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Results from a Secondary Data Analysis Regarding Satisfaction with Health Care among African American Women Living with HIV/AIDS

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ABSTRACT

Objective: To analyze satisfaction with health care among African American women living with HIV/AIDS.

Design: Secondary analysis of baseline data of African American women who participated in Protect and Respect, a sexual risk reduction program for women living with HIV/AIDS

Setting: HIV Care Clinic in an urban city in the northeast United States.

Participants: One hundred fifty-seven (157) African American women living with HIV/AIDS.

Methods: Regression analyses were used to examine the relationships between demographic variables, self-reported health characteristics, communication with health care providers, and satisfaction with health care provider.

Results: A majority of women reported satisfaction with medical services (88%, $n = 140$). Communication with health care providers, detectable viral load, education, income, self-reported health status, and sexual orientation were significantly bivariately associated with satisfaction with healthcare (all $ps < .05$). In the multivariate models, no variables significantly predicted satisfaction with healthcare.

Conclusion: Because satisfaction with health care can influence the quality of care received, health outcomes, and adherence to provider recommendations among patients living with HIV/AIDS, health care providers' ability to elicit satisfaction from their patients is just as important as the services they provide. This project is one of the first studies to find high rates of satisfaction with health care among African American women living with HIV/AIDS. Further examination of satisfaction with health care among African American women living HIV/AIDS may help in narrowing health care disparities and negative treatment outcomes.

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In the United States, one fourth of the population living with HIV infection are women (Centers for Disease Control and Prevention [CDC], 2013). African American women are disproportionally affected: 64% of new infections in women occur in African Americans, 18% in Whites, and 15% in Hispanic/Latinas (CDC, 2012a). Although the CDC (2001) reported a decrease in new incidence of HIV infections among African American women, 1 in 32 African American women will be diagnosed with HIV infection in their lifetimes.

African American women are disproportionately vulnerable not only to HIV infection but also to disparities in the health care system that affect the quality of care they receive and their access to health care. Overall, African American women are less likely to use health care services despite need (Copeland, Scholle, & Binko, 2003). African American women also face particularly high rates of poverty, with one in four living in poverty (U.S. Department of Health & Human Services, 2010). Poverty is linked to lower quality and limited access to education and health care for African American women (El-Bassel, Caldeira, Ruglass, & Gilbert, 2009). In addition to these disparities, HIV-positive African Americans experience prejudicial treatment by health care providers (LaVeist & Carroll, 2002; Sohler, Li, & Cunningham, 2007), have delayed access to care (Cargill & Stone, 2005), and lower rates of antiretroviral adherence (Bogart, Bird, Walt, Delahanty, & Figler, 2004;

Kleeberger, Buechner, & Palella, 2004) in comparison to Whites.

Currently, several opportunities are missed for linking women with HIV to health care. Among HIV-positive women, 85% have been diagnosed, however, only 70% have been linked to care (Kaiser Family Foundation, 2013). Further, 41% are in regular care, 36% are prescribed antiretroviral therapy (ART), and 26%are virally suppressed (CDC, 2012b). An alarming concern is that these factors are associated with poorer clinical outcomes and higher mortality among African Americans living with HIV/AIDS (Bogart, Wagner, Galavan, & Klein, 2010; Wong, Shapiro, Boscardin, & Ettner, 2002). Consequently, African American women have the highest AIDS death rate (23.8 per 100,000 population) among all races/ethnicities, which is 22 times as high as the rate of death for Whites (1.1) and almost 5 times as high as the rate for Hispanics/Latinos (4.5) (CDC, 2011).

Examining factors that result in treatment nonadherence is crucial for enhancing health care outcomes among African Americans living with HIV/AIDS (Bogart et al., 2010). The purpose of this study was to describe patient reports of satisfaction with healthcare among African American women living with HIV/AIDS (AAWLWH/A). In addition to reporting satisfaction with health care in general, determinants of satisfaction with health care were also examined (e.g., sensitive communication with health care providers and certain psychosocial and health characteristics).

Satisfaction with Health Care among People Living with HIV/AIDS

Patient satisfaction research began in the 1960s (Hall & Dornan, 1988) and has been the most analyzed independent variable linked to health outcomes. However, patient satisfaction research was limited in the field of HIV due to confidentiality limitations, the short existence of the disease, and the stigma attached (Emlet, 2007). Thus, examination of patient satisfaction among persons living with HIV/AIDS (PLWH/A) is a very new field of inquiry. Some researchers have examined satisfaction or dissatisfaction with health care as a contributing factor to health care utilization and adherence to provider recommendations. Recent authors also found that satisfaction with health care has a positive effect on adherence to ART (Burke-Miller et al., 2006; Heckman, Catz, Heckman, Miller, & Kalichman, 2004; Schneider, Kaplan, Greenfield, Li, & Wilson, 2004) and involvement in health care decision making (Apollo, Golub, Wainberg, & Indyk, 2006; Marelich & Murphy, 2003).

Among women of color in the United States, African American women are disproportionately affected by HIV/AIDS.

Variables that can influence patient satisfaction include race, socioeconomic status, cultural mistrust, experiences of racism and discrimination, trust in health care providers (Benkert, Peters, Clark, & Keeves-Foster, 2006), patient–provider communication (O'Malley & Forrest, 2002), and health status (Burke et al., 2003; O'Malley, Sheppard, Schwartz, & Mandelblatt, 2004). Overall, African Americans have been found to be less satisfied with their health care (Campbell, Ramsay, & Greene, 2001; LaVeist & Nuru-Jeter, 2002). However, existing literature regarding AAWLWH/A and their access to and participation in the health care system is extremely limited. In one study of dissatisfaction with health care among women living with HIV/AIDS, the authors found that women who reported being Latina, having a lower health status, not receiving ART, with depressive symptomatology, and no consistent health care provider were more likely to be dissatisfied with their health care (Burke et al., 2003). These factors are all relevant for the health outcomes of AAWLWH/A, as dissatisfaction with health care among PLWH/A can result in negative health outcomes such as treatment underutilization and discontinuity of care (Abel & Painter, 2003).

Gaps in the Literature

Although researchers have repeatedly demonstrated health disparities in access and quality of care overall affecting the African American community (Cohen, 2008; Institute of Medicine, 2003), few researchers have examined patient satisfaction specifically among AAWLWH/A. Some qualitative researchers have examined patient–provider interactions, social support, the role of the caregiver, and stigma among AAWLWH/A (Black & Miles, 2002). For example, the quality of the patient–provider relationship has been noted as influential toward the active participation of women living with HIV/AIDS in their own health care (Marelich & Murphy, 2003). In a quantitative study, Benkert and colleagues (2006) found that perceptions of racism and mistrust had a negative effect on satisfaction with health care among a sample of low-income African American

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