

**WHAT ARE THE FACILITATORS AND BARRIERS TO HEALTH LITERACY FOR
AFRICAN AMERICAN FEMALES IN MARYLAND, AGES 18 OR OLDER, IN THE
MEDICAID VERSUS COMMERCIAL LINES OF BUSINESS?**

by

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Abstract

This qualitative case study's goal is to identify patterns in the health disparities experienced by African American women and to identify the factors that help and hinder African American females' ability to become health-literate consumers in the commercial and Medicaid markets. This study focuses on African American women's health outcomes and how they relate to health literacy. The purpose of this study is to increase health literacy for the African American population of women, specifically ages 18 and older. Various trends in health literacy are observed among all demographics. An example of this, specifically with African American women, is the misinformation in women's care. In comparison to previous studies, this research will take a new approach. This approach takes into account the environment in which people reside and receive medical care. These methods include descriptive phenomenology. These secondary analysis and phenomenological research in the form of interviews. A purposive sampling of 15 African American women over the age of 18 participated in this study. Data collection procedures included surveys, interviews, and observations. The interview script and researcher notes, the teleconference and videoconference recordings, the audio transcription, and the data analysis were all employed as data-gathering instruments in this study. According to the participants' HQL survey results, only six out of 15 participants scored proficient in health literacy. This data is a direct reflection of how sociodemographic factors, backgrounds, and extent of health information used are relatable.

Keywords: Health Literacy, African American women, Minority women's care, Medicaid, Commercial Insurance, HQL, Health Literacy Questionnaire

Dedication

Dedicated to Christiana Adenike Benson, Mary Solape Thomas, Tunde Thomas, and Claudia Benson. I hope I made you all proud. Thank you, mom, for everything.

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Table of Contents

ABSTRACT.....	2
Dedication.....	3
Acknowledgments.....	4
List of Abbreviations	8
CHAPTER ONE: INTRODUCTION.....	9
Need for the Study	9
Statement of the Problem.....	10
Purpose of the Study	11
Significance of the Study	12
Research Questions and Hypothesis	14
Overview of Methodology	14
Definition of Terms.....	16
Limitations and Delimitations of Study.....	16
Research Organization	18
CHAPTER TWO: LITERATURE REVIEW.....	19
Overview.....	19
Related Literature.....	20
Themes/Subthemes	34
Summary	36
CHAPTER THREE: METHODS.....	38
Overview.....	38
Participants.....	38

Design of Study.....	40
The Researcher's Role.....	41
Data Collection	42
Interviews.....	43
Surveys/Questionnaires.....	43
Document Analysis.....	44
Data Analysis	45
Trustworthiness.....	45
Credibility	46
Ethical Considerations	47
Summary	47
CHAPTER FOUR: FINDINGS.....	49
Overview.....	49
Participants.....	50
Results.....	51
Theme Development.....	52
Outlier Data and Findings.....	55
Research Question Response	56
Conclusion	58
CHAPTER FIVE: CONCLUSION.....	60
Overview.....	60
Discussion.....	60
Interpretation of Findings	61

Implications for Policy or Practice64

Theoretical or Empirical Implications65

Delimitations and Limitations.....65

Recommendations for Future Research66

Conclusion67

REFERENCES69

APPENDIX.....75

List of Abbreviations

HL- Health Literacy

HLQ- Health Literacy Questionnaire

LHL- Low Health Literacy

WHO- World Health Organization

HIL- Health Insurance Literacy

HO- Health Outcomes

CVD- Cardiovascular Disease

CHAPTER ONE: INTRODUCTION

Need for the Study

Health literacy is "the degree to which people are able to receive, process, and understand fundamental health information and services necessary to make wise health decisions," according to the Institute of Medicine (IOM; Nielsen-Bohlman et al., 2011). Print literacy, oral literacy, and numeracy are the three main aspects of health literacy that have been found by researchers (Cutilli & Bennett, 2019). Reading and understanding printed materials are referred to as print literacy.

Understanding written patient education materials, comprehending informed consent, and being able to comprehend and follow hospital discharge procedures, to name a few, all require print literacy skills. Digital health literacy is defined by the World Health Organization (WHO) as the capacity to look for, interpret, and evaluate health information from electronic sources and then apply the learned information to address or resolve a health issue (Berkman et al., 2011). The two components of oral literacy are speaking and listening (Nielsen-Bohlman et al., 2011). The quantitative component of health literacy is numeracy, which is the ability to work with and understand numbers. To navigate the healthcare system, adhere to instructions, and make sensible health decisions, one must have adequate health literacy. The incapability to make equitable decisions about one's health is directly linked to decreased health literacy and is typically linked to a number of health disparities; it is still unclear how precisely these inequities and how health literacy connect to one another (Mantwill et al., 2016; Stormacq et al., 2018). The objectives of this research are to assess and bridge the gaps of the degree to which the relationship between health literacy and health inequalities in healthcare delivery has been systematically examined. The potential relationships and paths that have been identified but have

not yet been thoroughly explored specifically in relation to African American females ages 18 and older using public and private insurance.

Statement of the Problem

About 90 million adults in the US have low health literacy (Stormacq et al., 2018). Health spending is expected to increase by \$69 billion annually due to insufficient health literacy (Nielsen-Bohlman et al., 2011). Trends in health literacy are observed among certain demographics. An example of this, specifically with African American women, is the misinformation in women's care. Health literacy is typically higher among women than among men. Adults who identify as White or Asian/Pacific Islander have higher health literacy than adults who identify as Black, Hispanic, Indian or Alaska Native, or Multiracial (Sentell et al., 2020). The health literacy of adults 65 and older is lower than that of adults in younger age groups (Batterham et al., 2016). Adults with a high school diploma or a GED are likely to be more health literate than those without one (Kimbrough, 2016). Health literacy increases with each completed level of higher education once adults have completed high school. Even with this statistical information, African American women still seem to suffer more significantly with access to care and healthcare delivery; low health literacy is a direct impact of this (Kimbrough, 2016).

Individuals with health insurance via their employer, a family member's employer, the military, or privately purchased insurance are more likely to be more health literate than adults without insurance, those on Medicaid, and those on Medicare (Cutilli & Bennett, 2010). According to Lisa FitzPatrick (MD) of the WHO, low health literacy affects racial and ethnic minorities more than any other group, with 58 percent of African Americans (the majority of these being women) having basic or lower health literacy, compared to 28 percent of White

Americans. Even now, when the Affordable Care Act has dramatically increased healthcare coverage, all of this eventually affects health outcomes (Hoskins, 2022). Compared to White patients, African-American patients have more trouble speaking with medical professionals. African-American patients are more passive during medical contact, less likely to participate in joint decision-making, and more prone to distrust the healthcare system (Hoskins, 2022). Patients with low health literacy have more trouble comprehending medical terminology, appropriately documenting their medical history, and comprehending directions from healthcare professionals. Additionally, they are less likely to ask questions, participate in joint decision-making, and are more passive when interacting with service providers (Cutilli & Bennett, 2010). African American women specifically have communication barriers in healthcare settings when speaking about sensitive subjects such as women's health (Hoskins, 2022).

Purpose of the Study

This study focuses on African American women's health outcomes and health literacy. The purpose of this study is to increase health literacy for the African American population of women, specifically ages 18 or older. To obtain quantitative data from interviews and then further explain those results using qualitative approaches, an explanatory sequential qualitative method approach has been adopted. Survey data is being utilized in the initial analysis to ascertain whether health literacy is related to the level of insurance received and what variables moderate this relationship. In order to gain insight into the relationship between health literacy and either public or private insurance, qualitative semi-structured interviews have been undertaken in the second phase to investigate the experiences of people with varied levels of health literacy. The results from phases one and two have been combined using the phenomenological methodology. The research question in this study is, "What are the

Facilitators and Barriers to Health Literacy for African American Females in Maryland Ages 18 or Older, in the Medicaid Versus Commercial Lines of Business?"

Specific aims include:

- To determine the relationship between health literacy and health outcomes in women's health.
- Documenting the prevalence of low health literacy and its effect on health outcomes.
- Shed light on negligence in minority women's care.
- Bridge the gap between public and private insurance practices to improve health outcomes.
- Develop suggestive solutions to improve overall health outcomes of African American women.

Significance of the Study

There are significant gaps in the literature concerning health literacy barriers and facilitator interventions in African American communities. Priority should be given to studies that examine practical methods for enhancing health literacy in groups that experience health disparities. Further research is needed, particularly to better understand how African Americans prefer to receive health information in various contexts (D'Eath et al., 2012; Spruill et al., 2015). Despite significant health advancements for women in the United States over the past century, health disparities still exist (Chinn et al., 2020). These health disparities are largely a result of the discrimination that Black women face on a variety of social and economic fronts. This misunderstanding perpetuates discrimination because black women are not thought of as a minority who are health savvy or can make equitable decisions about their health (Nápoles &

Stewart, 2018). The communication barriers between healthcare workers and Black women many times lead to the belittling of patients; this is another example of how discrimination is perpetuated. An example of these behaviors is healthcare workers using medical terms that patients are not familiar with and not clarifying the meanings. Despite general advancements among Black women in other areas, like keeping up with appointments and preventative care, they still endure excess mortality compared to other American women, including shorter life expectancies and greater rates of maternal death (Chinn et al., 2020). In addition, chronic illnesses like anemia, cardiovascular disease (CVD), and obesity affect Black women disproportionately. The social context in which people exist has an impact on health outcomes (Chinn et al., 2020). In addition to contributing to the current crisis of maternal morbidity and mortality, the increased burden of these chronic diseases is a reflection of the systemic injustices that Black women have endured throughout their lives, both inside and outside the health system (Chinn et al., 2020). The health disparities that Black women face are not only a matter of time or the outcome of one particular incidence (Chinn et al., 2020). This research study is significant because many individuals do not recognize a link between healthcare delivery and minorities making equitable healthcare decisions. Many also fail to recognize how the type of insurance they carry might affect a variety of outcomes. A growing body of studies demonstrated that inadequate health literacy is associated with affordable insurance per individual; individuals with lower-quality insurance identify with inadequate health literacy (Literacy, 2015). This research study will improve the percentage of African American women who feel that they have fallen through the cracks. The first step taken was identifying the population, addressing the main issues of this problem, and finding strategies that promote health literacy.

Research Questions and Hypotheses

1. This study seeks to answer the following questions: What factors, such as health inequalities, sources of health information, and health literacy, are indicative of African American women's health literacy?
2. What sociodemographic factors, background, and extent of health information use are related to minority women's health literacy?
3. What are the facilitators and barriers to health literacy for African American females ages 18 or older?
4. What are the facilitators and barriers to health literacy for African American females in the Medicaid versus commercial lines of business?

Overview of Methodology

Ethnography is a qualitative data collection method that is extensively used in the social and behavioral sciences. Information was collected through observations and interviews in order to draw conclusions about how societies and individuals function. The most efficient methods for gathering the data required for this study topic were surveys, interviews, and observations.

This research has benefitted from the phenomenological qualitative approach to inquiry. The "phenomenological research" approach to qualitative analysis seeks to understand and define a phenomenon's essential components (Martiny et al., 2021). This approach sets aside the researchers' prior theories about the phenomenon and looks at everyday human experiences. With this method of inquiry, the researcher examines participants' experiences related to health literacy and equity objectively, without prejudice or assumption (Martiny et al., 2021). As a result, this research study is credible, the material is accurate and current, and the information is clear and exact.

In comparison to previous studies, this research takes a new approach. To eliminate disparities, a socioecological strategy is required. This approach takes into account the environment in which people reside and receive medical care. It has been interesting to learn if increased personal health knowledge would lead to people making healthier decisions, especially those who belong to vulnerable demographics. Given the myriad of risks that poorer populations experience—including food insecurity, problems with food access, unsafe neighborhoods, etc.—that are influenced by social settings, it is imperative to have realistic expectations for what improving health literacy may achieve, especially in African American communities.

Definition of Terms

Black Female: Women who self-identify as having a heritage within the African diaspora (Whitfield, 2014).

Health Literacy: The degree to which a person can locate, comprehend, and make use of information and services to support health-related decisions and actions for themselves and others is known as health literacy (National Institutes of Health, 2015).

Health Outcome: A change in an individual's or a group's health condition that can be attributable to an intervention is measured by health outcomes. By employing specified metrics both before and after treatment, health outcomes of care will be used to assess the effect of the care process or intervention on the patient's life (National Institutes of Health, 2015).

African American female: For the purposes of this study and literature reviewed, the definition of African American females was defined as African American females ages 18 or older (Benson, 2023).

Health Disparity: Health disparities are discrepancies that socially disadvantaged populations encounter in the burden of disease, injury, violence, or opportunity to reach optimal health.

These differences are preventable (National Institutes of Health, 2015).

Healthcare Delivery: The provision of healthcare is the aspect of the health system that is most visible to patients and the general public. The organization and delivery of all services related to the diagnosis and treatment of disease, as well as the promotion, maintenance, and restoration of health, are the key areas of focus (National Institutes of Health, 2015).

Health Equity: Achieving the best possible level of health for everyone is known as health equity. When everyone gets the chance to live as healthily as they can, we will have achieved health equity (National Institutes of Health, 2015).

Medicaid: Millions of Americans, including qualifying low-income individuals, children, pregnant women, elderly adults, and persons with disabilities, have access to health coverage through Medicaid. According to federal regulations, states are responsible for managing Medicaid. The federal government and the states each provide funding to the program (CMS, 2022).

Commercial lines of business: Commercial health insurance, commonly known as private health insurance, is protection provided by an individual, business, or organization. It does not come from any government-sponsored insurance, such as Medicare or Medicaid (*Forbes Advisor*, 342017).

Limitations/ Delimitations of the Study

The primary disadvantage of qualitative research is the length of the process. The limited interpretations are another issue. Observations and judgments are influenced by knowledge and personal experience. A qualitative study could therefore take several weeks or months. Also,

since this method relies on interpersonal communication to gather data, discussions frequently veer off the subject at hand. For qualitative research to produce accurate results, careful planning is necessary. Qualitative data cannot be mathematically analyzed. This kind of research relies more on judgment and opinion than it does on data. As each qualitative study is distinct, it is challenging to reproduce them (McKenna et al., 2020). With this research, readers are provided a deeper look into the developmental differences in minority health literacy through two lenses, Medicaid and commercial lines of business. A key study limitation is the very limited sample size and participant attrition. It must be taken into account that participants in the research should presumably have a varied range of health, sociodemographic characteristics, and life experiences to be able to provide an accurate description of experiences.

The analysis methodology used in this paper is its major shortcoming. Primary data refers to the first-hand data gathered by the researcher himself. Primary analysis prevented the researcher from planning the investigation using the given data (Stangor, 2016). Instead, the researcher created questions in response to the questions of the study that need to be answered. The absence of the descriptive correlational technique, which only permits the investigation of correlations (associations) of the research through secondary analysis, was another methodological constraint. Only by analyzing the information gained from participant interviews can this study establish cause and effect (i.e., cause being limited health literacy and effect being improper healthcare delivery).

Assumptions

1. Medicaid providers' time spent discussing health literacy with African American women may not reduce the racial disparity attached to the health disparity, but opportunities for improvement exist.

2. Commercial lines of business have a higher rate of health literacy among African American women.
3. This research study was carried out in a way that ensures the population of the United States is represented.
4. Every questionnaire utilized is a valid and reliable tool for assessing the targeted component.
5. Participants provided truthful answers to the questionnaires and interviews.

Research Organization

Chapter One reviewed the need for the study, the statement of the problem, the purpose of the study, the significance of the study, research questions and hypotheses, an overview of the methodology, the definition of terms, limitations/ delimitations of the study, assumptions, and research organization.

The second chapter will analyze recent related research on the significance of this dissertation's literature review in terms of planning future studies. There will be established themes and subthemes. The approach, research design, and techniques for this investigation are covered in Chapter 3. This will consist of the following:

- The Population (setting, background, participants)
- Design of the Study (research design, instrumentation reliability, description, threats to internal and external validity)
- Data Collection Procedures (processes, directions, controls)
- Analysis of Data (demographics, statistical analyses, data collection techniques/tools)
- Summary

CHAPTER TWO: LITERATURE REVIEW

Overview

Low levels of health literacy are typically linked to a number of the causes of health disparities. However, it's still unclear how precisely inequities and health literacy connect to one another (Mantwill et al., 2016). The aim of this review is to assess the degree to which the relationship between healthcare delivery and health disparities in health literacy have been systematically examined, as well as the potential relationships and paths that have been identified but not yet thoroughly explored. There has not been much research on the connection between low health literacy and self-reported access to care on account of insurance as it pertains to the types of health delivery individuals are receiving and how that impacts their health literacy. Despite well-established correlations between low health literacy, low rates of health insurance coverage, and poor health outcomes, there have been no major changes.

Databases were used in searches to look for peer-reviewed papers on this particular research topic. Each study was evaluated for inclusion and for gathering pertinent data; publications were taken into consideration for review if they contained a valid health literacy measurement, explicitly linked a health disparity to a social disparity, such as racial/ethnicity or educational status, and presented their findings by contrasting two or more socially disadvantaged groups. Findings will be organized in line with the disparities discovered and the contribution that health literacy made to understand them to better prepare for a more successful strategy.

Literature Review

Comparison of Low-Value Care in Medicaid vs. Commercially Insured Populations

Reducing pointless examinations and treatments is a potentially effective strategy for raising the value of medical care; however, surprisingly, little is known regarding the relationship between low health literacy levels and the provision of low-value treatment and local practice patterns or insurance types (Charlesworth et al., 2019). In order to compare low-value care between Medicaid and commercially insured populations, the researcher investigate the relationship between low-value care delivery and insurance type and determine if low-value care delivery is influenced by local practice patterns (Charlesworth et al., 2019).

Medicaid and commercially insured persons between the ages of 18 and 40 were included in this cross-sectional analysis of claims data from the Oregon Division of Medical Assistance Programs and the Oregon All-Payer All-Claims database (Charlesworth et al., 2019). Using 16 claims-based indicators, low-value care was evaluated. The relationship between Medicaid and commercial low-value care rates within primary care service areas and between Medicaid and commercial low-value care coverage was tested using logistic regression (Charlesworth et al., 2019).

Medicaid and commercial enrollment from 2018-2019 were included in this analysis. Despite being younger (58.5% of Medicaid subscribers were between the ages of 18 and 40 compared to 36.7% of 18–40-year-olds with commercial insurance), Medicaid participants often had worse health conditions and lower literacy rates than those with commercial insurance. The likelihood of being female (62.9% were African Americans and residing in a rural location) was similarly higher among Medicaid members (Charlesworth et al., 2019). There was no clear correlation between low-value care and the kind of insurance (Medicaid or commercial

insurance). Medicaid patients were less likely to obtain low-value care for health outcome measures and more likely to receive it for ten measures when compared to commercial patients (Charlesworth et al., 2019). These measures are just different instances of healthcare situations that were deemed valued or not valued. Medicaid patients were considerably more likely to receive low-value care for seven out of 11 low-value care measures if they lived in a PCSA with a higher rate of low-value care for commercial patients.

Health Insurance Literacy Perceptions and the Needs of a Working-Class Community

Despite a rise in the number of Americans with insurance, individuals still have trouble getting the treatment they need. Health insurance coverage is not always used to its full potential when health insurance literacy (HIL) is low (Kakar et al., 2022). Further contextualization of the connection between HIL and access to treatment is still required, particularly for insured working-class individuals. This reviewed study aimed to identify the mechanisms via which HIL influences urban working-class women's access to care and healthcare decision-making (Kakar et al., 2022).

Five focus groups were held with 45 adult residents of South Louisville, Kentucky, using a qualitative descriptive technique. The questions investigated the participants' perspectives and healthcare needs with regard to accessing health insurance information, as well as their experiences with insurance enrollment, use, and navigating the healthcare system (Kakar et al., 2022). Transcripts were open-coded independently by team members using inductive thematic analysis. A focused coding framework was then chosen, and emergent themes were found using constant comparison methods (Kakar et al., 2022). The majority of participants gave health insurance a high value and saw it as the most significant perk provided by their companies. Even though they had sufficient HIL, the majority of participants indicated annoyance with the amount

of time and effort they had to put in to choose the appropriate insurance plan, get access to services that were covered, and resolve claims—often with inadequate outcomes (Kakar et al., 2022). Despite having insurance, several participants' decisions to accept particular tests or treatments were influenced by cost, which in some cases led to delayed or skipped therapy (Kakar et al., 2022).

The results of this qualitative study show that access to healthcare is significantly influenced by both the structural context of the complicated, expensive healthcare system and the individual context of HIL knowledge, experience, and living circumstances. Because HIL gained from experiencing narratives was the most helpful in navigating the health care system, interventions to improve HIL should contain applicable examples and real-world scenarios (Kakar et al., 2022). This study contextualizes the manner in which HIL impacts consumers' decisions about their health care and access to care through the use of focus groups with members of a working-class community. Results show that access to healthcare is significantly influenced by both the structural context of the complicated, expensive healthcare system and the individual context of HIL knowledge, experience, and living circumstances (Kakar et al., 2022).

Health Literacy Interventions and Outcomes: An Updated Systematic Review

In order to update a 2004 systematic evaluation of healthcare service utilization, health outcomes, and therapies designed to improve these outcomes for individuals with low health literacy, "Health literacy interventions and outcomes: an updated systematic review" was published (Berkman et al., 2011). The effectiveness of interventions as well as the differences in health outcomes between various sociodemographic groups, was investigated. The usual Evidence-based Practice Center technique was used to grade this study, which involves a dual examination of the abstracts, full-text publications, abstractions, and quality ratings (Berkman et

al., 2011). Following an evaluation of whether more recent content was available for addressing crucial concerns, researchers increased the criteria for health literacy to include numeracy and oral health literacy. Researchers changed their methods to rank the quality of the evidence and determine the possibility of bias in individual studies. They also excluded intervention trials that did not explicitly measure health literacy (Berkman et al., 2011).

The Relationship between Health Literacy and Health Disparities: A Systematic Review

A systematic review was carried out to better comprehend the degree to which the relationship between health literacy and health disparities has been comprehensively studied, as well as which potential relationships and pathways have been identified (Mantwill et al., 2016). Five databases, including PubMed/MEDLINE and CINAHL, were used as resources for studies that had been peer-reviewed. There were 36 research studies included in the final synthesis. A small number of research studies systematically examined educational discrepancies after the majority of studies examined racial and ethnic differences (Mantwill et al., 2016). There is evidence that health literacy and numeracy may help to reduce racial and ethnic disparities in medication adherence and understanding of medication intake, as well as the mediating effect of health literacy on self-rated health status across racial/ethnic and educational disparities (Mantwill et al., 2016).

Does health literacy mediate the relationship between socioeconomic status and health disparities? Integrative review

In this study, the evidence for the hypothesis that health literacy mediates the relationship between socioeconomic status (SES) and health disparities was explored. Studies that particularly examined socioeconomic and sociodemographic characteristics linked to low health literacy levels, as well as the mediating role of literacy in the relationship between SES and

disparities in health outcomes, were found using the databases listed below (Stormacq et al., 2018). Mednar, Doaj, Medline, Cinahl, Embase, PsychInfo, Eric, Web of Science, Google, and Google Scholar. Methodological excellence was assessed for a select few studies (Stormacq et al., 2018). The sixteen published articles that were kept for inclusion were examined using the constant comparison method.

The review reveals that literacy mediates the association between SES and health status, quality of life, specific health-related outcomes, health behaviors, and use of preventive services. Poor SES, and particularly low educational attainment, are the most significant determinants of health literacy (Stormacq et al., 2018). It has been demonstrated that poor SES is a factor in low health literacy levels. Health literacy is a modifiable risk factor for socioeconomic health inequalities. According to the authors, it might be essential to increase the population's health literacy or increase access to health care for people with low health literacy in order to achieve more health equity.

Health Literacy: Applying Current Concepts to Improve Health Services and Reduce Health Inequalities

This study updated knowledge on recently developed measurement techniques that assess individuals' and groups' health literacy across a range of health literacy-related areas (Batterham et al., 2016). It is now possible to apply diagnostic and problem-solving methodologies to find solutions to deficiencies that have been identified thanks to the advancement of measurement. Researchers considered how this strategy might be applied in various settings where health literacy has been implemented (Batterham et al., 2016). They emphasize the various ways in which health service providers can use health literacy and the ways in which new information and tools, such as strategies based on an understanding of the various health literacy needs in a

target community, can improve practice.

Furthermore, researchers offer a model that attempts to integrate the notion of health literacy with concepts that are usually seen to overlap with it. With a detailed awareness of the contrasts between prevalent conceptions, health literacy can be utilized to supplement a variety of sectors, from individual patient treatment to community-level development and from boosting compliance to empowering people and communities (Batterham et al., 2016).

Health Literacy as a Contributor to Immigrant Health Disparities

Low health literacy among those with poor reading skills, limited English language competence, members of racial or cultural minorities, and immigrants is likely a major contributor to health disparities in the US (Agency for Health Care Policy and Research 1997). (Kimbrough, 2016). A series of focus groups with immigrants from East Asia, Africa, Central America, and South America were organized in order to better understand the perspectives of immigrants seeking healthcare services in a metropolitan county in North Carolina. The participants' remarks are divided into four categories: communication, patient education, cultural sensitivity, and medication compliance. We investigate the implications of raising health literacy among immigrant communities (Kimbrough, 2016).

Focus groups were conducted to better understand what immigrants saw to be their own needs in terms of health care and education. Participants in a group discussion were asked a series of questions regarding barriers to receiving healthcare, strategies, and policies in place to help patients with their literacy needs, and suggestions for enhancing provider-patient communication. The researcher developed these questions in consultation with a group of community members who are knowledgeable about health care, immigration challenges, and literacy (Kimbrough, 2016). During the focus groups, the researcher used questions and prompts

to better understand the aim and purpose of the participants' stories. The questions were designed to collect descriptive information about interactions between immigrants and healthcare professionals as well as ideas for improving the integration of immigrants into the healthcare system (Kimbrough, 2016). The focus groups were moderated by the researcher and a certified graduate student in public health. The researchers recorded the group discussions using Marantz recorders and multi-directional microphones. After the cassettes were transcribed, the transcriptions served as the basis for data analysis.

The results of focus group research showed some key elements. The primary issues can be categorized into four categories: cultural competency, medication compliance, patient education, and communication and translation (Kimbrough, 2016). Patients and providers both contribute significantly to each of these issues. When providing healthcare and health education to immigrant patients, professionals must take into account each individual's situation. In some circumstances, the problem cannot be resolved. Instead, if immigrants are treated with respect for the unique experience and insight they bring, treatment can be maximized, and health outcomes may be improved (Kimbrough, 2016). This study's shortcomings include its small sample size, the potential for selection bias brought on by participant self-selection, and the absence of quantitative data to describe individuals. For bigger research studies to better understand the issues of immigrant health literacy, data on the period of US residency, age at immigration, quantitative measures of health literacy status, and other factors that may distinguish health literacy levels among immigrant populations should be gathered (Kimbrough, 2016).

Interventions that Reach into Communities—Promising Directions for Reducing Racial and Ethnic Disparities in Healthcare

Improvements in the quality of medical care have had only a limited impact on healthcare

disparities, which are largely dependent on social determinants of health, as shown by the conceptual framework described in this review. It describes the underlying causes of differences in healthcare quality and outcomes. The evidence evaluation ordered to direct its efforts to eliminate racial and ethnic inequities was the main subject of this review. The recommended interventions, such as care coordination, culturally competent health education, and community health workers, extend the reach of health systems outside of clinics and hospitals and into the communities, social contexts, and cultural settings where patients live and where the majority of health promotion activities take place (Quiones et al., 2018).

In order to demonstrate that interventions with a wider reach have a higher impact on reducing inequities, a social ecology model was developed to map these evidence-based therapies onto sectors that affect individual health and healthcare (Quiones et al., 2018). According to this paradigm, a wide range of socioeconomic factors, including education and individual wealth, as well as community infrastructure and resources, influence racial and ethnic disparities in healthcare. Due to the extremely limited interactions between patients and doctors in this social situation, the majority of actual healthcare is provided (Quiones et al., 2018). Therefore, the most promising interventions for closing gaps are those that extend beyond typical clinical meetings and into patients' social and cultural contexts (Quiones et al., 2018). On the other hand, initiatives that concentrate on the internal workings of the healthcare system, such as the implementation of more regular or specific clinician reminders, typically fail to have a systemic health impact.

The Effectiveness of Cultural Competence Programs in Ethnic Minority Patient-Centered Health Care—a Systematic Review of the Literature

The purpose of this study was to evaluate the potential benefits of patient-centered care

models that emphasize cultural competency for patients from a range of cultural and language backgrounds (Renzaho et al., 2015). When performing the review, the preferred reporting items for systematic reviews and meta-analyses, as well as the suggestions for the critical appraisal skill program, were adhered to (Renzaho et al., 2015). Data from the research were gathered using a piloted form that had sections for the population being studied, the setting, the sample size, the results, and any limitations. The initial search turned up 1450 potentially relevant studies. Only 13 individuals qualified for inclusion. There were two qualitative and eleven quantitative studies (Renzaho et al., 2015). The conclusions drawn from the research that was preserved suggested that providing patient-centered care and being culturally competent increased practitioners' knowledge, understanding, and sensitivity to other cultures (Renzaho et al., 2015). There were no significant discoveries that might have improved patient outcomes.

The results showed that practitioners' knowledge of and awareness of dealing with patients from culturally diverse backgrounds were enhanced by using patient-centered models with a focus on cultural competency (Renzaho et al., 2015). It has not been thoroughly investigated if this increase in practitioner knowledge results in improved practice and, ultimately, better patient-related outcomes. As a result, further research on this particular relationship is needed.

Impact of health literacy on socioeconomic and racial differences in health in an elderly population

The review highlighted variations in health literacy levels by race and degree of education, although there is little hard evidence to back up this claim. The objective was to undertake cohort research to assess how low health literacy contributes to differences in health status and immunization rates between racial and socioeconomic groups. Self-reported health

status, SF-12 scores for physical and mental health, influenza and pneumococcal vaccinations, and ratings for physical health were dependent variables for the techniques and measures (Howard et al., 2019). There were independent predictors for health literacy, education level, race, income, age, sex, chronic health conditions, and smoking status (Howard et al., 2019).

When demographic and health-related characteristics were taken into consideration, the findings showed that people without a high school diploma had worse physical and mental health, as well as inferior self-reported health status. These disparities were reduced from 41% to 22%. (Howard et al., 2019). The self-reported health of Black people was worse, and they had lower pneumococcal and influenza vaccination rates. When health literacy was taken into consideration, the observed disparity in self-reported health was reduced by 25%; however, variations in vaccination rates remained unaffected (Howard et al., 2019). If literacy were disregarded, variations in health status and, to a lesser extent, vaccination rates would normally be attributed to educational attainment and race. However, only a small to moderate percentage of these variations may be attributed to health literacy (Howard et al., 2019).

Association of Health Insurance Literacy with Health Care Utilization: A Systematic Review

Understanding and applying health insurance terms and concepts (health insurance literacy) may be crucial for navigating the use of healthcare given the rising number of people who are undergoing transitions in their health insurance due to reductions in employer-sponsored insurance and changes in health policy (Yagi et al., 2021). The purpose of the study was to thoroughly review the data about the association between health insurance literacy and health care utilization.

In August 2019, searches were conducted on various academic journals and reference lists of published literature. There were no language or time limits for identifying quantitative,

qualitative, and intervention studies that evaluated the relationship between health insurance literacy as the exposure and health care utilization as the outcome (Yagi et al., 2021). Two to three reviewers independently evaluated the results. The inclusion criteria were met by twenty-one research totaling 62,416 people from three interventional trials, two mixed-methods studies, and sixteen cross-sectional studies (Yagi et al., 2021). In ten out of thirteen research on preventive care, it was shown that increased health insurance literacy was linked to higher use of primary care and other preventive treatments. In eight out of nine research on care avoidance, people with less knowledge of health insurance were shown to be more likely to put off or postpone seeking medical attention (Yagi et al., 2021). Regarding the use of surgical, inpatient, and emergency department care, a few research produced conflicting findings.

In conclusion, there is little research on the relationship between health literacy and healthcare use, and there are no established standards for measuring HIL (Yagi et al., 2021). According to a review of recent literature, having a low HIL prevents people from effectively utilizing crucial medical services like primary care, preventative care, medication adherence, and reducing delays or avoidance of treatment for urgent requirements. In order to promote more efficient and cost-conscious utilization, it may be effective to improve HIL and increase plain language communication of health insurance plan elements at the point of care navigation (Yagi et al., 2021).

Nurse Practitioners' Use of Communication Techniques: Results of a Maryland Oral Health Literacy Survey

As a part of a statewide oral health literacy evaluation in the state of Maryland, this study investigated how nurse practitioners used and felt about suggested communication approaches for the promotion of oral health (Koo et al., 2016). It has been shown that using patient-centered

communication methods and health literacy improves health outcomes. In 2010, 1,410 registered nurse practitioners (NPs) in Maryland were sent a 27-item self-report survey with 17 communication technique elements across 5 areas (Koo et al., 2016). Using descriptive statistics, the use of communication tactics and judgments regarding their efficacy were examined (Koo et al., 2016). To analyze provider and practice variables and forecast changes in the mean and total number of communication techniques employed on a weekly basis, general linear models were used.

According to the research, NPs who had evaluated their office for patient friendliness or who had completed a communication course in addition to their original training may be predictors of adopting more of the seven fundamental communication approaches (Koo et al., 2016). These self-reported results need to be confirmed by observational research.

The Value of Community Health Literacy Assessments: Health Literacy in Maryland

Traditionally, health literacy has not been taken into account in community health evaluations (Platter et al., 2021). In order to describe county and regional health literacy activities, assets, gaps, and opportunities in Maryland, this study established the Community Health Literacy Assessment (CHLA) framework (Platter et al., 2021).

From January to August 2018, researchers in Maryland used the CHLA framework. The 24 counties of Maryland were subjected to an environmental scan by researchers in order to uncover organizations, health indicators, and community resources (Platter et al., 2021). To learn what significant local groups across Maryland are doing to adopt health literacy best practices and policies, researchers conducted qualitative interviews with local health improvement coalitions and health departments in each county (Platter et al., 2021). In order to analyze, measure, and interpret the interview data, we used summative content analysis.

Participants from 56 organizations from all 24 counties of Maryland participated in 57 interviews. Three key themes emerged from data collected on various aspects of health literacy: health literacy assets and activities, health literacy gaps, and health literacy (Platter et al., 2021). The most frequently mentioned resource was gathering data to inform health literacy practices, the most frequently mentioned weakness was using jargon with community members, and the most frequently mentioned opportunity was raising public awareness of already-existing health programs through improved outreach and instructing health information-seeking behaviors (Platter et al., 2021).

A practical method to gather a lot of health literacy data that may guide strategic planning, identify community interventions, and eventually move us closer to a health-literate society is through a comprehensive community health literacy assessment (Platter et al., 2021). The authors of this study advise others to use the CHLA framework in order to operationalize health literacy as a health indicator and incorporate it as a metric for community health assessment.

Overview of Health Disparities: Maryland Considerations

Despite the fact that health and life expectancy have improved over the past 100 years, not all communities have benefited from advancements in public health and medicine. Lags in health status and life expectancy are caused in part by the failure of some populations to translate advancements in illness prevention and management. "Health disparities" are variations in disease rates and illness burden when compared to a reference population. It is clear that there must be equity and equality in access to high-quality healthcare, healthcare delivery, and health outcomes given the emphasis on population and individual inequities in health status and healthcare.

A national and international focus has established connected components, known as "social determinants of health," which stress the social, economic, and other aspects related to health inequalities (Baquet & Colgan, 2018). This has happened as research on the causes of health disparities and inequities has advanced. Health disparities are "...the unfair and avoidable differences in health status," according to the World Health Organization Commission on Social Determinants of Health.

The causes of health disparities are multiple, complicated, and may interact with one another. While some factors can be changed, others cannot. It is clear that many discrepancies may be avoided, nevertheless (Baquet & Colgan, 2018). Disparities may be attributed to risk factors and exposures such as cigarette use, alcohol use, environmental exposures, and family history. Racial disparities in disease treatment, poor health-seeking practices, such as postponing diagnosis or treatment or overusing emergency rooms, and a lack of funding for healthcare are all examples of poor quality healthcare (Baquet & Colgan, 2018). Furthermore, social determinants of health focus more on multidisciplinary approaches than single disease-specific approaches and play significant roles in health disparities (Baquet & Colgan, 2018). Freeman and others refer to the "discovery-delivery disconnect" as the inability to transmit research-generated data and clinical best practices to all populations, which can result in increased mortality and lower survival rates from diseases like cancer.

Themes/Subthemes

A surprisingly small number of research studies systematically examined educational discrepancies, and the majority of studies focused on racial and ethnic differences. There is evidence that health literacy and numeracy may help close racial and ethnic differences in medication adherence, especially with Medicaid. There is also evidence that health information

literacy (HIL) may help close gaps between racial/ethnic and educational disparities in self-rated health status (Mantwill et al., 2016). The predominant philosophical premise in the reviews was epistemological, and the predominant interpretive frameworks were social constructivism and pragmatism. Overall, there is a lack of credible research on the relationship between disparities and health literacy between state-funded and commercial insurance (Yagi et al., 2021). Studies differed substantially in terms of the health outcomes they were looking at and the health literacy metrics they were using. A majority of the study also lacked a thorough characterization of the routes that were considered, as well as a thorough explanation of the type of disparity that was being studied.

Predictably, higher relationships between the HIL measurement's increased specificity and patterns of healthcare utilization did not always hold across trials. This emphasizes the need for HIL researchers to decide whether it is more beneficial to measure HIL in a context-specific approach (for example, knowledge of coverage of a particular service) or as a general skill or habit that will be more likely to generalize across diverse healthcare situations. Another recurring theme in the reviews was the idea that high HIL could facilitate cost-conscious navigation of the healthcare system while low HIL might act as a roadblock. For instance, a number of research studies that evaluated delayed or skipped care discovered that decreased HIL was linked to disregard for necessary care. This reveals that HIL is an important intermediary for navigating the complex US healthcare system, including Medicaid and private insurance.

Summary

Health literacy was not a topic that disparities research specifically addressed until recently. Where does a paradigm for inequities fit health literacy? Is it harmful to your health, exactly as engaging in unsuitable exercise, misusing alcohol or other drugs, or smoking? Has a psychological component been considered? Has a biological component been identified? Health literacy is the capacity to acquire, process, and grasp basic health information and services in order to make informed health decisions (Literacy, 2015). Health disparities are variances in health that result from a variety of characteristics, including gender, ethnicity, income, education, disability, type of insurance, being located in a rural location, or gender identity, according to the federal government (Literacy, 2015). All of these variables also affect the kind of insurance that people can afford, and that will be useful to them. Health literacy does not recognize that these characteristics directly affect the delivery of healthcare to minorities, making this disparity even more of a priority. Education and health literacy may have some correlation.

Insurance is one of the many ways that health outcomes, health disparities, and health literacy are all assumed to be related. Because many individuals do not recognize the connection between the provision of healthcare and minorities' ability to make equitable decisions regarding their health, this research is significant to me. People also fail to understand how various outcomes can be affected by the type of insurance. I was able to see the gap up close because I am a member of a minority and work in a city health department. A growing body of data shows that access to inexpensive insurance for each individual is correlated with inadequate health literacy (Literacy, 2015).

A sample of individuals revealed that the majority had little understanding of fundamental health insurance terms and had trouble using their insurance to get the necessary

medical care (Edward et al., 2019). These results show that health insurance literacy is a significant issue in our community that disproportionately affects specific underprivileged groups, such as young adults, low-income groups, uninsured individuals, and, last but not least, African American women.

CHAPTER THREE:

The Population

The study population should be specified in all experimental, observational, and qualitative research involving human subjects to ascertain who is qualified to participate in a study (Eldredge et al., 2016). The identified demographic serves as the foundation for applying the study's findings to other pertinent populations (Eldredge et al., 2016). Early on in the research process, a study population should be precisely defined (Eldredge et al., 2016). This helps ensure the overall validity of the study results. Eldredge et. al (2016) indicate that there are three main reasons why the target population is crucial:

- Clearly defines the purpose and scope of the research and data types;
- Identifies the traits of the people who meet the requirements for the study;
- Gives the range of the entire population so that the sample size can be calculated.

(Eldredge et al., 2016)

Research on obstacles to health literacy and solutions in African American communities, particularly African American women ages 18 or older, has considerable gaps. Research will be prioritized on methods that work to increase health literacy in groups that face health disparities (Muvuka et al., 2020). More research is needed, specifically on how African Americans like to receive health information in various contexts. Examining the impact of the direct linkage of state-funded or commercial insurance health literacy would be of special interest (Muvuka et al., 2020). More study is required on community-based health literacy treatments because many health literacy programs are health system-focused. Furthermore, we must look into the factors that influence the development of health literacy, particularly among communities of color and other ethnic minorities (Muvuka et al., 2020).

Although Black women's health in the United States has significantly improved over the past century, health disparities still exist (Chinn et al., 2020). Shorter life expectancies and greater maternal mortality rates are among the excess mortality factors that Black women continue to endure compared to other American women (Chinn et al., 2020). Chronic illnesses disproportionately affect Black women. The social context in which people exist has an impact on health outcomes. In addition to contributing to the current maternal morbidity and mortality crisis, the increased burden of these chronic diseases reflects the systemic injustice Black women endure throughout their lives inside and outside the health system (Chinn et al., 2020). The health disparities that Black women face are not only a matter of time or the outcome of one particular incidence. Medicaid expansion is linked to improved coverage equity; however, Black people make up a disproportionately big part of adults in the remaining non-expansion states with incomes below 138 percent of the federal poverty level (FPL). Black women make up a sizable portion of those individuals (Janibropenal, 2017).

Black women come from various ethnic and nativity backgrounds (Chinn et al., 2020). Those backgrounds are not a single culture or language; instead, they are a diverse bunch. (Chinn et al., 2020) "Black women" refers to the collective identities of Black women, including women of other ethnicities, for the purposes of this research (Chinn et al., 2020). The women who were a part of the original study's population are referred to as "Black women" in the data used in this analysis. This study's targeted population is African American women ages 18 or older. Women from any background or community will be included and interviewed. A total of 15 participants will be included, as well as the review of systematic studies.

Design of the Study

A research design is a strategy or plan for carrying out research. It consists of a collection of strategies and practices used to generate accurate and legitimate data (Bhalerao & Parab, 2015). The research question being posed, and the sort of data being gathered must both be compatible with the study design (Bhalerao & Parab, 2015). Every study's design is more crucial than its analysis of the findings since a poorly designed study cannot be fixed, in contrast to a poorly analyzed study that can be reanalyzed to get a relevant conclusion (Bhalerao & Parab, 2015). Instead, how the data is best examined depends on the study's design. So, the study design has a significant impact on the study's scientific validity and the veracity of its data (Bhalerao & Parab, 2015).

The design of this study is a phenomenological research design. These methods include descriptive phenomenology. These methods include descriptive correlational in the setting of secondary analysis and phenomenological research in the form of interviews (Deakin University, 2021). Instead of identifying cause-and-effect linkages, descriptive correlational studies are used to describe the interactions or associations between variables (Garrett, 2022). Secondary analysis employs information gathered in another research to discover novel correlations or respond to various research questions (Garrett, 2022).

The phenomenological approach aims to shed light on the particular by identifying phenomena based on how the actors in a scenario perceive them (Paraguay, 2019). In the human realm, this typically entails obtaining "deep" data and perspectives using inductive, qualitative techniques like participant observation, conversations, and interviews and expressing them from the viewpoint of the study subjects (Paraguay, 2019). In phenomenology, experience is studied from the perspective of the individual, "bracketing" presumptions, and common modes of

perception (Paraguay, 2019). It is particularly successful at challenging structural or normative presumptions. Phenomenological approaches bring to the fore the experiences and perceptions of individuals from their own perspectives. Phenomenological research can be utilized to inform, support, or question policy and action by adding an interpretive component that enables it to serve as the foundation for practical theory (Paraguay, 2019).

The initial item pool of potential assessment questions was sent to two expert reviewers for comments in order to determine which question items performed the best in assessing health literacy among African American women ages 18 or older. Their comprehensive evaluation and scoring of the test components will aid in establishing the initial content validity of the health literacy grading scale by allowing respondents to comment on both the good and the bad health literacy measures.

A new measurement technique is statistically tested against an independent criterion or standard (concurrent validity) or against a future standard to determine its criterion validity (predictive validity) (Newmuis, 2016). Estimation of a measure's criteria validity is its degree of agreement with a gold standard (i.e., an external criterion of the phenomenon being measured) (Newmuis, 2016). The overall lack of gold standards is the main issue in criterion validity assessment for questionnaire-based measures. In fact, certain so-called gold standards might not even be able to determine a phenomenon's genuine worth with complete accuracy (Newmuis, 2016).

By regressing health status and health behavior-related variables (individually - as outcome variables) on several skill-set domains, criterion-related validity will be evaluated. This assisted in the interpretation of health literacy in the interviews. These variables were compared between commercial and state-funded insurance.

Data Collection Procedures

Data collection is the process of compiling precise data from numerous sources and evaluating it to identify trends, possibilities, and solutions to research problems, as well as to assess potential consequences (Talonise, 2021). A researcher must first respond to these three questions before they can start gathering data:

- What is the aim or reason behind this study?
- What types of data are they going to collect?
- What techniques and policies will be applied to gather, store, and process the data?

(Talonise, 2021)

Primary data is authentic, first-hand information gathered by data analysts. Prior to conducting any additional or connected study, this procedure is the first stage in acquiring information (Talonise, 2021). Results from primary data are quite accurate as long as the researcher gathers the data (Talonise, 2021). Yet, there is a drawback because in-person research may be costly and time-consuming (Talonise, 2021). Secondary data is information that has already undergone statistical analysis and has been obtained from other sources. This information is either information the researcher has looked up or information the researcher has asked others to gather (Talonise, 2021). Although secondary information is more accessible and less costly than primary information, its legitimacy and veracity are questioned (Talonise, 2021). The majority of secondary data is composed of numerical information.

In this phenomenological case study, the researcher's major objective is to conduct interviews. In addition to asking questions and recording the responses, the duty also included conducting interviews with open-ended questions. The key to collecting the data was inspiring the interviewees to want to take part in giving the questions honest and candid answers. Interviewing someone who is reserved can be challenging. Putting the person at ease, if

necessary, is one method to do this, but the most crucial step was to emphasize the significance of their participation. There are good and terrible days for everyone. Because of this, it is crucial to make sure that, as the interviewer, all personal distractions were addressed and that you were aware of what could be done first and what needed to be done later.

The study concentrated on examining the connections between demographic and background traits and health literacy, risk factors for health disparities, sources of health information, and insurance options. The ideal interview should be conducted in person; if this is an inconvenience for some, interviews can also be conducted virtually using any meeting tool for online video and telephone conferencing. A verbatim record is important, but it doesn't communicate gestures, tone, or body language. This study's availability of the participants for an in-person interview is one of its weaknesses. Clarification was necessary for the interviewer. This was avoided by using a script to ensure that everyone was asked the same questions. This also enables preparation for potential objections or queries, whether they are anticipated or not.

The participants were interviewed remotely through Microsoft Teams or Zoom, and the data was directly collected from their responses. Participants were notified by email for more information if needed. A follow-up phone call was placed after any emails that received no response asking for the interview. The researcher interviewed each participant using this approach. The interview script and researcher notes, the teleconference and videoconference recordings, the audio transcription, and the data analysis were all employed as data-gathering instruments in this study. By using the online conferencing technique, the interviews were recorded by the web media, sent directly to the computer, and stored there. The recordings were converted into text using transcription software in Microsoft Teams. The audio was internally stored on the computer as well as externally on a secure portable USB device.

The only tool utilized to acquire data was the interview script. The survey was taken into consideration as a viable data collection technique. Yet, this would reduce the amount of specificity in the participant's information. Open-ended questions gave participants knowledge and allowed them to answer freely without making assumptions. The open-ended interviews allowed for a great deal of in-depth responses that offered the level of information crucial to the data gathering for this project.

Convenience sampling was also used because participants were located in Maryland, which is convenient for the researcher (Edgar & Manz, 2017). Utilizing respondents who are "convenient" for the researcher is known as convenience sampling (Edgar & Manz, 2017). There is absolutely no pattern in how these respondents are found; they could be found by simply approaching people in the street, a public space, or a place of employment (Edgar & Manz, 2017). Because it is believed that people are being stopped "at random," the term is sometimes conflated with "random sampling" (in other words, haphazardly) (Edgar & Manz, 2017). The correct definition of random sampling (choosing possible respondents or participants from a sample frame using random numbers) typically yields a statistically balanced selection of the population (Edgar & Manz, 2017). The researcher recruited participants through professional relationships developed in the healthcare industry to gain willing participants, as well as adding snowball sampling as a protective measure in case the original technique did not yield enough participants.

The strategy is further explained by the purposive sampling technique that was used, which also addresses theoretical and practical concerns and explains the participant criterion (Dudovskiy, 2022). African American women between the ages of 18 and older are on the known target list (Dudovskiy, 2022). Everyone had access, and it encouraged additional

research. The sampling method also made it possible to conduct interviews with members of the community using questions that were consistent with the study's theoretical framework (Dudovskiy, 2022). The capacity to acquire information from people with a health literacy knowledge base was made possible by the purposive sampling technique, which also minimized sampling bias because the individuals were typical of the population of experts (Dudovskiy, 2022).

Analysis of Data

Data analysis gives the collected information credibility. It provides the information with reliable sources and a theoretical foundation on which to stand (Rishibon, 2017). Data analysis is another simple method for assessing how well others have understood the research material as a whole (Jena, 2016). It provides readers with information on the conclusions the researcher has drawn from all the available data. It also helps to comprehend how each person interprets the same. Giving insight and interpretation through analysis of all the data eliminates any possibility of human bias (Jena, 2016). Data analysis involves the researcher providing the precise message without any chance of the reader becoming biased because their work would be credible and free of gaps.

The second and most crucial section of this process is data analysis. While most researchers would not be able to conduct the analysis on their own, it is also the most difficult stage (Jena, 2016). To put it simply, data analysis is the process of reducing complex research information to its most basic and straightforward form (Jena, 2016). This aids in providing evidence and improving understanding of the study (Jena, 2016). Reporting must include not only the research data but also an interpretation of that data that has undergone in-depth examination.

In the analysis of this study's data, one or more research question was connected to each interview question. Participants were requested to use trigger words and/or precise wording in their responses to address the study topic. The research topic was coded and matched using the frequently occurring trigger words and/or phrases. Both automatic and human transcription of the recordings were done. To make sure the software didn't make any errors, a disinterested person and I checked each transcription three times. The transcripts were then forwarded to the participant for evaluation and review for the accuracy of their interview statements. The researcher summarized and confirmed the interpretation of what the participants said during data collection to check for accuracy and validity. This added to the study's validity and strengthened the interview question's usefulness.

One method available to confirm or corroborate the findings is to have a third party who is not involved in the study check the audio and typed transcripts for errors. As a result, any prejudice or distortion was removed, and the participant or researcher could ask for clarification. This added to the study's validity and strengthened the interview question's usefulness. Open-ended interview questions and responses were recorded on a voice recorder, video, and written notes as the data collection tools in this study. The research topics and the goal of this study were used to create the interview questions.

The foundation of excellent qualitative research is the reliability of the findings. Member checking, sometimes referred to as responder or participant validation, is a method for examining the veracity of results (Birt et al., 2016). Participants receive data or results back to verify accuracy and fit with their experiences. Member checking is frequently listed among the validation methods used in this research.

High ethical standards were upheld during this research. By doing this study, the

researcher hopes to contribute to the understanding of and efforts to mitigate the effects of low health literacy. Any research on health literacy would suffer if results were withheld, fabricated, or made up. Also, it would violate my sense of integrity. A lot of care was taken to make sure that nothing was omitted or misconstrued in the results. This acted as a check and balance, reduced any ethical problems, and gave the study credibility, validity, and integrity.

Summary

Health literacy is a complicated topic, perhaps even more so. There are similarities across communities, healthcare professionals, and patients, but none of them will ever be the same as the patients' or the physicians' neighbors. The usage of tools and guidelines will therefore vary based on the type of insurance, and healthcare providers cannot treat everyone equally. Hospitals, healthcare organizations, other organizations, physicians, nurses, patients, insurers, and administrators of healthcare are all impacted by this study. This study analyzed how organizations explicitly address health literacy by contrasting health literacy methodology in Medicaid and commercial insurance. This study sought to explore the perspectives of organizations at a more general level with regard to policy by looking at the best practices of communities experiencing low levels of health literacy.

The study design and purposive sampling were employed in this study's qualitative method using a phenomenological approach to gather data. The findings are more legitimate because of the case design (Cutili, 2010). The interview questions and replies were the instruments employed in this investigation. The research topics and the goal of this study were used to create the interview questions. The interviews were performed by teleconference or videoconference virtually. Participants confirmed that the transcript was a legitimate response as part of the dependability strategies, and a neutral third party checked the transcripts for accuracy.

The objective of this research was to raise awareness of and comprehension of low health literacy among everyone, including the participants. The strictest confidentiality was maintained for all electronic data uses (video and voice recordings, computer files, etc.) as well as paper data use (interview notes, agreements, etc.). This study was carried out with the utmost integrity.

Chapter Four: FINDINGS

Overview

In this qualitative case study, commonalities in the facilitators and impediments to health literacy among African American women in Maryland were observed. Low health literacy in their communities was the subject of this investigation. It was possible to take a closer look at the reality that recommendations are required for various organizations, regardless of level (local, state, federal, or charity), by examining and contrasting each participant's experiences. In order for patients and healthcare professionals to address health concerns more effectively, it may also be necessary to address the complexity of health literacy and assess the potential of a health literacy policy.

The United States has a problem with low health literacy; like health care itself, it is a complex issue brought on by patient demographics, the communities they reside in, and the wide variety of medical and healthcare providers (Howard et al., 2019). Although there is currently no explicit policy on health literacy, tools such as health literacy surveys and screening tests, have been developed to help practitioners reduce the dangers of inadequate health literacy. There are specific policies that have concentrated on delivering or providing healthcare specifically but do not touch on health literacy. We may have hit the limit of what provision can accomplish without increasing literacy. Although healthcare provision is of limited use without health literacy, health literacy is of limited use with healthcare provision.

Everyone is affected by this issue, including the patient, the providers, the community, and society as a whole. Effective service is undermined by low or bad literacy, while excellent literacy has the opposite impact (Jena, 2016). By contrasting best practices for health literacy and

their impact on the process of policy formation to address health literacy through formal policy, this study adds to the body of knowledge required to address this problem.

Following this overview will be a description of participants, results that include theme development, and outlier data findings, responses to research questions, and lastly a summarizing conclusion. The themes found relative to the participant interviews included *Experience with Clinician* with subthemes including frustration, anxiety, misinformed/misunderstood/misdiagnosed, rushed/unheard, *Cultural Competency* with subthemes including mistrust, alternative solution, and resolution, and lastly the third theme, *Understanding and Defining Health Literacy*. The research questions included:

5. What factors, such as health inequalities, sources of health information, and health literacy, are indicative of African American women's health literacy?
6. What sociodemographic factors, background, and extent of health information use are related to minority women's health literacy?
7. What are the facilitators and barriers to health literacy for African American females ages 18 or older?
8. What are the facilitators and barriers to health literacy for African American females in the Medicaid versus commercial lines of business?

Participants

This study's targeted population was African American women ages 18 or older. Women from any educational or socioeconomic background were included and interviewed. A total of 15 participants were recruited, and all 15 completed the HLQ survey as well as the interview. Two participants had both state-funded and commercial insurance, six participants had commercial insurance, and seven participants had state-funded insurance. No participants were excluded

from any portion of the study. Table 1 describes demographic characteristics of the sample population.

Results

Despite a rise in insured Americans, consumers still have difficulty getting medical treatment (Muvuka et al., 2020). Poor utilization of health insurance is correlated with low health literacy among African American women (Muvuka et al., 2020). Reaching African Americans with LHL more effectively also depends on adopting culturally tailored, interactive, and community-engaged health literacy approaches (Muvuka, 2020). Adopting universal health literacy precautions simplifies health communication and information processing for all consumers. The connection between health literacy and access to care must be further contextualized, particularly for minority women who use both Medicaid and private insurance.

The Health Literacy Questionnaire (HLQ) has been used since 2013. The HLQ was developed by Osborne et al. (Leslie, 2020). The scales that make up the HLQ each test a different aspect of the multidimensional construct known as health literacy (Leslie, 2020). The scales are listed in table 2. The aforementioned WHO definition of health literacy served as a guide for the creation of the HLQ. The HLQ was created with a variety of goals in mind, including describing population health literacy and guiding the creation and evaluation of interventions in the field. Participants were asked to complete the HQL survey prior to an interview with the researcher. Once the results of the HLQ were scored, all participants were interviewed. The interviews and themes combined are a combination of all responses. According to the participants' HQL survey results, only six out of 15 participants scored proficient in health literacy. Among those six participants, four had commercial insurance. This data is a direct

reflection of how sociodemographic factors, backgrounds, and extent of health information used are relatable.

Theme Development

Experience with Clinician

Frustration

Frustration was a running theme in all interviews whether participants experienced this in searching for answers about their health or felt dismissed by their doctors and healthcare professionals; it seemed to be a shared experience across the board. At least one person experienced frustration with each question asked in the interview. An example of this was when asked about being rushed out of health care appointments. Participant J7E's response was, "They are rushing through what they're trying to tell you, and it's almost like you're only spending about three minutes with the actual doctor, whereas you've been there for two hours". Participant E6M mentioned, "I think myself and others in my community can agree that managing your health is not easy without scattered little to no help from your doctors".

Anxiety

Being anxious is a common feeling when engaging with healthcare professionals. "I don't think I actively engage too well, I feel anxious most times", from participant T13MD was one of many responses when participants were asked about their engagement with healthcare professionals. The anxiousness felt by African American women when receiving care has caused an uneasiness that trickles down in the ability to navigate their own health. Participant O11G said, "Once they have info on the health care portal it's like, OK, well here, here's your log into this portal. With no explanation. So you're kind of just like on a figure it out from this portal where you had a human interaction."

Misinformed/misunderstood/misdiagnosed

It was astonishing to realize how often being misinformed, misunderstood, and even misdiagnosed had been communicated. This was another running theme that aided in the resistance of trusting healthcare professionals. Participants shared:

"Often I would say that's also about 50/50 because sometimes they will use words that I don't understand (Participant K9S) ".

"I was diagnosed with endometriosis in 2021, but it was a very like long time coming for me getting that diagnosis and even me getting it wasn't because my doctor advocated for me. I was misdiagnosed many times and overlooked severely" (Participant A1W).

Rushed/Unheard

This theme was developed from the question asked in the HLQ survey, "Do you feel rushed out of health-related appointments? Many participants identified with this reply, "I feel chaotically rushed because I feel just treated as a statistic or a lab specimen"(Participant E5S). I don't feel treated humanely by them, especially when I am advocating for myself and they know what advocacy looks like" (Participant A2M).

Cultural Competency*Mistrust*

"I don't want you to be in control of my care because you are not listening to me" (Participant J8F). This is one of the most significant realizations during participant interviews. Black women have a mistrust of healthcare professionals dating back to social injustices, this mistrust has been a result of fatal situations (Chinn et al., 2020). Participant E5S also shared, "I've had a doctor literally tell me when I was pregnant with my son that me going to the ER,

those are for emergencies only and I and she was the type of person where she ignored that I had preeclampsia, and I almost lost my son”.

Alternative Solution

Many participants mentioned holistic approaches as an alternative solution to issues they felt that their doctors were either not addressing at all or addressing incorrectly. Participant A1W mentioned, “So rather than to actually listen and take a more holistic approach like Western medicine has always been very anti-everything”. Participant S12E shared, “I do feel supported with community medicine like my Doulas or my holistic doctors. I think if they come from a more holistic and humane approach and understand the realities of everything rather than to just look at me like they don't care, like they're only doing this for a paycheck, I think that would be crucial.”

Resolution

Resolution to issues related to care and managing care for oneself was recurrent in participant responses when asked “What would you like people working in Medicaid agencies, health plans, doctor’s offices to know that would help them be effective in encouraging or supporting your health?”

Participants responded:

"Just understanding the population that you're working with and how to approach that, not using a one for all for all populations you know. Low-income individuals don't have as much access as you know, Medicaid and commercial Medicaid patients don't have as much access as commercial patients just due to, you know, racial disparities and things like that, but I think a way a big way for health care workers to really improve the way people manage their care and want the biggest thing is communication"(Participant C3P).

"You can't treat every patient; you can't treat everybody the same and think that everybody knows the same thing"(Participant D4W)

"I think it would be helpful for them to understand a more holistic approach rather than just say, hey, we are gonna just be inclusive because we are mandated too, you know, but actually to practice it, you know, to have these conversations like just because I might have two arms, 2 legs, 2 feet, all the things doesn't, that doesn't mean you can just treat me like any old person that has the same ligaments" (Participant E6M).

"I think the biggest thing would be to listen. I'm I think oftentimes they, whether it's their own history or just, you know, a compilation of like the patients they've seen before, they often sign, try to push on to you what they want or how they want it to be done rather than actually listening to you as far as what you want for your health, what you want to see yourself, what goals you have" (Participant S12E).

Understanding and Defining Health Literacy

Most of the participants were able to define a version of the meaning of health literacy. Participant Y15R shared "Understanding health information, the way people understand and make decisions based on what they know about their health", and participant V14C expressed, "I guess having a good comprehension of the things they're talking about and what exactly my overall health is supposed to be like".

Outlier Data and Findings

Two of the fifteen participants have identified feelings that can be an outlier theme. This outlier data is a result of the commonality of the shared experiences both participants had with endometriosis. Participant E5S mentioned, "I felt that I was a medical mystery when my endometriosis went undiagnosed, this is why I trust my holistic doula most.". The second

participant also had similar experiences where her OBGYN through her Medicaid insurance was unsure of a diagnosis for her and even opted for her to diagnose herself. This later resulted in a series of miscarriages. After going through these unfortunate situations, participant A1W mentioned, “I have been non-diagnosed with things, so I just personally have not had a good rapport with, you know, health care providers especially through Medicaid”. Though both participants shared themes with the other participants in relation to endometriosis like frustration, mistrust, and anxiety, these two participants’ experiences pertaining to endometriosis stood out as outlier findings.

Research Question Responses

- 1. What factors, such as health inequalities, sources of health information, and health literacy, are indicative of African American women's health literacy?*

All of these factors play a part in women’s health literacy. Health inequalities, sources of health information, and health literacy are major parts that differentiate Medicaid and commercial insurance holders. A direct result of this was confirmed in various interviews with participants who are African American women who felt unheard, misrepresented, and uncared for.

- 2. What sociodemographic factors, background, and extent of health information use are related to minority women's health literacy?*

Race and economic standing are huge barriers in minority women’s health literacy. It is important to note that this pattern is not universal. According to the HQL survey participants took prior to their interview, only six out of 15 participants scored proficient in health literacy. Among those six, four had commercial insurance. This data is a direct

reflection of how sociodemographic factors, backgrounds, and extent of health information used are relatable.

3. *What are the facilitators and barriers to health literacy for African American females ages 18 or older?*

According to Ownby et al. (2014), disparities in educational opportunities moderate the association between race/ethnicity and health literacy. Education is positively correlated with health literacy. African Americans have less access to high-quality education as a result of racial residential segregation and discrimination. The majority of the participants in this study had severe anxiety about trusting healthcare professionals. The growth of health literacy is hampered by mistrust because it has an impact on how people interact with the healthcare system, have access to resources related to health, and make decisions connected to their health. Due to a historical failure to take into account the requirements and preferences of racial and ethnic minority communities in the delivery of services and health information, the healthcare system has contributed to gaps in health literacy.

4. *What are the facilitators and barriers to health literacy for African American females in the Medicaid versus commercial lines of business?*

Health literacy challenges for African American women are generally caused by systemic reasons such as poor educational opportunities, racism, distrust of the health system, and a dearth of culturally appropriate health information and services. With commercial insurance, African American women are more likely to receive better care that can take many of these concerns into account. For improved care, many of the Medicaid patients in this study relied on holistic strategies. The inability to identify LHL patients results in a lost chance to customize communications between patients and

providers, which has an impact on how well patients understand and implement recommendations.

Conclusion

Interviewing 15 participants served as the primary method of gathering information for this case study. All participants gave a variety of answers to the 13 interview questions and HLQ survey. The variety of responses made the coding for the interview transcripts difficult. The coding was based on the key concepts of the questions, which corroborated with the themes that were forming. The structure of the study and interview questions were then determined by the coding. The study's dependability was reliant on the participants' willingness to participate in the interview and their capacity to answer the questions. Utilizing a checklist helped me to double-check the procedures and data during the research and data mining, which ensured confirmability. This involved checking the typed transcripts and audio recordings for errors to remove any bias or distortion and to support the intercoder reliability. The study complied with all the suggested criteria.

The initial HLQ survey was used to get a general feel for the level of literacy of each participant before the interviews. The research questions and interview questions that were created to analyze each are listed below along with the study's findings. Two interview questions related to defining and interpreting health literacy as well as determining if the participant had state-funded or commercial insurance were included in the first study question. Regarding provider support and participation, the second study topic included four related research questions. Three related interview questions regarding the degree of health literacy were included in the third research question. Four interview questions related to participant opinions

on how to improve their participation were included in the fourth research question. This data helped to provide the themes listed in the thematic analysis.

Chapter Five: CONCLUSIONS

Overview

This contextual research identified comparable characteristics in the facilitators and impediments to health literacy among African American women in Maryland. This investigation focused on their communities' low health proficiency. For patients and medical professionals to manage wellbeing issues more effectively, it may be necessary to address the complexities of health literacy education and assess the competence of a health proficiency approach. The United States strongly opposes low health literacy proficiency; similarly to medical services, it is a puzzling issue brought on by comprehending socioeconomics, the communities they live in, and the broad range of clinical and medical care suppliers (Howard et al., 2019). This issue affects everyone, including the patient, healthcare personnel, the local community, and society as a whole. Effective service is undermined by poor or inadequate health literacy education, whereas exceptional competency has the opposite impact (Jena, 2016). This study contributes to the gathering of knowledge required to fix this issue by distinguishing best practices for health literacy proficiency and their impact on the course of strategy building to handle health literacy through formal policy. This chapter will consist of a discussion section with the subheadings: interpretation of findings, implications for policy and practice, theoretical and methodological implications, limitations and delimitations, and recommendations for future research.

Discussion

About 90 million adults in the US have low health literacy costing up to \$238 billion annually in inefficiencies (Stormacq et al., 2018). Health spending is expected to increase by \$69 billion annually due to insufficient health literacy (Nielsen-Bohlman et al., 2011). Trends in

health literacy are observed among certain demographics. An example of this, specifically with African American women, is the misinformation in women's care. To navigate the extremely complicated US health care and insurance systems, one must possess a functional level of health literacy. People with LHL, for example, cannot access health information because it is typically written at or above the high school level (Rudd, 2007). Customers need to know how to use technical manuals, comprehend cost-sharing terminology, figure out if their provider is in- or out-of-network, and compute co-pays, deductibles, and co-insurance when it comes to health insurance (Quincy, 2012). In the end, LHL impedes the best possible navigation of the health system and insurance, which has an impact on health outcomes and access to care. This study sought to discover the facilitators and barriers to the issue of African American women's health literacy in hopes of reversing the stigma associated with this topic and improving health outcomes and access to care.

Interpretation of Findings

The themes found relative to the participant interviews included *Experience with Clinician* with subthemes including frustration, anxiety, misinformed/ misunderstood/ misdiagnosed, rushed/unheard, *Cultural Competency* with subthemes including mistrust, alternative solution, and resolution, and lastly the third theme, *Understanding and Defining Health Literacy*. This section will include a summary of thematic findings in the form of interpretations.

Influence of Socioeconomic Status

Participants' ability to control their own health and the degree to which healthcare disparities affected them were influenced by their socioeconomic standing. The findings suggested that financial hardship influenced both insurance status and health-related behaviors.

For instance, some participants were able to lessen health care concerns by getting help from their parents or families, something that others whose families were at lower socioeconomic classes were not able to do. Furthermore, a participant conveyed their eagerness to acquire insurance solely to avoid the tax penalty during tax season rather than for the genuine goal of preserving their health. One participant explained that she was uninsured because she was attending a school in another state and was unaware that she could still apply for medical assistance in Maryland. When she finally found out she could apply, accessing the application was difficult and she could not fully understand the questions being asked. This confirms findings that disparities in health care were a result of illiteracy or a lack of resources and information (Stormacq et al., 2018). According to Stormacq et al. (2018) and subsequent research, socioeconomic status has an impact on health care (Kakar et al., 2022) and people with higher socioeconomic statuses are more likely to practice preventative health care behaviors. The finding that income has an impact on insurance status and health care decisions is also consistent with these findings.

Self Empowerment

Even while socioeconomic status may have an impact on health care, the results of this study also demonstrated that self-empowerment was crucial for reducing health care disparities. Few studies in the reviewed literature looked into people's perceptions of personal empowerment drive in relation to health care, but the results regarding personal empowerment confirmed that even in situations where individuals lacked all the information necessary to make educated decisions about their health and were forced to look for other options, empowering themselves was frequently the source of coping mechanisms for health care issues and disparities. A few of the participants in this study sought out holistic approaches to become more health literate and

manage their health in a way that was conducive for them. The majority of participants believed that there was something they could do to increase their level of health literacy, including learning more about policies, inspiring others with stories, looking for better jobs with better benefits, prioritizing their expenditures, and looking into other insurance alternatives.

Health Literacy's Impact on African American Women's Communities

When it comes to reducing the low health literacy effects, the literature review discovered that knowing how health literacy affects society is more significant than defining health literacy. Though they defined health literacy during the 15 interviews, the participants were unaware of the significance of doing so. The literature review studies also note community is important when discussing the health literacy of African American women, yet they do not define community. According to research, a community is an environmental component that houses social networks, norms, and/or standards within individuals, groups, and organizations both formally and informally (WHO, 2012).

Responses to the first interview question "What does health literacy mean to you?" and the eighth interview question, "Do you have social or community support for your health?", align and continue the understanding of community. It connects the community to the complexity of health literacy among African American women and health care. The framework places the individual in the middle of each of the communities that the participants have formed, and it ends with the individual surrounded by law or policy. According to Mantwill et al. (2016), the complexity of health literacy is influenced by culture, society, and the educational and health systems, all of which have an impact on the outcomes of health literacy.

Comparison of Low-Value Care in Medicaid vs. Commercially Insured Populations

Each participant who had experience with both state-funded and commercial insurance expressed the difference in the care received by each provider. In the literature review, it was concluded that, that Medicaid participants often had worse health conditions and lower literacy rates than those with commercial insurance (Charlesworth et al., 2019). The likelihood of being female (62.9% were African Americans) was similarly higher among Medicaid members.

Medicaid patients were more likely to obtain low-value care for health outcomes when compared to commercial patients (Charlesworth et al., 2019). These measures are just a few of the different instances of healthcare situations that were deemed valued or not valued (cultural competency, health knowledge, communication with providers, etc). African American Medicaid patients were considerably more likely to receive low-value care for seven out of 11 low-value care measures.

Implications for Policy or Practice

The foundation for public policy reform is the ability to recognize a social change issue and comprehend the values affecting specific communities. As such, this study offers multiple indicators of the demands of a particular community with respect to the healthcare reforms that will be implemented by future legislators. These ramifications might be particularly important for lowering healthcare inequalities when Congress acts to amend, replace, or reform existing laws. The study's identification of the health requirements of African American women and their views gave rise to several crucial topics that marked the first stages of a stakeholder's obligation to the population it serves.

In examining alternate strategic solutions and ensuring that the health disparity goals are reached, every stage of the policy reform process needs to be precisely documented, examined, verified and reviewed regularly (Dye et al, 2016). The current study shows that there are still

healthcare discrepancies that have catastrophic consequences for the community being studied, which means that the country should continue to prioritize providing affordable, high-quality healthcare and health services. The issue should be the primary focus of efforts to increase collaboration with unconventional stakeholders, such as women in the community examined in this study. Limiting distractions that impede positive change can be achieved by including people with firsthand knowledge of the issue as active participants in politics and government. To close the gap and improve the management of women's health, confirming the needs found in this study with additional community leaders would be beneficial.

Theoretical and Empirical Implications

The theoretical implications of this study include the potential to influence patients', communities', healthcare providers', and legislators' understanding, knowledge, and habits. An individual's health and wellbeing are impacted by a variety of forces and factors, which sets off the intricate part of health and health policy. This in turn is reflected in the way they show interest in comfortably making informed decisions about their health.

Policy within the health system and/or institution, as well as provider education and training, are impacted by the healthcare system and its implications for providers. The consequences for the patient affect the person's behavior, consciousness of oneself, and higher education, which in turn affects the cornerstone of their overall health. This affects society, families, communities, schools, and the workforce.

Limitations and Delimitations

When asking questions, clarity of information became slightly problematic. It was assumed that all interview questions would be comprehended by all participants; while many did comprehend, a few seemed to have no grasp of what was being asked. I had to simplify terms

and explain a few questions more. However, after explanation, participants were more honest about their experiences.

The study being a primary analysis is one delimitation. Another delimitation of this study is that it consisted of all females. I presume that the female participants related more to me as the interviewer because I am also a woman, and this made them feel more at ease approaching and sharing personal information.

Because of the qualitative nature of this inquiry, limitations were unavoidable. One limitation was the possibility of researcher bias. To increase the trustworthiness of the data I obtained, I developed protocols for each participant interview, took detailed notes, and used a triangulation gathering technique that included member checking, audio recording, transcription, interviewing, and note writing. Each participant reviewed their own interview transcription to guarantee accuracy in the data. Memos and field notes were also meant to create an audit trail, strengthening the reliability of collected data.

Recommendations for Future Research

Several recommendations for additional research have been made in light of the study's findings. These suggestions emphasize both policy and best practices. A comparison of the leadership roles in health literacy policies among health literacy organizations is the first research suggestion. A closer look into the approaches of healthcare companies can help determine the most successful method for developing or participating in health literacy policies.

Establishing the community on which the study will concentrate is the second item of recommendation. The study should focus on a single community type or compare several communities in multiple cases. Determining which best practices apply to certain communities

might be aided by defining the community. Additionally, it will help with the development of policies aimed at those particular areas.

The final suggestion is to restrict the study to a particular best practice for health literacy within a specified community or a collection of non-defined communities. This will make it possible to comprehend how to create policies by applying certain best practices for health literacy. A further study recommendation is to examine how best practices within a certain community differ from one another. This can be extended to include creating and implementing policies for that recommended health literacy practice.

Conclusion

Every day, society is aware of the importance of health. Health is a valuable asset, and good health is desired by all. The efficacy and health outcome will be determined by a patient's health literacy. In this study, I investigated the facilitators and barriers that African-American women encounter and how these influence their health literacy best practices. According to the literature review, research on health literacy has concentrated on defining it and investigating the consequences of low health literacy. Similarly, policy research has been focused on provision, with little information on how health literacy groups address low health literacy and how health literacy varies depending on insurance type.

Future research recommendations include defining the study's focus community, restricting the study to a particular health literacy best practice within a defined community or a subset of non-defined communities, identifying the health literacy needs of African American women, investigating the reasons why health literacy organizations are not participating in the policy-making process, comparing the leadership involvement in health literacy policies within

health literacy organizations, and comparing one or more hospital policies or best practices within a defined community.

Learning how other organizations employ best practices for overall health literacy as a means of potentially shaping policy is one way that this could have good social change implications. This study's recurring themes were eye-opening in the realization of what it takes to ensure equitable healthcare practices. At the end of the interview, one participant said, "There is no one way to do health literacy; there are many different ways to do it." The communities served by healthcare organizations should benefit from best practices in health literacy which will lead to improved health outcomes. Health literacy ultimately should emphasize the use of health information rather than just understanding it; and making well-informed decisions rather than appropriate ones.

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Appendix

Table 1. Participants Demographics

A1W	25 year old African American Woman	Commercial Insurance
A2M	32 year old African American Woman	Commercial Insurance
C3P	54 year old African American Woman	State Funded Insurance
D4W	19 year old African American Woman	State Funded Insurance
E5S	29 year old African American Woman	Commercial Insurance and State Funded Insurance
E6M	29 year old African American Woman	State Funded Insurance
J7E	28 year old African American Woman	State Funded Insurance
J8F	20 year old African American Woman	Commercial Insurance
KPS	41 year old African American Woman	State Funded Insurance
M10R	30 year old African American Woman	State Funded Insurance

O11G	23 year old African American Woman	Commercial Insurance
S12E	32 year old African American Woman	Commercial Insurance
T13MD	59 year old African American Woman	Commercial Insurance
V14C	27 year old African American Woman	State Funded Insurance
Y15R	27 year old African American Woman	State Funded and Commercial Insurance

Table 2. HLQ

Health Literacy Questionnaire (HLQ)

The Nine Scales of the Health Literacy Questionnaire

1. Feeling understood and supported by healthcare providers.
 2. Having sufficient information to manage my health.
 3. Actively managing my health.
 4. Social support for health.
 5. Appraisal of health information.
 6. Ability to actively engage with healthcare providers.
 7. Navigating the healthcare system.
 8. Ability to find good health information.
 9. Understand health information well enough to know what to do.
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(Leslie, 2020)