Interpersonal and Attitudinal Factors in Healthcare Utilization among HIV-Infected Urban African American Men

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Abstract

This study describes health services utilization patterns and barriers to healthcare analyzing relationships among participant and situational variables. Using a cross sectional design with a sample of 117 HIV-infected African American men aged 21 to 60, a survey was administered to assess: socio-demographic indicators, health care utilization patterns, stigma, and self-efficacy relative to perceived attitudes toward their HIV healthcare providers (AHHCP). Fifty-seven percent reported not seeking health care when needed and 51 percent reported having missed appointments. Results revealed correlations between time spent by healthcare provider (HCP), ability to access care, lack of HCP commitment, and denial of care. Self-efficacy was correlated to the total AHHCP score and its subscales. This study provides important contextual perspectives on healthcare utilization barriers among HIV-infected African men in an urban setting. To reduce access barriers for HIV-infected patients, health care providers must understand better the patients' perspectives on the difficulties of accessing care and navigating the healthcare system.

Introduction

Current HIV/AIDS regimens encompass an array of complex treatment and processes that involve frequent interactions between the patient and the healthcare delivery system. Therefore, the relationship between healthcare providers and the HIV/AIDS patient is important to consider at both the personal and structural systems level. A visit to a primary healthcare setting by individuals living with HIV/AIDS provides an opportunity to address concerns openly about the HIV disease creating a working and trusting relationship with the HIV-infected patient.

Patient contentment with healthcare is an important element of quality healthcare. Many healthcare managers are eager to learn how their staff members are interacting with patients at the point of healthcare delivery with the physician and nurse in the examination room, and with other staff and non-medical personnel while healthcare is being administered. Patients' attitudes towards their healthcare provider influence HIV-infected individuals embrace self-management strategies and become proactive in their own care. This study advances previous work in the area of personal and structural barriers to healthcare service utilization among HIV-infected African American males in an urban setting--- a subpopulation that experiences a disproportionate rate of HIV/AIDS cases and burden in the U.S.

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Challenges to healthcare delivery systems

There is compelling evidence that racial and ethnic minorities experience increasing disparities in the morbidity and mortality rates of diseases and poorer health outcomes compared with their white counterparts (Mead, Cartwright-Smith, Jones, et al. 2008). Multiple complex factors contributing to differences in health outcomes are reported in literature. These factors are embedded in a healthcare system that is primarily based on market justice principles that negate the existence of inequalities and various levels of vulnerabilities among racial/ethnic groups. Minorities are in poorer health, experience substantial obstacles to receiving care, are more likely to be uninsured, and are at greater risk of receiving care of poor quality than other Americans (Mead, Cartwright-Smith, Jones, et al. 2008).

Access to healthcare services has been identified as the link between the healthcare system and population that the system serves (AHRQ 2009; Thiede, Akweongo, and McIntyre 2007). Within organizational analysis of the healthcare delivery system, the concept of utilization suggests that confirmation of access to healthcare services has been achieved by the patient (Shi and Singh 2008). The volume and type of services, ease of accessibility, cost, patient perceptions, the patient interaction with their healthcare providers and acceptability of services are all indicators having bearing on access and utilization of services (McIntyre, Thiede, and Birch 2009).

While the availability of insurance is critical for entry into the U.S. healthcare system, having insurance is not the panacea to obtaining optimal quality care. Other systems and/or structural challenges must be considered including the concepts of "acceptability" and "accommodation" (Marcinowicz, Konstantynowicz and Chlabicz 2008). The concept of "acceptability" represents the relationship between the client's attitudes about providers and providers' attitudes about acceptable client characteristics (e.g. perceptions of competence of care, previous family experiences, language, and providers' ability to deliver culturally sensitive and appropriate care) (Marcinowicz, et al. 2008). There are limited studies elucidating the concept of "acceptability" in healthcare. Acceptability is an important concept that influences outcomes such as utilization patterns and contentment with care, and cost-effectiveness in specific settings (Marcinowicz, et al. 2008).

Accommodation is part of the quality of healthcare dimension from a systems perspective. Accommodation refers to the relationship between how services are organized (e.g., hours of operation, appointment systems) and the client's ability to be accommodated to these factors (Kullgren, and McLaughlin 2010; Shi, and Singh 2008). For many individuals who are living with HIV/AIDS, convenience of the services will decrease barriers to utilizing healthcare services. Gaining an understanding of the factors that facilitate or hinder HIV-infected African men from fully utilizing healthcare services even when covered by healthcare insurance is essential to maximize care. Research identifying and describing the experiences and perceptions of HIV-positive African American men regarding healthcare utilization has implications for designing interventions that empower these men and enhance their quality of life.

Patient attitudes, satisfaction and acceptability of healthcare services

The acceptability of health services is an essential barrier to overcome in healthcare. It is defined as the communal and cultural detachment between healthcare

systems and their users (Goudge, Gilson, Russell, et al. 2009; Hausmann-Muela, Muela, and Nyamongo 2003; Marcinowicz, et al. 2008). In the case of HIV/AIDS, this detachment could result in failure to make an accurate diagnosis or non-compliance if an explanation is given that is not understood about one's condition. Avedis Donabedian a health systems expert, in describing the elements of the concept of acceptability, stresses the following facets: the patient-provider relationship, the amenities of care, patients' preferences regarding the effects, risks and cost of care and what patients consider to be fair and equitable (Donabedian 2003).

For many, living with HIV/AIDS requires frequent visits into the healthcare delivery system and interaction with diverse members of the health care team. Patient's perceptions and attitudes towards health care can be operationalized as the determinants, system and consequences of belief, values and action (Groudge et al. 2009). Effective management and high-quality care for HIV-infected patients is characterized by productive interaction between health care team and patients, and the complexities of treatment for HIV and co-morbid conditions.

Poor provider-patient interaction may lead to inadequate understanding of illness, inappropriate treatment actions, 'provider shopping,' and at times breakdown in cooperation, with patient 'giving up' on the health care system (Goudge, et al. 2009). To establish continuity of care, healthcare providers should embrace strategies in which they interact personally with patients. Such interactions involve mutual respect, concern, friendliness, courtesy, reasonable waiting times, and ease of reaching the provider when care is deemed necessary by the client (AHRQ 2009).

While many healthcare providers may perceive scientific and technical aspects of care as the basis of delivering high quality care, patients are heavily influenced by a healthcare provider interpersonal behavior (Napoles, Gregorich, Santoyo-Olsson, et al 2009). For people who are living with a stigmatizing condition such as HIV/AIDS, empathy is an important part of their plan of care. Comfort, empathy, and the experience of the doctor are recognized as important components of the doctor-patient relationships which could enhance patient contentment with healthcare received (Napoles, et al. 2009). Seeking compassion, comfort and encouragement in the patient-healthcare provider relationship are coping mechanisms utilized by patients suffering from chronic diseases such as cancer, diabetes, heart diseases, and HIV/AIDS (Wagner et al. 2001). To date, evidence-based research suggest that greater contentment with a healthcare provider is related to higher levels of adherence to prescribed HIV medication and treatment regimens (Russell, Krantz, and Neville 2004).

In a study examining attitudes toward healthcare providers and appointment attendance in HIV/AIDS patients, Bodenlos et al., 2007) found that attitudes toward healthcare providers, social support, and medication status were associated with appointment attendance. In the U.S., healthcare delivery is fragmented and market driven allowing for limited physician time with patients during a visit to the healthcare setting. In an effort to promote self-care management and behavioral changes integral to the maintenance of therapeutic regimens for HIV-infected individuals, it is crucial to employ methods to engage in positive patient-practitioner interactions with the goal of enhancing positive attitudes toward healthcare providers. Interactions are more likely to be fruitful if patients are proactive, knowledgeable about their condition and able to con-

verse about their own care strategies (Wagner et al 2001). It is important to explore and examine the perceptions and attitudes of HIV-infected African American men towards their healthcare providers and determine how such attitudes affect their care or treatment outcomes.

Stigma, self-efficacy and perceptions of care in healthcare settings

Individuals who are HIV infected and/or living with AIDS face an array of stigmatizing and prejudicial behaviors in almost every aspect of their lives including their place of employment, healthcare settings, insurance company interactions, educational institutions, and place of residence (Buseh, Kelber, Stevens, and Park 2008; Neal, Lichtenstein, and Brodsky 2010). Although nurses and doctors take oaths and pledge to care for everyone, professionals may have prejudicial attitudes which inadvertently percolate into how they plan and deliver care to diverse groups. African American men have reported facing triple discriminating behaviors from the public and healthcare providers due to their race, sexual orientation and HIV sero-positive status (Buseh, Stevens, McManus, et al 2006).

Stigmas can also potentially affect HIV medication compliance among African Americans. In focus groups conducted with Black Men who have Sex with Men (MSM) in New York, participants were asked to detail their experiences with medical institutions and providers (Galvan, Davis, Banks, and Bing 2008). According to Galvan and colleagues, in addition to their accounts of blatant racial and sexual orientation bigotry experienced, they also spoke of specific institutional barriers to healthcare. The social stigma associated with going to a certain clinic known for HIV care, long waiting times before one can see providers, problems with patient confidentiality and the uncongenial approach of healthcare staff were all factors influencing their decreased frequency of accessing healthcare services (Galvan et al. 2008).

Stigma has increasingly been suggested as a phenomenon to address in efforts to reduce the spread of HIV/AIDS while educating people about the importance of seeking early treatment (Auerbach and Beckerman 2010). Because people who are living with HIV/AIDS experience disease-related stigma in almost all aspects of their lives, an array of strategies must be incorporated when evaluating the attitudes of clients in an HIV healthcare setting (Bodenlos et al. 2004). Some patients may be sensitive based on previous stigmatizing experiences in other encounters; they may interpret their interactions with the healthcare provider based on their experiences associated with this stigma. Stigma may also prevent HIV-infected individuals from absorbing, accepting or disclosing their diagnosis (Derlega, Winstead, Gamble, et al. 2010). It may prevent clear communication between healthcare providers and their patients especially in cases where the provider lacks the skill or feels inadequately trained to discuss the diagnosis or treatment modalities (Chaudoir and Fisher 2010).

Self-efficacy refers to one's belief in his or her capacity to adapt and carry out difficult behaviors that are prerequisite to cope with abnormal situations along the human functioning continuum (Bandura 1977; Schwarzer and Born 1997). Self-efficacy reflects one's own confidence in their ability to set goals, invest efforts, maintain persistence and resilience, while overcoming setbacks to achieve control over behavior and social environment (Schwarzer and Born 1997). HIV-infected people cope with daily hassles as well as experiences of stressful changes in factors influencing quality of their

lives including physiological and psychological changes. Researchers have demonstrated that self-efficacy plays a substantial role in an array of life events spanning public health behavioral outcomes (Nordfjaern, Hole, and Rundmo 2010). An understanding of the relationship between self-efficacy and provider-patient relationships has the potential to inform interventions thus improving quality of life among people living with HIV/AIDS.

Purpose

The goal of this study is to advance knowledge in the area of personal and structural barriers to healthcare service utilization among HIV-infected African American males in an urban setting. Specific aims were to: (a) identify and describe healthcare utilization patterns and barriers to healthcare relative to their perceived attitudes toward their health care provider; (b) describe the interpersonal and attitudinal factors that characterize perceived attitudes toward healthcare providers; and (c) analyze relationships among selected participant factors and situational variables relative to attitudes towards healthcare providers.

Methods

This study uses a cross sectional, correlational descriptive design to explore and examine selected personal and structural barriers to healthcare service utilization among HIV-infected African American males in an urban setting.

Sample

Participants were recruited through collaboration with a local community-based organization (CBO) devoted to the health and social wellbeing of African Americans. Participants comprised a convenience sample (N = 117) of African American adult males from a large Midwestern city who self-identified as having been diagnosed with HIV infection. A snowball sampling approach was also used to recruit interested participants. The mean age of participants was 42.62 years (SD = 8.25; range 21 to 60 years). Approximately half of the participants received the diagnosis of HIV ten or more years ago from time of the interview. An additional 28 percent had been diagnosed for 5-10 years (M=13.17 years, SD=7.63). Almost one quarter of the men in the sample (22.6 percent) had not graduated from high school; 27 percent were high school graduates; thirty-eight percent reported some college education, and 12 percent were college graduates.

Over half (68.5 percent) was not in the workforce at the time of the study; the median annual income category was $5,000- $9,000 with 38 percent reporting an annual income of less than $5,000. Three quarters of the participants received Supplemental Security Income (SSI) or Social Security for Disability (SSD). Over half (57.3 percent) identified their sexual orientation as bisexual or homosexual; 82 percent were single. In relation to disease progression, 36.6 percent described their condition as asymptomatic HIV, 45.5 percent as symptomatic HIV, and 17.9 percent as having full blown AIDS. Sixty percent reported currently taking antiretroviral medications. Forty-two percent indicated using illicit drugs in the last 6 months. Almost all (94.8 percent) received health insurance through a government program. Fifty-seven percent reported not being able to obtain healthcare when it was needed.

Procedures

A community-based organization (CBO) advertised the project, which alerted

prospective participants. Interested volunteers initiated contact with the investigator to inquire about the study and scheduled an interview time and place that was mutually convenient. The study questionnaire administered by the investigators and took approximately one hour to complete. Participants were provided a modest incentive for their time and effort, a $30 gift card. The University Institutional Review Board Committee approved all procedures, and all participants provided informed consent prior to data collection.

Instruments and measures

The instruments used in this study have been previously tested, used in African American populations and shown to have adequate reliability.

Socio-demographic characteristics. Relationships of individual level variables associated with the construct "Attitudes toward HIV Health Care Providers" were examined. To provide a description of the sample, participants were asked their age, education, employment, income, sexual orientation, marital status, insurance, years since HIV diagnosis, disease progression self-rated as (asymptomatic, symptomatic, or full-blown AIDS) and if they are currently taking antiretroviral medications.

Healthcare utilization. Questions representing the variable healthcare utilization were developed by the University of California Los Angeles Center for HIV Identification, Prevention and Treatment Services (UCLA 2009). Health care utilization was operationalized as the response to five distinct questions assessing if: (1) the participant has a usual source of routine primary care (i.e., clinic) where they seek care; (2) they receive the necessary health care; (3) they have ever been refused medical treatment; (4) they feel their doctor or health care provider should be more strongly committed to the treatment of HIV/AIDS; and (5) their health care provider devotes enough time to their treatment. These questions do not represent a scale as shown with the other concepts.

Stigma. The degree of stigma experienced by participants was assessed using the HIV Stigma Scale (Sowell et al. 1997). In response to 13 questions, participants were asked to indicate how often they experienced thoughts and feelings of being stigmatized or put in jeopardy because of their illness. Using a 4 point Likert-type scale with (1 = not at all to 4 = often) a total score, representing a single HIV stigma construct, was calculated by computing the sum of the 13 items; the possible range of scores was 13 to 52, with higher scores indicating increased stigma. In this study, stigma scores ranged from 13 to 49 (M = 26.84 SD = 8.90). The Cronbach's alpha for the overall HIV Stigma Scale in this study was 0.89.

General self efficacy scale (GSE). General self-efficacy is understood as personal competence to deal efficiently with stressful and difficult situations. The General Self-Efficacy Scale, designed for the general adult population (Schwarzer and Jerusalem 1995) uses a 4 point Likert-type scale with (1 = not at all true to 4 = exactly true). A possible range of scores for the sum of the 10 items ranged from 10 to 40 with higher scores indicating a higher level of self-efficacy. In this sample the Mean=27.56 (SD=7.36) with a Cronbach's alpha of 0.93.

Attitudes toward HIV healthcare providers. The Attitudes toward HIV Health Care Providers (AHHCP) instrument is a 19-item scale that assesses patient's attitudes toward their health care providers. This scale examines perceived attitudes of patients towards their health care provider, considering factors such as the relationships, interaction dur-

ing visits, and stigma experienced during a healthcare visit (Bodenlos et al. 2004). Individual items from the questionnaire were scored using a six-point Likert-style rating system (ranging from 1 = strongly disagree to 6 = strongly agree). Items on the scale were both positively and negatively worded, with higher scores indicative a more positive attitude toward the HIV health care provider. The AHHCP instrument provides two subscales: professionalism and emotional support. The Chronbach's alpha for the overall scale in this sample was .95 and the subscales of professionalism and emotional support yielded an internal consistency of .89 and .91 respectively.

Data management and analysis

All data were coded, entered, verified, and analyzed using SPSS version 18.1 for Windows®. Means, standard deviations, and frequency distributions were used to describe the participants' socio-demographic and contextual characteristics. Item analysis was performed using frequency distributions and means. To examine the relationship between individual (social demographic) characteristics, health care utilization, stigma, and self-efficacy, and attitudes toward HIV health care providers, a series of analysis were executed. Bivariate correlations were computed to examine the relationships between all of the measures and Attitudes toward HIV Health Care Providers total score, and the subscales of Professionalism and Emotional Support. A hierarchical linear regression was performed to assess the relationship of measures of health care utilization, stigma and self efficacy in explaining Attitudes toward HIV Health Care Providers controlling for the individual characteristics of age, income, and disease progression, length of time since diagnosis, taking antiretroviral medication, self efficacy and stigma. Insurance source, education, employment, sexual orientation, and marital status were excluded from the regression models due to the homogeneity of the sample.

Results

Healthcare and healthcare utilization patterns

Participant responded to a series of questions regarding their healthcare utilization and patterns. Sixty-seven (57.3 percent) of the participants indicated they did not seek health care when needed. The reasons given most frequently for not seeking healthcare when needed included: feeling they were too sick to go in; not being sick enough to seek health care; difficulty in getting an appointment; health care cost too much; and inconvenient hours (Table 1). Sixty (51 percent) of the respondents indicated that they have missed at least one appointment with their HIV healthcare provider. The reasons most frequently given were they forgot their appointment (75 percent); could not get an appointment (35 percent) and did not have transportation (32 percent).

Participants were asked about their usual source of care when they have a health problem (i.e. physician practice, clinic, emergency room). Sixty-two (53 percent) of the participants indicated multiple sites; 55 (47 percent) indicated only one source. For comparison, data were clustered into two groups, those with one usual source of healthcare provider and those with multiple providers. Three reasons for not seeking healthcare that revealed differences between these two groups are: (a) Participant having one usual source of provider perceived that they are receiving the best available healthcare (M=5.18, SD=1.44) scoring significantly higher than those with multiple providers with a M=4.48 (SD=1.72, t=2.27 df =108 p =.025); (b) Participants with one provider scored significantly higher in their perception that their medical team does not

judge them (M=5.04, SD=1.68) as compared to those with multiple providers (M=4.21, SD=1.81,t=2.53, df=114 p =.013); (c) Additionally, participants with one provider scored significantly higher in their belief that their team knows about new HIV treatments (M=5.52 SD=.93, n=54) than those with multiple providers (M=5.10, SD =1.29), t =2.00 df =115 p =.048).

Mental health is a major challenge facing people living with HIV/AIDS. Approximately three quarters (n = 89) of the African American Men in this study reported seeking help from a psychiatrist, psychologist or social worker. Participants were asked why they had received help and were instructed to indicate all of the reasons that applied. Among those 89 participants seeking mental healthcare, the most prevalent reasons were depression (80 percent), anxiety (67 percent), relationship problems (52 percent), drug/alcohol abuse (46 percent), and suicidal ideation attempt (30 percent).

Interpersonal and attitudinal factors that characterizes perceived attitudes towards HIV healthcare providers

The use of antiretroviral is essential in enhancing the quality of life of those that are HIV infected. Persons who are taking antiretroviral need consistent monitoring and interaction with their healthcare provider. Seventy (60 percent) of the participants reported currently taking antiretroviral drugs. A two way MANOVA was computed to examine the association of taking antiretroviral medication and the number of healthcare providers (single vs. multiple providers) with the two sub-scales of attitudes towards healthcare providers; professionalism and emotional support. There was a significant interaction effect between the number of providers and use of antiretroviral medication (F (2,112) =5.47 p =0.005), therefore the data were stratified by antiretroviral use for further analysis.

For those not taking antiretroviral medication, there was a significant difference between the groups of single versus multiple providers (F (2, 44) =8.098, p =.001) concerning their attitude toward healthcare providers. Participants with only one source of healthcare provider scored significantly higher in the both of the AHHCP subscales; emotional support (F (1, 45) =13.85 p < 0.0005; Partial $\acute{\eta}^2$=0.245), and professionalism (F (1, 45) =14.57 p < 0.0005; Partial $\acute{\eta}^2$=0.263) compared to those who receive care at multiple sites. For the participants taking antiretroviral medication, there was no difference between the groups (F (2, 67) =0.016, p =.580, Partial $\acute{\eta}^2$=0.016).

Table 1:
Patterns and Barriers to Health Care Utilization among HIV-Infected African American Men

Reasons For Not Getting Health Care (N=67)	N	Percent	Reasons For Missing Appointment (N=60)	N	Percent
I was too sick to go in	21	31	Forgot about appointment	45	75
I was not sick enough to bother	19	28 t	Can get another appointment	21	35
Too difficult to get an appointment	19	28	Did not have transportation	19	32
It cost too much	18	27	Too busy to go	17	28
Inconvenient office hours	16	24	Too sick to go in	16	27
I was afraid to go	13	19	Too hard to get there	12	20
I didn't think it would help	12	18	Will stay sick anyway	11	18
I did not care enough	9	13	Couldn't afford to go	10	17
I did not feel respected	8	12	Had to make money	10	17
I needed to get high	7	10	Embarrassed to go to HIV clinic	8	13
Other reasons	3	4	Afraid to go	7	12
			Didn't want others to know	6	10
			Didn't think it was necessary	6	10
			Didn't think a doctor could help	4	7
			Your privacy will be violated	4	7
			Figured doctor would not care	3	5
			Had more fun things to do	2	3
			Being with friends is more important	2	3

Participants were asked if they feel that they can access their healthcare provider whenever needed. Fifty (43 percent) of the participants indicated that they feel that they can always see a healthcare provider when they need to. These 50 participants scored significantly higher than those who feel they can only see a HCP sometimes or not at all in their attitude toward healthcare provider total score as well as the subscales of professionalism and emotional support.

Table 2:
Attitudes toward HIV Health Care Providers (AHHCP) Based on Perception of Being Able to See a Health Care Provider When Needed

	Cannot Always See a HCP (n=67)	Can Always See a HCP (n=50)	
	Mean (SD)	Mean (SD)	t (p) df=115
Professionalism	4.91 (0.97)	5.45 (0.92)	3.04 (0.003)
Emotional Support	4.77 (1.00)	5.46 (0.99)	3.69 (<0.0005)
Attitude Toward Health Care Providers (Total Scale)	4.83 (0.96)	5.45 (0.94)	3.53 (0.001)

Relationships among selected demographic and healthcare utilization factors

Pearson's correlations were computed in order to examine the association of demographic characteristics and healthcare utilization variables with the total attitude

toward HIV healthcare providers scale and the subscales of professionalism and emotional support. There were no significant correlations between the socio-demographic variables and the AHHCP total scale.

The measures of healthcare utilization were all significantly correlated to the AHHCP total scale. Indicators that were positively correlated to the AHHCP were (a) having a usual source of routine primary care (b) being able to access care when needed, and (c) having a HCP who spends enough time with them. The strongest positive correlations were between the HCP spending enough time with both of the subscales emotional support ($r = .380$, $p < .01$), and professionalism ($r = .337$, $p < .01$) as well as the total AHHCP scale ($r = .372$, $p < .01$), followed by the ability to access care when needed with emotional support ($r = .312$, $p < .01$), professionalism ($r = .217$, $p < .01$) and the total scale ($r = .303$, $p < .01$).

Participants perceiving lack of health care provider commitment and having been denied care when needed were negatively correlated to the total attitude toward HIV healthcare providers scale and the subscales of professionalism and emotional support.

Self-efficacy was significantly correlated to the AHHCP total score and the subscale of emotional support. Stigma was not correlated with the total AHHCP scale and the two subscales of professionalism and emotional support.

Table 3:
Correlations of Relationships between Selected Socio-Demographic Variables, Health Care Utilization, Stigma, Self Efficacy and Attitudes toward HIV Health Care Provider (N= 117)

Variables/characteristics	Total Scale	Professionalism Sub-scale	Emotional Support Sub-scale
Current Age	-.057	-.120	-.014
Length of time since diagnosis	-.120	-.158	-.089
Self rated clinical stage of disease	.048	.046	.046
Income	.140	.132	.141
Years of Education	.126	.125	.121
Taking antiretroviral medications	.096	.101	.087
Usual source of routine primary care	.263**	.282**	.241**
Perceived lack of MD commitment	-.344**	- .297**	-.361**
Denied medical treatment	-.224*	-.193*	-.239**
Can access care when needed	.303**	.271**	.312**
HCP spends enough time with you	.372**	.337**	.380**
Stigma	-.159	-.157	-.155
General perceived self efficacy	.188*	.171	.191*

Note: *p<0.05 **p<0.01

Participant and situational factors

To examine the contribution of healthcare utilization, stigma and self-efficacy to the total attitude toward HIV healthcare providers scale adjusted for socio-demographic variables, hierarchical multiple regressions was performed. In the first step the socio-demographic characteristics of age, length of time since diagnosis, income, years of education and taking antiretroviral medication were entered as control variables and explained 10.2 percent of the variance with taking antiretroviral medications a significant factor.

The health care utilization variables explained another 28.0 percent of the variance with usual source of routine primary care, perceived lack of MD commitment, denied medi-

Table 4:
Summary of Hierarchical Regression for Variables Predicting Attitudes toward HIV Health Care Provider: Adjusted for Socio-Demographic Characteristics (N = 117)

	Attitudes Towards HIV Health Care Provider—Total Scale	
Measures and variables	**ΔR^2**	**β**
Step 1 Socio-demographic variables	.102	
Current Age		-.093
Length of time since diagnosis		-.143
Self rated clinical stage of disease		.139
Income		.091
Years of education		.009
Taking antiretroviral medications		.291*
Step 2 Health care utilization variables	.280	
Usual source of routine primary care		.247**
Perceived lack of MD commitment		-.175*
Denied medical treatment		-.195*
Can access care when needed		.128
MD spends enough time		.210*
Step 3	.007	
Stigma		-.050
Step 4	.034	
Self efficacy		.198*
	R^2=.422	
	F(13,94)=5.28 p<.0001	

cal treatment and the physician spending enough time being statistically significant. Stigma explained 0.7 percent and finally self-efficacy explained another 3.4 percent. The model explained 42.2 percent of the variance in the total Attitudes towards Healthcare Provider.

Discussion

HIV-Infected urban African American men's attitudes toward their health care providers - does it matter? Yes, HIV/AIDS patients must be able to see the art of 'humanism' when interacting with their healthcare providers. Healthcare providers have been criticized for not treating their clients holistically; rather, providing healthcare that focus almost exclusively on the technological aspects of care (Shaw, Ibrahim, Reid, Ussher, and Rowlands 2010). The growing awareness of the concern for physicians and nurses to practice with empathy has led to emphasis on holistic healthcare delivery. This stresses the need for education and training of healthcare providers in the care of the total human being including addressing issues of health literacy (Smith, Dixon, Trevena, et al. 2009).

From our study, a number of interpersonal- attitudinal factors emerged that were associated with the participants healthcare utilization patterns and perceptions toward healthcare providers. These factors have implications for HIV healthcare providers. Participants reported several personal and structural reasons for not seeking health care: too sick to go for care, not sick enough to bother going in, too difficult to get an appointment, and inconvenient office hours. While it may be somewhat difficult to address all the personal challenges of these participants, factors related to scheduling appointments, costs of care, office hours and patients feeling respected within the healthcare setting can be addressed. Patient perceptions of need included perceived difficulties or

delays in obtaining care and problems getting care as soon as it is deemed necessary. Although patients may not always be able to evaluate their own need for care, tribulations and challenges obtaining care when patients perceived that they are ill or injured plausibly reflect considerable barriers to care (AHRQ 2009).

Over half of the participants reported missing appointments with their healthcare provider. Prominent among these reasons were: forgot appointment, did not have transportation, too busy to go, could not afford to get care, embarrassed to go to an HIV clinic, and did not want others to know. Many of these factors are amendable by system changes. The most frequent reason given by the participants for missing appointments was "forgetting their appointment." This area could be addressed by having personnel place a reminder telephone call to patients 24-48 hours before their scheduled appointment emphasizing the need for the patient to keep his appointment. Alternately, an automated phone system could be established in healthcare settings that automatically sends an appointment reminder to patients. Providing transportation is another area that can be addressed to decrease missed appointments. In a study that examined attitudes towards health care providers relative to appointment attendance, investigators found that tangible support (transportation) facilitated appointment attendance (Bodenlos, et al. 2007).

The impact of taking antiretroviral medication emerged as a noteworthy factor in this study. Taking medications contributed positively to the total AHHCP in the regression analyses. Participants who were taking antiretroviral medications may have been spending more time with their healthcare providers and thus, may have developed a rapport with these providers. Future studies with HIV-infected African American men should include "adherence" to evaluate the influence of attitude towards health care providers in adhering to their medication and treatment regimens. Bodenlos and colleagues (2007) found that patients being prescribed HAART medications were more likely to have better appointment attendance. Participants in this study who were taking antiretroviral medication reported comfort with both single and multiple providers unlike those not on medications who preferred single providers.

Having a usual source of routine care and having a HCP who spends adequate time with the participants contributed to a more positive attitude toward the total AHHCP scale. The challenges of healthcare access noted in this subpopulation are not unique to the participants in this study. Along with the millions of people in the U.S. that lack health care insurance, many Americans also lack a usual source of care. People with a usual source of care are reported to experience enhanced health outcomes and reduced disparities (AHRQ 2009). The 2009 National Health Care Disparities Report written by the Agency for Health Care Research and Quality reported that people with a primary healthcare home are less costly to the healthcare system than those individuals who do not have a regular site for their healthcare (AHRQ 2009).

Having a usual source of primary care provider is also associated with greater trust and confidence in a person's healthcare provider and good patient-provider communication (AHRQ 2009). Trust also plays a central role in all medical relationships and is an important contributor to optimistic beneficial outcomes (Musa, Schulz, Harris, et al. 2009). From patient-centered care, the doctor-patient relationship changed to a costumer-supplier of services, as is the case in other fields of the consumer society

(Siebzehner, Balik, and Matalon, 2008.). A primary care home provides a milieu in which the same provider can learn in-depth about the patient diverse health care needs over time and appropriately coordinate services with secondary care levels (specialists) to better meet the patient needs (Glazier, and Redelmeier 2010). Finally, having a primary healthcare home is purported to be associated with receipt of continuity of superior quality health care and management of chronic diseases (Hennessey, Suter, and Harrison 2010).

The need for appreciating patient satisfaction with health care and attitudinal factors that influence healthcare outcomes including adherence and quality of life among HIV-infected individuals is even more crucial amidst the call for current U.S. healthcare reforms. For many individuals with HIV/AIDS, comfort, empathy, and consolation may be much more important than the success of the technological aspects of the care. Assessing and evaluating HIV-infected patients' attitudes and perceptions towards their healthcare providers is an essential means to learn about the many interpersonal aspects of health and health care.

Mental health care is one of the major challenges in the management of people living with HIV/AIDS. Approximately three quarters of the African American men in our study reported seeking help from a psychiatrist, psychologist or social worker. The most prevalent reasons for care were depression, anxiety, relationship problems, drug/alcohol abuse, and suicidal ideation/attempt. Mental health care must be integrated in HIV/AIDS related care. Without effective treatment of mental disorders, HIV treatment outcome is poor. Many of the participants in our study of HIV-infected African men were suffering from triple diagnosis of mental illness, HIV, and substance misuse. Triply diagnosed patients, individuals living with HIV, and diagnosed mental health and substance abuse disorders, account for at least 13 percent of all HIV patients (Weaver and Conover 2009).

In our study, stigma does not resonate among the participants as a statistically significant factor in influencing their attitudes towards their health care providers. The lack of statistical significance between the attitudes toward health care providers and stigma in this sample is in dissonance with past research studies that have shown significant relationships and influence of stigma in quality of life of HIV-infected African American men (Buseh, Kelber, Stevens, and Park 2008; Rintamaki, Scott, Kosenko, and Jensen 2007). In examining the experiences of male patient perceptions of HIV stigma in health care contexts, Rintamaki and colleagues (2007) outlined a variety of behaviors performed by health care personnel that men in that study perceived to be indicative of HIV stigma, ranging from ambiguous nonverbal cues (e.g., minimal eye contact) to blatant discrimination (e.g., physical abuse of HIV-positive patients).

In the bivariate analysis, general perceived self-efficacy resonated as having a significant association with the total AHHCP scale and the subscale of emotional support. In the regression analysis, self-efficacy contributed to a more positive attitude towards the HIV health care provider total score. Self-efficacy is an important psychosocial construct that is increasingly becoming a core construct for people living with HIV/AIDS—confidence to carry out a behavior necessary to reach a desire goal (Parsons, Rosof, and Mustanski 2008). Self-efficacy can be incorporated into the healthcare provider-patient relationships enhancing communication; the ability of patients to ask questions and seek

clarification is beneficial to all parties. Interactions with HIV-infected patients are more likely to be productive if patients are active, informed participants in their care (Wagner, et al 2001). HIV patients must have the information, skills, confidence and trust, to make use of the resources being provided to them.

One of the barriers to care in this study was HCP not spending enough time with the men during visits. Greater time per patient visit in which the health care provider can occasionally sit and converse with the patient, is one suggestion for implementing structural changes that may foster more positive interactions (Johnson et al 2006). Greater patient centered care for HIV-infected urban African American men is advocated. Greater patient-focused interventions in disease management have been shown to enhance HCP skills that improve patient-provider visits (Harrington, Nobele, and Newman 2004). Finally, to streamline the communication during visits to a healthcare setting, HIV-infected men can be encouraged to make lists of questions for the provider - a process, if mutually agreed upon, that would have a beneficial effect on the provider-patient relationship and interaction, thereby improving self-efficacy and adherence to treatment protocols. Such a patient centered focus has implications for primary care in that co-morbid conditions could be addressed early through positive patient-provider interactions.

Limitations

Although results from this study provide insights for hypothesis-generation about interpersonal and attitudinal factors influencing health care utilization in urban HIV-infected African American men, a larger study with a representative sample from diverse locales is warranted to more fully describe the phenomena of interest and provide generalizable implications for practice and policy in relation to this subpopulation. In future studies of HIV-infected African American men, investigators should include a more diverse sample from within this racial group. Methodologically, a longitudinal design would capture time series changes in quality of life for African American men with HIV and more fully explain the factors involved across the trajectory of HIV disease. A cross-sectional correlational design does not allow for assessment of causality and change overtime on factors influencing AHHCP.

Results of this study should be interpreted with caution. The sample was convenience, non-random, and geographically limited. Subjects were drawn from a CBO that primarily served African Americans, thus generalizability of these results to other HIV infected African American men who are not connected to their community is limited. The survey instrument did not include data related to clinical assessment markers (e.g., CD4 cell count, HIV viral load) that would strengthen predictions of AHHCP. In future studies, socio-demographic indicators like those collected in this study might be combined with clinical indicators to examine how healthcare utilization variables interact with changes in clinical outcome data to affect the AHHCP and subsequently quality of life in this subpopulation.

Conclusions

The data obtained from the current study provides important contextual perspectives on health care utilization barriers among HIV-infected African men in an urban setting. Key findings from this study point to the fact that HIV patient and provider interactions do encompass an array of different aspects of care, including whether pa-

tients have a usual source of care, perception of physician commitment, and whether the health care provider spends enough time with their patients. This provider-patient relationship also includes whether patients were able to get appointments or health care they needed in a timely manner, whether they feel respected and listened to, and whether they understand the care that is being provided to them.

Large scale controlled studies should be carried out with African American men living with HIV/AIDS to assess their attitudes toward their healthcare providers and how such attitudes influences their health care outcomes including adherence to treatment regimens, appointment visits, and other health care utilization patterns. With increasing competition in healthcare marketplace, there will be a greater demand for health care professionals to incorporate patient contentment within their plan of care.

Effective HIV care requires productive interactions between informed patients and organized and well-equipped healthcare teams and settings. In order to reorganize healthcare systems to reduce access barriers HIV-infected patients, the patients' perspectives on the difficulties of accessing care and navigating the health care system needs to be understood. Productive interactions between the healthcare provider and patient is essential for all individuals who are ill and may be even more important for individuals who are HIV-infected African American urban men because of limited access to resources and their vulnerable states of living with a stigmatizing condition.

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