I need a doctor more in tune with the human body. So, to understand what the problem could be. You know my doctor, he doesn’t act like he knows anything.

Participant CD9 explained,

> Sometimes, information or instructions can be a little confusing just because of how they may word things. But once it's written out, you know, sometimes medications have different instructions on when to take it and what to take it with, but once it's written out, I understand it better. But, sometimes, when they vocalize it, I don't understand it as fast as when it's written out for me.

Participants shared responses, which discussed how it was not unusual to call their healthcare providers for further health instructions after their doctor’s office visit or clinic visit because the participants did not clearly or thoroughly understand the instructions. GL5 elaborated,

> I was confused when I left the doctor’s office. So I called back to ask him to clarify and break it down more so I understand what type of stuff I must do. They said it was a small hole in one of my chambers, which worried me. So I was like, do I have a specific time or something? Is there something you are trying to tell me? So, I was confused when I left the hospital.

Participant CE6 shared, “Most important for the doctor to listen to what I have come here to tell him about me. If it is something I don't understand, I get on the phone and call him.” MW10 stated, “They want to replace or adjust the IV in my arm used for dialysis. They want to lift it. I think they want to make more money.”

Participant MS8 shared, “The doctors gave pamphlets and online resources to help me understand.”

Theme 2: Doctors/Healthcare Providers' Deficient Interactions with Low SES African American Adults Sustain Low HL

Interaction with the healthcare provider is an essential aspect of communication between the participant and the healthcare provider, primarily an exchange of dialog. Communication could involve just the healthcare provider informing the patient. However, an interaction will discuss information, and thoughts, ideas, conclusions, and decisions will be shared. MS8 shared“ "I do not ask questions unless something is urgent.” GL5 asked, "Will I be covered? Is there a copay? If it is a copay, how much, and if it is not, how much are they willing to cover as far as anything I need to be done?” CE6 stated, "Listen to what I say and tell me what to do about the situation. “ MW10 shared, The doctor needs to know my needs, my sickness, my ailments, you know, for him to give me the proper medication for it, and that I take it on time. How serious is the problem, when is the next office visit, and how often do I take my medication?" BA2 shared, "I had a knee operation and a foot surgery, and everything was written, so they gave me prescriptions. They gave me just the sheet. I had to read the sheet, and there wasn’t a conversation." CV1 shared, "Like once I was in the hospital, a lady came in with this needle. I had to ask what this is for?" MK7 stated, "Doctors that deal with patients on Medicaid focus mainly on surface issues and don’t dig deep to find the cause until the medical problem has worsened. He didn’t explain stuff unless there was a problem. CD9 stated, "I don’t like going to the doctor’s and speaking to two, three, or four people about the same issue, and no one knows what's happening. So I “like it when they're efficient in helping me with whatever I have going on.”

Discrepant Findings:

Participants BC4 and WD3 particularized aspects concerning communication and interactions with their healthcare providers that did not align with the literature. BC4 shared.

> My visits to the doctor are good. I understand my medical problems and very seldom ask questions. If I have specific questions, they answer them. The only healthcare instructions are on my pill bottle. I don't need to ask questions about what is on the pill bottle. My doctor talks to me every session when he checks my blood pressure. I have no doubts or problems following healthcare instructions. I follow healthcare instructions pretty well.

Participant WD3 detailed,

> I understand my medical problems perfectly. Because of the way my doctors explain everything to me. First, if anything is hurting me, he will tell me why. Then, he will give me health information about what is wrong with me. Each doctor explains everything to me every time I go to the doctor. First, they take my blood pressure and ask about my feelings, especially my lung doctor, about my breathing. Then, he will test if I'm doing my medication right and tell me to

ensure I'm doing it a certain way because ’it’ll help my breathing more. Then, they tell me what’s wrong and what to do.

**Table 2**

*Open Codes/1st Cycle*

| Code: In Vivo/value (V), (A), (B) | Participants | Excerpt |
|---|---|---|
| “Had to ask.” (B) | CV1 | “He gave me a new prescription he wouldn’t have suggested. So I had to ask.” |
| “Curious” (V) | BA2 | “Being human is curious. I just don’t heed whatever people tell me.” |
| “Needs clarification.” (B) | BA2 | “After surgery, I had to read a sheet of paper. It wasn’t a conversation. I needed clarification for big words. |

**Table 3**

*Open Codes/1st Cycle*

| Code: In Vivo/value (V), (A), (B) | Participants | Excerpt |
|---|---|---|
| "Initiating conversation" (B) | CD9 | "If they see a drastic change, they say something. Other than that, it would be more like me initiating conversation." |
| "Pronouncing stuff" (V) | CV1 | "I am not great at pronouncing stuff and understanding words and what they mean." |
| "Doesn't explain." (V) | MK7 | "He doesn't explain stuff unless there's a problem." |
| "Need a doctor to listen." (V) | CE6 | "Need a doctor to listen to why I came." |

**Table 4**

*Open Codes/1st Cycle*

| Code: In Vivo/value (V), (A), (B) | Participants | Excerpt |
|---|---|---|
| "A little confusing."(B) | CD9 | "Sometimes it can be a little confusing just by how they say things." |
| "I think (A) wanted to make more money." | MW10 | "He wanted to change or replace the IV fistula. I think they just wanted more money." |
| "Got messed up" (B) | CV1 | "Had surgery three days in a row." |

**Table 5**

*Open Codes/1st Cycle*

| Code: In Vivo/value (V), (A), (B) | Participants | Excerpt |
|---|---|---|
| “Always skeptical” (A) | BA2 | “Always skeptical anyway about going to the hospital.” |
| Don’t trust doctors.” (B) | BA2 | “They treat us like Guinea pigs.” |
| “Just to make money, keep you dependent.” (A) | CV1 | “Wanna give Black people medicine when you probably don’t even need it? It’s to make money, and some are to keep you dependent.” |

**Table 6**

*Open Codes/1st Cycle*

| Code: In Vivo/Value (V), (A), (B) | Participants | Excerpt |
|---|---|---|
| “Didn’t know” (B) | CV1 | “He told me after 'cause he didn’t know if I had it or not.” |
| “How to know that they know” (V) | BA2 | “They will tell you anything because you don’t know, and my thing is, how do you know that they know.” |
| “Dig Deep” (B) | MK7 | “Doctors that deal with Medicaid patients don’t dig deep.” |
| “Doesn’t know anything” (B) | MK7 | “You know my doctor acts like he doesn’t know anything.” |

**Table 7**

*Open Codes/1st Cycle*

| Code: In Vivo/Value (V), (A), (B) | Participants | Excerpt |
|---|---|---|
| “Know what’s going on.” (V) | CD9 | “Speaking to 2,3 or 4 people about the same health issue, and no one knows what’s happening.” |
| “ Turned into a business” (A) | BA2 | “People are blind to see the money in medicine.” |
| “Copay” (V) | GL5 | “Will I be covered? Is there a copay?” |
| “Medicaid is nothing.” (B) | MK7 | “When you are on Medicaid, you get what you get, which is nothing.” |

**Table 8**

*Codes and Categories/Axial Coding 2nd Cycle*

| Category | Code | Participant | Excerpt |
|---|---|---|---|
| Communication | | | |
| | "Had to ask" | CV1 | "He gave me a new prescription. I had to ask." |
| | "Initiating conversation." | CD9 | "Only if drastic change." |
| | "Needs clarification." | BA2 | "After surgery, given a sheet of paper. Needed clarification" |
| | "A little confusing." | CD9 | "The way they say words is sometimes a little confusing." |
| Respect of Persons | | | |
| | "Doesn't explain." | MK7 | "He doesn't explain stuff unless a problem." |
| | Need a doctor to listen." | CE6 | "Need a doctor to listen to why I came." |
| Insurance Issues | | | |
| | "Copay" | GL5 | "Will I be covered? Is there a copay?" |
| | "Medicaid is Nothing." | MK7 | When on Medicaid, you get what you get, which is nothing." |
| Medical Knowledge | | | |
| | "Unnecessary surgery." | CV1 | "Had surgery3 days in a row." |
| | "Doesn't know anything." | MK7 | "My doctor acts like he doesn't know anything." |

| Category | Code | Participant | Excerpt |
|---|---|---|---|
| Trust | “How to know that they know.” | BA2 | “They will tell you anything. You don’t know. How do you know that they know.” |
| | “Always skeptical” | BA2 | Always skeptical about going to the hospital.” |
| | “Just want to make money. Keep you dependent.” | CV1 | “Wanna give Black people medicine you probably don’t even need? It’s to make money, and some are to keep you dependent.” |

**Table 9**

*Categories and Themes*

| Category | Theme |
|---|---|
| Healthcare Providers' Communication/Respect of Persons | Theme 1: Doctors/ Healthcare providers lack the communication skills to help low-SES low HL African American adults improve health outcomes. |
| Navigating insurance issues<br>Accepting healthcare providers' medical decisions.<br>Trusting healthcare provider decisions | Theme 2: Doctors/Healthcare providers' deficient interactions with low SES African American adults sustain low HL. |

## Summary

In Chapter 4, I completed the data analysis of responses to interview questions answering the research question. This study was developed from one research question that explored the experiences of low SES low HL African American adults. A purposeful sample of 10 low SES low HL African American adults, including one participant from Columbia, MD., one from Wilmington, DE., and eight from Philadelphia, PA., were chosen. Semi structured face-to-face interviews allowed them to share their perspectives relative to their experiences navigating the healthcare system. Data were analyzed based on an established data analysis process recommended by Saldana (2016). The two themes that emerged from the data reflected 80% of the participant's perspectives relative to the research question: What is the experience of low SES African American adults who self-report low health literacy when navigating the healthcare system?

Lack of communication was a concern of eight of the 10 participants interviewed, and each offered a different type and level of frustration concerning communication with their healthcare providers. Additionally, each participant shared how they felt confused about their healthcare problems, given they were not explained clearly or thoroughly. Participants shared they had the impression that their healthcare providers showed little interest in their health problems. The participants found interacting with healthcare providers who needed encouragement to discuss their health problems challenging. The participants resented asking for treatments they believed the healthcare provider should have suggested based on how the participant presented medically.

The terminology used by the healthcare providers confused the participants, and there was an ongoing need to ask for clarification about essential aspects of their health, such as post-operative care. One participant shared that after surgery, the patient was given written instructions. They shared during their interview that it was an unacceptable way to provide post-operative information. One participant offered that they did not appreciate their role as an initiator relative to questions concerning changes in health. The participants shared that they would feel more secure with a doctor who engaged more often, for example, at each doctor's visit, in an exchange of dialog concerning their health, not just when there was an acute onset of a new medical problem or condition.

Eight participants complained that their healthcare providers did not explain anything unless new medical problems developed. Participants stated that they found it challenging to pronounce medical terms, and their healthcare providers did not offer an explanation or pronunciation of complicated medical terms. Participants said they had to rely on family members to help with complex medical terms. Participants also expressed frustration with words that the healthcare providers used and did not consider that the participant may be at a disadvantage given they do not have a medical background. Hence, participants found the terms and language used by the healthcare providers confusing.

Participants misunderstood and misinterpreted necessary medical procedures as a money-making venture when the healthcare provider did not take the time to explain a procedure or process before the medical event was scheduled. One participant's mistrust of healthcare providers/doctors has led to them not taking any medications, not going to doctors, and self-treating medical problems with herbs and his faith in God.

Interactions between the participant and healthcare providers are not at levels that dictate quality healthcare. Participants feel their providers are unaware of what qualifies as quality healthcare given that medical treatment, considered standard for specific medical problems, was not provided, thereby allowing patient suffering, which could have been avoided. Another participant shared their viewpoint concerning treating patients who receive government-sponsored insurance. They feel that medical providers do not respect them because they have low SES, and healthcare providers who treat patients on Medicaid do not try to discover the problem. They don’t care and only treat the symptoms.

Two participants agreed that when you have low SES, you must speak to maybe four people about the same problem before you are seen, and it is as though no one knows what is happening. Two participants in this study felt that medicine was a business, and the patients with money were treated well, and the patients with low SES were treated poorly. Patients on Medicaid do not regularly interact with their providers in an exchange of dialog concerning their health. Medicaid patients’ insurance is charged at the same rates as private insurance, but the patients on Medicaid are not treated as equitably as patients with private insurance. Chapter 5 will provide an interpretation of the results, limitations, recommendations, implications, and conclusions.

# Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this basic qualitative research study was to understand the experiences and barriers to healthcare as perceived by low SES African American adults who have shown low HL due to the lack of understanding of basic healthcare instructions and information when communicating with healthcare professionals and navigating the healthcare system. Another purpose of this study was to understand how to increase the HL of the low HL low SES African American adults through interventions guided by the theoretical framework of Pender’s (2011) HPM, which cognitively informs sustained health-promoting behaviors committed to a plan of action. Also, I sought to clearly understand how perceived barriers might impact the low SES African American adult's ability to navigate the healthcare system successfully by using the theoretical propositions of Pender’s HPM.

The nature of this study was a basic qualitative design using a narrative inquiry methodology. Narrative inquiry provides a format in which the phenomenon's understanding is through semi structured interventions designed to encourage the free flowing of subjective responses germane to a basic qualitative research study (see Worthington, 2013). This study was conducted to allow participants to express their feelings and explain their experiences when accessing healthcare. The narrative inquiry format also provides for unencumbered preconceived notions that questions or inquiries have corrected responses or answers. Studies addressing low SES African American adults with low HL are abundant across the research literature (see Ali et al., 2018;

Amadeo & Scott, 2020; Cole et al., 2017; Juvigny-Canal et al., 2020; Muvuka et al., 2020; Wallace, 2010; Yen & Leasure, 2019).

I conducted this study to understand why chronic illness, acute illness, health inequities, and disparities disproportionately impact this population, perpetuating healthcare behaviors that lead to poor health outcomes. The disproportionate impact of inequities and disparities, which affect the low SES low HL African American adult patient, is highlighted in the literature and explained as a reflection in the context of culture, cognitive processes, and environmental factors unique to this study's participants.

## Key Findings

According to the literature, there is an overwhelming lack of quality communication and interactions between the low SES African American adults navigating the healthcare system and their healthcare providers, thereby mitigating positive healthcare behaviors (Miller et al., 2018). The literature also noted that the lack of quality communication and interactions was an independent determinant of low HL among low-SES African American adults (Amadeo & Scott, 2020). The findings of this study concerning the relationship between low SES and low HL African American adults confirmed the literature, which found there were correlations between low SES and low HL among African American adults (see Brittain et al., 2016; Cole et al., 2017; Muvuka et at al., 2020; Rosario et al., 2017).

Findings in the literature have shown previous studies addressing low HL African American adults were primarily presented as quantitative, often using the test of functional health literacy in adults that measured comprehension and numerical ability (Weekes, 2012). Based on quantitative measures results, The teaching interventions implemented to improve low HL among African American adults were limited relative to sustaining healthcare information and improving HL (see Yen & Leasure, 2019). The literature findings noted that when healthcare providers harbored biases toward low SES African American adults, quality healthcare communication and interactions were adversely affected, leading to substandard healthcare and low HL (see Ali et al., 2018; Noonan et al., 2016). The literature confirmed these biases did exist, often without the healthcare providers being consciously aware (Baciu et al., 2017; Howard et al., 2019; McBride & Kochly, 2015; Noonan et al., 2016; Stewart et al., 2015). The literature also concluded income determines the quality of healthcare received in the United States. Therefore, the SES of African American adults is a critical factor in determining their experiences when seeking healthcare (see Carnethon et al., 2017).

## Interpretation of the Findings

The data in this study supported the literature research in Chapter 2. The research found low SES catalyzes low HL among African American adults. Eight of the 10 low SES, low HL African American adults in this study spoke to the lack of communication and interactions between them and their healthcare providers when accessing healthcare. Coupled with the mistrust participants voiced toward their healthcare providers in this study, communication and interactions were further compromised. The findings in this study were confirmed in that they reiterated the literature. The literature was consistent with the low SES African American adults' interpretation of their healthcare experiences when navigating the healthcare system, which determined that low SES led to low HL among African American adults (McCleary-Jones et al., 2013). This basic qualitative approach of my study allowed the participants to subjectively express their perceived challenging barriers when navigating the healthcare system. The semi structured interview questions allowed an exploration of the data, which led to manual open/inductive code development and thematic analysis.

This study’s findings revealed two participants had discrepant responses that disconfirmed the literature. The first participant with a discrepant reaction shared that their communication and interactions with their healthcare providers were always positive, with clear explanations concerning healthcare instructions/information. Their experiences relative to communication when accessing healthcare and navigating the healthcare system, which they verbalized, were inconsistent with the literature's interpretation of communication between low-SES low HL African American adults (see Agarwal et al., 2015; Brittain et al., 2016; Cole et al., 2017; McCleary-Jones et al., 2013; Muvuka et al., 2020; Rosario et al., 2017). However, I found the second participant’s reference to positive communication with their healthcare provider did not meet all the criteria determining positive healthcare communication and interactions between participants and healthcare providers. The only healthcare instructions/information this participant received were instructions on the pill bottle. This participant did not express concern nor understand that medication instructions shown only on the pill bottle did not reflect quality healthcare communication.

The second participant’s discrepant responses to the interview questions expressed satisfaction with their healthcare experiences regarding communications with their healthcare provider and navigating the healthcare system. Roter et al. (1998) concluded that quality communication between the patient and the healthcare provider allowed for a thorough assessment of the participant’s health knowledge, thus confirming the legitimacy of the first discrepant response. Therefore, the second discrepant response concerning quality communication between the participant and the healthcare provider did not meet the agreed upon standard of quality communication between the participant and the healthcare provider (see Roter et al., 1998). The remaining eight participants spoke about experiences inconsistent with healthcare promoting positive health outcomes. Therefore, as indicated in responses shared through a semi structured interview, eight of the 10 participants in this study found communication and interaction between study participants and the healthcare providers inadequate, thus confirming the literature findings, which highlighted consistent ineffective communication between low SES African American adults navigating the healthcare system and their healthcare providers.

The theoretical framework based on Pender's HPM was appropriate for this study in that Pender's HPM can potentially circumvent the barrier of low SES, which perpetuates low HL, by implementing the benefits of the psychologically driven cognitive aspects of Pender’s theoretical propositions unique to the needs of the African American adult in this study (see Pender, 2011). Pender's HPM also presented interventions appropriate for the subjectively expressed barriers to healthcare (Pender, 2011), which plague the African American adult population. Based on the tenets of Pender's HPM, the risk factors perpetuating low HL and causing increased healthcare costs are mitigated when increased HL has led to improved health behavior predicated on Pender's HPM theoretical propositions (see Pender, 2011).

Data from interview responses of the low SES African American adult concerned their experiences when navigating the healthcare system, which included all aspects involving the communications and interactions with healthcare providers, which included understanding healthcare instructions and information, keeping follow-up appointments, and preventative healthcare behaviors. The literature continuously revealed low SES perpetuates low HL. Therefore, the low HL of this population of African American adults may stem from their low SES (see Ali et al., 2018; Baciu et al., 2017; Benes & Alperin, 2019; Carbado & Roithmayr, 2014; Carrataia & Maxwell, 2020; Health and Human Services, 2015; Howard et al., 2019; Kajanova, & Rimnacova, 2019; Noonan et al., 2016).

The quality of communication between healthcare providers and the participants in this study was determined based on how well the participants understood and followed healthcare information/instructions. However, 80% of the participants in this study often complained of not understanding the information/instructions given by their healthcare provider and that they frequently had to ask for an explanation about medical terms, processes, and procedures. The participants expressed frustration when having to ask questions about these issues. The participants indicated they would have appreciated having their healthcare matters explained clearly before leaving the doctor's office or the health clinic.

The literature argued that if healthcare providers' communication and interactions with the African American adult patients were positive, they demonstrated improved health knowledge, which was reflected in positive health behaviors that manifested as positive health outcomes perpetuated by an increase in HL as a result of deliberate quality communication and interactions of the healthcare provider with the African American adult patient (see Kajanova & Rimnacova, 2019; Khodaveisi et al., 2016). However, the findings from my study's data have shown that the experiences of low SES African American adult patient’s communication and interactions with their healthcare providers have been ineffective. This study's African American adult participants found that healthcare providers' communication and interactions with them were limited, and quality discussions concerning health issues were rare.

The literature has consistently shown that low SES influences low HL and supersedes all other determinants of low HL (see Howard et al., 2019; Kajanova & Rimnacova, 2019; Noonan et al., 2016). Low SES negatively impacts self-efficacy and agency, the constructs that are the leading positive determinants of proficient HL. Cognitively determined self-efficacy and agency influence HL, promoting positive health behaviors and diminishing adverse health behaviors (Pender, 2011). However, I found participants' interest in their health was not always effective in stimulating constructive communication between the healthcare provider and the participant (see Miller et al., 2018). Conversely, the exception is that interest and concern about their healthcare and asking questions encouraged healthcare providers to communicate concerning their health matters. Yet, based on the responses to many of the interview questions in this study, healthcare providers continuously have shown subjectively inadequate communication and interactions with this study's African American adult participants (see Stewart et al., 2015).

Williams et al. (2017) suggested African American adults' low HL may be a genetic predisposition, given their low HL levels have been consistently lower than their White counterparts with the same SES demographics. Genetically determined HL levels are predicated on epigenetic processes that stimulate a chemical reaction that influences the cognitive processes that govern health motivations and behavior (Weitzman,2012). Noonan et al.(2016) found adverse psychological and or physiological environmental factors allow an epigenetic process. Studies found the psychological and physiological stress associated with slavery, followed by four hundred years of systemic structural racism, has determined an epigenetic process that reflects negative health behaviors, which are hereditary. Therefore, McBride and Koehly (2017) suggested that the high rates of low HL among African American adults might also be epigenetically determined, and epigenetic processes are informed by genetics. Therefore, genetics are another factor to consider when determining low HL among low SES African American adults. Positive cognitive motivation is necessary to mitigate adverse health behaviors perpetuated by damage from environmental factors unique to this population alone. Communication, epigenetics, racial biases, SES, and intimidation contributed to the low HL levels of this ethnic minority (McBride & Kochly, 2017).

## Limitations of the Study

This study's limitations included elements germane to qualitative research. Trustworthiness, the first criterion of credibility, was shown to have a limitation associated with internal validity informed by social desirability. When study participants want to appear knowledgeable, in agreement, or appear to understand the phenomenon of interest, they may fabricate responses that falsely claim understanding or an acknowledgment that they agree with the factors determining the phenomenon of interest (Latkin et al., 2017). Hence, social desirability is an aspect of the internal validity criterion and will weaken the credibility associated with deciding trustworthiness. Therefore, responses reflective of social desirability could inform a lack of credibility. For example, the discrepant responses offered in this study may not represent a different response but the participant’s desire to answer the questions in a way that would be considered an acceptable answer/response concerning their health experiences.

I aimed to interview eight to 12 purposefully selected African American adults of low SES to explore their healthcare experiences when navigating the healthcare system. However, after 12 recruitment interviews were completed, 10 participants agreed to participate in the study and signed a consent form. I reached saturation after six interviews. However, I interviewed four additional participants, and saturation continued up to and including the eighth interview participant. A discrepancy was detected in two of the 10 participants' responses. This difference could indicate a limitation in this study, given future studies using a larger sample size could yield different subjective experiences.

Although steps were taken to avoid researcher/interviewer biases and keep the limitation of conflict of interest to a minimum, the existing embedded limitations informed overarching threats to credibility in qualitative research, and the nature of qualitative research informs limitations involving researcher biases (Chenail, 2011). Therefore, the researcher/interviewer must include memo writing, reflexivity, and bracketing to lessen researcher/interviewer biases, thus mitigating the inevitable limitations (Chenail, 2011) associated with qualitative research and the researcher/interviewer biases, which determine trustworthiness.

## Recommendations

This qualitative research study has focused on the importance of communication and interaction between the healthcare provider, the African American adult patient, and the correlation between inequitable patient healthcare, SES, and race. The first recommendation I propose would be to promote an atmosphere of trust and concern between the healthcare provider and the African American adult patient. I understand change is "easier said than done.” However, "practice makes perfect." The first approach to providing quality care to low SES, low HL African American adults should include a supportive dialog between the healthcare provider and the patient. For example, how are you feeling today? Has there been any new health concerns since your last visit? Do you have any questions about your medications? Have you been able to follow up with your health screening appointments? I understand that time is of the essence during the doctor's visit. However, addressing a few of these issues concerning the patient's health experiences and behaviors since their last visit may convey to the patient that their healthcare provider has concern for their well-being relative to their health behaviors and outcomes. Additionally, many of the challenges confronting the low SES African American adults concerning their healthcare could be mitigated if healthcare providers were aware of potential biases that might influence communication and interactions involving low SES African American adults.

I would also recommend using a larger sample size to conduct a qualitative research study. The two discrepant participant responses, which highlighted positive quality communication and interaction between the healthcare provider and the low SES low HL African American adult, have led me to conclude that additional discrepant responses could emerge when using a larger sample size.

This study discussed the importance of time to the healthcare provider, which could compromise quality communication when the healthcare provider feels rushed or needs to see several patients in a limited time frame. Therefore, to alleviate insensitive responses, which could manifest in a rushed atmosphere, I recommend each doctor's office and clinic consider sensitivity training videos and modules for their doctors and registered nurses addressing the skills necessary to communicate or interact effectively with marginalized ethnic minority patient populations. Furthermore, the questions asked by the healthcare provider should be in the form of a script with critical health issues addressed first because this form of questioning will allow the researcher/interviewer to capture the essence of essential aspects concerning the low SES low HL African American adult’s healthcare needs. Suppose the registered nurse is the healthcare provider who will gather healthcare information in an exchange of dialog. The outcome of this subjective psychological exchange should be relayed to the patient's doctor along with the physiological reports, thus promoting holistic health care.

To gain insight into which determinant may be the dominant factor determining low HL, adverse health behaviors, and outcomes among African American adults, I would also recommend a qualitative research study among African American adults who self-report an annual income above the federal poverty guideline, have a 12th-grade education or higher, have insurance coverage, and report a family history of a chronic illness, thereby helping the researcher/interviewer determine if HL among the African American adult patient population is determined racially/ethnically, economically, genetically, or a combination of two or more determinant factors. The literature has shown White Americans with the same low SES as African American adults have higher HL levels and more positive health outcomes than African American adult patients of the same SES.

I recommend that the state-run healthcare clinics begin to conduct healthcare classes focusing on improved health outcomes and increased HL levels. These classes should cover cardiac problems, hypertension, diabetes, exercise, and weight loss benefits. To help convince patients to attend these classes, I recommend using Pender's step-by-step theoretical proposition educational intervention model. The first step will be determining how important good health is to the low SES, low HL African American adult patient. Therefore, the recommendation is that the healthcare providers chosen to discuss positive health behaviors use the step-by-step actions of Pender's HPM plan, which is most beneficial for this patient population. Next, I recommend the healthcare provider follow the script mentioned previously and engage in a discussion to understand the African American adults' perceptions about their health and their ability and desire to improve health outcomes (pre-contemplation). In addition, I recommend that the healthcare providers remain in the pre-contemplation stage of the HPM with the low SES low HL African American adult until the patient is ready to move on to the next step. Finally, the healthcare provider should assess the low SES low HL African American adult's readiness to proceed, and the key is not to rush to achieve the goals, which are the five steps of Pender's HPM Plan, pre-contemplation, contemplation, planning/preparation, action, and maintenance. Thus, following Pender's HPM will allow the low SES, low HL African American adults to work on strategies to modify their perceived barriers to positive health behaviors through discussion with their healthcare provider. Pender’s HPM is the theoretical framework used for this study. However, I recommend that researchers also consider the use of the CRT. The CRT suggests how unequal treatment of the less powerful by the privileged powerful in societies to maintain a hierarchical status as elite community members may contribute to the low SES of African Americans (Carbado & Roithmayr, 2014).

However, I recommend implementing Pender's HPM. Based on this population's experiences and their potential for poor health outcomes perpetuated by adverse health behaviors due to low HL maintained by low SES, Pender's HPM aligns with the cognitive skills needed to motivate and improve this marginalized population’s ' health behaviors and outcomes. I recommend the healthcare provider discuss the patient's health progress at each visit. For example, are they still in the pre-contemplation stage, or have they taken a step toward contemplating making behavioral health changes? Before any of these stages to improve the health behaviors of the African American adult patient population are implemented, I recommend forming an interdisciplinary team to discuss the planning process, who will be responsible for follow-up, and which healthcare provider will determine the next steps or recognize that the patient is ready for the next step, guide or encourage the patient to move forward in the direction that demonstrates self-efficacy and agency. Praise the low SES low HL African American adult patient at each successful stage completed toward improved health behaviors because this will indicate support from the healthcare provider. The encouragement received from the healthcare provider is the social support needed to continue through the stages of Pender's health promotion model. The cost-effectiveness of this health behavior initiative will be appreciated if conducted in groups of three to five low SES low HL African American adults. Not only will this allow for cost-effectiveness, but the support generated by the group interactions and following Pender’s HPM Plan will positively influence behavioral change.

## Implications

This study has provided a panoramic view of the healthcare problems, issues, and concerns that plague the low SES, low HL African American adults navigating the healthcare system. Addressing these problems, concerns, and issues improves the health of this group nationwide, with positive social change realized for these individuals, their families, communities, and society by a positive change to local and national government policies relative to the provision of healthcare to this marginalized group. When implemented, the processes that improve healthcare for low HL low SES African American adults are not unique to one community. The expectation is that the benefits will become evident statewide and potentially nationwide.

When the healthcare of the low SES low HL African American adult improves in one community, this could translate into an improvement in the health and QOL for most communities of low SES low HL African American adults. The recommendations to improve HL and health behaviors for low SES African American adults in society will extend to other communities until improved health behaviors and HL have become nationwide, impacting positive social change. Positive social change is not an unknown concept and can apply to most constructs concerned with improvement in an adverse behavior for the common good of society. In the past, when American society determined that certain population behaviors were threatening an individual’s overall QOL, such as cigarette smoking, steps to implement positive social change were sought and implemented with successful outcomes. Hence, the same steps apply when improved HL for low SES African American adults in the community are needed, potentially perpetuating social change starting at the individual level. When responsible, healthcare providers promote positive health behaviors in low SES and low HL African American adult communities, and the targeted individuals grasp the essence of positive health behavior; HL will improve because the importance of maintaining improved health behavior is cognitively determined. When individuals develop improved health behaviors predicated on increased HL, this will directly impact and influence the positive health behaviors of other individuals in their environment, such as family and friends. The cyclic effect of improved HL perpetuation of positive health behaviors and outcomes determines positive social change concerning improved health and QOL.

Low SES is the overarching conclusion determining low HL based on the literature. However, the researcher/interviewer can circumvent low SES perpetuation of low HL by employing Pender's theoretical HPM of cognitive self-motivation's thought processes determining health behaviors. When significant groups of the population practice positive health behaviors, communities benefit, which often manifests statewide with the potential to become nationwide, thereby influencing social change relative to improved HL for this marginalized group of individuals on the national level. In addition, when an individual's health behaviors, outcomes, and HL have improved, this translates into an improvement in QOL, allowing an individual to enjoy continuous employment without an undo number of interpretations in job/career due to chronic or acute illnesses, which might negatively influence their SES concerning income. Also, employers want a productive, healthy workforce, which is an asset to an organization. Organizations with healthy workforces meet their quotas for producing goods and services nationwide. Healthy workforces are an asset to the nation's economy and decrease healthcare costs to the nation's economy. Therefore, improvements in an organization's flow of goods and services relative to a healthy employee workforce also contribute to factors that determine positive social change.

## Conclusion

Low SES will likely determine the healthcare quality provided to an African American adult in the United States. The implicit biases many healthcare providers harbor have likely diminished the quality of healthcare provided to the low SES low HL African American adults in the United States. Many healthcare providers' communication and interaction with this marginalized population is limited because the healthcare providers caring for low SES low HL African American adults hesitate to engage this group in conversations about their health that could stimulate communication, leading to increases in healthcare knowledge that would be beneficial to the low SES low HL African American adult's overall health, health outcomes, and HL.

When low SES, low HL African American adult patients exchange dialog with their healthcare providers, the healthcare providers usually do not consider that this patient population may feel intimidated during their encounters with them. Intimidation allows for the reluctance of this patient population to inquire or ask for clarity concerning health information/instructions. Therefore, healthcare providers must be made aware of biases concerning their interactions, communication, or exchange of dialog with this patient population and the possibility of intimidation concerning their patient's ability to interact and communicate with the healthcare provider concerning their health problems.

However, the first factor the healthcare provider must address is the difficulty of recognizing their biases, which may have a racial component. Therefore, considering the possibility of introducing health provider implicit biases in didactics provides insight to healthcare providers, which involves racial prejudices that the healthcare provider was unaware existed. In addition, how to recognize implicit racial biases can be included in the curriculum for those healthcare providers who receive their healthcare education in the form of a traditional classroom, for example, nursing students and physical, occupational, and respiratory therapy students.

Hence, biased healthcare professionals can compromise the low SES low HL African American adults' healthcare because they are unaware they may harbor racial biases. For those healthcare professionals who manifest explicit biases, their employer should take measures necessary to address this unacceptable behavior with consideration given to possible termination. The increased mortality and morbidity rates among the low SES low HL African American adult directly result from the inequities and disparities associated with the ineffective healthcare the low SES low HL African American adult receives. In addition, the literature has shown that healthcare providers may harbor biases toward African American adult patients notwithstanding their SES. In other words, an African American adult with an SES above the federal poverty guideline may not sway any preconceived notions that inform their biases.

The high healthcare costs to the United States economy attributed to low HL should give the governing political bodies pause relative to the inverse relationship between low HL and increased healthcare costs to the United States economy. The question, therefore, is maintaining the status quo, instead of implementing strategies to diminish ineffective healthcare, more important than the economic gains realized when the HL levels of low SES African American adults increase, and their health behaviors and QOL improve?

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# Appendix A: Interview Guide

## Research Question

RQ: What is the experience of low SES African American adults who self-report low health literacy when navigating the healthcare system?

## Interview Guide

Date of Interview

Location of interview

Start time: End time:

Name of interviewee:

Name of interviewer:

**Introduction:**
Hello/Hi: Name of Participant, Thank you for agreeing to participate in this study. This interview will gather the information that may lead to an understanding of improving the health literacy of the low-income African American adult patient. You do not have to answer any questions you do not want to answer, and you may withdraw from the interview. This interview will take about 60 minutes. Do you have any questions before we begin?

| Interview Question | Interviewee responses (utterances/gestures) | Interviewer observations or reactions |
|---|---|---|

| | | |
|---|---|---|
| 1. What is most important to you when visiting the doctor or the health clinic? | | |
| 2. How was your last visit to the doctor or the clinic? (Probe) | | |
| 3. How well do you understand your medical problems? (Probe) | | |
| 4. What questions do you ask your healthcare providers about your medical problems? (If do ask- explain/ If do not ask- why not) | | |
| 5. What healthcare information/instructions have you taken home? | | |
| 6. How well did you understand healthcare information/instructions? (Probe) | | |
| 7. How often does your healthcare provider explain or talk to you about your health? (Probe) | | |
| 8. How have conversations with the doctor or nurse helped you understand your medical problems? (Probe)) | | |
| 9. How confident are you that you can follow healthcare instructions after leaving the doctor's office or the healthcare clinic? (Probe) | | |
| 10. What do you think about your health knowledge? (Probe) | | |
| 11. How comfortable are you when completing admission healthcare forms? (Probe) | | |

Potential Probes:

- Could you explain that….
- How did that make you feel when….
- How often….

**Conclusion:**

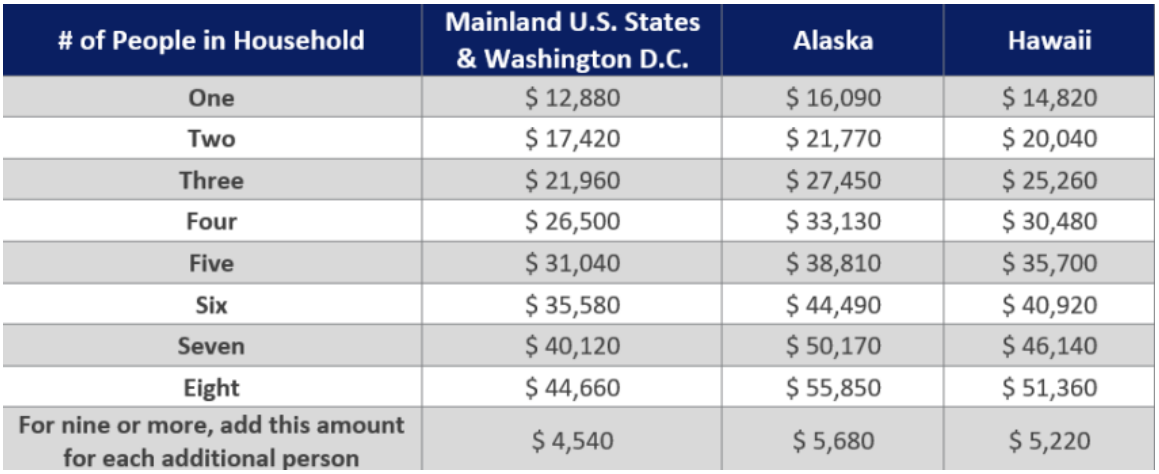
Thank you for your time today. I greatly appreciate your contribution to this study. I will contact you again, but only once, to share my understanding of your responses and get feedback on whether I understood you correctly.

Debriefing Statements used by the researcher/interviewer.

A debriefing at the end of each interview will reiterate and explain the goals of this study to the participant, informing "respect of person,"

- The study was developed to help understand why low-income African American adults continue to have the highest rate of low HL.
- The researchers/interviewers hoped to learn what steps may help improve HL among low-income African American adult patients.

# Appendix B: Federal Poverty Guidelines 2021



| # of People in Household | Mainland U.S. States & Washington D.C. | Alaska | Hawaii |
|---|---|---|---|
| One | $ 12,880 | $ 16,090 | $ 14,820 |
| Two | $ 17,420 | $ 21,770 | $ 20,040 |
| Three | $ 21,960 | $ 27,450 | $ 25,260 |
| Four | $ 26,500 | $ 33,130 | $ 30,480 |
| Five | $ 31,040 | $ 38,810 | $ 35,700 |
| Six | $ 35,580 | $ 44,490 | $ 40,920 |
| Seven | $ 40,120 | $ 50,170 | $ 46,140 |
| Eight | $ 44,660 | $ 55,850 | $ 51,360 |
| For nine or more, add this amount for each additional person | $ 4,540 | $ 5,680 | $ 5,220 |

# Appendix C: Flyer

## Walden University

## Understanding Healthcare Information

This research study will explore ways to improve low-income African American adults' understanding of the healthcare system and healthcare information or instructions.

As a Ph.D. psychology student at Walden University, I am conducting a study to explore and understand African American adults' experiences when using the healthcare system to attend to their healthcare needs.

**WHO:** The study recruits low-income African American adults 18 or older.

**WHAT:** As the researcher and interviewer for this study, I will wear a mask and maintain a 6 feet distance from individuals during the interview. I will ask individuals who have agreed to an interview to wear masks. I will ask 11 interview questions, which will be about your experiences when receiving healthcare services or getting healthcare information or instructions. Each session will last no longer than 60 minutes. Individuals agreeing to participate in the study will receive $25.00 cash after signing the informed consent.

**WHERE:** There will only be one interview session, and it will be scheduled based on the individual's availability and preferences. The interviews will take place at the location of the individual's choice. The interviews will be recorded.

**CONTACT INFORMATION:** email:
Phone number:

# Appendix D: Audit Trail

An audit trail will confirm that the responses are more of those of the participants and not an interpretation of the researcher's preconceptions and biases. The audit trail will provide transparency concerning the data collection, analysis, and coding process, reflecting the participant's narratives. I will conduct an audit trail after the completion of Chapter 5