



# Giving Voice to Black Men: Guidance for Increasing the Likelihood of Having a Usual Source of Care

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## Abstract

Black men suffer inequalities in health and health-care outcomes relative to other racial/ethnic groups, requiring well-informed efforts for health promotion. Fewer Black men have a usual source of health care, which may be a contributor to these disparities. Increasing access to and the likelihood of a usual source of care among Black men are important to address health and health-care disparities. In this focus group study, we sought to better understand how Black men think about primary care and usual sources of care. A total of six focus groups were conducted with  $N = 25$  men. Groups were a mix of men with and without a usual source of care. Several themes were identified through analysis of the data regarding factors that contribute to Black men going to the doctor. Themes identified in the data analysis included Lack of Health Insurance as a Barrier to Establishing Usual Source of Care; Family Promoting Health Care Use; Relationship With Doctor, Trust, and Empowerment; Age and Maturity in Health Promotion; and Positive Tone of Messaging. Future research should explore if similar findings are obtained among men in different regions of the United States or between Black men of different backgrounds. Taking a step beyond this research, specifically, future research can also examine the impact of particular health messages/messaging on Black men's health-care-seeking behaviors.

## Keywords

men of color, special populations, access to care, health-care issues, qualitative research, research

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Health and health-care disparities among Black men compared to their White counterparts have been well documented (Gilbert et al., 2016). Life expectancy is lower for Black men compared to White men (Chang, Yu, Carlsson, Liu, & Colditz, 2017; Pathak, 2018). The National Center for Health Statistics documented life expectancy in 2014 at 72.5 years for Black males compared to 76.7 years for White males (National Center for Health Statistics, 2016). Despite advances in the medical field, there are indications the Black–White life expectancy disparity is widening (Olshansky et al., 2012).

Part of the racial disparity in life expectancy has been attributed to diseases that can be either prevented or ameliorated with timely medical care (Elo, Beltran-Sanchez, & Macinko, 2014; Pathak, 2018). Black Americans, and in particular Black men, have higher incidence and mortality rates for several chronic

diseases, including heart and cardiovascular disease, hypertension, stroke, and diabetes (Beckles & Chou, 2013; Mozaffarian et al., 2016). As with life expectancy, there is little indication that these disparities are improving (Pathak, 2018). Black adults also have some of the highest incidence and mortality rates for cancers (Centers

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for Disease Control and Prevention, 2017), including screen-detectable cancers where early detection and intervention may improve outcomes. Prostate cancer is a striking example of cancer disparities, where Black men have a mortality rate (42.8 per 100,000) more than twice that of White men (18.7 per 100,000; American Cancer Society, 2017). These health inequities are costly. One study estimated that an excess \$24.2 billion in medical expenditures of Black men between 2006 and 2009 was due to health inequalities (Thorpe et al., 2015). Taken together, this information points to the importance of reducing the inequities in Black men's health.

These disparities in disease outcomes may be related to the racial/ethnic differences in access to and use of both primary and secondary care services. Specifically, Black men report lower health-care utilization than many other groups (Onukwugha et al., 2014). One strategy to promote timely and appropriate health care and health-care utilization could be to help men establish a usual source of health care or a medical home that promotes patient-centered and coordinated health care to meet their needs. Referencing Starfield (1994), scholars define a usual source of care as "the provider or place a patient consults when sick or in need of medical advice" (Du, Liao, Chen, Hao, & Hu, 2015, p. 1). The concept of a usual source of care is closely related to the patient-centered medical home model, which refers to a regular or primary source of health care that is coordinated to maximize patient outcomes and offers patients a medical team at a single location (Scholle, Torda, Peikes, Han, & Genevro, 2010). Multiple studies have demonstrated benefits of a usual source of care or medical home. Having a usual source of care is associated with earlier diagnosis, higher rates of preventive care, and higher rates of follow-up for health care, along with better disease management and outcomes (Breen, Wagener, Brown, Davis, & Ballard-Barbash, 2001; Du, Lin, Johnson, & Altekruze, 2011; Du, Meyer, & Franzini, 2007; Du et al., 2015; Fisher et al., 2004; Rhee et al., 2005; Spatz, Ross, Desai, Canavan, & Krumholz, 2010). Many community health centers have adopted the medical home model as a way to meet the "triple aim": improving patient care, improving population health, and reducing costs (Berwick, Nolan, & Whittington, 2008). Patient-centered care was among the six aims specified by the Institute of Medicine (IOM) for improving the health-care system (Institute of Medicine, 2001). Specifically, patient-centered care focuses on "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (IOM, p. 6).

Epstein and Street (2011), in their discussion of patient-centered care, draw attention to the significance of communication to achieving patient-centered care.

Patient-centered communication refers to "communication among clinicians, patients and family members that promote patient-centeredness" (Epstein et al., 2005, p. 1517). Patient-centered communication has the potential to increase acceptance of provider recommendations (Saha & Beach, 2011) as well as satisfaction with care (Wanzer, Booth-Butterfield, & Gruber, 2004). Cooper et al. (2012) note that implicit biases among physicians negatively impact patient communication among Blacks. Biases in provider communication that are shaped by the intersectionality of race and gender for Black men may further exacerbate existing disparities in their health care and health outcomes.

It is necessary to understand barriers to establishing a usual source of care for Black men. Of note, Black men have lower rates of having a usual source of care compared to other groups in the United States (Carpenter et al., 2009; Centers for Disease Control and Prevention/National Center for Health Statistics, 2016). Davis (2014) reported that approximately 40% of non-Hispanic Black men ages 18–64 years did not have a usual source of care, compared to about 29% of non-Hispanic White men of the same age group. Several factors have been discussed as barriers to health care and health-seeking behaviors for Black men. Cheatham, Barksdale, and Rodgers (2008) identified the collectivity of barriers including socioeconomic status, masculinity, racism, and the influence of peers as making the difficulties Black men face with regard to accessing health care particularly unique. Masculinity is important to our discussion of Black men having a usual source of care, having been cited as both a barrier and facilitator to health care-seeking behavior. Of note, Black male focus group participants discussed the digital rectal exam for prostate cancer screening as challenging their manhood (Blocker et al., 2006). In contrast, Hammond, Matthews, Mohottige, Agyemang, and Corbie-Smith (2010) found masculinity to be associated with a decreased likelihood of particular screening delays.

Coupled with extant literature on masculinity, Black men in search of a usual source of care may assign a greater significance to establishing trust in the health-care system. Medical mistrust accounted for the disparity between Blacks and Whites regarding the risk of using the emergency department compared to primary care as a usual source of care (Arnett, Thorpe, Gaskin, Bowie, & LaVeist, 2016). Looking at Black men, specifically, scholars concluded that medical mistrust played a stronger role in delays to receiving regular screening than masculinity (Hammond et al., 2010). It is important to understand factors that are associated with medical mistrust among Black men. Both masculinity and perceived racism in health care were associated with medical mistrust among Black men (Hammond, 2010). Compared to

Black women, Black men were found to have lower mean scores, indicating less trust, on the following two dimensions of trust: (a) “doctor influenced by insurance rates” and (b) “doctor performs unnecessary tests” (Wiltshire, Person, & Allison, 2011). Additionally, rural residence and not having a doctor visit in the preceding 12 months were unique correlates of mistrust compared to Black women (Wiltshire et al., 2011).

While trust is a factor to consider in relationship to the likelihood of having a usual source of care, establishing a usual source of care may be a means of overcoming barriers to care such as mistrust. In a recent paper, we reported that in a low-income sample that was predominantly Black, having a usual source of care was more strongly associated with cancer screening than medical mistrust was (Arnold, McGilvray, Cooper, & James, 2017). Others have also similarly suggested that having a usual source of care may be as important as or more important than physician trust or mistrust as a predictor of preventive care and early detection for cancer (Carpenter et al., 2009). Understanding, from the perspective of Black males, factors that inhibit their having a usual source of care can guide targeted efforts that focus on the needs of Black men that may vary regionally and by different communities. Encouraging Black men to establish a usual source of health care and supporting their efforts in doing so may be a promising strategy for reducing some health disparities. In this focus group study, we sought to better understand how Black men think about primary care and usual sources of care.

## Methods

### Study Overview

This qualitative research was the second phase of a two-phase mixed methods study (Creswell & Creswell, 2017). The overall research question was to better understand factors associated with Black men’s use/establishment of a usual source of health care. This was an exploratory, mixed methods design, where the qualitative research was conducted after the quantitative survey. In the first phase, participants were recruited through a university resource that went into the community to reach men. Focus groups took place in St. Louis, Missouri, a racially diverse, Midwestern city. The U.S. Census Bureau reported the total St. Louis City population as 319,294. Of this total, 157,160 were Black or African American alone and 140,267 were White alone (City of St. Louis). A total of 483 Black men completed the comprehensive quantitative survey. Approximately 63% of men in the survey reported having a usual source of care. We then recontacted survey participants to participate in focus groups. We planned to stratify our focus groups based on

baseline usual source of care. Due to challenges in attrition and scheduling, however, we were not able to do so and groups were mixed. Additionally, we found that some men gained or lost health-care status between the quantitative study and the focus groups, such that stratification might not have been successful. Thus, a total of six focus groups were conducted with  $N = 25$  men. Groups included both those with and without a usual source of care. Focus groups sessions began in March of 2014 and were completed in July of 2014. All study procedures were approved by the institutional review board at Washington University in St. Louis. Men provided informed consent for both parts of the study.

### Recruitment and Participants

Survey recruitment was conducted through a community-based university recruitment resource. At the time of the study, the recruitment center maintained a “storefront” office located in a neighborhood adjacent to the medical campus. Men were recruited for the survey through three methods: searching the center’s database of research volunteers, outreach activities conducted by the recruitment staff in various locations across the city, and posting flyers and word of mouth from former participants. Surveys were administered by a community health worker. At the end of the survey, men were asked if they were willing to be recontacted to participate in a focus group. We recontacted men several months later to assess interest and availability for the focus groups. We called participants sequentially until we filled six focus groups. Individual survey data were not linked to the focus group data.

*Focus group methodology.* Focus group methodology was a suitable methodology to employ for this phase of the research, providing a unique benefit beyond the one-on-one interviewing format. Kitzinger (1995) writes, “Group processes can help people to explore and clarify their views in ways that would be less easily accessible in a one to one interview” (p. 299). Specifically, the interactive component between multiple participants provides the opportunity for rich, introspective discussion occurring among participants, yielding meaningful insights into the phenomena.

The moderator was a Black man (to race and gender match to participants). In one focus group, the moderator was a Black woman because the intended primary moderator was unexpectedly unavailable. The decision to match the focus group moderator on race and gender was driven by the prior experiences of the research team in this community. Literature also supports race matching of moderator to participants, suggesting race matching allows for participants to be more open (Skop, 2006). Both moderators were trained and experienced. A notetaker

was also present for the focus group. Focus groups were held at a room in the university and generally lasted 1 to 2 hours. Men received a \$40 gift card and snacks for participating. Groups were audio-recorded and the recordings were professionally transcribed.

The semistructured moderator's guide was developed by the research team with input from the moderator to address how men perceived having a usual source of care, whether having a usual source would influence decisions about seeking care, what kinds of situations would influence health-care seeking, and where men went to get health information. The closing question in each focus group asked men for suggestions about messages and programs that could be developed to promote having a usual source of care or getting routine health care. In each case, the moderator wrote a field note after the group to debrief, summarize main ideas that were discussed in the groups, and add context to the group activities.

### Analysis

Transcripts were reviewed using an inductive approach as described by Bernard (2017) to identify topics from the data generated from the focus group sessions. In a two-tiered process, transcripts were reviewed and topics were generated based on initial analysis. After consultation with another member of the research team, topics that were generated from initial analysis were then further narrowed to themes that specifically addressed the question "What contributes to Black men going to the doctor?": This second investigator independently reviewed topics and data to check rater agreement. Given topics and relevant data, themes are discussed in the Results section that follows.

The overall goal of this qualitative study was to explore how Black men think about primary care and usual sources of care. The focus group conversations, however, focused very much on accessing a doctor. Our inductive approach to coding and analysis led to coding that was informed by how men talked about going to the doctor.

### Results

The six focus groups included a total of 25 men, all of whom self-identified as Black or African American. The mean age was 56 years (range 41–70). Most participants were low income (annual income <\$20,000), but the majority of men had health insurance (see Table 1). Some participants were U.S. Service Veterans who had insurance from the military (24%,  $n = 6$ ).

Several themes are addressed regarding factors that contribute to Black men going to the doctor. Themes included Lack of Health Insurance as a Barrier to

**Table 1.** Description of the Focus Group Sample ( $N = 25$ ).

Demographics	% (n)
<b>Education</b>	
Less than a high school education	20% (5)
High school education or GED	36% (9)
Education beyond high school	44% (11)
<b>Marital status</b>	
Never married	36% (9)
Married or living as a couple	20% (5)
Divorced or separated	44% (11)
<b>Current employment</b>	
Working full-time	12% (3)
Unemployed	28% (7)
On disability	44% (11)
Retired/student	16% (4)
<b>Annual income</b>	
<\$20,000	56% (14)
≥\$20,000	16% (4)
Did not answer	24% (6)
<b>Health-care factors</b>	
Has one place for health-care needs other than the emergency department	84% (21)
Has a personal doctor or health-care provider	72% (18)
Currently has health coverage/insurance	68% (17)
Insurance plans cover some prescription costs	40% (10)

Note. GED = General Education Development.

Establishing Usual Source of Care; Family Promoting Health-Care Use; Relationship With Doctor, Trust, and Empowerment; Age and Maturity in Health Promotion; and Positive Tone of Messaging. The participants' dialogue during the focus groups illuminate factors that can influence primary care usage and the establishment of a usual source of health care. Each respondent quoted is addressed by a pseudonym.

#### *Lack of Health Insurance as a Barrier to Establishing Usual Source of Care*

Although having health insurance did not always guarantee use of primary care resources, it was clear that not having health insurance could be a limitation to access:

The last time I went to one place [an FQHC], I went in there to get some health care and I told them that I have no insurance or nothing you know, I have nothing. I just got Food Stamps. I said, "this is all I got" and they told me I needed a \$75 co-pay. So you know what I did, don't you? I walked back out the door (Quincy).

Men in the focus groups expressed that lack of insurance not only can limit access to health care but can also affect quality of health care. As one man said, "In most

instances if you don't have good insurance or some money, you can't get quality health care. It's just that simple" (Josiah).

Respondents offered additional commentary to highlight the importance of having insurance, for example, "You know what, though, the important thing about going to the doctor is that you have insurance" (Tom). Specifically, a participant commented, "I have a co-pay and sometimes I have to complain about it but it's better than if I had no care at all" (Josiah). Respondents also noted the importance of cost:

Moderator: What would be important if you are trying to find a place to go [for health care]? Like what kinds of things would you bring up?

Eric: The first thing would be cost for me.

Earl: Yeah, that would have to be the first.

Another participant described how when his income increased, he stopped going to the county facility and

"went to another facility . . . but it cost me, it really cost me . . . but the treatment that they gave me was very more effective than what I was getting for free. So I said, well maybe I do need to acquire some health insurance because that's kind of hard to pay out of pocket." (Peter)

Having health insurance was seen as a practical means that facilitated health-care usage, and across the groups, participants acknowledged health insurance coverage as a key factor in usage.

Lack of health insurance limited the establishment of a usual source of care. In contrast, having health insurance facilitated having a usual source of care for several participants. Both Medicaid and the Department of Veterans Affairs were discussed as sources that facilitated a usual source of care.

### *Family Promoting Health-Care Use*

Respondents also discussed other key factors that promote going to the doctor that went beyond access. The influence of family played a key role for respondents deciding to go to the doctor. Family members can play both active and indirect roles in encouraging men to go to the doctor. Families that are fairly close-knit can recognize symptoms of potential health problems and urge men to go to the doctor. Several men described instances where family members encouraged, both directly and indirectly, the man to seek health care.

So I started urinating, I couldn't go six minutes without, I couldn't get six minutes down the street without having to stop at a service station. I have the kind of family that is concerned and they said "you need to see a doctor." (Peter)

One respondent provided a lively description of the effort it takes for a family member to compel him to use health-care services, saying, "My sister have to drag me by the collar and belt buckle to get me just to go with her [to the doctor] because she worries so much about me" (Quincy). This same respondent went on to discuss how his family, including brothers and sisters, factors into his desire to care for his health and acknowledged wanting to take care of his health while still facing challenges: "I mean, I've got nieces and nephews who want me to be around a long time to keep playing with them, so I'm going to do it for them as well as for myself." Peter and Quincy both highlight the direct ways in which family can encourage health-care use that may serve as an initial step toward establishing a usual source of care.

The focus group conversations around the importance of family highlight how important family can be in communicating health information that may encourage taking advantage of health-care services. In a line of dialogue as to where the best information comes from, one respondent ultimately said: "Family and friends first. You know your family first. You know you look at your family first, then your friends next" (Howard).

For Howard, family is a first point of contact for receiving health information. Another respondent described how family is an important source of information and support:

You say Channel 2 news, I'm not really up on that. They repeat the same thing over and over, so one thing I will say and this probably comes from my past experience: There is nothing like sitting at the kitchen table with the family. (Hezekiah)

Informed and concerned family members can be encouraged to have conversations in the home in settings such as around the kitchen table that promote health awareness and facilitate going to the doctor. Family members may act as critical supports to health-care utilization and to establishing regular use of a usual source of care.

### *Relationship With Doctor, Trust, and Empowerment*

Respondents indicated that a doctor's bedside manner is important to the health-care experience and their use of health-care services. When asked whether the manner in which he was treated affected his health-care utilization, one man offered a longer commentary:

Yes, it does. Because if you feel that the person is not talking to you right, you're not going to feel comfortable, you know what I'm saying, if that person diagnoses you or whatever. . . . Because that's going to be on your mind, you know what I'm

saying. Yeah, I mean it matters, it matters. To me it does, you know because you don't want to go see no doctor that be talking crazy to you. [You'd] be like, I'm not going to let them do anything to me, they might mess me up. It just triggers other thoughts off of your mind about this doctor. . . . So I can see that affecting a person when they communicate with you. You know, because you want it firsthand, you want good information from them and if you feel like they've got an attitude or something about you, [you] are going to feel like they're not being honest with you. Whereas a doctor who talks to you nice . . . you feel more relaxed [and you'd] be like, "okay we can do this." (Reuben)

Respondents provided additional discussion regarding the importance of establishing rapport with a doctor. One man, introducing the concept of rapport to the conversation, described its importance in this way,

And once you get a rapport you're pretty much, you know, you're more open to that doctor, telling him what's going on with you instead of going to the emergency room and messing with someone you don't know or a free clinic. (Derrick)

The idea of rapport with a doctor and its impact on health care was echoed by another man, who commented:

You've got a rapport with that doctor. You know and it's like they care about you and I think longevity in that relationship doctor-patient creates that and you can talk to them freely about issues that you would not normally talk about probably in some other setting with a doctor that you don't know and you don't have a rapport with. (Andrew)

The possibility of greater mistrust among Black male patients can present a unique challenge to the establishment of a usual source of care. Through targeted efforts on the behalf of providers to allay fears or concerns related to a provider's trustworthiness, positive doctor-patient relationships can be established. Despite the possible proliferation of masculine ideals, the "medical encounter" (in De Maio, 2010) is one in which Black males may feel disempowered and that their masculinity is challenged even without particular physical exams that may challenge their masculinity in more readily noticeable ways. Discussion from a participant is illustrative.

I feel like as an African American male a lot of us don't question our doctors about what they are doing. A lot of doctors want to come in and in five minutes, boom boom and they're gone and your bill. So I stop them and say, hold on, wait a minute, let's break it down. (Derrick)

It is clear that perceptions of mistreatment and poor attitude from a physician can hinder the potential health benefits that could be gleaned from the doctor-patient

interaction. On the other hand, positive rapport can promote honest dialogue that can ultimately yield health benefits. Black men experience systemic inequalities in health care and otherwise. Through positive provider interactions, providers can gain the trust of their Black male patients. Furthermore, Black male patients can be empowered to speak honestly about their health and feel a greater sense of ownership with regard to establishing and maintaining good health. The quality of the doctor-patient interaction is highly important to the establishment of a usual source of care.

### *Age and Maturity in Health Promotion*

Among the respondents, conversation emerged demonstrating an increased need to take advantage of health-care services as one ages. Here, men described their thinking about getting regular checkups as they aged:

I began to realize at the age of 53 that I needed to see a physician at least once a year or maybe every 6 months just to make sure that everything is on point and I just started like that. I just started going to see the doctor. (Simon)

Another man commented,

When you're younger you know you can skip out, but once you start hitting that 39 it's time to start getting yourself on a regular basis as a checkup. Get checked out you understand because there could be things there that you don't even know where they are. (Frank)

The preceding portions of conversation related to age and maturity imply that self-health care increases in importance as one ages, although men set different ages at which they decided to start paying more attention to their medical needs.

Additionally, respondents spoke of the role that elders can play as facilitators in the process of obtaining a usual source of care.

Brian: When we're sitting around talking like we are it would be great to have four or five younger brothers to hear this. Hearing it firsthand.

Hezekiah: Because the ones that we get probably don't, they might have a couple of babies out there somewhere, you know baby mamas as they call them and all that, but they don't even have a regular doctor. And they might be 35 years old before they start having some kind of illness and make them be concerned as we are now about it, so.

In this exchange, there is a notable interest in health promotion among younger Black males. The participants' discussion signals the possibility of mentoring younger

Black males regarding their health in a manner that could ultimately lead to the establishment and maintenance of a usual source of care.

### *Positive Tone of Messaging*

Discussion provided by respondents indicates that the tone of health-care communication can influence one's health and wellness. One respondent indicated the potential perils of negative communication from health-care providers when talking about his father's best friend: "I went in there and they told me he had cancer and 'you'll be going soon' and this and that. Don't keep saying that. That right there will break you down faster than anything" (Quincy).

In another example, a respondent talked with the moderator about alternatives to communications that emphasized negative and fatalistic messages.

Mark: A lot of times, . . . they sort of have it in their mind to tell you the worst information to a person to prepare you. They don't believe in optimism.

Moderator: So you prefer them to be more upbeat and positive than to bring you the negative first?

Mark: Yes I do: Here's how we can treat it. You know.

In Mark's discussion, he points to a focus on treatment. Through focusing on treatment doctors can provide hope to Black male patients. While doctors can offer positive messaging that emphasizes treatment, the benefits of treatment, and doctor-patient collaborative efforts in treatment, the men saw that they themselves could also convey positive messages. One participant described it in this way, "The fact that I'm a testimonial, I can testify and say that this happened to me and these are some concerns and after I corrected all those things I'm better" (Hezekiah).

Fear is a barrier to health promotion among Black men. Combating fear through positive messaging may increase the likelihood that Black men will take the initial steps toward establishing a usual source of care. Additionally, positive messaging can help to ensure the establishment and maintenance of a usual source of care in the event that an illness diagnosis is made.

## **Discussion**

Black men occupy a unique position of systemic disadvantage with regard to having a usual source of care. The literature has pointed to the significance of masculinity, racism, and mistrust with regard to Black men's health behaviors. In this study that aimed to glean Black men's perspectives on having a usual source of care, respondents highlighted several points that could aid in efforts to increase awareness of the importance of having a usual

source of care. Not surprisingly, lack of health insurance is a barrier to establishing a usual source of care. The theme of lack of health insurance limiting health-care access is consistent with previous literature underscoring socioeconomic status as a barrier. There is additional need to understand how different types of health insurance may be related to quality of usual source of care among Black men.

The importance of the family in encouraging having a usual source of care should not be understated. Previous literature has emphasized the importance of female family members as facilitators of health-care-seeking behaviors (Blocker et al., 2006; Cheatham et al., 2008). Family members beyond female family members such as mothers and spouses can serve as conduits to the establishment of a usual source of care among Black men. Given the significance of family, as indicated in the extant literature and by our respondents, viewing the family as a resource can be incredibly beneficial. To capitalize on the family as a resource, it could be important to think about the potential significance of family members such as siblings, nieces, and nephews.

Programs that promote family togetherness and healthy quality time activities may be particularly useful. Health-care researchers and community health facilities can lead efforts in empowering the family through providing health education. Health messaging should encourage family dialogue about health including family health history. This dialogue can include discussion about what is going well in addition to problems or warning signs of a problem. Together, families could design a family health agenda that includes health goals and means by which to pursue attaining these goals.

Health-care experiences shaped by the convergence of race, masculinity, and mistrust are important to the examination of the medical encounter between patient and provider for Black men. Greater mistrust of the health-care system (LaVeist et al., 2000) and a decreased likelihood of trust in physicians (Boulware, Cooper, Ratner, LaVeist, & Powe, 2003) among Blacks relative to Whites has been documented. The influence of mistrust and racism on patient satisfaction among Blacks cannot be ignored. Of note, medical mistrust and perceived racism accounted for the relationship between race and satisfaction with care (LaVeist et al., 2000). Focusing specifically on Black men, both masculinity and perceived racism in health care was associated with medical mistrust (Hammond, 2010). While it is important to be aware of the ways in which perceptions of bias can impact medical mistrust, it is particularly useful to be able to identify ways in which biases among providers may impact the health-care experience. Specifically, Cooper et al. (2012) demonstrate a relationship between implicit bias and poor provider

communication toward Black patients. The implicit biases that providers possess may prohibit the development of rapport and honest dialogue between Black males and their providers and, ultimately, the establishment of a usual source of care.

In the medical encounter, it is imperative that doctors are aware of the unique needs of Black males and actively work to interrogate the implicit biases they possess that may hinder the provision of optimal care for their Black male patients. Providing such care may require the proper cultural competency training and interrogation of biases that may influence care delivery. Our findings point to the significance of establishing patient-provider rapport for Black men. Making the effort to provide optimal care for Black male patients should include efforts to establish rapport. With rapport, providers gain their patients' trust and patients, in turn, should feel empowered and comfortable being honest about their health with their provider. The doctor-patient relationship between Black men and their doctors can be one that is culturally sensitive and ultimately promotes having a usual source of care.

Older age has been associated with health-care promotion. In this study, several men described points in time in the aging process when they began to pay better attention to health. Effective health messaging might convey that having good health should be a concern over the life span, instead of waiting until a particular older age when disease risk starts to rise. Prevention messages need to emphasize that prevention needs to happen early to avoid disease. With regard to age, older generations can also serve as a resource. Participants indicated wanting younger Black males to be present for dialogues about health. Murray and colleagues underscore the significance of role models and peer-led advertising for health-promoting behavior among Black men (Murray, Toledo, Brown, & Sutton, 2017). Hearing the voices of Black men in this study signaling a desire to promote positive health of younger Black males is an important addition to the conversation regarding strategies for promoting a usual source of care among Black men. In addition to the significance of peers, there can be a wisdom that comes from the elders of communities that perhaps remains untapped. Black men appear to be receptive to health mentoring by other Black men (Murray, Toledo, Brown, & Sutton, 2017). Our findings indicate desire among Black men to serve as health mentors. Efforts to promote dialogue between members of both older and younger generations are necessary. Such intergenerational dialogue can encourage those of the younger generation to be aware of their own health-care needs and can motivate older members to take care of their own health and establish a usual source of care.

Finally, positive health messaging is an important consideration with regard to establishing a usual source of care. Fear of diagnosis and death may discourage Black males from pursuing health care and establishing a usual source of care, but through the voice of Black men we can see that positive messaging is perhaps a necessary component to encouraging seeking health care and establishing a usual source of care. Through such positive messaging the public discourse around masculinity can be reframed in such a way that masculinity can be health promoting rather than a deterrent. Additionally, providers must take care to engage in patient-centered communication with their Black male patients. Based on our analysis, communication with Black male patients should focus on positivity associated with ways to overcome health challenges.

Given the importance of family and wisdom of the elders, as expressed by participants, health messaging targeted at Black males could encourage making a visit to the doctor a family affair that involves going to the doctor with dad, an uncle, or older brother, or cousin. Such messaging could emphasize the possibility of family becoming and/or staying healthy together. Additional messaging could take the form of a question that asks: "Do you know where your uncle goes to the doctor?" Of course, "uncle" could be substituted with some other close male relative or mentor. Such messaging has the potential to be thought-provoking and lead to dialogue among Black male family members about health that can lead toward establishing a usual source of care.

It stands to reason that increasing opportunities for Black men to establish a usual source of care warrants expanding opportunities to gain access to health insurance. Notably, Missouri was a state that did not expand Medicaid. Given the instability of the American health-care system, there may be limited health-care options that are available to Americans, including Black men, and therefore this may limit early and consistent access to a usual source of care. Expanding access to government-sponsored health care may be critical to increasing the likelihood of having a usual source of care among Black men in this part of the United States.

As is likely the case in much of qualitative research, these study findings cannot be said to be generalizable, definitively applying to Black men across the whole of the United States. It is also worth noting that an additional limitation of our research is that men who agree to participate in focus group research conducted at a medical school may be more comfortable speaking up about their health care, further underscoring that our findings are not generalizable. While the interaction of focus group methodology is a strength, this interactive component also has the potential to be an additional limitation. Specifically, participants may influence each other's



contributions to the focus group in ways that may affect the validity of these contributions within a particular focus group. Having multiple focus groups as we do in this study can minimize the potential impact of this particular weakness on findings yielded and subsequent analyses of data yielded.

Our sample consisted of a relatively homogeneous group with regard to age, income, and health care/usual source of care. The homogeneity of our groups is an additional limitation of our study. We perhaps do not capture diversity in perspectives related to a usual source of care. Future research can incorporate greater diversity of Black male participants with regard to these key factors of age, income, and health care/usual source of care. Regarding age, future study may implement a life course perspective (Burton-Jeangros et al., 2015) to examine possible relationships between the ages at which Black men establish a usual source course and critical developmental moments in their lives. Additionally, further research should explore if similar findings are yielded among men in different regions of the United States. Examining differences among Black men by country of birth, for example, may answer the persisting question as to how nativity may influence the complex experience of establishing and understanding of the need for a usual source of care. Taking a step beyond this research, specifically, future research can also examine the impact of particular health messages/messaging on Black men's health-care-seeking behaviors.

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