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The purpose of this study was to explore Black women's use of telehealth using the lens of Black feminist theory. Black women historically have experienced poorer health outcomes, higher rates of specific diseases, less education and career opportunities. Telehealth is a virtual health strategy that exploded in use during the COVID pandemic and is continuing as a care delivery mechanism. This is an initial examination of Black women's experiences with telehealth. The study included 21 Black women ages 24 to 65 who reported using telehealth within the last 2 years. The sample was recruited through social media. Semi-structured interviews were completed using completed using Zoom and Google Meet virtual platforms. The interviews were audio-recorded and transcribed verbatim then reviewed for accuracy. The data was analyzed using descriptive content analysis with open coding, categories, and theme abstraction. The themes were discussed within a Black feminist thought context. Findings from this study provide a foundation for care delivery and interventions that may improve the healthcare that Black women receive or may lack.

BLACK WOMEN'S EXPERIENCE WITH TELEHEALTH USING THE LENS OF BLACK FEMINIST THOUGHT

by

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Approved by

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DEDICATION

"Every great dream begins with a dreamer. Always remember, you have within you the strength, the patience, and the passion to reach or the stars to change the world."
-Harriet Tubman

I would first like to thank GOD, for through him this was possible. I dedicate this dissertation to my parents, who are no longer physically with me but have always dared me to dream. This work is a long-awaited dream, but through strength, patience, passion, faith, hope, and the love of my family, in some way, I am changing the world. I thank my husband, who kept pushing me even when we both were tired; he nudged in his way to keep me going. To my lovely children, Brandon, Kharin, and Christian, you made being a graduate student, provider, and working mother easy. You all agreed to support me in this journey, and you allowed me to do it with ease and grace. Being blessed to be your mom was the easiest part of the whole journey. I did this for you, so your voice will always be heard. To my grandmother, thank you for showing me what perseverance looks like. Thank you for being the voice that I think about when I take care of women in all walks of life. To my sister Angela, thank you for being all the things even when you did not even know what I needed. To my cousin Trevis, your positive voice always gave me the push. To my best friends, you have walked along aside me through the greatest and hardest parts of my life. My personal and work-family your support in so many ways, I could not have done this. Lastly, to every woman's voice that I represent, past, present, and future, I thank you for sharing your words, experiences, and life with me. I see you, a direct reflection of myself. I see me.

APPROVAL PAGE

This dissertation written by Tiffany Gibson has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro.

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"Show me a successful individual and I'll show you someone who had real positive influences in his or her life. I don't care what you do for a living—if you do it well, I'm sure there was someone cheering you on or showing you the way. A mentor." Denzel Washington

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FOREWORD

My understanding of health and healing is shaped by my mother's, maternal grandmothers, and paternal grandmother's experiences. Both of my grandmothers farmed their food, relied on herbal treatments for healing, and led healthy lives. They required wellness checkups; nevertheless, hospitals were established to treat illness, and it was our responsibility to keep people in our family well. We were each accountable for our own health, which was central to our daily lives. My grandparents were childhood friends who were both high school graduates. As I have gotten older and acquired experience working in healthcare, I have fostered the mentality that your healthcare provider is your health partner, and that cultural care and generational health is vital components of being a Black woman in the modern period.

CHAPTER I: INTRODUCTION

Background of the Problem

Historically, Black women are less likely to use telehealth for health care access (S. George et al., 2012; McCall et al., 2019). The decreased utilization of telehealth is concerning given health disparities among Black women since the increase in telehealth since the emergence of COVID-19 (Chang et al., 2021; Ghebreyesus, 2020). Many diseases have well-documented racial disparities in incidence, morbidity, and mortality rates. African Americans have a higher cancer incidence and death rate than Whites, Hispanics, and Asian/Pacific Islanders; these inequalities may be seen in incidence rates for colon, rectal, and breast cancer mortality. African Americans are also more likely to develop hypertension, diabetes, and coronary heart disease. It is a public health goal to eliminate these and other health inequities.

Many providers have developed communication systems for clinical results, appointment scheduling, health alerts, and health maintenance reminders utilizing these Electronic Medical Record (EMR) systems. Access to these systems is critical to advancing health care transformation and delivery. Consequently, if Black women do not have access to these systems or are hesitant to use telehealth, the benefits of virtual appointments and e-visits (electronic visits) will not assist them in acquiring access to healthcare. They may also not serve as a complete platform in decision-making or help women feel more informed and empowered; healthcare information technology is crucial to healthcare quality.

The federal government adopted the Affordable Care Act (ACA) in 2010 in response to the changing healthcare landscape in the United States. The 2010 Affordable Care Act (ACA) has three goals: (1) to enhance access to healthcare, (2) to improve healthcare quality, and (3) to bend the cost curve to make healthcare more affordable (Van Denmark, 2012). The Affordable

Care Act focuses on preventing and transforming healthcare systems to promote health and wellness (Centers for Medicare & Medicaid Services [CMS], 2010). Telehealth is crucial to the ACA's goals. Telehealth has proven to be a valuable care delivery approach for increasing access to care while lowering costs and improving quality. Telehealth encourages innovation and is sponsored by federal and state programs, but compensation varies by Medicaid and Medicare (Pearson, 2013). Furthermore, according to Pearson, just 19 states had some form of funding through Medicare and Medicaid (Pearson, 2013) when the ACA was implemented. The Federal Health Information Technology Strategic Plan, 2015-2020, was developed to address the evolution of care delivery to include patient-centered mobile health applications and the seamless delivery of knowledge sharing via technical platforms, networks, various locations, and providers (Office of the National Coordinator for Health Information Technology [ONC], 2019).

Electronic health records (EHRs) are becoming increasingly common for storing patient care information and communicating with physicians, hospitals, and insurers. EHRs have aided in the delivery of care to patients and providers. Many EHR systems supplied by private and public health care facilities include a patient interface (Pérez-Stable et al., 2019). Access to a patient's online medical record is the responsibility of healthcare practitioners, as three out of ten patients were permitted access, and six out of ten patients viewed their medical information (Chaet et al., 2017; Patel & Johnson, 2019). Any patient that does not have equitable access to their information is concerned. The lack of access to medical records prior to and throughout treatment raises ethical concerns about not having the necessary knowledge before, during, and after treatment. Health data should be readily available and well-managed, and the software utilized should help individuals maintain their beneficial health care habits (Patel & Johnson, 2019). The American Academy of Family Physicians (AAFP) and the American Academy of

Nurse Practitioners (AANP) have collaborated to increase the availability of telehealth services for providers and the public (AANP Board of Directors, 2019; American Academy of Family Physicians, 2020). The healthcare delivery landscape expanded telehealth usage during the previous twenty months as a result of the COVID-19 epidemic (Brotman & Kotloff, 2021).

Background

The United States has a long-standing history of racism, bias, and gender oppression against its citizens (Ben et al., 2017; Forde et al., 2019; Jupka et al., 2008; T. T. Lewis & Van Dyke, 2018; Rapp, 2019; M. F. Watson et al., 2020). Race and the systemic oppression associated with segregation have influenced the quality and accessibility of health care (Adebayo et al., 2021; Homan, 2019; Moaddab et al., 2018). Patients' attitudes, desires, and values may be inconsistent with the providers' views, contributing to tension within the patient provider relationship. This impacts the medical encounter, reduces the number of physician interventions to patients, and leads to decreased adherence and improperly managed chronic health problems (Bailey, 2000; Canty, 2021; Okoro et al., 2021; Sims, 2010). As will be documented, Black women have managed to "armor" themselves against healthcare bias by repressing their emotions, working hard, and code-switching to compensate for negative preconceptions (Adebayo et al., 2021; Allen et al., 2019; Canty, 2021; Sacks, 2018).

Within and outside the Black community, African Americans, particularly Black women, have continued to face gender inequality, racism, oppression, and injustice (J. A. Lewis et al., 2017; T. T. Lewis & Van Dyke, 2018). Black women's social marginalization in various environments contributes to their morbidity and mortality (Adebayo et al., 2021; Homan, 2019; T. T. Lewis & Van Dyke, 2018). One example is the experience of the witnessing of Black women experiencing more police violence compared to White women resulting in increased intrapersonal stress, anxiety, and feelings of oppression and how those emotions translate in healthcare interactions. Because of the racial and gender intersection oppressions that occur with Black women, medical providers must be aware of bias, misconceptions, and power structures that marginalize Black women from being seen, valued, and respected. As Dr. Kimberlé Crenshaw remarked in her TED talk on Intersectionality, December 7, 2016, “If we can’t see a problem, we can’t fix a problem.”

Telehealth Access

The Affordable Care Act of 2010 brought changes in health care accessibility and patient protections (Breslau et al., 2018). Unfortunately, Black women and men fared the poorest in improved health care access during pre-and post-health care reform (J. Manuel, 2018). In a study conducted by Manuel, there were no significant improvements in healthcare access among Black respondents from 2012 to 2014, implying that access deteriorated initially and never recovered throughout the early years of health care reform (2018). When the Affordable Care Act was passed into law, a high level of technology was included and recommended as a crucial component to accomplishing the “triple aim”: to offer the highest quality of care at the lowest possible cost while providing the best patient experience (Pearson, 2013). Hi-Tech was expected to accelerate the use of telehealth (2013), but this model of care delivery did not gain momentum until the COVID-19 pandemic (Health Resources & Services Administration, 2020).

One of the two primary goals of Healthy People 2010 was to eliminate health inequities (Jupka et al., 2008; Kreps, 2006, 2017). Concurrently healthy people 2020 and now 2030 have continued with the same recommendations (Healthy People 2030, 2019; U.S. Department of Health and Human Services [USDHHS], 2019). To accomplish this, Healthy People 2030 has proposed an aim to increase the use of telehealth to improve access to health services—

AHS-R02. This aim currently has research status, suggesting a high-priority public health concern with no evidence-based solutions. It may or may not have valid baseline data available. This aim might become a core Healthy People 2030 target if baseline data and evidence-based therapies are available (USDHHS, 2020). The data on telehealth access is sparse, so this study must be conducted to further investigate telehealth use to enhance access to care, which may lessen inequities for Americans, particularly Black women.

Access to Care

Access to treatment in the absence or presence of a pandemic is an ethical consideration. According to the ONC, approximately 8% of individuals visited a health care facility at least once in the previous year. Approximately 32% of these patients experienced a gap in information sharing (ONC, 2019). Currently, one in every 20 people (0.2%) who have seen a doctor in the last year have reported a lack of information exchange. Because the previous test or diagnosis lacked a date, one out of every 20 persons who visited a doctor in the previous year will require a repeat examination or treatment. One in every five of those people will have previous test results available (ONC, 2019). Patients frequently use technology to assist in health care, but physicians must regularly incorporate the patient in the technical process and not forsake the process.

Significance of the Problem and Justification

Despite tremendous improvements in health for Black women in the United States over the last century, health disparities persist. Black women have a lower life expectancy, higher maternal morbidity, and mortality, and are more prone to suffer from chronic diseases such as hypertension, anemia, CVD, diabetes, and obesity (Chinn et al., 2021). Black women are also more likely than White women to die from aggressive breast cancer before the age of 45

(Armour-Burton & Etland, 2020a). In 2012, Black women had a 42% higher mortality rate than White women (DeSantis et al., 2016).

It is difficult to determine the extent to which African American women have used telehealth in the last two years. The United States Census Bureau is currently releasing data; however, the most recent focused research used probability sampling to recruit 6000 active respondents over the age of 18 via the Internet. Between February and April 2019, the RAND American Life Panel (ALP) surveyed the U.S. public about their desire to adopt telehealth (Fischer et al., 2020; U.-P. Lori et al., 2020; Pollard & Baird, 2017). Women were more likely than men to utilize telehealth, with a considerably lower rate among those over 65 compared to those under 65, as well as a lower percentage among those with a high school education compared to those with advanced degrees, regardless of sex, race, urban/rural location, or wealth (Pollard & Baird, 2017). This study did suggest that Black persons and respondents living below the federal poverty line were also less likely to declare a desire to use video conferencing for healthcare (33.6%) than respondents of all other races (51.5%) (Fischer et al., 2020) and socioeconomic status (2020). Significant differences in willingness to utilize telehealth were not connected with sex, region, or urban location (Fischer et al., 2020).

There is a clear interest in the experience of Black Women’s interaction with healthcare utilizing telehealth during prenatal, antepartum, and the postpartum period for morbidity and mortality, psych-mental health, and management of chronic conditions (Clare, 2021; S. George et al., 2012; Rovner et al., 2021; Still et al., 2018). Governmental research initiatives have facilitated more interest in and knowledge of the experiences and issues associated with Black women’s use of telehealth (USDHHS, 2020). While researchers have studied the interaction of Black women with specific telehealth interventions, there have been few randomized controlled trials (RCTs) targeting Black women across all healthcare disciplines since 2003 that include Black women in sufficient numbers to generalize their findings (Abel & DeHaven, 2021; Gerber et al., 2013; R. Jones & Lacroix, 2012; Miranda et al., 2003; Pekmezaris et al., 2019). Despite these efforts, there remains a paucity of information about Black women's experience with telehealth, the narrative of the experience of their encounter, and the intersection of race, gender, and discrimination that they may experience in face-to-face encounters that may now be reflected in telehealth in encounters. Therefore, this study aims to explore the experience of Black women with telehealth.

Purpose

The purpose of this qualitative study investigated Black women's perspectives and experiences with virtual healthcare delivery (telehealth). This investigation was undertaken from the viewpoint of Black Feminist Thought, which permits understanding and articulation of how racism and sexism have influenced their opinions about the health care system during the last two years with the growing digitization of healthcare delivery. This research was guided by Black Feminist Thought and the concept of the intersection of race, gender, and discrimination.

Black Feminist Thought provides a platform for Black women to express themselves beyond the confines of feminism and to gain knowledge about what it means to be Black and Woman in numerous categories through discourse (P. H. Collins, 2015). The qualitative descriptive methodology enables dynamic descriptions of Black women's voices as recounted via their own experiences, free of theoretical and methodological constraints. Qualitative descriptive methods are compatible with Black Feminist Thought because they enable the researcher to engage in the analysis of data in order to create something new while remaining authentic to the material in its original form (P. H. Collins, 2002; Sandelowski, 1995).

While quantitative methods can measure, predict, and explain phenomena, certain topics cannot be quantified until they have been investigated qualitatively. Background information is required to learn more about Black Women and their experiences with telehealth. The existing telehealth literature is insufficient, outdated, and does not adequately represent Black women who use telehealth. Furthermore, while trust in the system has a significant impact on telehealth engagement, less attention has been paid to the experiences of Black women who use telehealth.

Research Questions

Following a review of the literature, gaps were identified, and this research study addresses the following questions:

1. "What is the experience of Black women's use of telehealth for their healthcare?"
2. "How, when, and why do Black Women use telehealth?"
3. "What experience as a Black Woman influences decisions to use telehealth?"
4. "What experience influences a Black woman's future use of telehealth?"

Framework

Black Feminist Thought was used as the perspective for this study. African American women's (AAW) social perspectives and identities may be clarified through Black feminist thought. Black Feminist Thought is a paradigm for understanding and interpreting AAW's experiences (P. H. Collins, 2002). Black Feminist Thought does not share the notion that all AAW have the same experience. AAW, on the other hand, share several traits that their experiences have shaped in a patriarchal society in the United States. From the standpoint of AAW, Black Feminist Thought is a construct that may be used to develop health knowledge.

The positivistic perspective, which focuses on characteristics that are "measurable" and "observable," is used in a great deal of research on Black womanhood. A positivist approach to studying a phenomenon is founded on the assumption that positive verification of observable experience using measurement to yield knowledge, rather than introspection or intuition. Prediction and control, empirical validation, and value-free research are all aspects of positivistic research (Cohen & Crabtree, 2016; Creswell & Creswell, 2018). By ignoring this part of Black womanhood, the experiences and viewpoints of Black women may not be placed in the proper cultural context. This constraint contributes to a pathological picture of African American women's behaviors in healthcare.

The study of Black women and their health experiences has grown over time, but it remains vastly understudied. Black women are frequently used in studies as comparator groups for Black men and White or Hispanic women. Many studies focus on what problems exist for Black women, such as poverty, HIV/AIDS, and other adverse conditions that impact Black women. This positivist approach makes it difficult for researchers to determine the interpretive effects of metaphysical experiences with this viewpoint due to it being better suited for quantitative research. For example, positivism does not permit qualitative investigation of the long-term impacts of multigenerational trauma caused by ongoing oppression (Alinia, 2015; Degruy, 2005).

Furthermore, positivistic research emphasizes the significance of maintaining an objective and dispassionate perspective throughout the study process (Lindsay-Dennis, 2015). A realism ontological stance is employed to investigate within this framework, which posits that there are real-world objects other than the human knower (Cohen & Crabtree, 2016). This one-sided perspective may ignore the rich individual experiences of Black women.

Women intellectuals of African American descent have constructed theoretical frameworks that articulate and explain the perspective of an African American woman. A significant component of these frameworks is examining the impact of race, class, and gender on women's lives (Banks-Wallace, 2000; P. H. Collins, 2002; Crenshaw, 1989). The terms womanist theory, Womanism, and Black feminist philosophy have all been used to describe this body of work (Alinia, 2015; Banks-Wallace, 2000; P. H. Collins, 2002; J. Y. Taylor, 1998; A. Walker, 2004). Many academics consider Womanism to be a synonym for, an extension of, or a subset of Black feminism (Banks-Wallace, 2000; P. H. Collins, 2002). The driving framework for this study will be Black Feminist Thought, which incorporates Black women's experiences based on race, gender, and class, all of which are entrenched in oppression defined feeling uncomfortable, worried, and feeling that their race or gender prevents them from freedoms and opportunities that White women would have experienced.

Black feminist theory's analytical and methodological ideas have contributed to current thinking about women's issues. The simultaneity of condition, Black women's subjugation, is emphasized by intersection theory (Anderson-Bricker, 1999). Several Black feminist theorists have argued that Black women's experiences as women and African Americans are inextricably linked. Because they are always "both/and" analyses that profess to investigate gender while ignoring a critical posture toward race and class invariably do so at the expense of the experiences of African American women.

Patricia Collins's (2002) Black Feminist Thought (BFT) is based on the perspectives of Black women and evaluates racism, protest, advocacy, and liberation politics. How domination is structured and operates in different spheres of influence is exposed by Black feminist thinking. It also depicts the journey of struggle to liberation while emphasizing the obstacles and complexities in overcoming Intersectionality. The relationship between dominance and opposition is highly dynamic due to the multiple influences of social agents and the simultaneity of various intersecting sites of oppression on the other.

There are five distinguishing features of Black feminist thought. First, gender, class, ethnicity, sexual orientation, and country all contribute to the dominant structure in the United States, which also frames the inequality and challenges of African American women. Second, the cultural consciousness of Black American womanhood is defined by the ontology of oppression and resistance. Third, Black women as a cultural identity entail internal divisions and distinctions. Individual Black women are treated differently within patriarchal systems and hierarchies of social status, sexual orientation, education, location, age, and religion. Fourth, amid these internal heterogeneities, mutual wisdom and identity are founded on a shared history and heritage and shared everyday experiences as a Black woman in the United States of America. P. H. Collins (2002) discusses this collective understanding and perspective has been referred to as a ‘fundamental paradigmatic change’ (p. 291) and has been theorized and developed by Black women thinkers based on their daily experience and practice. This self-defined anti-hegemonic awareness is critical for raising consciousness, developing political identity, and mobilizing opposition. Finally, the importance of transformation for Black feminist discourse as a vital social philosophy is discussed. This has become possible due to the complex interaction between Black feminist theory and reality (Alinia, 2015; P. H. Collins, 2002, 2015).

Intersectionality

Intersectionality is a framework for understanding how social identities, such as gender, race, ethnicity, social class, religion, sexual orientation, ability, and gender identity, intersect with one another and with systems of power that oppress and benefit people in the workplace and the larger community (Crenshaw, 1989). Intersectionality has become the primary way of conceptualizing the relationship between oppressive systems that construct numerous identities and our social positions in power and privilege hierarchies (Alinia, 2015; Carastathis, 2014; Gopaldas, 2013).

The term “intersectionality” refers to how social identity constructs such as race, class, and gender combine to shape life experiences, especially those of privilege and oppression (Alinia, 2015; Crenshaw, n.d.; Gopaldas, 2013; Okoro et al., 2021). Understanding how a Black woman’s race and identity have influenced her encounters with health care engagement, connectivity, and confidence is relevant to discuss with Black feminist thinking. The experiences of the Black woman with the digitalization of health care can only be relayed through the lens in which they view it and having the collective experience analyzed to capture their voice.

Intersectionality emphasizes the racialization of gender and the importance of Black feminist thought in analyzing the interconnection between gender and racial inequality from the perspective of women’s, experiences. Collins reflects on the African American civil rights movement, the impact of Black women, and racial segregation. Black women’s resistance took two forms: group survival and institutional transformation that disrupted the matrix of dominance. Group survival was accomplished by projecting obedience and conformity to the regulations of those in power through practices such as accepting handouts rather than raises while consciously rejecting being objectified, the private experience of opposing identities.

Intersectionality (Crenshaw, 1989) which arose from the Black Feminist movement, is a conceptual framework for understanding how power dynamics related to gender, race, and class combines to create oppressive social environments for women of color. Oppression is the result of “isms” (such as racism or sexism) that are maintained by systemic or structural power, such as laws and practices in the government, education, legal, and healthcare systems (McGibbon, 2012)). Living at social intersections can lead to psychological stress and poor physical health.

Intersectionality was utilized to investigate areas where Black women were being excluded, such as employment, and to evaluate race and gender policy. It's hard to evaluate because not all Blacks and women were excluded. Are racism and sexism being exploited if the two sources of action of prejudice are Black and women? (Crenshaw, 1989). The experience of Black women with gender discrimination was compared to that of White women, while Black women's experience with racism was comparable to that of Black males (Crenshaw, 1989). The framework was used to depict the experience of being both Black and female and facing discrimination due to the junction of the two. The institutional structures discriminate against a specific set of individuals, not others, for example, Black, female, and homosexual. These institutions strengthen patriarchy, feminism, and racism (Crenshaw, 1989).

There have been insufficient interrogations of patriarchy, and feminism has harmed women and people of color. Racism and feminism have continued to influence politics and social justice movements. Because the standard lens is not acclimated to imagining via an intersecting prism, these ramifications have not been adequately studied. Intersectionality is utilized to go beyond patriarchy, racism, and sexism to see the experience of gender with women of color and the oppressive structures that surround them (Crenshaw, 1989; J. A. Lewis et al., 2017; Serrant, 2020).

Crenshaw's Intersectionality has fueled the "#SayHerName" campaign, which seeks to expose the gender-specific ways in which Black women are disproportionately afflicted by racial injustice (Crenshaw et al., 2015) This movement aims to address women's marginalization in both mainstream media and the #BlackLivesMatter movement, which began in 2015; however, examples of this marginalization can be seen throughout American history (Crenshaw et al., 2015; Simmons, 2015)). Other characteristics considered by #SayHerName include cis or trans status, education, geographical location, and disability (Crenshaw et al., 2015). As Black women are disproportionately affected by police brutality, they also face marginalization in healthcare, emphasizing the importance of the ongoing study to ensure these perspectives are heard and an assessment of how their experience with telehealth might benefit their interaction with healthcare systems.

Intersectionality has been applied to many aspects of the Black Woman’s experience. The synergistic effects of multiple forms of discrimination have carried over into healthcare, so the effects of the use of telehealth need to be explored. Evaluating Black women’s healthcare experience in telehealth, the role of social institutions such as hospital systems, healthcare systems, and private office systems, and how Black women use telehealth to access these systems need to be researched. Black women are already underrepresented in health outcomes with several diseases with the system as it is; adding telehealth as an option to access care needs to be evaluated for discrimination. Social intuitions are key determinants of health. Evaluating racism, sexism, and other intersections will help add to the body of knowledge to help enhance these systems to improve health outcomes and access to care.

Black Feminist Thought with Intersectionality provides an excellent theoretical framework to provide a contextualized understanding of the experiences and perspectives of Black women. Black Feminist and Intersectional theories are cultural perspectives that consider the contextual and interactive effects of her-story, culture, race, class, gender, and other forms of oppression (Alinia, 2015; Lindsay-Dennis, 2015). Black feminist thought has been used to evaluate Black girls experiences for their stories to further scholarship of Black girls’ experiences, as well as contextualizing the experiences of Black women as pertaining to health promotion activities (Armour-Burton & Etland, 2020b; Banks et al., 2006; Banks-Wallace, 2000; Lindsay-Dennis, 2015).

The Application of Black Feminist Thought and Intersectionality

Anecdotal information of telehealth usage experiences does not contribute to nursing expertise. There is no academic basis for investigating self-defined anti-hegemonic consciousness without a conceptual framework. Using this perspective, researchers may learn about how dominance is constructed and works in many circles of influence and have a deeper understanding of the AA women's collective perspective and point of view. This study aimed to depict the Black Woman's telehealth experience via their own lenses. These lenses may include race, gender, and discrimination in accordance with the theoretical underpinnings of Black Feminist thinking (P. H. Collins, 2002) and Intersectionality (Crenshaw, 1989), a research inquiry with Black women. Several experiences with various intersections may be uncovered throughout the study process. Based on the women's own intersections, these experiences may be similar but slightly different depending on the personal lens. These women's experiences will strive to give data to understand the phenomenon better: "What is the experience of Black women using telehealth?"

Definitions

For the purpose of this research study, the following terms were defined:

1. Black Women: women who self-identify as Black or African American.
2. Black: relating to or belonging to Black or dark, brown-skinned people, especially those who dwell in Africa or whose ancestors came from Africa:

3. Telehealth: Telehealth is defined by the US Department of Health and Human Services Health Resources and Services Administration (HRSA) as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration. Videoconferencing, the Internet, store-and-forward images, streaming media, and terrestrial and wireless communications are all examples of technologies (HealthIT, 2020).
4. EHR: An Electronic Health Record (EHR) is an electronic version of a patient's medical history that is maintained over time by the provider and may include all the key administrative, clinical data relevant to that person's care under that provider, such as demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports (Centers for Medicare & Medicaid Services, 2021).
5. PHR: A personal health record, or PHR, is an electronic program that allows individuals to keep track of their health information (and that of those for whom they have permission) in a private, secure, and confidential setting (Office of the National Coordinator for Health Informtion Technology [ONC], 2016).
6. Intersectionality: Intersectionality is a lens that allows you to observe where power originates from and collides with it, where it interlocks and intersects (Pérez-Stable et al., 2019). A paradigm for conceptualizing an individual, a group of people, or a social problem as being impacted by a variety of discriminations and disadvantages. It considers people's overlapping identities and experiences to comprehend the complex prejudices they confront (Mcleod, 2021).

7. Racism: Unlike racial prejudice, hostility, or discrimination. Racism entails one group wielding the authority to carry out systematic discrimination through society's institutional rules and practices and developing the cultural beliefs and values that support those racist policies and practices (Mcleod, 2021).
8. Systemic Racism: Also known as institutional or structural racism, systemic racism is a combination of systems, institutions, and factors that benefit White people and disadvantage people of color result in widespread harm and disadvantages in access and opportunity for people of color (D. R. Williams, Lawrence, & Davis, 2019).
    - Systemic racism includes policies and practices embedded in existing institutions that result in the exclusion or promotion of specific populations. It is distinct from overt discrimination in that no individual intent is required (Mcleod, 2021).
    - Systemic racism is inequalities embedded in a society's system-wide operations that preclude a considerable percentage of members of specific groups from meaningful participation in major social institutions (Mcleod, 2021)
9. Oppression: Oppression is defined as the systematic and institutional misuse of power by one group at the cost of another, as well as the use of force to perpetuate this dynamic. An oppressive system is premised on the idea that some groups are superior to others (Mcleod, 2021)
10. Sexism: discriminatory and biased ideas and behaviors directed against one of the sexes, mainly women; sexism is related with the acceptance of sex-role stereotypes and can occur at several levels: individual, organizational, institutional, and cultural.

> It can be overt, involving open endorsement of sexist beliefs or attitudes; covert, involving the tendency to hide sexist beliefs or attitudes and reveal them only when it is believed that one will not suffer publicly for them; or subtle, involving unequal treatment that may go unnoticed because it is part of everyday behavior or perceived to be unimportant (APA Dictionary of Psychology, 2020).

Assumptions

The assumptions for this research study are:

1. There are varying personal experiences among Black women with their healthcare providers that intersect with race, gender, and discrimination.
2. Black women have unique and complex experiences, which impact their decision to use telehealth.
3. There are multiple ways of knowing, and a qualitative descriptive study is an avenue to explore the voices and truths of Black women based on their realities interacting with healthcare providers using telehealth.

Delimitations

The limits of this research study will be to individuals who identify as female and

1. Black
2. 18 years of age or older
3. Has used telehealth in the past two years
4. English Speaking
5. Live in the United States

Summary

Following a review of the history and literature, research gaps must be filled to address the experience of Black women with telehealth. The "digital divide" contributes to poor health outcomes. This study will carefully explore the Black women's experience with telehealth and hope to learn how women feel or experience exclusion or inclusion of their health care decision-making, health equity, and access to quality care.

The digital health care movement has facilitated access to care, but it is essential to remember that healthcare movements only begin when everyone is included. Examining the role of Black women in the future of care attainment and delivery is critical to the movement's success. Black women have put their bodies, health, and safety at risk for health care, and they are often the last to reap the benefits. It is time to change that narrative and embody all women's voices; through this research, we will capture the voice of the Black woman with dignity and respect for her vulnerability and power.

CHAPTER II: REVIEW OF LITERATURE

The extant literature on the factors affecting Black Women's experiences with healthcare and telehealth is synthesized in this chapter. First, race and gender stereotypes in healthcare are reviewed. Second, because morbidity and mortality in reproductive health, breast cancer, cardiac disease, and mental health are more prevalent in Black women, the literature is reviewed to present findings of barriers to survival such as biological factors, issues with access to care, disparities in treatment, and perceived or actual discrimination in care. Lastly, the literature on the digital divide to synthesize studies that investigate Black women's experience with telehealth is discussed.

Black Womanhood Stereotypes

Being Black and female plays a crucial part in the experience of systemic oppression that may include, unequal treatment, and institutional and individual forms of racism and discrimination, all of which have been found to induce "weathering" and lead to racial health disparities in Black women (Forde et al., 2019). According to the weathering hypothesis, continuous exposure to social and economic disadvantage causes an accelerated decrease in physical health outcomes and may help to explain racial differences in a variety of health disorders (Forde et al., 2019; Geronimus, 1992). Racial discrimination has been identified as a particularly significant source of psychosocial stress among AA women. Specifically, early-life experiences of racial discrimination have been identified as crucial to their view of themselves in connection to the larger social world—that is, stigmatized, stereotyped, excluded, and devalued. Racial prejudice is a recurrent stressor for AA women that manifests itself in various ways throughout their lives. These interactions are described as extremely traumatic, with long-term consequences for their personal and group identities, as well as how women see situations involving encounters with others, especially Whites (Nuru-Jeter et al., 2009).

Perceived stereotypes about Black women foster a climate of inauthenticity, limiting Black women's ability to perform or truly engage with their providers, and as a result, the women's discussions and authenticity of feelings and symptoms are repressed (Okoro et al., 2021; Sacks, 2018a). From depictions like "the mammy" to "the Jezebel," Black women have been represented unfavorably throughout history (P. H. Collins, 2002). The government has also contributed to unfavorable stereotypes, such as the Reagan administration's portrayal of Black women as "welfare queens," who refuse to work and illegally steal money from the government to live off the welfare system (P. H. Collins, 2002; Gilliam, 1999). In the recent 2020 census, 46.3% of Black households were single-parent families, predominantly women led (U.S. Census Bureau, 2020). Racism has a cumulative effect on health, therefore if Black women do not have equitable access to non-biased services or treatment, health disparities will continue to exist and may expand.

Discrimination in Healthcare

Due to historical oppression and brutality against African Americans, today's racism, covert, implicit yet systemic, institutional, and individual. This creates an atmosphere of distrust in the community and results in many inequities, such as access to poor quality of health care delivery, and less access by women of color (J. I. Manuel, 2018; Yearby, 2018). Uncertainty, solitude, sadness from financial or personal losses, police violence and its fetishization in the news media, and polarizing political discourse add additional layers of complexity that individuals must appropriately handle. Discriminatory practices in the healthcare system, according to research, may also contribute to inequities (Bleich et al., 2019; Blendon & Casey, 2019; SteelFisher et al., 2019; D. R. Williams, Lawrence, Davis, et al., 2019; D. R. Williams & Wyatt, 2015).

For instance, research has shown that racial discrimination during healthcare encounters such as hospital staff, healthcare encounters, and perceptions lead to decreased attempts to seek assistance to conceive as well as increased risk of adverse infant and maternal health outcomes, delay in diagnosing depression, preeclampsia, delayed blood transfusions due to pregnancy bleeding complications, uterine and incisional infections leading to increased maternal and morbidity complications (Cortés & Breathett, 2021; Creanga et al., 2014; Crear-Perry et al., 2021; Davis, 2020; Lemke & Brown, 2020; Omeish & Kiernan, 2020; Roman et al., 2017; J. K. Taylor, 2020). The experiences that may occur for Black women through their life course have an impact on the care they receive. Women are more likely to visit their primary care providers, but more likely to have needs unmet, while Black women felt they were not heard ((Barlow & Johnson, 2021; J. I. Manuel, 2018; Nuru-Jeter et al., 2009; Socías et al., 2016). Not being heard may also be a result of being silent or disengaging by the patient (J. R. Lori et al., 2011; Roman et al., 2017; Slaughter-Acey et al., 2019).

Black women face dualistic racism and sexism, with racist attitudes leading to a more aggressive form of sexism for Black women. Black women may develop strategies to mitigate gendered racial discrimination by remaining silent, confronting their perpetrator, or shifting (e.g., altering how one speaks and behaves; Dickens & Chavez, 2018; J. C. Hall et al., 2012; K. S. Hall et al., 2015; W. J. Hall et al., 2015; M. S. Jones et al., 2021). Black women are also subjected to gendered racial microaggressions, which predict both negative mental and physical health outcomes. The link between gendered racial microaggressions and poor mental and physical health was significantly mediated by disengagement coping. Furthermore, Black women who experienced more gendered racial microaggression used more disengagement to cope, which had a greater negative impact on physical and mental health outcomes (Carter et al., 2017; J. A. Lewis et al., 2017; Williams, Lawrence, Davis, et al., 2019).

Gendered racism (Essed, 1991), which is institutional racism is a daily experience for may Black women on various levels micro to macroaggressions that negatively impact physical and mental health that will impact how providers play a role in the care of Black women. The chronic stress of racism and discrimination has lasting impacts on women's health. According to research, increased gendered racism is associated with higher levels of psychological distress in Black women from community and college samples (M. S. Jones et al., 2021; J. A. Lewis & Neville, 2015). Individuals who belong to disadvantaged social groups (due to their ethnic origin, gender, or sexual orientation) face social pressures (discrimination) as a result of their group membership, which has a detrimental effect on their mental health (Flentje et al., 2020; Meyer, 2003). Individual and systemic gendered racism has a detrimental effect on Black women, reducing their likelihood to seek self-care (Allen, Wang, Chae, Price, Powell, Steed, Black, et al., 2019; N. N. Watson & Hunter, 2015; Woods-Giscombé & Black, 2010).

Many of the upstream determinants of health, such as governance, policy, and cultural or social norms and values that influence who has access to health-promoting resources and opportunities and who does not, are unlikely to be directly controllable by individuals. From this vantage point, it is possible to comprehend why social factors emerge from structural determinants and cannot be handled independently. In other words, no matter how empowered, aware, or eager someone is to modify their behavior, structural determinants of health disparities may prevent them from doing so (Crear-Perry et al., 2021). Discrimination and racism impose an unacceptably high impact on the health of Black women that health care practitioners cannot ignore. It is critical to assess prejudice and the impact of racism on women's health and their ability to seek physical and mental health care.

The Digital Divide

The term "digital divide" was coined in 1994 to describe the differences between those who have access to computers and the Internet and those who do not on an economic, educational, and social level (Romano et al., 2015).). Just 23% of Blacks and 25% of Hispanics use smartphones or handheld computers for Internet access, compared to eight out of 10 Whites, Blacks, and Hispanics (Perrin & Turner, 2019). As a result, Blacks and Hispanics are more likely to have their cell service disconnected that are considered low-income (2019). However, more Blacks (42%) than Whites (25%) and Hispanics (24%) use library Internet connections to look up jobs and health records (Perrin & Turner, 2019). In many ways, the digital divide is already narrowing due to improved Internet access and technological/process advancements. People who have schizophrenia, PTSD, and bipolar disorder, for example, have had their care successfully supplemented by new technology. However, issues that persist being poor, female, or Black all correlate with a lower likelihood of completing a telehealth visit, and millions of Americans lack adequate Internet access to complete telehealth visits (Chang et al., 2021; Demeke et al., 2021; Jaffe et al., 2020).

Regardless of the patient's insurance form or coverage status, access to the patient's electronic health record should be available. According to Patel and Johnson's (2019) data, 54% of those covered had access to online health records, compared to just 25% of the uninsured, and that provided insurance. Insured people according to data were treated 57% of the time, compared to 34% of uninsured people. Healthcare oversees ensures that emergency services are available to everyone, regardless of insurance coverage. Patients can review their medical history and receive health care treatment from a clinic, including telehealth. Since the patient requires health care, providing them with access to records is ethical and moral. Health Information Technology aids in the elimination of patient care information sharing delays and lack of information and reduces the time it takes for a patient to obtain critical medical information.

Access to Telehealth

The provision of reliable and effective Internet access and telephone networks is referred to as telehealth access (Anderson et al., 2019). Previous research has demonstrated that telehealth is beneficial and may be utilized to improve access to services. According to the findings of a small exploratory study (N=102), the use of video conferences to connect with a professional for anxiety and depression management is well accepted (> 70% approved). Age and agreement with video calls had statistically significant correlations, with younger women (under 50 years old) more likely to express acceptance (p's .05) (McCall et al., 2019).

Disparities in telemedicine access mirror those of in-person healthcare access. The causes of disparate use are complex and reflect the individual, community, and structural factors and their intersection, many of which are the result of systemic racism. Evidence about telemedicine disparities can be used to inform tool design and systemic efforts to promote digital health equity (Chunara et al., 2021). Continued use of telehealth for routine treatment necessitates a close examination of accessibility.

Access to quality healthcare telehealth may be a hurdle for low-income patients and patients living in distant places which lack access to computers, cellphones, or readily available and stable broadband Internet. Access to personal health records (PHR) and access to phones and the Internet has been shown to be barriers to telehealth. According to a Kaiser Family Foundation poll, more than one-fifth of Medicaid beneficiaries did not use the Internet, did not use a phone, and did not send or receive an email in 2017 to correspond, research any type of information (Weigel et al., 2020). According to the Harvard School of Public Health, 21% of rural Americans cited problems with high-speed Internet connection and their family's capacity to utilize the Internet. Furthermore, many older people lack the willingness or aptitude to use these mechanisms. According to the Pew Research Center, in 2019, 27% of persons aged 65 and up reported never accessing the Internet (Anderson et al., 2019). Rural Americans are 12% less likely to have a broadband Internet connection than suburban and metropolitan residents. These findings support those of Goel and colleagues (2011) who found even after an order to enroll in patient portals for communication, half of Blacks were less likely to utilize patient portals due to technical literacy barriers, access and distrust of the system among older Black Americans.

The availability of patient portals and apps is a technological aspect that influences telehealth use. There are ethnic differences in technology usage, and various race groups may use technology differently. Patient portals are mobile apps or systems that link patients to their EHR and enable them to access information, receive alerts, notifications, schedule appointments, and receive telehealth services. A lack of access to an online portal was reported by 10% of respondents as a reason for not accessing a patient's electronic medical record (Patel & Johnson, 2019). The Pew Research Group discovered that while Blacks and Hispanics use mobile devices more than Whites, they often spend less time on the patient health portals that they have access to on through mobile devices (Perrin & Turner, 2019). According to the report, 82% of Whites owned a laptop or desktop computer, compared to 58% of Blacks and 57% of Hispanics, while 79% of Whites, 82% of Blacks, and 79% of Hispanics owned smartphones (Perrin & Turner, 2019). Whites own 53% of mobile computers, Blacks own 58%, and Hispanics own 43%, but Whites own 79% of cable subscriptions, Blacks own 66%, and Hispanics own 61% (Perrin &

Turner, 2019). Connecting effectively via broadband or the Internet is critical for telehealth (Seto et al., 2019). One research study revealed that White women aged 30-65 were more likely than Black and Hispanic women to use patient portals for health information exchange and to communicate sensitive health information with health care providers through these portals than Black and Hispanic women (Goel et al., 2011).

Telehealth Policy

Policies and laws that provided the framework for healthcare services, reimbursement, and telehealth benefits were among the political factors leading to telehealth's rise. The American Recovery and Reinvestment Act of 2009 (ARRA) contains provisions close to previous iterations. From a cultural perspective, as healthcare moved into the realm of information technology, some patients and clinicians believed that the information technologies would be more user-friendly (Qiao et al., 2015). Political research demonstrates that bipartisan legislation was needed to be passed to enhance the HIT networks, and aid was offered through fiscal, legal, and technological facilitation by funding and supporting the infrastructure of these systems (Obey, 2009). The ARRA Act is a carbon copy of its facilitators. The recommendations to HIT policy support have been updated to reflect the health concerns of the twenty-first century. Technological problems included the high cost of implementing healthcare quality changes due to a shortage of funding and vice versa (World Health Organization, 2010).

Economics of Telehealth

Economic considerations affecting telehealth adoption include fees that are sufficient for fee-for-service, no loss, and facility fees that can be billed with billing modifiers between 1/27/20 and 6/30/20 (Center for Connected Health Policy, 2020; CMS, 2020; Lowey, 2020). Connection to technology requires mobile phones, smartphones, tablets, servers, and phone and

Internet access with a landline (Anderson et al., 2019). To overcome these barriers, the U.S. Department of Health and Human Services, the American Academy of Family Physicians, the American Academy of Nursing, and the Medicare Payment Advisory Commission have all called for the expansion and reimbursement of telehealth services for this community(American Academy of Family Physicians, 2020; American Academy of Nurse Practitioners, 2020; American Hospital Association, 2016; Hersh et al., 2001; Shigekawa et al., 2018). Other economic considerations include the cost of the facilities used to provide telehealth services. Internet access through mobile data or wi-fi, income disparities may affect residents of various areas, predominantly rural and underdeveloped (Goel et al., 2011).

There is uncertainty over whether telehealth can administer adequate care in the same way as traditional face-to-face visits (Weigel et al., 2020). If having Medicare pay for telehealth services is an ethical concern, Medicare Advantage plans are not limited in their ability to provide telehealth services. Now, only 180 codes are required to be reimbursed when clinician-delivered services are delivered via telehealth (CMS, 2020). Additionally, there are regulatory impediments, with some states only currently developing their telehealth and telephonic consultation rules (Center for Connected Health Policy, 2020).

The meaningful use programs have issued a call to action to increase patient interest in PHRs to aid in patient-centered decision-making for their wellbeing (Dontje et al., 2014; Moon, 2017; Rathert et al., 2017). PHRs enable patients to connect with their providers' Electronic Health Records, allowing them to access their EHRs, use telehealth, track current conditions, check lab results, and order refills. Access to the Internet facilitates this adoption and will shift the focus from provider to customer to patient-provider contact (Dickerson & Brennan, 2002).

The National Quality Forums (NQF) Rural Telehealth and Healthcare System Readiness Committee supported and funded by the Centers for Medicare and Medicaid Services (CMS), outlined a framework of measures to use while assessing the impact of telehealth on healthcare system readiness and health outcomes during pandemics, natural disasters, mass violence, and other public health events, particularly those that may impact rural areas, in December 2021 (National Quality Forum, 2021).

Despite the rapid adoption of telemedicine in the U.S. healthcare system, telehealth quality monitoring is still in its early stages. Standardized, rigorous evaluation is required to fully realize the potential of telehealth to improve care delivery, access, and health outcomes for all. To improve rural telehealth, the Committee offered many measurement categories. The five groups are as follows: (a) Access to care and technology; (b) Costs, Business Models, and Logistics; (c) Experience; (d) Effectiveness; and (e) Equity (National Quality Forum, 2021).

According to the NQF's analysis of the literature, various current metrics, including general process and outcome measures for care, might be adapted to assess the efficiency and usefulness of telehealth delivery in remote locations. The study also recommends the development of new tools for examining areas such as broadband access, organizational readiness to transition to telehealth during emergencies, and treatment inequities (2021).

Despite a significant increase in young female adoption rates, women report greater distress when obtaining health, credit, or other personal information (Elhai et al., 2017; Moon, 2017; Qiao et al., 2015). According to Moon (2017), significant factors correlated with negative health data sharing attitudes by consumers/patients include those aged 18-24, a lack of awareness about health data, those over the age of 65, and those with a high school diploma or less. Additionally, ethnic minority communities have a lower confidence in e-services and online systems due to their providers' mistrust. Furthermore, there is a perceived stigma associated with limited healthcare coverage due to this evidence and cultural and institutional bias (Moon, 2017). Understanding why minority women are less willing to disclose health information can assist in explaining the phenomenon.

Health Inequalities and Social Determinants of Health of Black Women

Women's life expectancy and health status have increased for most older American women over American men, owing to technological advancements and a renewed emphasis on preventive health (Dobis et al., 2020; Krieger et al., 2002; Sims, 2010). According to Dobis and colleagues (2020), the past five years have shown a decline in women's life expectancy, especially in Black women. Racial, ethnic, economic, and geographical factors have an impact on life expectancy (Carrillo et al., 2011; Chetty et al., 2016; Clarke et al., 2010; Cristia, 2009; Dobis et al., 2020). Regardless of wealth, education, or insurance status, African-American women over the age of 40 continue to experience a higher rate of sickness, disability, and early death than their White counterparts of comparable ages (National Center for Health Statistics, 2021). The impact of provider-support personnel connections in clinical health encounters, often known as "patient-centered treatment," is critical for modifying risk factors affecting the health and wellbeing of Black women (Sims, 2010). Black women in America experience shorter lives than White women, and race appears to be a factor determining women's life expectancy.

As of 2019, 58.7% of non-Hispanic Blacks in the South (Office of Minority Health, 2021). Of the 10 states with the highest Black census, seven are in South Texas, Georgia, Florida, North Carolina, Virginia, and Louisiana (2021). In the United States, as of 2019, 12.9% of the population are Black women (U.S. Census Bureau, n.d.). Blacks have lower high school diploma attainment than White's 87.2% compared to 93.3% (2021). White Americans have obtained a higher bachelor's degree or higher than Black Americans, 36.9% compared to 22.6%, and Black women had higher degree obtainment at 37.3% (Office of Minority Health, 2021). According to the Office of Minority Health (2021), 8.6% of non-Hispanic Blacks have a graduate or professional degree compared to 14.3% of the non-Hispanic White population.

Large health inequalities exist among African Americans and other economically disadvantaged racial and ethnic minorities, as well as communities of all races with poor socioeconomic status. Inequities exist among Black women and Black men; Black women have earned far less than men (Frye, 2020). Economically, Blacks are more disadvantaged than Whites. In 2019, the median household income for non-Hispanic Black households was $43,771, while the median household income for non-Hispanic White households was $71,644. Blacks have a poverty rate twice that of non-Hispanic Whites (21.2% vs. 9%), as well as a higher unemployment rate (7.7% and 3.7%, respectively; Office of Minority Health, 2021). Fischer and colleagues also discovered that Blacks living in poverty (33.6%) were less likely than other racial groups (51.5%) to say they were inclined to utilize videoconferencing as well as wealthier White individuals with an income of over $200,000 a year before the COVID-19 pandemic (Fischer et al., 2020). Economic status substantially impacts health outcomes.

Social determinants—the environment in which individuals live, learn, work, play, and worship—are increasingly recognized as having an impact on health and causes of inequities. Poverty, lack of access to high-quality education or employment, poor housing, work and neighborhood circumstances, and exposure to neighborhood violence are all social factors that have a detrimental impact on health and well-being (Braveman et al., 2011; Thornton et al., 2016). There is enough evidence of effective outcomes to warrant policy interventions aimed at decreasing disparities in education and early childhood development, urban planning and community development, housing, income improvements and supplements, and employment. Cost-effectiveness analyses demonstrate that these initiatives save money in the long run, but they demand more regular attention to cost concerns (Paskett et al., 2016; Purnell et al., 2016). The obstacles to implementation, including the requirement for long-term funding to scale up effective interventions for local, state, and national implementation.

Insurance coverage is another aspect of social determinants of health that influences health. Non-Hispanic Blacks lacked the same level of health insurance coverage as non-Hispanic Whites in 2019 (55.9% and 74.7%, respectively; Office of Minority Health, 2021). In the South, there are further barriers to insurance coverage due to a decreased expansion of Medicaid. Lack of health insurance has increased the risk of stroke and adverse effects (Reshetnyak et al., 2020), increased risk of maternal morbidity and mortality due to late access to care (Gadson et al., 2017) and delay or absence of screening mammograms and seeking care for breast abnormalities (Henderson et al., 2020). Insurance coverage is an important factor in health care access and mitigating healthcare disparities.

Black women need access to health care to reduce health disparities with chronic illness and decrease maternal, perinatal, and infant mortality disparities (Adebayo et al., 2021; Canty, 2021; J. I. Manuel, 2018). Social injustice such as racial segregation, housing opportunities, school quality, and employment have a major impact on Black Women’s health (Massey & Denton, 1993). Even though decreasing health inequalities necessitates a range of approaches, Improving the quality of care at all points of entry and throughout the lifespan (Howell, 2018; Howell et al., 2016; Howell & Zeitlin, 2017). Another strategy is to create evidence-based procedures and tools to assess intersectional stigma to improve the quality of Black women’s evaluation and care (Turan et al., 2015). We might be able to avoid disease-related exacerbations and retain minority females in optimal health if we can reduce their marginalization by enhancing their technology health literacy and involvement in their healthcare plan (Lin et al., 2015; Moon, 2017; Paige et al., 2017). I believe that via healthcare digitalization, Black women may be empowered and avoid additional oppression of their voices, bodies, and needs by the same healthcare system that does not respect them.

Black Women's Trust and Sense of Security with Telehealth

HIPAA

HIPAA guidelines have been relaxed in terms of the types of communications that can be used to reach patients (Skype, Facetime), as well as Stark regulations (Rights (OCR), 2020; Wicklund, 2020). According to Patel and Johnson (2019), 14% of individuals expressed concern about the safety and confidentiality of their online medical records in 2018 also noted privacy and confidentiality were a concern with telehealth among Black users (S. George et al., 2012). Dissatisfaction with telehealth programs, the individuals responsible for collecting their information, and their comprehension of how the information would be used can lead to mistrust ((Nunnally, 2012; D. M. Walker et al., 2017).

Building Trust

Historically, African American's have mistrust of the healthcare system and medical research. The generation of African Americans over the age of 40 recalls past injustices. For these individuals, unwanted testing was not merely a problem of the past; they believed African Americans were currently the objects of unwanted studies, and they felt susceptible to such dangers (Jupka et al., 2008). These attitudes about experimentation impact faith in the medical system and may dissuade African Americans from accessing much-needed healthcare, particularly preventive care. With trust being related to being "seen" or physically assessed by the provider, are you truly being seen or touched in telehealth, which is not a trusting relationship (S. George et al., 2012).

Minority women suffer disproportionately in terms of telehealth access and utilization. As a minority woman, I am concerned that we will be left behind in the rapidly changing healthcare system. Increasing Black women's exposure to telehealth and increasing utilization of technology to assist the approach are two strategies for closing healthcare gaps (Brotman & Kotloff, 2021; Ramirez et al., 2021; Rovner & Casten, 2021). By increasing utilization among Black women, clinicians could very well gain insight into and contribute to the development of trusted relationships with patients and the system, as well as engage them in the PMR and, hopefully, strengthen their commitment to patient-centered care by identifying the barriers to trusting the system and those associated with it (Irizarry et al., 2015; James & Harville, 2018).

It is critical to maintain patient confidentiality and to establish trust with partners and patients. The concept of trust in provider-patient relationships can influence patients', customers', and healthcare providers' attitudes and perceptions. Trust is essential for integrating digital wellbeing with consumer/patient feedback and participation (Ancker et al., 2012; Dontje et al., 2014; Moon, 2017; Qiao et al., 2015; Rathert et al., 2017). However, another new qualitative research investigating abortion care through telehealth in rural settings discovered that telehealth may be helpful for such intimate care as abortion care and that women trust and feel more ease in the interaction with the provider through telemedicine (Grindlay et al., 2013).

As a result of the issue, patients who activate patient portals in EHR and use telehealth services are more vulnerable (Gibson, 2019; Hupcey et al., 2001; J. D. Lewis & Weigert, 1985). Creating those ties raises vulnerability since the sufferer must rely on someone else to perform as expected (Hupcey et al., 2001; J. D. Lewis & Weigert, 1985). Mistrust can result in a decline in patient satisfaction, reduced quality of life, and a decreased proclivity to trust, all of which are adverse effects that African-Americans and women have been subjected to in a literature study (Arnett et al., 2016; Beldad et al., 2010; Kinlock et al., 2017; LaVeist et al., 2009). Telemedicine can be utilized with this content in various circumstances where it may not be well accepted but may be valuable to clients who encounter barriers to treatment access.

Telehealth for Blacks

The history of Black people in the United States is steeped in racial injustice, and there have been several attempts to address this legacy of oppression. Poverty (Firebaugh & Acciai, 2016), mass imprisonment (Western & Wildeman, 2009), infant mortality (Chambers et al., 2019; J. W. Collins et al., 2000; J. W. Collins & David, 2009), poor health care access (Agency for Healthcare Research and Quality, 2018; Chang et al., 2021; Copeland, 2005), mental health access and utilization (Christensen et al., 2020; McCall et al., 2019)and health-related illnesses such as heart disease (Carnethon et al., 2017), diabetes (Marshall, 2005; Rovner & Casten, 2021), stroke (Kissela et al., 2004), renal disease (Laster et al., 2018), respiratory sickness (Barnes et al., 2007; Ejike et al., 2019), and human immunodeficiency virus (HIV) (Laurencin et al., 2008) all impact Blacks disproportionately (Laurencin & McClinton, 2020).

African American women are more likely than the general population to suffer from anxiety or depression. Despite the high need for mental health treatments, African American women use them at considerably lower rates. Anxiety and depressive symptoms were found to be significantly reduced in previous mobile health studies after the intervention. For African American women seeking access to mental health services and resources, mobile applications may help remove or mitigate obstacles. Black women have also been shown to underutilize mental health care dramatically.

Many people are familiar with their disadvantaged status and have firsthand knowledge of the catastrophic effects of social injustice in their communities. Perhaps these particular social circumstances prompted many people in Black communities in the United States and throughout the world to believe in the myth of Black immunity to Coronavirus illness 2019 (COVID-19); the possibility of immunity against a worldwide disaster provided one less fight among many (Glanton, 2020; Laurencin & McClinton, 2020).

The complex intertwined risks of health disparity, economic instability, environmental injustice, and communal trauma have been brought to our attention by COVID-19. COVID-19 presented its own unique obstacles from 2019 until the present, over the course of this investigation. Healthcare institutions and clinicians were forced to actually flip a switch in order to satisfy the needs of healthcare service lines while limiting viral spread (Abd-Alrazaq et al., 2021; Brotman & Kotloff, 2021; Fryer et al., 2020; Hollander & Carr, 2020; Lieneck et al., 2021; Ramaswamy et al., 2020). Continued use of telehealth for routine treatment necessitates a close examination of accessibility. The COVID-19 epidemic has already been shown to have disproportionately negative health and financial consequences for vulnerable populations, and several recent studies have found socioeconomic inequities in telehealth use in other medical specialties (Darrat et al., 2021; Eberly et al., 2020; Jaffe et al., 2020; Wegermann et al., 2021).

Non-latinix mainstream dominates the macro and micro-level activities of the healthcare systems are informed and shaped by White cultural norms (Watson et al., 2020). The nonrepresentative morbidity and mortality rates in Black and Latinx populations across the United States have clearly highlighted racial inequities in the COVID-19 epidemic (Chang et al., 2021; Chunara et al., 2021; M. F. Watson et al., 2020; Webb Hooper et al., 2020; Yancy, 2020).

These myths, including the challenge of COVID-19 vaccine adoption has presented challenges, divide and mistrust of government, and healthcare communities (Kricorian & Turner, 2021). Race/ethnicity was known for 62% of those who have gotten at least one dose of the vaccination as of November 2, 2021, according to the CDC. 60% were White, 11% were Black, 17% were Hispanic, 6% were Asian, 1% were American Indian or Alaska Native, and 1% were Native Hawaiian or other Pacific Islander, with 5% reporting multiple or other races. According to CDC data, the recent share of immunizations received by Black people is the same as their percentage of the entire population (both at 12%) (Ndugga et al., 2021) Vaccine apprehension towards COVID-19 in the Black community further marginalizes them, putting them at an increased risk of illness and mortality.

While the promise of healthcare technologies such as telemedicine is exciting, the “digital divide”—the disparate access to and use of technology and the Internet among communities and populations of various race/ethnicity and socioeconomic demographics due to social, linguistic, financial, and other barriers—has the potential to exacerbate disparities (Chang et al., 2021; López et al., 2011). Also adding to the digital divide, lower-income people are less likely to have broadband Internet at home and are more likely to rely on their phones for Internet access, and race was not a significant indicator (Schenker et al., 2021). While some research suggests that telemedicine can reduce healthcare disparities for patients in remote areas, (Lieneck et al., 2021; Loeb et al., 2020) other research suggests that the exacerbation of healthcare disparities may be an unintended consequence of large-scale telemedicine deployment, with factors like lower socioeconomic status and technology literacy contributing to increased health disparities Institutional racism and ageism are well-documented in in-person healthcare access and usage con- tracts; such variables have roots in racism, sexism, ageism, and their intersections (Ben et al., 2017; Crenshaw, 2017; Madubuonwu & Mehta, 2021).

During Phase 1 of the COVID-19 epidemic, studies found that, while African Americans used telehealth more than Whites, their uptake was not similar (Chunara et al., 2021). However, before the COVID-19 pandemic, Pierce & Stevermer (2020) found that those that had received a post-secondary education had higher telehealth utilization. During COVID-19, older Black patients (over 65) were more likely to use telephone rather than video for treatment, and those Black patients on Medicaid, Medicare, or self-pay status were more likely to use telephone rather than video for care (Fischer et al., 2020; Madubuonwu & Mehta, 2021; Pierce & Stevermer, 2020). Another research study of 140,184 patients found that compared to the same period in 2019, the proportion of Black patients utilizing telemedicine increased, however, this increase was driven by young, female patients (Chunara et al., 2021). Chunara and colleagues also found and adjusted odds ratio (aOR) of 1.07 (95% CI, 1.02–1.13) for probable COVID diagnosis following a visit was greater for Black patients who used telemedicine than for White patients who used both in-person and telemedicine. The odds of a Black patient testing positive for the virus (of those who got tested) were higher compared to White patients, with an aOR of 1.63 (95% CI, 1.36–1.94) positive for COVID-19. Together, these data imply that while Black patients used telemedicine more frequently during the pandemic, they use it less than White patients and may be clinically worse from COVID-19 while using it (2021). Overall, this research contributes to the literature by examining inequities in healthcare access, especially using telemedicine, during a time when the demand for remote healthcare access was strong.

Furthermore, the observed intersectionality of disparities, i.e., in Black and older patients, echoes well-documented challenges in healthcare due to institutional sexism and ageism (due to bias and cultural competencies among providers, access to resources, and other factors); and this review of disparities and COVID-19 highlights how these forces manifest in telemedicine access (Chunara et al., 2021; Crenshaw, 2017; Jaffe et al., 2020; Kane & Kane, 2005; Levy et al., 2015). During COVID-19, increased access to care, as well as personalized culturally oriented treatment, is critical. While telehealth offers numerous potential benefits in terms of providing access to care during a pandemic, policy adjustments should address the hurdles that disproportionately affect vulnerable patient populations and those who serve Black women.

Role of Black Feminist Thought Researcher

The Black Feminist Thought (BFT) researcher not only approaches research with a broad lens, but she also acknowledges the ethic of risk that underpins educational and social scientific literature (Beauboeuf-Lafontant, 2002; P. H. Collins, 2002; Lindsay-Dennis, 2015). This does not mean that African American women are not at risk; however, it does mean that women must always be at the center of their studies (J. W. Collins et al., 2000; P. H. Collins, 2002). By focusing the research on Black women, they are moved from the fringes to the center of the discussion. Personal bias affects judgments concerning study questions, data collection processes, and data analysis procedures, according to the BFT perspective. It is critical to recognize how personal assumptions about Black womanhood influence the investigation instead of ignoring these distinctions. Although it is not necessary to suspend personal beliefs and experiences, personal biases and assumptions must be monitored. Keeping extensive field notes and journaling about the entire process is one strategy that a researcher can use to monitor bias. This data can also be used to document beliefs and judgments. Awareness of bias can reduce the likelihood of incorrectly interpreting data, silencing participants, and ignoring participants' diverse experiences and perceptions; therefore, to ensure that studies about/on African American females are rigorous, real, and accurate, the researcher focuses on personal responsibility and self-awareness (P. H. Collins, 2002; Few et al., 2003; Lindsay-Dennis, 2015).

Gaps In Literature

In terms of economic, technical, unconscious bias, racism, policy, and access to care, the latest research tackles established socioeconomic determinants of health that affect Black women. There are gaps in the research about the experiences of Black women who use telehealth in different parts of the country, and these same variables and experiences may or may not influence telehealth usage. Systemic racism and ageism, which are at the root of both in-person and telemedicine care inequities (Chunara et al., 2021; López et al., 2011; Madubuonwu & Mehta, 2021; Schenker et al., 2021) must be further investigated in the Black community to provide an awareness of specific populations for whom telemedicine acceptance is limited. The study, which was undertaken in the United States, helped aim to close these gaps. Another gap in the research has been recognized as the dearth of qualitative studies aimed at understanding Black women's perceptions of telehealth usage in the context of race, gender, and systemic discrimination.

Summary

The Intersectionality of disparities, that is, in Black and older patients, echoes well-documented challenges in healthcare due to institutional sexism and ageism (due to bias and cultural competencies among providers, access to resources, and other factors); and, once again, demonstrates that these forces manifest in healthcare access via telemedicine (Ben et al., 2017; Crenshaw, 2017; Jupka et al., 2008; Kane & Kane, 2005). Thus, by undertaking this integrated and comprehensive evaluation of Black women's experience with telehealth and healthcare literature, strengths, and gaps in the research about Black women's telehealth usage have begun to be discovered. According to the literature, telehealth utilization has been driven by the provider and pandemic-driven quantitative studies, which have used post-hoc EMR system data, Press-Ganey surveys, or post-care surveys. There is a growing body of research on the relationship between racial disparities in specialty care and telehealth utilization. However, there has been little qualitative research into the experiences of Black women. This research is guided by the gaps in the literature concerning Black Women and Telehealth to begin to examine the experience of Black women with telehealth and access to their providers, bias experienced, satisfaction of care provided and if racism and gender bias may have affected their experience.

CHAPTER III: METHODOLOGY

The purpose of this study was to examine the experiences of telehealth use among Black women. The research design and methodology that were utilized to answer the study questions are described in this chapter. The protocols for recruiting participants, as well as a description of the setting and research sample, criteria that were applied to ensure scientific rigor, and the safeguards in place to protect human subjects, are discussed. The study was submitted to the University of North Carolina at Greensboro's Institutional Review Board and received approval on March 21, 2022, as exempt, IRB-FY22-383.

Qualitative Method

Descriptive qualitative studies, which are typically eclectic and adopt methodologies, provide for comprehensive discussion of phenomena (Polit et al., 2017, p. 678; Sandelowski, 2000). Naturalistic inquiry is a method of investigation that involves studying something in its natural state (Lincoln & Guba, 1985, as cited in Sandelowski, 2000), extracting data from its source, and analyzing the information closer to the data (Lincoln & Guba, 1985; Sandelowski, 2000). When the study is performed according to naturalistic inquiry principles, qualitative description entails no variable pre-selection or manipulation, as well as no *a priori* commitment to any theoretical perspective on the facts (Polit et al., 2017; Sandelowski, 2000). Given this, Black feminist thought is a perspective, however, the data was generated from the stories of the participants. Qualitative descriptive studies are used to generate themes based on members' shared descriptions and discover trends based on data from individual participants (Creswell & Creswell, 2018). The emergent data is descriptive, focusing on perceptions and experiences, and is represented in the classification of themes that happen as the data arises during the data analysis process (2018). Knowledge is generated by a sociolinguistic process including various realities, restructuring thinking, and collaborative reflection, all of with are appropriate for knowledge production in an uncharted or understudied subject (Duane & Satre, 2014; Lincoln & Guba, 1985).

Qualitative techniques provide a means for health sciences to investigate novel phenomena via the experience of those being investigated. Little manipulation is used, and the researcher collects data in a natural setting, up close and personal, using focus groups or individual interviews, without the use of instruments (Creswell & Creswell, 2018). The researcher is the instrument, conducting interviews and collecting data according to a protocol; nevertheless, the researcher is also the information gatherer and interpreter; they do not rely on questionaries or instruments developed by other researchers (Creswell & Creswell, 2018; Lincoln & Guba, 1985). The qualitative research tradition is based on intuitive and emotional knowledge rather than quantifiable data (Creswell & Creswell, 2018).

Research Design

A qualitative descriptive research design was used to explore the experiences of Black Women's use of telehealth. This method explored these experiences of utilization of telehealth for their healthcare. It is the best method for determining who was involved, what was involved, and where the phenomena occurred. The validity and reliability of qualitative studies differ because the researcher seeks believability based on coherence, insight, and instrument utility, as well as trustworthiness via the verification process (Creswell & Creswell, 2018; Lincoln & Guba, 1985). This study sought to uncover the themes that reflect Black Women's experience with telehealth, while exploring intersections of race, gender, and discrimination with telehealth use.

The researcher has integrated the Black Feminist Thought framework with the Intersectionality conceptual framework to contextualize the participants' experiences. Although the theoretical basis for this study will be Black Feminist Thought with Intersectionality, the researcher required a low theoretical sensitivity to prevent clouding the research data as themes emerge from the qualitative responses of the participants. It refers to the ability of a researcher to find relevant and important evidence to explain a phenomena (Chun Tie et al., 2019).

Research Questions

The research questions that guided the study are:

1. "What is the experience of Black women's use of telehealth for their healthcare?"
2. "How, when and why do Black Women use telehealth?"
3. "What experience as a Black Woman influences decisions to use telehealth?"
4. "What experience influences a Black woman's future use of telehealth?"

Sampling and Setting

In general, any deliberate sampling strategy can be used in qualitative descriptive research (Lambert & Lambert, 2012; Patton, 1990; Sandelowski, 2000). Purposive sampling and snowballing were utilized in this study. The sample size in qualitative research varies according to the research aim, research question, the study's sensitivity and breadth, the kind of data analysis employed, the richness of the participants' data, the technique of data collection, available time and resources, and data saturation (Braun & Clarke, 2013; Morse, 2000; Patton, 1990). A small number of participants (15-20) for qualitative description is considered ideal for a "medium study" as a first attempt to grasp an understudied phenomenon (Braun & Clarke, 2013). The process will be repeated until the researcher and committee believe that thick data has been sufficiently collected from the participants. The process was repeated until the researcher and committee believed that thick data had been sufficiently collected from the participants *N=21*.

Data was obtained in the real world, in environments where Black women live, work, and use telehealth in the United States. Qualitative research conducted in the participants' settings aids in the collection and analysis of phenomena in natural situations in a single data point (Polit et al., 2017). In this study, Black Women refers explicitly to African Americans who identify as female and Black, who live in the United States, ages 18-65. The selection of this population for this study is based on the majority representation of Black women who have unrestricted access to telehealth. The participants of this study met the following inclusion criteria. The participant 1) must have used telehealth in the past two years to access care; 2) own a computer, tablet, or cell phone; 3) read and communicate in English and 4) ages 18-65 years of age. The exclusion criteria were Black women who: (a) have been in the United States less than two years; (b) have not utilized telehealth for their care in the past 2 years; (c) non-English speaking; (d) women who are less than 18 years old and older than 65 years old; (e) White women or other racial groups.

Recruitment

Purposive sampling and snowballing were utilized in this study. The primary recruitment strategy used the researcher's personal Facebook page, which primarily consists of women of all ages, races, and backgrounds, as well as the Facebook groups, Doctoral Mom Group Inc, DELTA Dissertations, no additional sites were needed due to great participant response, thirty-seven participants were prescreened that were eligible for the study. The researcher obtained permission to post in those groups from the owner of the social media groups. Following IRB approval, digital recruitment flyers detailing the study's purpose and the inclusion criteria used to determine research participant eligibility were posted on the above-mentioned Facebook groups once participant data saturation was met. A twenty-dollar digital Amazon gift card was offered at the completion of the final interview. The researcher's UNCG student email address was disclosed to these potential participants. Although the sampling plan recommended 15-20 participants, an extra number of 25 was entered for IRB modification and approved, if participants withdrew or are lost due to attrition or data saturation not met.

Those who demonstrated an interest in participating in the study was contacted by the researcher. To determine eligibility, the inclusion and exclusion criteria will be determined with an emailed prescreen in Qualtrics. The following questions were asked during the prescreen: 1) Are you over the age of 18? 2) Are you familiar with Zoom? 3) What type of telehealth did you employ? Phone or video chat? 4) Do you identify as a Black Female living in the United States? 5). Have you used telehealth in the last two years as of today? After these pre-screening questions have been answered, if the participant wishes to proceed a virtual interview time will be arranged and utilized a shared google calendar with the choice of video call, ZOOM or Google Meet. Participants were scheduled on a first come first serve basis based on data saturation from the interviews.

The final number of participants was determined when data saturation was reached, which is a widely and accurately used rationale for determining sample size in qualitative studies (Bowen, 2008; Braun & Clarke, 2013). Saturation occurs when individuals report the same aspects of the phenomena being examined repeatedly and consistently; it occurs when no new themes arise from the participants' replies (Creswell & Creswell, 2018; Polit et al., 2017).

Information sheets that address the nature, purpose, benefits, risks, ethical considerations and data collection technique by an information sheet were provided by email twenty-four hours before scheduled virtual interview.

Data Collection

Demographic data was collected via Qualtrics before the interview and verified with participants and SPSS utilized to report those responses. Individual interviews lasted 25 minutes to 60 minutes and were conducted virtually by the electronic platform of participant choice i.e., ZOOM and Google Duo. Allowing enough time for the interview helped the researcher build the participants' trust. Follow-up, clarifying questions, and extra time was used to obtain data from individual participants. Public health concerns related to the COVID-19 epidemic made face-to-face interviews difficult so virtual one-on-one interviews were utilized. The interviews were recorded using two digital voice recorders. The researcher wrote field notes of the responses of the participants during the interview. Field notes were written after each interview is completed to provide context for the understanding and the women's experiences. Also, the field notes allowed for examination of researcher's personal bias researcher judgement during the interviews and analysis. The field notes were reviewed after each level of data analysis. The interviews were transcribed verbatim and then reviewed and cleaned by the researcher. The researcher immersed herself in the transcripts and listened to the recorded interviews up to three times while taking loose notes as the content was clarified.

Virtual interviews, offered a number of benefits: 1) It was more convenient for both the researcher and the participant because they could interview in the comfort of their own homes; 2) it gave the participant a greater sense of control and empowerment because the researcher's physical presence did not threaten them; 3) it provided more privacy and confidentiality, potentially making it more ideal for sensitive topics such as experiencing racism, sexism, or ageism, which may have resulted in embarrassment or anger (Braun & Clarke, 2013; Carter, 2007; Homan, 2019). Its disadvantages may have included: 1) limited accessibility to some groups where online networks or mobile devices were limited; 2) potential loss of context and a lower chance of producing thick data if the researcher was unable to observe the participants' nonverbal behavior; and 3) risk of data security breach due to insecure networks and mobile devices (Braun & Clarke, 2013; Polit & Beck, 2017). Given the advantages and disadvantages of conducting virtual interviews, the researcher ensured that the participant's interview followed ethical guidelines to protect the participants' autonomy and assure beneficence and non-maleficence while maximizing the opportunity to collect rich data for the study.

Research Instrument

The primary interactive data gathering strategy for this project was a semi-structured individual interview. This approach was appropriate and geared at determining the who, what, and where of the underlying essence of the phenomena to be examined and is consistent with the qualitative description. There are two components to the interview. The demographics were in Part I, while the interview questions were in Part II. The PI gathered demographic information virtually using Part I in Qualtrics. The 12-item demographic questionnaire asked participants about their age, gender, sexual orientation, race, geographic region, highest educational attainment, salary range, available Internet access, which mobile device was preferred to use for the interview and was used (cellphone, tablet, or computer), where they first used telehealth (PCP, Specialist, both, or online service), and whether they first used telehealth during COVID 19 or before the pandemic. This demographic information offered details about the individuals' characteristics and took less than 5-7 minutes to complete and verify by verbal questioning. We used SPSS (D. George & Mallery, 2016) to analyze the demographic data.

To accomplish the study's aims and answer the research questions, the semi-structured interview, Part II of the interview guide, was guided by the following questions:

1. When you hear the word telehealth what does that mean to you?
2. Describe for me your experience with telehealth? Help me understand everything you went through.
3. Can you help me understand what was discussed or what you and the provider talked about during the telehealth visit?
4. Can you help me understand if there were things missing or what type of things were missing or different by using telehealth rather than in the office visit?
5. Based on your care experience, what will help you decide to use or not use telehealth in the future?
6. What else would you like to share regarding your telehealth or other care experiences? Anything and everything I would be glad to hear.
7. What would you like to share with healthcare providers about the experience of telehealth to help other Black women?

Follow-up questions and prompts that asked when, where and how that affected your experience were asked depending on how the participants answered the main questions. This enabled the researcher to gather more information to produce rich and thick data on their telehealth experiences. These semi-structured questions were developed based on the review of literature of what is known about Black women and gaps in literature regarding telehealth use.

Data Management

Data Storage and Protection

Various strategies ensured proper data storage and security to preserve the confidentiality, privacy, and anonymity of the research participants and to adhere to ethical principles in the conduct of research. Demographic information was gathered, the participants were de-identified and given a code number, the names of participants were not associated with their transcribed data. The confidentiality of the participants was ensured by assigning each participant a pseudonym and tape/transcription code number. The voice recorders and transcriptions were handled safely by the researcher in a secure and lockable cabinet. Furthermore, data was saved in UNCG's Box to securely share with the Ph.D. reviewer for audit trail and peer review. Per the standards of the UNCG IRB, the recorded material from both voice recorders will be destroyed, and transcriptions will be shredded 5 years after completion of the dissertation. The master list with participant names and emails were destroyed at the completion of the dissertation.

Data Analysis

Before collecting data, the researcher did not identify the themes, allowing them to develop naturally. To allow the themes to emerge from the data rather than the mode, statements and discussion by the participants guided the formation of ideas, categories, and themes (P. H. Collins, 2002; Crenshaw, 2017). Qualitative content analysis is a collection of approaches for analyzing textual data and explaining themes (Vaismoradi et al., 2013), Because it is a content-sensitive method, content analysis has advantages in nursing research. It also allows for greater flexibility in study design (Elo & Kyngäs, 2008a). The themes are developed from participant data where codes are produced during the study's development. It is a methodical way to find codes to offer a description of social reality via the creation of themes (Elo & Kyngäs, 2008; Sandelowski, 2000). The researcher immersed herself in the data, rereading it and open coding transcribed interviews and field notes. The interviews and transcripts were reviewed with two experienced researchers supervising the research and continued to identify codes until saturation was met, no new categories emerged, and no further interviews were required. The data analysis was an iterative process in which data gathering and analyzing occurred simultaneously (Braun & Clarke, 2013; Lambert & Lambert, 2012).

During the interview, the researcher gathered and evaluate data simultaneously, then prepared notes for prospective inclusion in the study report. The abstraction process was the step of qualitative content analysis when theme or concepts were created. This method was required to accurately identify the themes that emerged from the data of the participants without being influenced by an a priori insight on a specific theoretical framework. This is important because the qualitative description is data-driven, with patterns, codes, and themes emerging from the data during the study (Lambert & Lambert, 2012; Sandelowski, 2000).

Although the Black feminist thought model (BFTM) with Intersectionality (Crenshaw, 1989) was used as the conceptual framework for this study, the five components of the BFTM were not defined before data analysis, but rather the perspective was used to develop the questions and will be used in the interpretation context. Thus, the participants' responses were not coded to suit these concepts in a quantitative manner. The textual data were tagged or coded as the participants presented the data. Consistent with the qualitative description, establishing codes based on participants' own words or descriptions brought the data analysis closer to its natural state without employing an elaborate interpretative lens (Lambert & Lambert, 2012). Furthermore, reflexivity and bracketing of the researcher's personal telehealth experiences as a user and provider, as well as presenting the participants' viewpoints in their own words, helped ensure that the findings are representative of the participants' perspectives.

The data analysis processes employed in this study were based on Creswell & Creswell's five-step guideline (2018). Transcribing interviews, visually scanning data, collecting field notes, and organizing data will be the first steps in categorizing and preparing the data for analysis. The researcher will thoroughly review all transcribed individual interviews from transcription services to immerse herself in the data. While the data was being transcribed, this procedure allowed for early data analysis. Second, the data were examined to form a broad picture and make conclusions about its significance. Reading and reviewing the data assisted in figuring out what the research data really means, according to the participants. Third, coding occurred, which was the process of bracketing or placing words in the margins of ordered data to represent a category. Participants' statements were initially coded to determine their experiences and find ideas that helped or hindered their telehealth interactions.

Based on the research questions and interview questions, as well as the terminology provided by the participants, patterns and classifications were formed. To create categories, statements or quotes with the same coding were grouped together. Continuous analysis or comparative content analysis were undertaken while transcribing each interview and before performing the next interview to discover trends and the development of themes, as well as when data saturation was reached, using qualitative data analysis methodologies. Individual interviews came to an end when no new codes or categories emerged. Descriptions and themes were created that reflect a variety of perspectives and were accompanied by actual quotations to clarify the themes. People, locations, and events in the context are discussed. Participants' comments that indicate interesting, different, or opposing opinions were identified within themes. The description of categories and themes are offered in a descriptive narrative passage. This approach is helpful because an open-minded attitude and moderate theoretical sensitivity were used to produce a thorough description of the participants' experiences. As categories emerged, they may reduce into more relevant themes through a process known as winnowing or by focusing on specific characteristics of the data to aggregate them into a smaller number of cogent themes (Creswell & Creswell, 2018).

After these steps according to Creswell and Creswell (2018), the further analysis approach is the content analysis which used the inductive approach to organize the data. According to Elo and Kygäs (2008), inductive approach was best when there was not enough former knowledge about the phenomenon, Black women's experience with telehealth. This procedure helped place the broad themes produced in the data preparation the particular to general to observe examples and combine them into bigger of entire general assertions (2008). The three phases: preparation, organizing and reporting were the main processes and preparation were carried out using the five phases of data preparation as discussed above. The goal again was for the researcher to become immersed in the data.

The next stage was to organize the data, which was where this approach was helpful for grouping. Organizational phases included open coding, category creation, and abstraction. Open-coding similar to that of Creswell and Creswell (2018) required notes and headings written in the text while it was being read and reread. Headings continued to be developed to describe the content was done on the transcription sheets and then transferred to a coding sheet (Elo & Kyngäs, 2008a). Following that, the categories were grouped under higher-order headings to reduce the number of categories by those that are similar or dissimilar, which aided in defining the phenomenon and so deepening comprehension (2008). Abstraction followed categorization by producing categories that were named utilizing content-characteristic terms to give a broad description of the issue (Elo & Kyngäs, 2008a; Polit & Polit, 2010). Similar subcategories were then combined as categories, and subsequently into primary categories, until all categories were grouped as much as feasible (Elo & Kyngäs, 2008a).

The researcher found themes that met the study objectives and answered the research questions at this stage of data analysis. This was accomplished by identifying topics and quotes that illustrate telehealth experiences, enabling factors, impediments, power struggles, trust, gender, age, or color discrimination. The themes have been presented in tables and well as a model as presented in Chapter IV. A table was added to show the relationships between data and findings, as well as deidentified quotations to back up the data (Elo & Kyngäs, 2008a).

Establishing the Rigor of the Study

Positionality

The researcher must acknowledge positionality in conducting qualitative research. Positionality is the distinctive position of the knower in any setting as characterized by race, gender, class, and other socially important factors (Elo & Kyngäs, 2008). As a Black, American female, who is middle class, politically independent, and a health care provider who is an advocate for women's health, special attention had to be paid to my relational position or value that an individual possesses that is impacted and influenced by a variety of contextual elements such as social, political, historical, educational, and economic considerations (Louis & Calabrese Barton, 2002; Maher & Tetreault, 1994; Secules et al., 2021). Acknowledging positionality is essential for comprehending the researcher's subjectivity, which may influence the participants' reports of their experiences. Without a clear understanding of the researcher's positionality, the participant's perception of their experiences may be distorted, and the researcher's abilities and study findings may be jeopardized, restricting knowledge advancement (Louis & Calabrese Barton, 2002; Secules et al., 2021).

While these characterize my own experiences, they could be sources of bias during the data collecting and analysis phases. Furthermore, reflexivity examined how my status as a Black female healthcare researcher may have impacted data analysis. Knowing my personal experiences and background was crucial in distinguishing my own experiences when I use and deliver telehealth from individuals' unique experiences. It was vital to separate my personal experiences to avoid clouding data analysis and interpretation. The study findings have been presented as a concise summary of descriptive information from the collected data, grouped logically with categories and subcategories (Lambert & Lambert, 2012). Consistent with BFT, the author provided her reflection of the study after the conclusion of the study.

Reflexivity, which may be attained by identifying my personal experiences as distinct from the participants' experiences, was essential in bracketing my viewpoints as a researcher. Being cognizant of the researcher's prejudices and personal experiences as a Black female nurse practitioner, these characteristics must not distort the participants' experiences. The researcher might use an emic approach to better grasp the notion and context of Black women's experience with telehealth. In qualitative investigations, it is critical to provide information about how the researcher's background affects the interpretation of data (Creswell & Creswell, 2018).

To maintain objectivity and ensure the validity of the findings in this study, caution was exercised when describing participants' experiences, as the researcher's beliefs, political views, and cultural background, as well as gender, race, age, socioeconomic status, and educational background, may have affected interpretation (Bourke, 2014; Louis & Calabrese Barton, 2002). To assure the study's objectivity, two professional researchers read transcripts randomly in small batches to provide feedback and ways to improve on the following interviews. My race and gender provided me an advantage in recruiting, creating trust and rapport, and providing an insider's perspective on the participants' personal experiences as a Black woman. My previous experiences as a nurse practitioner in the southern United States have prepared me with a comprehensive understanding of the systemic concerns that may affect participants' barriers and facilitators to telehealth use. To also acknowledge, that we are still having the same discussion about Black women and racial disparities from twenty-years ago, now just addressing telehealth as the access point (Banks et al., 2006; Banks-Wallace, 2000; Barlow & Smith, 2019). To minimize bias when reporting the participants' perspectives, it was critical to understand the researcher's background. If this does not happen, it may bias participants' views of reality and have an influence on the study's results (Bourke, 2014; Secules et al., 2021).

Peer debriefing was the process of meeting with objective peers to evaluate and discuss various parts of the research project, notably the data analysis process. Throughout the data analysis and writing phases of the proposed study, peer debriefing was employed. Throughout the study's duration, the investigator met or had a discussion with the dissertation chair or co-chair on at least a twice-weekly basis and as needed to examine the findings. The study's advancement and data analysis were addressed on a regular basis with research chairs and bracketing discussions.

Trustworthiness

Credibility, reliability, conformability, transferability, and authenticity are all concepts used to describe the trustworthiness of qualitative content analysis (Elo et al., 2014). To assess trustworthiness, techniques to ensure findings' credibility, reliability, conformability, and transferability were employed. In a qualitative investigation, the goal of trustworthiness is to back up the claim that the findings are "worth paying attention to" (Elo et al., 2014; Lincoln & Guba, 1985). The following areas are iterative and complimentary in nature.

Credibility

Researchers must guarantee that persons who participate in study are appropriately recognized and characterized in order to build credibility (Elo et al., 2014; Lincoln & Guba, 1985). Recognizing one's positionality as a researcher was one way to demonstrate reflexivity. The audit trail, the process of collecting materials that allowed an independent auditor to investigate the study's conclusions, was used in conjunction with peer review and debriefing. During and after each interview, the researcher wrote memos and reflexive notes. Keeping track of events and decision-making processes during the research process is aided by this. In addition, a codebook will be created to guide data analysis. This codebook was a written document that described the precise definitions of the various codes used during data analysis (Polit & Beck, 2017). The codebook helped to ensure consistency in data coding and participant response analysis. This study's audit trail consists of these documents, memos, reflective notes, and codebooks.

Reliability

The study's findings were evaluated for reliability using Lincoln and Guba's (1985) standards for evaluating truth value in qualitative research. These are recommended techniques to ensure qualitative research findings' validity, reliability, and transferability (Polit et al., 2017). Validity refers to the data's veracity (Polit & Beck, 2017). The study's validity was checked via member checking and dual review of data. Participants' transcripts were checked individually to confirm that the results correctly reflected their responses compared to their interview (Creswell & Creswell, 2018; Lincoln & Guba, 1985; Polit et al., 2017). During data collection, this was done informally by asking participants to acknowledge that their experiences and perspectives have been understood (Polit & Beck, 2017).

The key benefits of a personal interview: 1) accessibility, which allowed the researcher to interact with the participant and observe behaviors and settings that were useful in creating memos or field notes, which were necessary for producing thick data; 2) control, which allowed the researcher to probe and ask unplanned questions; and 3) flexibility, which allowed the researcher to probe and ask unplanned questions (Braun & Clarke, 2013; Creswell & Creswell, 2018).

Transferability

Transferability refers to how easily a qualitative study's findings may be transferred to a new population or place (Polit et al., 2017). The term "transferability" refers to the ability to extrapolate. It is based on the assumption that results may be generalized or applied to different contexts or populations (Elo et al., 2014). Purposive sampling, data collection, and dense description building were utilized to show transferability. To find individuals who have encountered the phenomena under study, purposeful sampling was helpful. Determining participants' traits beforehand facilitates purposeful sampling, enhanced the data collected (Creswell & Creswell, 2018; Polit et al., 2017). Individual interviews provided a more comprehensive assessment of participants' experiences, adding to the study's validity (Creswell & Creswell, 2018). In addition, the study instrument contained a component that requested demographic information from participants. This information was required to describe the participant profiles and give the appropriate context for their telehealth experiences.

Dependability

Dependability is vital for trustworthiness since it establishes the outcomes of the research investigation as consistent and reproducible (Elo et al., 2014). Dependability refers to the reliability or stability of research data over time and conditions (Polit & Beck, 2017). Audit trail and member checking were used to establish the study's dependability (Elo et al., 2014; Polit et al., 2017). An audit trail acts as an objective point of reference for tracing and reflecting on participants' accounts of the phenomena under investigation (Polit & Beck, 2017). The study's findings were presented to two members of the dissertation committee who hold a Ph.D. and are experts in the technique of inquiry to foster trust in the research data. The latter was accomplished with qualitative researchers and theoretical framework researchers. This served as a form of peer review, establishing both reliability and confirmability. Additionally, member checking aided in ensuring the reliability of the study data by conducting member checks throughout and after the interview procedure (Guba & Lincoln, 1985).

Confirmability

Confirmability is concerned with the objectivity of the study data as reported by participants, not with the researcher's prejudices or opinions (Polit & Beck, 2017). Reflexivity, an audit trail, peer review, and debriefing were all criteria that contributed to the study's confirmability (Polit & Beck, 2017). The term "reflexivity" referred to the researcher's knowledge of their history and experiences, as well as their possible effect on the research process and results (Polit & Beck, 2017). The researcher employed reflective field notes to facilitate self-reflection to get a more nuanced understanding of the phenomena under investigation based on the participants' viewpoints rather than subjective judgments (Koch, 1994; Koch & Harrington, 1998). Recognizing the researcher's background and how it influenced the interpretation of the data is a hallmark of effective qualitative research (Creswell & Creswell, 2018).

Individual member verification was done during and at the end of the interview. Throughout the interview, the researcher asked participants for clarification to ensure that they understand their replies correctly. In this way, participants may check the correctness of their statements and provide details to the researcher. After data collection and analysis, participants could be contacted directly and asked to consent to a second contact if they have any questions. They all agreed but no further clarification was needed. The responses were summarized, and further points of clarification were asked or anything else they would like to add.

The process of establishing confirmability includes presenting the study's findings to other experienced qualitative researchers. Two dissertation committee members will review the recordings independently as well as the transcripts. Four different transcripts were reviewed for first-level confirmability and discussed. Those tapes were initially coded utilizing open coding, an inductive approach to assess ideas, and headings, and started seeing groups of themes. This n coding occurred from the PI and the experienced researchers and analyzed data to determine the data adequacy and coding from the participants' responses This will be critical in determining the presence of any biases or errors in presenting the study's findings. Quotes from participants were used when necessary to link the main concepts of the data (Elo et al., 2014).

Authenticity

The degree to which researchers accurately and truthfully depict a diversity of realities is referred to as authenticity (Elo et al., 2014; Lincoln & Guba, 1985; Polit et al., 2017). The data collection and analysis strategies are detailed in order to provide an accurate picture of the methods and analysis used in this study throughout all phases, which will be scrutinized by an external auditor with expertise in qualitative research methods (Creswell & Creswell, 2018). Reviewers for the study are experienced in qualitative research.

Protecting the Rights of Human Subjects

Regardless of the design or technique utilized, the researcher must adhere to specific ethical norms and take all possible efforts to preserve the participants' rights. Informed consent, privacy, and confidentiality are fundamental ethical principles in scientific research involving human participants (Eysenbach & Till, 2001). The following section review how this study's permission was obtained, as well as the techniques the investigator used to protect the participants' and data confidentiality. The Institutional Review Board of the University of North Carolina at Greensboro (UNCG) will authorize all study materials and methods (IRB).

Human Subjects

Before any recruiting efforts begin, IRB permission was requested at the University of North Carolina in Greensboro and the study was exempt. Potential volunteers were given an information sheet that describes the study and its goals, allowing them to make an informed decision about whether to participate. Once the individual was identified, the PI arranged for the participant to do an interview at their leisure. Demographic data was collected before the semi-structured interview guide and placed into Qualtrics and verified with participants before recording began.

Data Protection

All participants' names were changed to pseudonyms including letters and numbers during the study to ensure privacy and confidentiality. A transcription service AutomaticSync™ a verbit company approved by the UNCG School of Nursing signed a privacy consent to transcribe all audio recorded interviews within 4 days. That data is stored on a secure server then moved into UNCG Box, a password-protected storage system. The computers used are firewalled, password protected as well as Microsoft Authenticated.

Furthermore, the PI used UNCG Box to exchange data with dissertation committee members, limited access to the PI and the dissertation committee. After the transcriptions were cleaned by the PI, a second Box was established containing just audio files engaged by the PI another Box folder for clean transcriptions. A third box file was created for coded transcripts. However, the PI maintained the audio file in the UNCG Box until the analysis is completed and all data will be destroyed according to the UNCG School of Nursing data policy and UNCG IRB policies after 5 years.

Summary

The purpose of this research is to examine the experiences of Black women who use telehealth technology. The qualitative methodology of the study, including participant recruiting processes, the setting of the study, data collecting, data management, and analytic techniques, was explained in this chapter. The criteria employed to ensure scientific rigor, as well as the safeguards in place to protect human subjects, were also described.

The narratives obtained during the virtual interviews were evaluated using inductive content analysis to explain emergent themes about Black women's use of telehealth in this study. The experiences of Black women, as elicited through semi-structured interview questions, can help us better comprehend their recent telehealth experience. The issues that arise from this qualitative descriptive study will add to research on Black women's telehealth experiences and how to incorporate this information into the expanding body of knowledge on telehealth using their own voices. In many areas of healthcare research, the voice of Black women is not heard or recognized; as a result of this, and the rapid adoption of telehealth, it was critical to capture their voice and perspective early on so that we do not repeat history in the care of Black women by failing to recognize their needs.

CHAPTER IV: RESULTS

This study employed qualitative content analysis, as stated in Chapter III. According to Elo and Kyngäs (2008), qualitative content analysis is a content-sensitive approach with advantages in nursing since the procedure allows for study design flexibility, and themes are built from participant data and codes generated throughout the analysis. Qualitative content analysis is a rigorous approach to uncovering themes that describe social reality (Elo & Kyngäs, 2008; Sandelowksi, 2000). This method allows the researcher to study the participants' experiences through interviews that produced codes and influenced the construction of categories and themes that align with Black Feminist Thought (P. H. Collins, 2002; Crenshaw, 2017; Vaismoradi et al., 2013). Black Feminist thinking with Intersectionality necessitates a low theoretical sensitivity to avoid clouding the study themes as they arise from participant responses, allowing the researcher to identify relevant and crucial evidence to explain the phenomenon (Chun Tie et al., 2019; Elo & Kyngäs, 2008; Lauri & Kyngäs, 2005).

Per the qualitative content analysis, semi-structured interviews were used to explore research questions. Those questions were: (a) "What is the experience of Black women's use of telehealth for their healthcare?" (b) "How, when, and why do Black Women use telehealth?" (c) "What experience as a Black Woman influences decisions to use telehealth?" and (d) "What experience influences a Black woman's future use of telehealth?" The interviews yielded rich information. Five superordinate themes emerged with a subtheme in Theme 3, which are noted and examined in detail below. Each participant reported using telehealth in the past 2 years because of the COVID pandemic except for one participant who used telehealth beforehand due to access with the VA.

The data were interpreted using a Black feminist lens. This means that the participant comments/responses are interpreted through oppression, racism, stereotypes, assumptions, and experiences. The researcher immersed herself in the data, rereading it, open coding transcribed interviews and field notes. The interviews and transcripts were reviewed with two experienced researchers supervising the research and continued to identify codes until saturation was met. No new categories emerged, and no further interviews were required. The data analysis was an iterative process in which data gathering and analyzing occurred simultaneously (Braun & Clarke, 2013; Lambert & Lambert, 2012).

The experiences varied, but telehealth was vital to each person during the COVID-19 pandemic. Twenty-one people were questioned regarding their telehealth experience. Participants were assigned letter-and-number pseudonyms (A1-A21) to safeguard their privacy. The qualitative content was used to analyze data. The researcher carefully observed how the individuals expressed their experiences. The researcher and two experienced researcher advisors rigorously read and reread transcripts and listened several times to the recorded interviews, resulting in the five superordinate themes.

Demographic Data

All participants lived in the United States and had Internet access and a device to utilize telehealth. All 21 participants were Black females and identified as Black females (100%), with ages ranging from 24 to 65 years, with a mean age of 42.8. Out of 21 participants, one (4.76%) woman identified as homosexual. Sixteen (76.1%) of the women were from the southeast, two (9.52%) of the women were from the Midwest, one (4.76%) was from the southwest, one (4.76%) was from the south, and one (4.76%) lived in the northeast. This sample represented 10 states. Of the participants, ten (47.62%) held master’s degrees, five (23.81%) held doctoral degrees, three (14.29%) held bachelor’s degrees, one (4.76%) held a professional degree, one (4.76%) held an associate degree, and one (4.76%) held less than a high school degree. The participants’ salaries ranged from less than $10,000 to more than $150,000. Eight participants (38.10%) salary ranged from $40,000-$49,999. Three participants (14.29%) reported a salary of $10,000-$19,999, two participants (9.52%) reported salaries of more than $150,000, two more participants (9.52%) reported $100,000 to $149,000, and two (9.52%) additional participants reported salaries $50,000-$59,999. The remaining four participants, one each (4.76%), reported salaries of $90,000-$99,999, $80,000-$89,999, $30,000-$39,999 and less than $10,000, respectively.

Telehealth Demographics

The participants were asked when they first used telehealth; five (23.8%) reported 0-1 years, 12 (57.14%) reported 1-2 years, two (9.52%) participants reported 2-3 years, and two (9.52%) reported 5+ years ago. Eighteen (85.71%) of the participants first used telehealth during the COVID-19 pandemic, and three (14.28%) of the participants used telehealth before the pandemic. The participants were asked how many telehealth experiences they have had over the last 2 years, five participants (23.8%) used telehealth 1-2 times in the past 2 years, and 10 participants (47.6%) reported they used telehealth 2 to 5 times in the past 2 years. Lastly, six (28.6%) participants used telehealth more than five times in the past 2 years.

The type of Internet access could be answered with multiple answers, but I found it interesting that the most used type of Internet access was high-speed cable, used by 18 participants (69.23%). A mobile hotspot was used by four (15.38%), landline two (7.69%), and other Wi-Fi or high-speed fiber optic by two (7.69%). The women who used telehealth answered with multiple responses. Fourteen (48.28%) participants mainly used telehealth to access their primary care providers. Ten (34.48%) participants then reported they used specialty care, i.e., endocrinology, therapy, neurologist, bariatrician, mental health (psychiatrist and therapist), psychologist, dermatologist, gynecologist, podiatrist, allergist, Total Brain Injury (TBI) neurologist, and sleep medicine. Five (17.24%) of the participants reported using it for other types of telehealth services such as Teladoc, pediatric care for children, through work for immediate care.

Findings and Discussion

In this chapter, the respondents' interview responses provide insight into Black women's experience with telehealth over the past 2 years, specifically how access to healthcare through technology either created barriers or enhanced care. To protect the identity of the research participants and prevent any potential backlash they may experience by sharing their stories, respondents' personal details are kept anonymous by using pseudonyms. During the semi-structured interviews, the participants discussed their definition of Telehealth, Telehealth experiences, access to the healthcare team through technology, racial barriers, their decision to use telehealth, and factors that will influence Black women to use Telehealth in the future.

This chapter presents and discusses the findings of thematic content analysis. The interview results have been open-coded and organized into categories leading to themes. These themes include insight into the telehealth experiences of Black women.

Qualitative Themes

Interviews were conducted via Zoom or Google Duo video rather than in person; the manifest content was analyzed to avoid meaning interpretation. The data were then open-coded, providing groupings of similar meanings with 14 initial codes. Then higher-order categories were determined to describe the phenomena through decision and interpretation. The final abstraction (themes) resulted (Elo & Kyngäs, 2008b). Their individual stories were loosely organized into a 14-item coding three to four times that developed the code list below, in agreement with other experienced qualitative researchers, and checked four times we developed those into nine categories through inductive content analysis (Elo & Kyngäs, 2008b). Each theme played a significant role in how the participants interpreted and explained their current perceptions and experiences as Black women using Telehealth.

Semi-structured interviews with participants revealed many insights and experiences, resulting in several themes outlined below and will be discussed and analyzed further. Because there was insufficient research on the phenomenon of telehealth experience with Black women, inductive content analysis was used to move from specific quotes to general statements (Elo & Kyngäs, 2008b; Lauri & Kyngas, 2005; Sandelowski & Barroso, 2003). After using this type of analysis in the preparation phase, quotes related to the questions were selected to provide the women's voices to their individual stories. They were loosely organized into a set of color open codes that led to sixteen codes. These codes were then were reviewed three or four times by the researcher that developed the code list below, in agreement with two other experienced qualitative researchers, and also checked four times as they were developed into eight generic categories through inductive content analysis and then developed into five themes with one subtheme (Elo & Kyngäs, 2008b).

Table 1. Open Codes

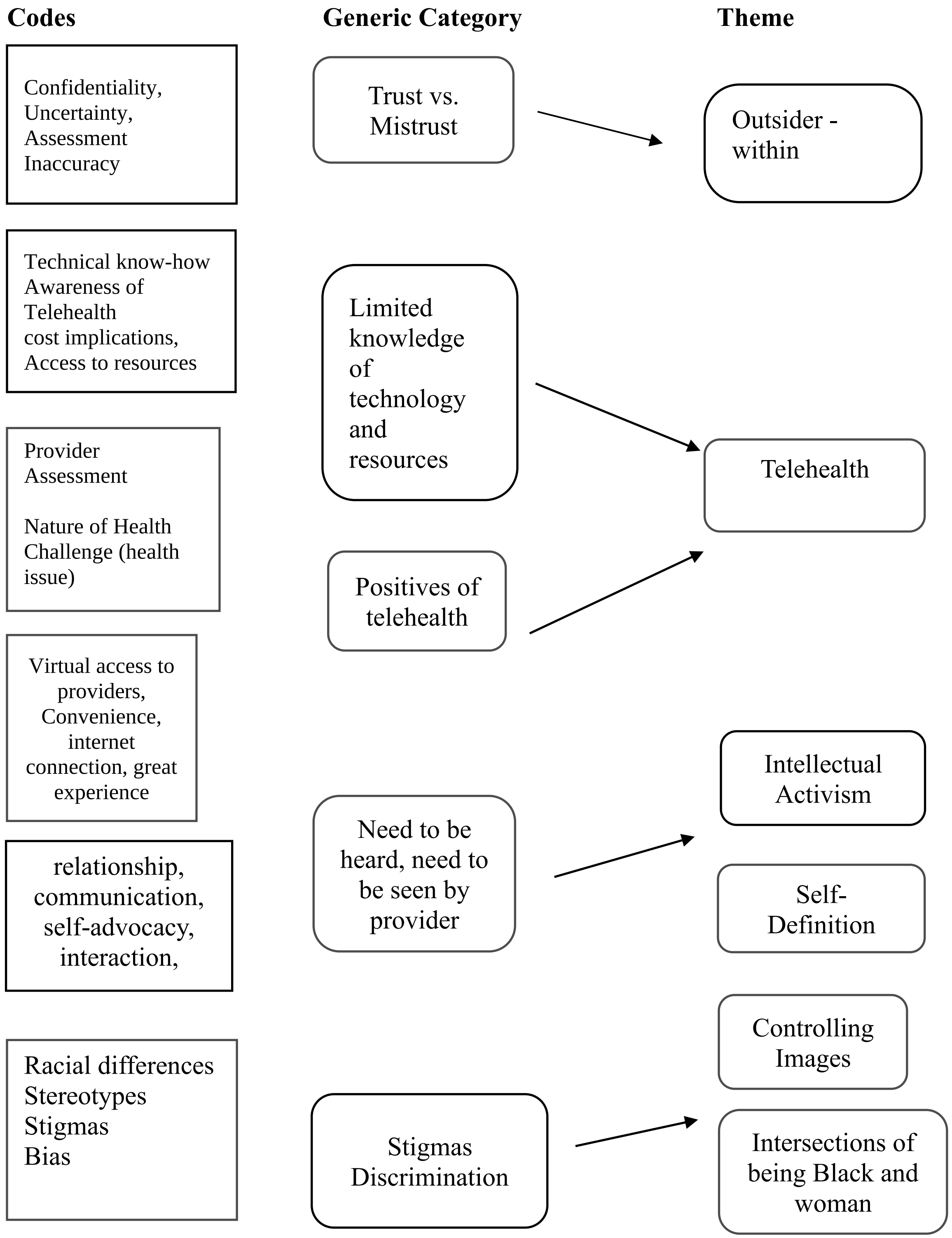
Codes	Open Codes
Confidentiality, Nature of Health Challenge, Uncertainty, Assessment Inaccuracy	Burgundy: Telehealth Barriers/Trust
Virtual access to doctors, Convenience	Red: Telehealth Definition
Communication cost implication, convenience	Orange: Experience with Telehealth
Racial differences	Black: Negative Experience telehealth/healthcare
The therapeutic relationship, convenience	Yellow: Positive Experience with telehealth
Technical know-how, Awareness, Assessment Inaccuracy, access to resources	Blue: Preconceived telehealth issues
Need to be heard	Purple: Feelings negative about women or the environment
Racial differences, need to be heard	Brown: Black women’s feelings issues
Internet Connection, Nature of Health Challenge, access to resources, uncertainty	Green: Telehealth Appt Issues
Racial differences, therapeutic relationships, stereotypes, Assessment Inaccuracy	Light Yellow: Experiences and family beliefs
Communication, need to be heard, confidentiality	Lavender: feelings about sharing to provider
Stereotype	Mint: Stigmas
Stereotype	Pink: strong woman, roles, superwoman
Awareness, communication, therapeutic relationship	Light blue: what improves, more services/Apps/transparency

Table 2. Codes, Frequency and Descriptions

Codes/Frequency	Description
Stereotype/51	Black women are being stereotyped and expected to be voiceless 51 comments from the participants described experiences with their provider that they perceived as stereotyping them as a Black person and Black woman
Need to be Heard/120	Black women need caregivers to listen and pay attention to their medical needs. 120 comments from the participants described or made statements that they need to be heard and seen as a unique person by their provider
Therapeutic Relationship/80	Establishment of the caregiver-to-patient bond. 80 comments discussed the importance of the relationship of the provider/caregiver to the patient.
Internet Connection/12	Problems associated with poor Internet connection during appointments. 12 comments described the impact of poor internet connection on the appointment quality.
Nature of Health Challenge/9	Some health challenges are better examined in person. 9 comments described the belief that some health issues experienced by people/women need to be examined in person instead of telehealth.
Access to telehealth Resources/23	Inadequate access to resources, tools, and devices. 23 comments described not having adequate resources for telehealth, such as items needed to collect data for telehealth and appropriate devices to use telehealth.
Technical know-how for Telehealth/24	Limited technical knowledge 24 comments stated that those who need access to telehealth might not have digital literacy or technology knowledge
Confidentiality during Telehealth visits/18	Concerned about information and data security. 18 comments indicated a concern about how information is used and shared and the security and privacy of the telehealth visit.
Access to Doctors Virtually/24	Telehealth is described as a virtual meeting with doctors. 24 comments stated that telehealth is about virtually meeting with doctors and providers or healthcare teams using video n video or phone.
Convenience of Telehealth/30	Telehealth is convenient and can be accessed "on the go." 20 remarks regarding how using telehealth were convenient as telehealth can be used at home, work, or in transport. A person does not have to be in one place.

Codes/Frequency	Description
Awareness of Telehealth/17	Educate more people on the concept and importance of Telehealth 17 remarks were made regarding how educating and making the Black community and Black women aware of telehealth and how it can help with their healthcare access
Racial Differences/61	Every race shouldn't be given the same prescription, and no race is more important than another. 61 mentions racial differences in various ways, how Black women are seen differently, and the history of Black women in racial problems. The experience of racial inequities and being able to talk openly about being a Black woman in America.
Uncertainty about Telehealth/15	Anxiety about what to expect from Telehealth. 15 comments described being uncertain what telehealth entailed and how the appointment would work or help with their health condition.
Assessment Inaccuracy/20	Symptom assessment might not be accurate. 20 mentions of being worried that the correct diagnosis, medications, and other assessments were correct. Worries of misdiagnosis. Worries about not improving.
Communication/37	Need for openness during telehealth appointments. 37 discussion or mentions about being able to be open with their providers during telehealth to discuss their issues.
Cost Implication/14	Cost of accessing telehealth. 14 mentions of the cost of using telehealth, will it cost the same as in-person visits. Is the cost-benefit worth it and not having a physical assessment?

Figure 1. Initial Codes That Were Conceptualized Into Similar Categories and Then Related to Themes



There were five themes, with one theme having two aspects that emerged from the categories developed from coding to categories (a) outsider-within (P. H. Collins, 2002), (b) telehealth experience, (c) Intellectual Activism (P. H. Collins, 2002) and self-definition (P. H. Collins, 2002), (d) controlling images (P. H. Collins, 2002), and (e) intersections of being Black and woman (Hill Collins, 2019; Crenshaw, 1989). Theme 1, Outsider-within, as developed, discusses how the feelings and experiences of Black women with telehealth assumed that they had the knowledge and resources of telehealth, and they trusted the system being used; as a result, the space could feel oppressive, and women could feel like outsiders in this telehealth use and knowledge. Theme 2, Telehealth experience, discusses the experiences of the actual telehealth use, positive and negative. Theme 3, intellectual activism, is giving attention to the voices and needs of Black women that have been marginalized due to race, class, and gender that are not usually heard (P. H. Collins, 2002). With a perspective of self -definition from the need to be heard and seen, the women discuss how they wanted providers, healthcare, and the rest of the world to see and hear them as human and person, but also as Black women in this society, and how they wanted to control their own images and name their own reality.(P. H. Collins, 2002). Theme 4, controlling images, discusses the negative stereotypical, oppressive representations of Black women. These include the discussion of Racial differences and the experience of being a Black woman. Stereotypes were about the perception and bias of providers and care teams and the stereotypes that Black women are trying to overcome. Finally, Theme 5 explores the intersection of being Black with oppression and discrimination, as well as those related with being a woman (gender) and how their experiences interact. This discusses how the experience of being a Black woman in the United States has impacted their care experiences, views of healthcare systems, stress, and pressures of being a Black woman and navigating healthcare systems to get the best care for their bodies and not be dismissed.

Theme 1: Outsider-Within

Category: Trust vs. Mistrust

Participants discussed the mistrust of healthcare systems and the treatment of Black women and bodies. There is ambivalence if the telehealth system will truly add transparency, advocacy, and health equity to the healthcare experience for Black women.

Confidentiality. In general, the participants explained the need for information security. Black women want to ensure that the problems they share with care providers over the internet are confidential. Telehealth information and data should be a private and intimate conversation. If women's privacy is ensured, they will feel very involved and comfortable speaking about their feelings.

> And because, especially if they're just dealing with the information that I'm giving them, there might be things that I need to share that I don't know that I need to share. (A1)
>
> Confidentiality is one of the biggest things I think is a factor. Maintain your records and privacy is definitely a factor. (A5)
>
> I will say, some women are very guarded, and they're not going to be as transparent as easy as they may be in-person versus over Zoom or phone. (A7)

When asked how this could be fixed, some women stated that there needs to be an awareness of telehealth among other Black women. This awareness will change their mindset about telehealth and reassure them that their information is safe.

> And also, we’ve got to also it’s good to speak about it now because keep that mindset shifted from the old school way of thinking that I’m not, everything is recorded and it’s going to be out over the Internet and, you know because that’s what a lot of the it is. (A5)

> I just have a thought like, what about women who are like, going through domestic violence and things like that? Telehealth cannot be beneficial at all, especially those going through like, not even the women, but the kids that are going through the system, foster care, who can’t do telehealth. They can’t as a clinical practitioner, you are a mandated reporter. You can’t have that they won’t feel comfortable enough being opening up and being transparent with you so they can get help because they it feels, it doesn’t feel personal. (A7)

> I just feel like I can’t really let it all out the way that I can in person, and I don’t know what it is. Maybe it’s because I’m seeing a human, and I’m in that comfortable environment. Even being at home, it’s just like a completely different vibe. (A8)

Uncertainty of Telehealth. From this research, many participants reported feelings of heightened anxiety and uncertainty when trying to use Telehealth for the first time.

> And I was a little nervous at first using it. Because I’d never done it before. And it really wasn’t clear with the doctors how you access. (A6)

> So, I was a little nervous at first, because I didn’t know exactly what to expect. You know you call the doctors, tell you a time, you’re going to receive a link. (A12)

Specific challenges related to how to set up for the meeting, what to expect, how to present, required resources, etc., They were rather anxious about, how this would turn out. Without a prior relationship, dealing with a professional in a virtual area.

> So, I didn’t worry as much. But you know, when I got that link, and then it was like, make sure you have this, make sure you have that. And I’m like—if I log out, am I going to lose my connection, am I going to lose my spot? You know, so it was just a lot of uncertainty there. (A12)

> In the beginning, it was a little—I don’t want to say scary, but it’s foreign, and I didn’t understand it, so I didn’t even know how to just get into it and let him know—understand the waiting room and things like that and, you know—so the beginning, it was kind of scary and just confusing, and then it was comforting just to see my physician that I knew, and it was a big pandemic and everyone was uncertain, but I had one certain thing is that I was able to see him and talk to him about whatever I was dealing with. (A14)

Assessment Inaccuracy. Some participants expressed concern about the potential risk of assessment inaccuracy since telehealth relied on the patient’s self-reporting symptoms rather than physical observation. As a result, participants felt that the diagnosis might be faulty or not as accurate.

> I know I had a visit, and one minute the doctor said, “Okay, we see one thing on the scan.” I go back and have another full scan, and you don’t see—I’m hearing a different story on this particular organ. And so, it’s like, okay, well what was the truth? (A6)

> And there was no bloodwork or anything to be analyzed or discussed. So, I don’t think it really served a purpose. (A3)

Observation and physical assessment of health challenges are integral parts of healthcare, including noting body language, unusual growth, body disorders, sensations, movements, and allergies. All these are limited in telehealth as care providers may not be able to see the defects clearly. Also, some challenges require a physical examination before prescriptions.

Unfortunately, a high percentage of medical diagnoses is based on the health history, not physical examination. The women expressed this concern.

> Because she actually got to feel my face and see, like, issues I was referring to versus just seeing me on the Zoom call because the lighting is different. You can't really tell. (A7)
>
> Yeah, dentistry cannot be in telehealth. I mean, I've got to go to the orthodontist to get my braces taken care of and my teeth. What are you going to do, give me an exam through a robot? I mean, give me a filling through a robot or something? I've got to come see you. (A7)

Theme 2: Telehealth Experience

Category: Limited Knowledge of Technology and Resources

Technical Consideration. Although we live in a technologically advanced world, many people are not tech-savvy. There is a need for technical inclusion to improve the quality of telehealth; this implies making telehealth digital tools and platforms friendly to all users. Also, there should be some form of orientation on using the platform.

A woman explained this in her interview by saying that telehealth should consider elderly persons in that service delivery mode:

> I will continue to use it if it's still offered. The only reason that I would not tell someone to use it if there was an elderly patient that wasn't familiar with electronics or with how to get to the link. (A5)
>
> I have to tell people all the time that we're a different generation now where they didn't have the technology that we have they didn't have it. You had a telephone and that was it and now you have all these electronics and buttons and one button do this and that. So, they don't know and they weren't taught and trained in this stuff. So cell phones are

> bigger and all these gadgets on it they don't know. They just had a regular phone. So, you don't have, the elderly also you have to take into consideration their eyesight has diminished so they can't see some of that stuff on that cell phone as you think you can, and they don't know, it's blurry to them they don't know what they're hitting, some of them might not be able to read. (A5)
>
> Even though I am familiar with healthcare, just healthcare, in general, can be complex. So, to the extent—and I don't know how one does that, but to the extent that we can simplify the experience because I know the average consumer, or the average patient, doesn't understand all of what's going on. (A11)
>
> Just maybe giving them a little bit more like a tutorial trying to help someone, whether it's your assistant, to kind of walk them to the process. (A14)

Awareness of Telehealth. Black women's experiences with Telehealth technology indicated that it is a feasible way to render and receive medical care. Still, many Black women are yet to be informed about its existence and importance. Participants emphasized the need for awareness programs and workshops to keep people informed about telehealth.

> I guess more workshops on it to teach people. You know, the benefits of it. I mean, it can have some of the positive side of it. (A19)
>
> So, I think workshops would help it even more pushing it. You know, having the people and even having the doctors a little more hands-on with it. Like saying, you may have a group of them like if you're under Kaiser, having it where you have the doctors doing seminar sessions to explain how they feel like people can benefit using telehealth. (A11)

> And so, it was kind of weird because I remember like when they were first talking about telehealth, I was like, how are you really going to take care of someone over a computer screen? Like that doesn't make sense. (A8)

Some participants added that creating awareness will encourage Black women to not only know about the concept of Telehealth but also may lead them into using it.

> I hope that at some point, more people will not just discover this is an option, but actually utilize it because the stats show if you use it once, you will use it again. (A11)

With regards to awareness, participants highlighted that care providers be educated on the existence of diversity and how to deal with the specific needs of each patient.

> And being able to have that training or knowledge in diversity, and equity, and, you know, being able to treat that patient, like, regardless of whatever their class, or education, or race, like, just being able to treat the patient, period. (A16)

> … if they're really trying to be in tune with us but also providers, you know, their own preconceived prejudices or biases about the fact that, you know, Black women tolerate pain more, so you just want this to be, you know, a [STUFF AROUND THOSE NATURES]. But I think if we had more access and resources to telehealth, it would help alleviate some of this running that we have to do and having to go and show up at a doctor's office just to have a conversation where there are no actual tests being ran, where some of this earlier conversation can be had then. (A4)

Cost Implication. Aside from the many other considerations shared by these Black women, cost optimization was an integral part of their experience. Black women in this research believed telehealth should not be as expensive as in-person visits. They want to know that, by using the alternative, they could have cost savings with telehealth or be less expensive than face-to-face visits.

> And it's costly and so I don't want to waste my money and I don't want to waste your time where you could be helping somebody else. (A4)

A participant added that even though telehealth is made available, cost-effectiveness is needed. If people cannot afford the care provided, the impact becomes intangible.

> I just think make it, it's good that we can get more services available and push it out to the communities will be great and Cost-effective probably but even though services out there to the communities would be awesome. (A5)

> … it's like in that slippery slope where it's like more accessible but not that much more accessible because you still have to have internet, something to be on it with. But I think the fact that it can be more affordable than going in person is so helpful because the doctor is expensive. (A8)

As mentioned by another Black woman, if telehealth costs the same as an in-person consult, choosing telehealth over an in-person consultation would be meaningless.

> But the visit was maybe ten minutes, and I was charged the same as I would if I went in person, so that was a little discouraging. (A3)

Access to Resources. Participants shared that not everyone has access to resources and devices necessary for telehealth. Some people are more privileged than others. Thus, to ensure a good telehealth experience, supporting resources and tools should be made available and accessible to all.

> But I think if we had more access and resources to telehealth, it would help alleviate some of this running that we have to do and having to go and show up at a doctor's office

> just to have a conversation where there are no actual tests being ran, where some of this earlier conversation can be had then. (A4)

Black women in this research emphasized that tools and equipment for health care should be provided in all locations, for example, bringing resources closer to patients.

> Providing preventive care is another factor I think that should well hopefully it's offered more in making it accessible for individuals to get to those places or bringing those preventive measures to the areas will be nice, would be nice to do. So, I think that would be something I would suggest. (A5)
>
> So, I think those things will be nice. I forgot what they call it mobile mammogram. Bringing it out to the neighborhood would be nice and having some kind of way you can sign up and get that done would be nice. (A13)
>
> You might have an elderly person who doesn't have a smartphone, so what's their next option? They may not have a computer, what is their next option? (A2)

Category: Positives of Telehealth

Access to Doctors Virtually. When participants were asked what they understood the concept of Telehealth, they all gave a similar meaning. They described Telehealth as anything relating to the provision of healthcare virtually. Below are some of their responses.

> It means that I have access to any of my doctors or medical professionals, whether it's by phone or video, that I don't actually have to go into their office to seek care. (A4)
>
> That I'm going to be on some type of phone device to have my interaction with my healthcare provider. (A6)

> So, for me, it means that I’ll be discussing any health condition or concerns that I have on some type of electronic device, so that’s either over the phone, so tele, you think of like telephone, or on a laptop or iPad, or anything that’s electronic. (A3)

> Telehealth really means to me getting healthcare via any kind of teleconferencing, whether it be phone, whether it be computer, whether it just be, you know, Zoom, any of those media outlets that are not in-person. (A13)

Convenience. One of the most appreciated attributes of Telehealth is how convenient it is. Black women in this study commended Telehealth providers for making health care very convenient and conducive to obtaining health care.

A participant who introduced Telehealth to her husband and colleagues explained how convenient it is to see a doctor without traveling down traffic. In her report, she stated thus.

> He’ll do it in the office with me, and I’ll leave out most of the time, but he enjoys it because he saves sometimes of leaving work dealing with traffic, and it’s just convenient. So, and I say the same thing as well. And most of the time I heard other veterans say the same thing as far as because they don’t want to leave the house, or they don’t have someone to take them to their appointments. (A5)

> I didn’t have to drive 45 minutes to get there, I was able to be home. So, I felt like I could be open. I didn’t have to be like, oh, well, can we talk about this or not. So those experiences went pretty well. And then I also have had visits with just like regular, like primary care as well. And one of the visits was really good. (A9)

Since telehealth is done virtually, participants highlighted how easily it fits into their daily schedules.

> I enjoy the telehealth visits because it's just easier and more convenient to be able to fit those types of visits in my schedule. (A4)

The women appreciated how easy it is to book an appointment with telehealth. Participants explained that they did not have to wait long hours to be seen. Instead, they just log in when it is time for their appointment.

> For one, I don't have to wait as long for an appointment. I have noticed that if I choose—when I'm trying to book an appointment with my family physician, that if I select telehealth, I'm seen way quicker than if I try to book in person. (A10)

Category: Negatives of Telehealth

Nature of Health Challenges Examined Using Telehealth. Telehealth is a virtual experience. According to Black women in this research, there are limitations to telehealth. Certain health challenges cannot be examined and taken care of online.

> Like especially depending on like what you're using telehealth for, like someone who's using it for like a checkup for like physical health or something is going to have a completely different experience than someone who's using it for mental health, and each person is just going to go about it completely differently. (A8)

Face-to-face communication was deemed more beneficial when treating people with certain challenges and conditions. Similarly, participants noted that providing education and supporting patients in understanding and adhering to education regarding chronic disease management was made difficult when face-to-face communication was not possible.

> I think it's nice to have telehealth as an option, honestly. I don't think I would ever do like solely telehealth or solely in person. I like the hybrid because it's like sometimes you really just don't want to leave your house, or you're not feeling good, or like something

> happens and you don't want to put somebody at risk. So having that option where you can do it online but also do it in person is great. I think there are benefits to both of them. Like sometimes like, especially with something like therapy, it can be hard to like to sit in that room and, like, feel like someone's just, like, staring into your soul. (A8)

Another participant added, "But sometimes you really do have to go to the doctor because I know some things are still better assessed in-person" (A17).

Internet Connection. Some participants complained about a problem in the video transmission due to poor internet connection during the video telehealth appointment. Poor video quality and camera cutoffs were bothersome and a barrier to a good telehealth experience. These issues sometimes led to communication problems and disconnection, which increased mistrust in the systems being used.

> And you have to like stay in frame and make sure your connection is good. So sometimes it's like those little things like poor connection or like your Internet going out, your sound not working quite well, your video not working, all of those take away from your slotted time. (A8)

> One, there's usually, especially with the mental health provider, there's a connection—there's usually a connection issue. (A10)

> Hey can cause a little discouragement because, you know, you kind of see the lag in the video, and then all of a sudden, the video will cut out, and then, now she's calling, "Well, I lost connection and." (A10)

Overall, telehealth is well appreciated by Black women in this study based on how convenient it is. Most participants described telehealth as a tool to keep the doctor and patient informed and organized and connect with their daily routines. For many, medical care appointments are integrated into their regular daily schedules and are considered a *more convenient route* for medical appointments. Telehealth has advantages for Black women to access care, the convenience, and even have great experiences when they need care. However, technology problems, low awareness of telehealth and its use, the unknown cost of use, and the access to telehealth resources created negative experiences about telehealth. Throughout these interviews, the concern of whether the provider assessment would be correct for their complaints and whether telehealth is appropriate for various health issues was also a major concern due to concerns of misdiagnosis.

Theme 3: Intellectual Activism

Category: Need to be Heard and Seen

Need to Be Heard and Seen. Throughout this research study, all the participants emphasized the need to be heard during telehealth appointments and healthcare interactions in general. If Telehealth providers are willing to improve the experiences of Black women, providers should be more attentive. The need of every woman is different. Black women need to feel valued and validated and know that the care provider cares for them by listening to them.

> … generally, what this looks like but not really paying attention to the nuances that we as Black women carry or go through or understand and how that also plays into our health. And, you know, being aware of some of those things and trying to figure out okay, well, I'm listening to you. (A6)

These Black women expressed their dissatisfaction and reported that they often feel rushed and unheard.

> Because what's not going to happen is me feeling like oh, you're not listening to me. You know, you're wanting to rush me or you're putting me in this box, and this is where you

> want me to stay in. No, this is what’s going on with me, and I need you to hear that this is what’s going on with me. (A4)
>
> Honestly, I try not to go there, but I’m going to say it was the color of my skin. I’m going to say that. And what I did not do was I did not know that I had a background in the medical field. I’m actually glad—I’m pretty sure if my husband would have been in there, a lot of that would not have gotten said, because for starters, I’m married to somebody that’s 6’-4”, 280 pounds. You ain’t going to say that.” (A10)

When asked what needs to be done to improve their experiences with Telehealth and healthcare visits, all the participants emphasized the need to be heard. They advised that care providers and Practitioners pay more attention to their patients. According to them, “a woman knows her body, and only she can explain how it feels.”

> They don’t listen to their patients. I mean, we know our bodies. I mean, but you know, some doctors, they get in their head about I got a degree, you don’t know what you’re talking about. (A2)
>
> Listen, listen, take notes if you have to, don’t, don’t dismiss someone’s feelings or their thoughts. I know I’m not a doctor, of course, but I know me better than anybody else knows me, so I know that something’s wrong with my body. Listen, don’t just say, that’s not normal, or that can’t be. I mean, it’s my body, so I know. (A21)

From the responses in this research, women thought care providers needed to be more present with their patients’ needs. Providers must ask relevant questions and listen to what the patient says about her body. Doing these things will improve Black women’s experience with Telehealth.

> I would just say, be present and listen to us. Because I feel like when you're on the computer, like, it's easy to like type, type, type, but it's like, what are you typing? Are you typing a text message, or are you typing up notes? Like, what are you doing? Like just be present and listen to us. Like no one listens to us. And so often, like, I feel voiceless, and I feel like I'm not being fully cared for. And when you do have that computer, sometimes you really just don't have like that human connection with you. So just like, listen to us, pay attention, be attentive, and ask us questions. Like I feel like asking us questions will help us open up because it's like talking at someone but having a conversation with some of those are two completely different things. (A8)

Communication. Black women in this research explained the need for women to be open about their health and life problems with their providers. According to them, a care provider can only offer help based on the information available to them.

> … that's one of the things that my therapist also keeps telling me about how open—I was telling her that, you know, I came here because I was feeling some type of way, didn't really understand what was going on. But you can't help me and do your job if I don't tell you what's going on or if I don't share or if I'm holding things back and I'm not being open and honest. (A4)

> I think that making sure that individuals are open-minded because I think one negative remark can change someone's perspective of telehealth. (A5)

On the other hand, caregivers should be open to listening. They need to reassure patients that they value and care about the patient.

> You still need to reassure your patient that you care. Not just, "Oh, I'm going to do this telehealth call with you and then I'll be done." Because I'll leave a doctor quick. (A6)

> I think that sometimes if they ask the right questions, it'll be, I'm not saying I'm rushing to my phone, but asking the right questions can get to the underlying issue quicker. (A21)

Sub-Theme 3: Self-Definition

Category: Need to be Heard and Seen as a Black Woman

To deal with these racial preferences from care providers, Black women often look for a fellow Black practitioner. According to them, a Black care provider is more relatable to their experiences and more welcoming. A participant mentioned that even though she had to wait extra days, she would gladly do so instead of being matched with a White Practitioner.

> I know if I was a White woman, I wouldn't really have those things because it's like I can talk to a White therapist, but they won't understand me on that deeper level. And understanding me on that deeper level is where the true help begins. Because if you can't understand me there, how are you really going to help me out? (A8)

> … is I think even the Black professionals that we do have, but they are being taught in systems that are rooted racism that oftentimes they may not even be aware that they are operating under that same bias. So, I think that the education that happens in healthcare education has to change. Like we have too many people aware of what their own personal bias are, so they learn to check themselves. And I'm not saying, I think that most people go into healthcare, they do so because they truly do care about the well-being of people. But you can care about the wellbeing of people, but your bias can be such that you don't hear me when I'm telling you what you are presuming or making perception—your perceptions of me are not accurate. (A18)

> And that's why at the—that's why we are always looking up those Black people who are in healthcare. We also want to hold them to a higher standard because they can relate.

> They understand like, the difficulties that we faced dealing with these doctors and practitioners who, they didn't believe when we said we were going to pay and didn't believe our grievances. (A7)
>
> Yeah. With my therapist specifically, like we have discussed it in one of our telehealth sessions, and I chose a therapist of color—like I wanted a woman of color. I specifically wanted a Black woman. But when I looked on the place that I go to is like just Black women. And I think like one indigenous woman. And the indigenous woman is who I felt could help me out the most based off of just like the profile. Like, I don't think it necessarily had to be a Black woman because Black people can always help Black people. (A8)

One participant acknowledged to be seen and heard is to be seen by another Black female provider, to relate on that level of being Black and female.

> OK. You know, one of the most important things for me with my doctor, my healthcare provider, is to know that she, a Black woman, really cares about me. (A19)

Therapeutic Relationship. Developing a therapeutic relationship with patients via telehealth was deemed important by participants. One of the best ways to assure a positive experience, according to these women, is to build a strong bond with your provider. Even though telehealth is virtual, it should not hinder or delay the capacity to interact with patients, read body language, respond to communication signals, and engage in dialogues that allow for a connection to develop and extract important supporting information from the patient. Patients with good rapport with their providers were more likely to share more freely with them.

> So, with me, because I feel like I'm never really had a provider or relationship. That's the key. To have a relationship with a provider. Nowadays, a lot of times because our insurances can change so much, you may not always be able to keep that provider. (A6)

Another participant highlighted the importance of establishing a relationship between patients and care providers. In her interview, she explained as follows:

> Yes, but I feel like they have to feel comfortable first. It's all about comfort, not feeling like it's an inconvenience on both sides. There's—it's about having that bond with their doctor or practitioner, whoever they're having a telehealth conference with. (A7)
>
> He gave me that, like, really warm environment, like warm, caring environment. And most of the time, I would be sitting in my car because I had to, like, get out of work to do the appointment. But even then, it just didn't even feel like I was in my car. Like it felt like we were actually like sitting face to face and talking and like laughing and like having fun while he's actually like, you know, doing his job. (A8)

In addition, participants believed that women are more likely to share extra, useful information during a Telehealth consultation, particularly when the care practitioner speaks informally from a relationship-based vantage point.

> And I never felt like they were, they had like any type of judgment towards me. And I think that's what made me more open to the help and receiving the help because I didn't feel any type of judgment. It was just like; it is what it is. Here's what I'm feeling. (A8)
>
> And I think I just felt comfortable, and it wasn't like I was sitting in this unknown place and I'm talking to somebody I don't know. (A9)

Theme 4: Controlling Images

Category: Stigmas

Numerous factors were identified as barriers to good telehealth experience for Black women. One of the most notable ones was stereotypes as described by almost all the participants in this study. Participants explained how they are often seen as “not good enough” or undeserving. Racial-based stigmatization and devaluation seem to shape how some care providers respond to Black women.

According to a participant, practitioners treat Black women based on some myths and stereotypes that are not true, thus causing a barrier in the quality of care and mistrust.

> Especially being a Black woman, like, knowing how certain practitioners treat Black women and Black people based on stereotypes that aren’t even true, based on old things back to the slave times how they used the work on slave women just to see how things—like the new surgeon and things like that because felt as if we didn’t feel no pain. (A7)

Stereotypes, whether self-imposed or reinforced by healthcare systems, clinicians, and healthcare education, can negatively impact how patients are treated, services are provided, patient satisfaction, and health outcomes. Providers must be mindful of the preconceptions enforced in Black communities onto women and those that the health system passes on to and communicates to patients. To destroy these stereotypes and enhance understanding of the physical, psyche, and spiritual well-being of Black women, more care to avoid stereotypes and provide a more clear cultural understanding is imperative.

Highlighted in the responses from women in this study are that Black women are expected to stifle their truth, suppress feelings, and behave in certain ways to be accepted and cared for by the health care system and providers. This is a learned self-imposed behavior from family and environmental cultural norms and discrimination.

> I think as Black women, we don't generally just tell all because I feel like at some point, we are expected to be the superwomen. So, we just have to kind of, you know, wear the S on your chest and keep it moving. You know, but I think to have a provider slow down enough to ask us those questions would make me feel more comfortable. (A9)
>
> I have to carry that I'm fine, I'm good, I'm having a great day until I'm able to know that it's a safe space and be able to explain it, or I may just not even explain it. I may just have to take fake it out through the whole time and leave and go somewhere else. (A9)

Participants emphasized the need for Telehealth providers to remove the barrier of racial stereotypes from their interactions with patients. Black women do not want to be judged based on some form of myth or single story.

> We perform for the satisfaction of others so we won't be labeled so that they will … say, OK, no, I really am in pain. But I did not want anybody to think that I was drug-seeking or anything like that." (A9)
>
> … there's something about being Black. There are some things you just cannot just do. You just can't say. You can't do. And you just if you do, again, there is the labels. … In the world we live in, you have to be OK whether you really are or really not." (A12)

Theme 5: Intersections of Black and Woman

Category: Discrimination

According to those who took part in this research, racial differences are one of the most significant obstacles in providing high-quality telehealth and healthcare experiences. Compared to how other individuals are treated, Black women report frequent discrimination. According to the participants' reports, there is bias based on racial differences in some situations.

> I think the last thing would just be, that if telehealth is going to continue, it needs to, they need to make sure it's equitable for all, for everyone, not just, you know, Black women, but everybody. And it needs to be a real health visit. (A3)

Respondents explained women are made to feel differently; thus, telehealth should not be a "one-size-fits-all."

> So, just those things. It's things that could happen in my body that may not happen in a White lady's body versus whatever needs—you know, just start really doing your research. Stop categorizing everybody in one little pool, are really step away and research everybody's genetic makeup to really understand the powerful right of each person based on their ethnicity. (A6)

Before delivering therapy and treatment, health care practitioners must consider the effects of racial/biological composition. For example, women vary biologically from males, and Black women may suffer differently from other health conditions than women of different races (Chinn et al., 2021). Therefore, medical treatment should be provided while considering the patients' racial disparities and culture.

> So, I think probably the first and most important thing is understanding that there are differences. And I know it's hard to try to treat everybody based on their differences, but I think that that's kind of the only way that you're going to make sure that you are providing the best care for your specific patient. (A4)

> I mean, those—there's really some type of divide in that, just in general. Because the respect that I get as a Black mother to a—you know, especially looking young, yeah, it's

not—that's another—don't feel very welcome. It's very, you know—you know, oh, we can just tell them whatever, and it was like, you know—because I'm thorough. I'm very thorough, and you're going to give me the best that I need—I mean, especially when it comes to my child. You know, like, for myself, but of course, for my child, oh, yeah. We're not cutting corners. But, you know, it's just the stigma. Like, oh, young Black mother, probably not educated, poor, you know, doesn't come from, like, an—and so, those are the things. Then, once they come in, then they're like, well, what—and I don't know if they do this for every patient, but, like, they have asked me, like, what do I do. Like, they have asked me, like, my occupation, mm-hmm, mm-hmm … And, you know—and I've had the doctor—like, the nurse that comes in before—because the doctor—and his doctor is Black. I mean, not Black, White male, phenomenal, though. Not for myself, but for my child, he seems to really—I mean, I identify okay with that. Like, that's okay, but yeah. Like, the nurse that comes in, yeah, she's like, what is your occupation? Like, what do you do? And I don't see what the relevance of that question is, and I feel like you're already trying to—if I didn't know that doctor, she was already trying to be like, okay, well, she's this or that, and we can just kind of—and, yeah, it's definitely some divide there. The level of respect is—yeah. Until I'm like, oh, yeah, well, you know, I actually have a master's degree. You know, then it's like, oh, oh, okay. Well, okay. Okay. So—and, yeah, it's amazing how the conversation changes from that point, as if it somehow becomes a different conversation. It's amazing how the conversation and the service that we're—it's different at that point. So, we're now talking about education, and, you know, your race. Like, those are—yeah, it's a mess." (A16)

Because of the legacy of injustice and tragedy perpetrated on Black women in the past, the women have expressed strong views about White caregivers, particularly males, not being part of their care team. It is no longer taboo for Black women to discuss the differences, disparities, and evidence of the unequal treatment of Black women in the United States when discussing navigating the healthcare system. Being aware of the intersection of being Black and a woman in the United States requires one to be constantly aware of the intersection of being Black and a woman and being reminded that just because you are a Black woman, you must be on a social welfare system. One participant reported,

> … also, kind of—something else I noticed during that visit was—you know how normally when you go to the emergency room, they'll come in, they'll get your information, find out if you have insurance, anything? That didn't happen until after the doctor said he was discharging me. Yeah. A young Black lady is who came to get that information. She never once asked for my insurance, and I turned around and said, "Well, don't you want my insurance information?" When I said that, she looked at me like a deer in headlights. Like it surprised her that I had insurance. … Even the young lady that came—even though we the same color, it was just like a deer in headlights when I asked her—because she did not ask me for insurance information. … All she asked was for my name—she was like, "Is this your name?" "Yes." My date of birth, my address, and I turned around and said, "Do you not need my insurance card or my insurance information?" And she literally looked at me like a deer in headlights. When I tried to give her the insurance card so I wouldn't have to read the stuff off to her, "No, you can just tell me." I said, "Well, don't you think that it may be better if you have the card so

> that you can see yourself instead of trying to understand what I'm saying? I have on a mask. You have on a mask." (A10)

Not only do women face bias from other races, even within systems, but the assumptions made and the images portrayed about Black women also become almost automatic. Not all Black women are on welfare or social systems as portrayed in media. Black women make use of their voice and choices whenever it is possible to do so to manage their healthcare experience and get the best possible outcome. One of the participants' statements profoundly emphasized the voice of Black women advocating for themselves and trying to heal in oppressive systems, biased providers, and racial discrimination.

> So, I think, and the other thing is we have to teach people how to be advocates for themselves. I, you know, sought out a Black chiropractor, and I went to the practice. You know, and on the day that I showed up, a White female came in and I said, "It's really nice to meet you. I came here because I was told that it was a Black chiropractor here, and that's why I'm here. And I don't want to be treated by you … And it has nothing to do with you, but I cannot heal in the presence of my oppressors. So, therefore, you can't work on my body." And to say that unapologetically, and you know, I know it made her feel taken aback. But at the end of the day, this is my body. And if I don't advocate for it, nobody else will. (A18)

Summary

The voices of the Black women that participated were from different parts of the United States. Their interview responses were translated into their voices with the assistance of several open codes, categories, and five themes that emerged over time. Consider the myriad experiences of Black women; some are the same, but others are unique due to the personal, environmental, social, and familial relationships that have shaped their lives. The vast amount of data presented not only offered a deep understanding of the use of telehealth but also demonstrated how this relates to healthcare experience in general for Black women.

CHAPTER V: DISCUSSION

This qualitative descriptive study aimed to explore Black women's perspectives and experiences with virtual healthcare delivery (telehealth). This chapter discusses significant findings related to the literature on Black women's experience with telehealth, describing what it is to them, experience using telehealth, uncertainty with telehealth, the need to be heard in healthcare encounters, provider stereotypes, and racial differences. These were all considered by Black women when being cared for by a healthcare provider. Also included is a discussion of the connections of this study to Black Feminist Thought and Intersectionality (Crenshaw, 1989, 2019; Hill Collins, 2009, 2019). The chapter concludes with a discussion of the study's limitations, implications for practice, recommendations for future research, reflection, and summary.

Black feminist thought with the intersectionality is the thought that reclaims the voice to Black women's experiences with other social justice forces in this country and provides a framework for thinking about Black women's subordination in this country within intersecting oppressions of race, class, gender, and sexuality (Hill Collins, 2009, 2019). Black Feminist thought with intersectionality is multidimensional and evaluating the experience of Black Women using telehealth using this lens revealed five themes and one subordinate theme that gave voice to Black women: (a) outsider-within, (b) telehealth experience, (c) intellectual activism, self-definition (d) controlling images and (e) intersections of being Black and women that exist in Black women's life experience, treatment differences and providers understanding the treatment of Black female bodies based on social determinants of health. Some factors deal with telehealth, but the rich data from the interviews revealed how Black women experience healthcare interactions. The themes were developed using the inductive approach to content analysis by Elo and Kyngäs (2008a) to allow the data to tell the story of the phenomenon, which aligned with some of the principles of Black Feminist Thought (Hill Collins, 2009).

As telehealth continues to be utilized as a care delivery system, the inclusion of marginalized groups as standards of care must continue to be developed. As intersectionality explains, we do not have to wait until it is time to focus on Black women and the telehealth experience. Focusing on marginalized groups can be accomplished through the constant improvement and training of the providers who use the system for care delivery, the Black women who have utilized it, and those who will utilize the modality in the future. As the use of telehealth continues to rise among Black women, especially since the COVID-19 pandemic and mental health treatment, we cannot ignore the improvements needed based on the experience of Black women in this study.

Within this research study, Black women's experiences with telehealth are not uniform since Telehealth delivery systems, providers, healthcare access location, and demographics all differ, resulting in subtleties in healthcare cultures. Research has revealed sufficient commonalities across experiences to support a position regarding the experiences of Black women in healthcare. The following section examines the studies about the present experience of Black women employing telehealth to receive healthcare. This chapter will also evaluate the findings from Chapter IV while citing literature that supported and was not fully consistent with previous studies.

Discussion: Summary of Research Questions

The first research question addressed what Black women experienced when using telehealth as their healthcare method. The second question addressed how Black women use telehealth when they use telehealth and why they chose that method of healthcare access. The third question addressed what personal experiences, health, family, environment, or other factors influenced Black women’s decision to use telehealth for their healthcare delivery. Lastly, the fourth question addressed what experiences, whether personal, environmental, social, or otherwise, will influence a Black woman’s use of telehealth.

Participants A1-A21 had utilized telehealth in the previous two years during the COVID-19 pandemic because it was the only option accessible during the early phase of the COVID-19 pandemic or had high-risk health concerns that hindered in-person visits. All the women mentioned having a satisfactory experience with telehealth, whether it was the ease of accessing treatment or being able to meet a healthcare need. Over half of the women discussed having quicker access to care, but the experience was based on the nature of the health challenge. As discussed by participant A8, hybrid telehealth and in-person are the experiences to choose what you need when you need it based on how you feel. Some women experienced connection issues, not on their end but on the provider’s end. These connection issues reduced the effectiveness of the visit, particularly with mental health or specialist visits, as described by A10, where there was usually a connection issue with her mental health provider, causing discouragement about the visit.

Black women reported that they preferred telehealth with their primary care physician, who is often female, Black, or of another race or culture (non-White). Women felt more at ease when they could pick an on-demand provider who was a Black female to reduce the chance of being stereotyped. Many users reported feeling better understood about their issues without explaining everything. Persons discussed that they thought they had to be “put together” in person or could not show up or speak up without being “labeled.” If you have a bad day, as A9 described, if you’re frazzled, you start being labeled by the front desk and the nurses instead of trying to figure out what's wrong with this Black woman. Other women felt they were part of an algorithm to get items checked off during telehealth because there was no physical exam, only questions asked and checked. This combination of race, gender, and the power structure of the institutions in use creates a unique experience for Black Women (P. H. Collins, 2002). However, as Participant A9 described, as Black women seeking healthcare, we are either portrayed as heroes, villains, or invisible. This reciprocates how women repress their sentiments and decreases honest dialogues about symptoms and feelings. This is similar to reports by Okoro et al. (2021) and Sacks (2018b).

Black women talked about how they utilized telehealth since it was convenient to have an appointment wherever they were; they did not have to drive significant miles in some locations to use telehealth. Other women reported that they could stay at home with their children because they were doing homeschooling and trying to work from home to conduct their appointments. Several women stated that their husbands worked away or did some type of travel work or were truck drivers, others were single parents, and it was more convenient to navigate their health care while staying at home. Many participants stated that they utilized healthcare for acute ailments such as colds and coughing. Other women described using telehealth for COVID-19 evaluations or long-term chronic health care difficulties such as neurological follow-ups for headaches, multiple sclerosis, and traumatic brain injuries. Dermatological concerns, as well as bariatric monitoring and screening, were monitored. Many ladies claimed that it was helpful for their mental health concerns, such as therapy, counseling, psychiatry, and psychology. During the COVID-19 pandemic, they reported several of them faced issues they were unaware existed. Problems such as grieving triggered anxiety and sleep problems. For the women, having therapy available via telehealth was very effective in helping them maintain balance and work through some critical issues affecting them during the COVID-19 pandemic, during which they felt isolated and alone.

The participants discussed multiple reasons why they used telehealth. The main reason was that they were forced to during the COVID-19 pandemic. There was no other way to access providers due to healthcare office closures. Still, other women reported using telehealth before the COVID-19 pandemic with the VA and through their jobs with their insurance companies that provided online emergent care such as urinary tract infections, sinusitis, coughs, colds, rashes, and other minor issues. Additionally, many women discussed their challenges with having multiple roles in their womanhood that made it difficult to travel to in-person appointments due to work, school, and parental roles. Also, women discussed missing time from work to go to appointments, the hassle of getting to appointments, or the lack of transportation.

The women reported that they did not have to put on a performance or not show up as their authentic selves since they were in the comfort of their own homes. Some other women reported that they felt labeled if they presented in the doctor's office and did not dress in a certain way if they had a bad day. They could be in their pajamas or their kitchen or bedroom and feel like they could be more themselves and talk to their providers without the performance or being labeled. This was all made possible by telehealth, which allowed them to simply show up as they were without worrying about their makeup. They could feel like they could be more themselves and talk to their providers as themselves without the performance or being labeled. Another experience Black women reported was that they could see their provider during their telehealth experience, which made for a better experience. Some women noted that not having to spend their gas money to take long drives to see their specialists or different providers was convenient and helped them save money. Also, women reported that they could navigate their appointments with their children’s providers, encouraging telehealth use. One participant stated that telehealth helped their family cope with her mother’s death in the hospital when they could not be with the mother. Telehealth was used to be able to communicate and sing to her mother and understand what was going on with her health care. At first, they were left in the dark. Once telehealth was involved, they could be there as a family and be on zoom to talk with their mom. The family felt that she was not alone because she could hear their voice and responses to her, and they could see her and see what was happening. This use of telehealth aided the transition with grief for this participant. She was grateful for the availability of telehealth. Similarly, another participant reported that she could connect with her elderly mother through telehealth for her appointments and assist her since she was at high risk of going in person to office visits or there was a delay in an office visit. Those factors influenced her decision to use telehealth and encouraged her mother to use telehealth.

The interviewees discussed some experiences that influenced their future use of telehealth. As the interviews were conducted, most participants reported that convenience was one of the main reasons they would continue to use telehealth. Additionally, suppose there was an app or some type of messaging system, such as MyChart, where they could have transparency of what was being done by the provider. In that case, they could ask questions, and it was more of an on-demand connection to telehealth. Another indicator of the influence of the utilization of telehealth in the future was to have more additional appointments available sooner rather than an in-person visit. Technology enhancements would include an increase in broadband or high-speed internet and supplies that would help acquire more information during telehealth visits, such as the ability to obtain vital signs and have devices that could do some physical assessment for specific issues, such as listening to heart and lungs. Also, services that would allow mobile mammograms to be in the areas where they were needed, the ability to order and obtain lab work closer to their homes, and the ability to choose the type of provider that they wanted to see based on race, gender specialty, sexual orientation, and their experience with various health conditions.

The themes that emerged through Black feminist thought provide clear insight and understanding of the experience of Black women utilizing telehealth and navigating the healthcare system. Five themes emerged from the study: outsider-within, telehealth experience, intellectual activism with the sub-theme of self-definition, controlling images, and lastly, the intersection of being Black and woman. As discussed in Chapter IV, the outsider-within theme focused on the feelings and experiences of Black women, assuming they have the tools, knowledge, and know-how to utilize systems (P. H. Collins, 2002). Telehealth was a new access to care for many of the women interviewed, and they had no experience with using the systems. The women openly discussed what caused trust versus mistrust in the systems and providers.

Telehealth experiences among the women included three categories of findings: limited knowledge of technology and resources, positive telehealth experiences, and negative telehealth experiences. Black women discussed how technical know-how, awareness of telehealth, cost implications, and access to resources could be disparities among Black women and their own experiences. Many women were positive about having telehealth increase access to care having access to various providers. The convenience of telehealth and they had positive experiences with most of their interactions; there were still undertones of them being very conscious of their needs, scheduling ease, the providers they choose, and their expectations with the care model. Negative telehealth experience from the Black women was associated with inaccurate or incomplete provider assessments and the nature of the health challenges they were experiencing. The more complex or uncontrolled their health issues, the less appropriate they thought telehealth was to treat their health issues accurately. Also, the participants reported trusting their privacy and who was getting their data or the algorithms utilized to care for them. These sentiments from the participants aligned with research on data privacy and security in healthcare (Arnett et al., 2016; Bansal et al., 2010; Bari & O'Neill, 2019).

The third theme, intellectual activism, reclaimed the voice of Black feminist intellectual traditions by not suppressing Black women's voices and other marginalized groups and allowing their voices to be part of the scholarly work. In this work, this was accomplished by the women articulating self-definition (P. H. Collins, 2002). The power to name their reality and what that reality looks like in safe spaces for Black women by not having spaces silence them (P. H. Collins, 2002). From the interviews, it is important to note that the researcher found the category of needing to be heard and have a voice from all 21 participants 120 times. This need to be heard and Black women's voices being heard in their healthcare interactions has been one of the central tenets of Black Feminist Thought, to give Black women the space to have a voice to be heard while they negotiate identities (Barlow & Smith, 2019; P. H. Collins, 2002). The importance of provider relationship, communication, self-advocacy, and provider-patient interaction were important codes that represented how Black women needed to be heard and be seen as Black women by their providers.

The fourth theme, controlling images, stems from the voices of Black women who do not want to be discriminated against or stereotyped (West, 1995). Individuals explored stigmas, prejudice, and preconceptions that impact how they portray themselves in healthcare encounters to repress their symptoms, feelings, and honest dialogues to avoid being labeled in a way that may diminish their treatment. According to research, gendered microaggressions, such as controlling images of Black women and suppressing genuine self, promote depression symptoms in Black women (Jacob et al., 2021; M. G. Williams & Lewis, 2019). Participants reported that they present as strong Black women or superwomen to resist the oppressive images that are placed on Black women, which increases health risk, inauthentic relationships with providers, and delayed entry to care, all of which are costly to their health (Allen, Wang, Chae, Price, Powell, Steed, Black, et al., 2019; Beauboeuf-Lafontant, 2009; M. K. Jones et al., 2021; Woods-Giscombé & Black, 2010). As the theme of controlling images emerged and women of various ages and statuses were concerned about being perceived as negative stereotypes, all but two participants reported receiving some type of mental health care during this time due to the amount of stress, roles, and interpersonal issues that were exacerbated by the pandemic.

Lastly, the theme reflected the intersection of being Black and a woman with the oppression and discrimination and the issues associated with gender (woman) and how they intersect their experiences. Black women experienced being Black and a woman simultaneously, and healthcare teams recognized that there are unique positive and negative experiences that shape a Black woman's navigation of their identities while confronting the healthcare system. Furthermore, environmental and political issues are not monolithic among all Black women but must be considered to care for Black women's bodies (Barlow & Johnson, 2021; Barlow & Smith, 2019; Blount, 2018; J. A. Lewis et al., 2017). Black women have various experiences that can lead to various intersectional oppressions, which must be addressed as part of the health care paradigm for Black female bodies to be healed since oppression in health care is not caring.

Conclusion

Based on their experiences, the Black women who participated in this research found telehealth efficient in receiving medical treatment. Many participants were favorable toward telehealth usage due to the numerous benefits it offers in terms of therapeutic engagement. By cultivating participants’ confidence in the caregiver and guaranteeing the confidentiality of their data, we can reduce the likelihood that they would experience discomfort and be hesitant to discuss personal and sensitive subjects. Black women should not be restricted in their ability to voice their opinions. According to the findings of our study, participants believed that telehealth was a great tool, and once they felt valued and heard, they were willing to share personal information. Some participants did express some reservations, but overall, participants believed that telehealth was a useful product of access to care. Telehealth has allowed patients and caregivers to maintain their connection to the healthcare system during COVID-19 and beyond. Participant reports indicate that telehealth usage has increased dramatically and will continue to climb as more Black women become aware of the availability of the service and the necessity of using it. Two essential benefits that participants in this study highlighted were maintaining health access for patients and reducing the stress caused by travel and waiting periods. According to this study's findings, a few obstacles prevent Black women from having a beneficial experience with telehealth. These obstacles include racial discrimination, preconceptions, and not being heard or respected.

According to the findings of this study, Black women want their opinions to be valued, their voices to be heard and appreciated, and caregivers to give them greater leeway to express themselves freely. On the other hand, Black women emphasized the significance of maintaining a therapeutic relationship with their providers. Therefore, the proper education of patients on the use and applicability of telehealth and the education of caregivers on the importance of attentiveness and diversity inclusion are necessary for the successful utilization of telehealth.

The perspective of Black feminist thought was beneficial to guide this study and provide a context for women’s voices. Black feminist thinking has six distinct characteristics. The women in this study provided examples of the interplay between Black women's oppression and their actions. Because of the multiple types of oppression that Black women face, Black women's activism is required. Because of this discourse, black women's activism is in a unique position. The sheer existence, durability, and theoretical orientation of a movement that exists solely to resist oppression. U.S. racial and gender equality, freedom, and justice groups are fighting against these universal human rights. U.S. Black women may ask, as Sojourner Truth expressed, "Ar'n't I a woman?" because of the past unequal distribution of these privileges (McKissack, 1992).

Implications

Based on the findings of this study, several areas of additional work are required. Bias, discrimination, and stereotypes cannot be ignored when caring for Black women. Research has made it clear that many health disparities affect Black women, as we discussed, including healthcare access, cardiovascular disease and mental health disparities, the digital divide, and increased maternal morbidity and mortality rates among Black women. The intersection of race, gender, sexual orientation, and class has been examined in healthcare; however, since telehealth is now a utilized avenue for access to care, scholarly research needs to continue to examine the impact of these intersections on Black Women.

Black women have been painted with a negative picture of their human responses and emotion. To change the controlling images in healthcare, the nursing scholarly discipline can spearhead research on how these images impact various forms of healthcare delivered to Black women and used by Black women. Theoretical frameworks such as Intersectionality and Black feminist thought, womanist ways of knowing, gendered racism, Super-Woman Schema, and various other thoughts and frameworks guide the study of Black females and other oppressed populations in nursing science (Banks-Wallace, 2000; Barbee, 1994; Barlow & Smith, 2019; P. H. Collins, 2002; Sacks, 2018a). And as this article states, “The Secret to Black Women’s Health: Ask, Listen, Do” (Blount, 2018). Simply engaging in research that asks Black women about their own experience with various aspects of healthcare, listening to what they say, and staying true to the “voice“ they are allowing you to share and “Do” something about it would have a strong impact. Translating research findings into action and creating improvement in the areas that their voice defines is needed. If you listen to Black women, they have many things that are right about their lives, but they are no longer silent about the wrong things, so be prepared to ask the question and get an honest answer. Scholarly nursing research should be interdisciplinary to thoroughly conduct integrative, comprehensive studies that reveal the multiple lenses to see, hear and act. The new approach to Black Women’s Health is that Black women are using loud and clear voices to tell the researcher what they think, feel, believe, and do about their health and what they need to achieve it (Barlow & Smith, 2019; Blount, 2018).

Nursing scholarly research must recognize that it is predominantly White and female-driven, with the latest census in 2019 reporting that 88.5% of nursing in the United States is female and 68.4% of registered nurses are White non-Hispanic (*Registered Nurses | Data USA*, 2019). Therefore, it is important that teaching through various theoretical lenses such as Black feminist thought to gain better insight about racial and gender disparities through the lens of intersectionality is a positive method to better understand that we may not have the shared experiences but recognize the experiences of our participants and patients and provide individualized care plans. All care must be based on the patient’s needs from their experience and perspective, giving them a platform for their voice to be heard (Barbee, 1994; De Sousa & Varcoe, 2022).

Regarding nursing informatics and research, we must understand that these systems need to provide culturally specific data and how we analyze that data. Big data matters, and using that data to help further health app usability, telehealth adherence, chronic disease management, and adherence is a major addition to e-health and m-health technology (Brennan & Bakken, 2015). To successfully implement such projects, nurses, researchers, and informaticians must emphasize the cultural, economic, social, physical, and policy contexts of nursing informatics technology. Institutional, local, and federal regulations on interoperability and meaningful use frequently impact and constrain informatics efforts. Taking context into consideration while analyzing intervention effects converts clinical research into systems-oriented research. Sustained engagement with target users is maintained by concentrating on usability, feasibility, and acceptability. These findings support the active identification of the nursing informatics intervention's target users, content, organization, information flow, and technology features (Brennan & Bakken, 2015; Wang et al., 2019). Considering this research, developing an app and website that creates an inclusive database about the different providers by specialty and zip code and areas of focus, gender of provider, culture, and picture will be beneficial for all. It can help remove barriers for providers who are comfortable addressing certain issues related to different cultures, race, gender, and sexuality, as recommended by the participants. These apps and programs must be sustainable, easy to use, and have buy-in from both the user and the clinician to benefit the patient and the provider. PsychologyToday.com, for example, provides a provider purchase in a list that lists, by photo, psychologists and therapists based on zip code. The website or app can provide information about specialized care, education, allied assistance, cost, specialty, issues, mental health, and sexuality of the providers. In addition, laypersons can use the sites and apps to share about the client's age, community, job specialty, single mothers, veterans, and treatment approaches (Sussex Publishers LLC, 2022). BetterHelp is an online mental health platform that lists the same type of information to improve client matching and a questionnaire that prescreens customers depending upon their needs (BetterHelp, 2022). These platforms would be useful in all specialties and for Black women.

Black feminist thought researchers can be Black males, White females, and LGBTQ because it allows giving voice to the Black woman while examining their own positionality. Utilizing a platform to focus on Black women's experience and not removing the women's words or voices, but highlighting those and understanding the personal role of the researcher to listen, reflect, report, and do something about what you have learned about the Black Woman's experience is important (P. H. Collins, 2002; McCann et al., 2020). Some notable Black male feminists were W. E. B. Du Bois and Fredrick Douglass who possessed feminist thought (McCann et al., 2020). Feminist theories have been integrated into women's health curriculums for advanced practice nurses. But ensuring that the theories and feminist perspective encompass Black women and other minorities as evaluated in one college curriculum is important (Andrist, 1997; De Sousa & Varcoe, 2022). It is difficult not to discuss reproductive justice, maternal morbidity, and mortality without the lens of Black feminist thought and intersectionality because these issues affect Black women (Barlow & Smith, 2019; Crear-Perry et al., 2021; Omeish & Kiernan, 2020).

In terms of practice, avoiding racial prejudice and stereotyping is another approach that medical practitioners should use to overcome telemedicine's obstacles. Training aids providers on the meaning of race, gender, intersectionality, bias, gendered racism, and the narrative of Black women in this country. Also, willingness and openness to explore personal and learned prejudice and stereotypes through a test such as the implicit association test IAT have proven useful (Greenwald et al., 1998). This information may need to be examined through a different lens, such as the provider's capacity to give adequate care to patients via telehealth or traditional office care regardless of oppression, racism, preconceptions, stereotypes, and bias. Other patients face these intersections; however, Black feminist thought allows for other factors that may be at play to be brought to the surface and examined (Barlow & Johnson, 2021; Barlow & Smith, 2019). Special attention is needed for understanding cultural considerations with care, going beyond competence but demonstrating culturally competent care. Providers can foster this by utilizing additional pre-assessment questions to help them tailor their services to the unique requirements of their Black and minority-ethnic patients as recommended by the participants. According to the findings, women should look for providers they are comfortable with and be open to changing providers. However, searching for a provider may result in a delay in care, which may contribute to a delay in diagnosis and treatment. A study conducted in rural South Carolina with 62% non-Hispanic Blacks with an average income of $49,999 or less found that telehealth appointments for contraceptive attainment and discussion of community well-being were important with providers they had relationships with from the offices and health departments they visited and aided in acquiring contraception and discussing health needs more quickly (Sundstrom et al., 2019). As another example, in a study evaluating telehealth for postpartum hypertension follow-up adherence during COVID-19, the engagement follow-up of non-Hispanic Blacks for postpartum hypertension was higher than pre-telehealth, which showed that telehealth could reduce racial disparities in postpartum hypertension adherence (Khosla et al., 2022). There is a need to understand that race-based care algorithms can be harmful (Maina et al., 2018; Vyas et al., 2020). Race-based care algorithms correct results based on the race listed in the patients' medical records. As a result of the algorithms, this can exacerbate racial inequalities that currently exist in healthcare (Maina et al., 2018; Vyas et al., 2020). Racism, sexism, and prejudice contribute to distrust about and refusal to use the healthcare system, resulting in negative health effects and late diagnosis of illnesses.

Policy leaders have not always been at the forefront of listening. Organizations such as the Black Women's Health Initiative (BWHI) are working to change emphasis and information by employing social listening tools and data science to turn what Black women are saying about their health into programs, messages, and policies to give them the strategies and resources to improve their health right where they are. Organizations are working to change how policy leaders listen (Blount, 2018). Furthermore, policies need to be developed, addressed, and enforced with accountability systems surrounding the intersections of Black women's oppression. The ACA's nondiscrimination clause is in Section 1557. It expands on long-standing nondiscrimination legislation prohibiting discrimination based on race, color, national origin (including LEP), age, handicap, or sex. The Obama administration released a final rule implementing Section 1557 in 2016. Parts of the rule are still being challenged in court. In 2020, the Trump administration released a new final rule that drastically reduced many safeguards afforded by section 1557 under the 2016 regulation.

Unlike the 2016 regulation, the 2020 rule defined sex discrimination as discrimination based only on gender at birth. The 2020 regulation included no mention of sexual orientation or gender identity discrimination (Helmer, 2021). With a looser interpretation of Section 1557, there is room for discrimination based on intersectionality, and Black Queer and transgender women can be affected. In a place that is supposed to do no harm, we cannot allow health systems to refuse service because of gender or race. There is no clear pathway to ensure the depth, breadth, and quality of healthcare services are appropriate and consistent. We have specific policies in place to ensure hiring and protections for the following categories: Age, Disability, Equal Pay/Compensation, Genetic Information, Harassment, National Origin, Pregnancy, Race/Color, Religion, Retaliation, Sex, Sexual Harassment, Sexual Orientation, and Gender Identity (EEOC, 2022). However, there are no policies or laws for the specific care provision for Black women. Recommendations are that policy covers the intersections of race, gender, and sexual orientation. One intersection does not surpass another; they can all be examined simultaneously to increase equitable healthcare and hiring practices across this country.

Culturally our society is at a pivotal point in history where the empowerment movement of being Black and female is reframing how Black girls and women view themselves. With The Crown Act legislation about not policing Black women's hair in workplaces, we still are fighting to be seen as human and stop identity politics (Sacks, 2018a, 2018b). The first Black/Asian Woman Vice-President in the United States was elected in 2021, Madame Vice President Kamala Harris. In February of 2022, many Black women once again celebrated the appointment of Ketanji Brown Jackson as the first Black woman to serve on the U.S. Supreme Court. Even though she was exceptionally competent, many people in the United States did not think her education, experience, or accomplishments were sufficient to be a Supreme Court Justice, although her preparation for the role was extraordinary. She was simply another Black lady occupying a position that should have gone to another person.

The narrative must change regarding the portrayal of Black women. Black women are becoming weary of trying to sit at the table, so they are creating spaces for their own voices, where they are valued, seen, heard, and appreciated without being apologetic (Carr, 2017; Chisholm, 2010). Sometimes the voice of the Black woman can be heard in the form of art, poetry, dance, song, sketch shows, podcasts, entrepreneurial endeavors, movies, comedies, books, political office, non-profit organizations, social groups, historically Black Sororities, Facebook groups, and even healthcare practices that are open to all but are not ashamed to cater to the needs of the oppressed groups (P. H. Collins, 2002, 2015, 2016). These are all examples of how Black feminist thought has been integrated culturally, and the need for a safe place to express the experience can be unapologetically expressed. As a non-monolithic race and gender, Black women have endured pain, stigma, and microaggressions and try to remain strong, endure, and fight to be the Super Woman because who will save us? We must advocate for ourselves (Allen et al., 2019; Banks-Wallace, 1998; Barlow & Johnson, 2021; Blount, 2018; P. H. Collins, 2002; M. K. Jones et al., 2021; Wallace, 1979; Woods-Giscombé, 2010).

The interviews of 21 Black women across the United States who have had various telehealth experiences have revealed rich data that may begin the transformation of care needed utilizing digital health delivery. Telehealth has become an additional means of healthcare access. The National Quality Forum (NQF), released in December of 2021, recommends advancing the field of measuring the quality of care delivered by telehealth. Despite the significant rise of telehealth in America's healthcare delivery system, quality monitoring for telehealth is still in its early stages. Standardized, thorough measurement is essential for informing the use of telehealth to improve care delivery, expand access to care, and promote positive health outcomes for all. Based on Committee deliberations, measuring in numerous categories was proposed to promote rural telehealth measurement. These are divided into five categories: (a) Access to Care and Technology Access; (b) Costs, Business Models, and Logistics; (c) Experience; (d) Effectiveness; and (e) Equity (National Quality Forum, 2021). Healthy People 2030 also emphasizes the need for more studies addressing telehealth use to improve access to health services – AHS-R02. Also, this study lays the initial foundation for beginning evidence-based strategies and interventions to help Black women enhance access to care (USDHHS, 2020). This study of Black women's telehealth experiences contributes to evaluating telehealth delivery and accountability of use. This study has started a deep conversation about the perspectives of Black women who experience health disparities and access to care challenges and intersecting oppressions to establish accountable care methods.

Limitations

There are some typical limitations to qualitative research. Qualitative research is time-consuming. It takes time to conduct, transcribe, and reiteratively code the interviews. Data are not quantifiable; they are used to understand and uncover thoughts and opinions. The researcher must understand their positionality with qualitative research to authenticate the coding process.

This study's limitations were specific to the demographics and type of qualitative investigation. Because the ladies in this study were well educated, with college degrees and middle-class incomes, their experiences with telehealth may not be representative of other Black Women's experiences. Additionally, all women had incomes that allowed them access to telehealth, the Internet, and a device to utilize telehealth. This is not reflective of all Black women. Furthermore, they were homogeneous in their sexual orientation and not reflective of the intersection of gender, race, and sexuality. Finally, the study was limited to Black women who had access to and used social media platforms for recruitment. There is potential that utilizing online interviews may have limited the women's discussion or responses.

Reflections

I ponder over the last several months of this study and the previous 2 years of the American climate. Being Black, a woman, and a healthcare practitioner has caused me great anguish as if my voice had been silenced. There were and still are different political, social, hierarchical, and economic powers at work in our healthcare institutions and in everyday life. I experienced the murder and trial of George Floyd through the eyes, feelings, and emotions of one of my best friends, a member of the Floyd family. Additionally, as a nurse practitioner, I sat through many appointments with patients who had ideas on a subject that was extremely deep in my soul and smiled through it, listening to rants, opinions, and sentiments that were like knife wounds every single day. Yet I was committed to and still provided exceptional care.

During the year before and of the study, I listened to and cared for Black people, particularly Black women, who were attempting to survive the terror of the COVID-19 epidemic, sorting through the propaganda, facts, conspiracies, and falsehoods to make the best option for themselves and their families. I offered scientific facts and what was known and what was unknown related to COVID, including the myths that this virus was a way to kill Black people and the significant disparities in testing and vaccinations. I was given the information to share with patients from an institutional perspective. I delivered the information I had been given, hoping it might save another Black woman from dying from COVID. My first two devastating COVID deaths as a provider were of Black women. I attempted to assist Black women in negotiating their sentiments and outrage over debates about systemic racism, environmental racism, and political racism in their workplaces and how it broke them down psychologically and physically. Women continually told me, “No one is listening, no one cares, we are dying, our sons and daughters are dying, and WE ARE TIRED!” I held space for every patient, regardless of race, gender, or socioeconomic status. Still, the reflection of Black Women, the eyes, the tears, the quiet pain, and the anger directly reflected the voice I could not speak as the provider. As a Black woman, using that voice meant owning the pain and shame, recognizing that I may not be seen as human, and acknowledging my mistrust within the healthcare system. For the first time, I was forced to acknowledge myself as all the Black women I cared for and interviewed.

This journey, developing my voice, simply holding space for the various experiences I was tasked with, and echoing the voices of Black women who, like me, felt as though we were in the spotlight, and no one cared.. Black women began to yell #BlackLivesMatter but soon realized that more than just Black lives mattered; Black women's lives also mattered. We have earned the right to be heard, seen, and cherished. We deserve safe zones to protect our feelings and emotions. WE DESERVE healthy births and to live to watch our children develop. We deserve our bodies to be respected with the same regard as the White women with whom we interact. We deserve our children to grow up not fearing the police but seeing them as comrades. WE deserve to be heard. As we witnessed various Black women die due to police violence, we chanted #SAYHERNAME as a call to view ourselves as human and deserving (Crenshaw et al., 2015).

I began this research 4 years ago, intending to increase health equity by extending telemedicine for women. Still, I have since realized that the struggle for health equity is much more than a hashtag, a survey, or an interview. This research is only the beginning.

The voices of every patient I encounter reverberate in my mind, but now screaming in my soul, the fire, the why behind this study is the voice of a mirror of me; a Black woman who just wants to be seen, heard, and cared for without fear that my life is unimportant to the healthcare community. This is only the beginning of a discussion because oppression does not exclude all other groups. This effort will contribute to advancing all genders, races, classes, sexual orientations, and classes. We all have a VOICE; it is up to us how we choose to use that voice, and my patients, participants, friends, family, committee, environment, and even my workplace fertilized the space for my VOICE to be heard to contribute to the body of research on health equity, Black Feminist Thought, Intersectionality, and digital health equity. I have the luxury of being a Black woman, a Black health care practitioner, and a Black educator. Also, I have the disadvantage of being a Black woman, a Black health care provider, and a Black student in a mainly White society with White-focused systems. I own my privilege, inequities, battle, and duty of fighting for those facing similar challenges.

I depart this moment, speaking for myself and the women who generously participated in this study; this poem summarizes our daily journey as Black women. In a Litany for Survival, Lorde (1978) addresses this fear: “and when we speak, we are afraid our words will not be heard nor welcomed, but when we are silent, we are still afraid. So it is better to speak remembering we were never meant to survive” (Lorde, 1978, p. 32).

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APPENDIX A: SEMI-STRUCTURED INTERVIEW QUESTIONS

1. When you hear the word telehealth, what does that mean to you?
2. Describe for me your experience with telehealth? Help me understand everything you went through.
3. Can you help me understand what was discussed or what you and the provider talked about during the telehealth visit?
4. Can you help me understand if things were missing or what type of things were missing or different by using telehealth rather than office visits?
5. Based on your care experience, what will help you decide to use or not use telehealth in the future?
6. What else would you like to share regarding your telehealth or other care experiences? Anything and everything I would be glad to hear.
7. What would you like to share with healthcare providers about the experience of telehealth to help other Black women?

Follow-up questions and prompts that ask when, where, and how that affected your experience were asked depending on how the participants answered the main questions. This enabled the researcher to gather more information to produce rich and thick data on their telehealth experiences. These semi-structured questions were developed based on the review of literature on what is known about Black women and gaps in the literature regarding telehealth use.

APPENDIX B: OPEN CODES

OPEN CODES COLOR CODE

Color	Code
Burgundy	Telehealth Barriers/Trust
Red	Telehealth Definition for participant
Orange	Experience With Telehealth
Black	Negative Experience telehealth/healthcare
Yellow	Positive Experience telehealth
Blue	Preconceived telehealth issues
Purple	Felt experience negative about women or environment
Brown	Black women's feelings or issues
Green	Telehealth appointment issues, cost
Light Yellow	Experiences and family beliefs that impact care decisions
Lavender	Feelings about sharing with a provider
Mint	Stigmas regarding gender, race, sexuality, SES, education
Pink	Strong woman, roles, superwoman
Light Blue	What improves use, more services that areas suggested, Apps, Transparency

APPENDIX C: ITEM RATIONALE TABLE

Research Questions:

1. “What is the experience of Black women’s use of telehealth for their healthcare?”
2. “How, when, and why do Black Women use telehealth?”
3. “What experience as a Black Woman influences decisions to use telehealth?”
4. “What experience influences a Black woman’s future use of telehealth?”

Interview Question	Research Question	Literature Reference (Theoretical, conceptual, and/or empirical)
When you hear the word telehealth, what does that mean to you?	R1	(Chang et al., 2021; Demeke et al., 2021; Jaffe et al., 2020) (Anderson et al., 2019) (Dickerson & Brennan, 2002)
Describe for me your experience with telehealth. Help me understand everything you went through.	R1, R2, R3, R4	(P. H. Collins, 2002; Okoro et al., 2021; Sacks, 2018a) (J. R. Lori et al., 2011; Roman et al., 2017; Slaughter-Acey et al., 2019)
Can you help me understand what was discussed or what you and the provider talked about during the telehealth visit?	R1, R2, R3, R4	(Barlow & Johnson, 2021; J. I. Manuel, 2018; Nuru-Jeter et al., 2009; Socías et al., 2016) (J. R. Lori et al., 2011; Roman et al., 2017; Slaughter-Acey et al., 2019) (Alinia, 2015; Carastathis, 2014; Gopaldas, 2013).
Can you help me understand if things were missing or what type of things were missing or different by using telehealth rather than in the office visit?	R1, R3, R4	(Cortés & Breathett, 2021; Creanga et al., 2014; Crear-Perry et al., 2021; Davis, 2020; Lemke & Brown, 2020; Omeish & Kiernan, 2020; Roman et al., 2017; J. K. Taylor, 2020). (Chunara et al., 2021) (Seto et al., 2019)
Based on your care experience, what will help you decide to use or not use telehealth in the future?	R3, R4	(Allen, Wang, Chae, Price, Powell, Steed, Black, et al., 2019; N. N. Watson & Hunter, 2015; Woods-Giscombé & Black, 2010). (Chang et al., 2021; Demeke et al., 2021; Jaffe et al., 2020). (Anderson et al., 2019) (Qiao et al., 2015) (Fischer et al., 2020; U.-P. Lori et

Interview Question	Research Question	Literature Reference (Theoretical, conceptual, and/or empirical)
		al., 2020; Pollard & Baird, 2017) (P. H. Collins, 2002)
What else would you like to share regarding your telehealth or other care experiences? Anything and everything I would be glad to hear.	R1, R2, R3	(Goel et al., 2011) (Seto et al., 2019) (Fischer et al., 2020). (Abel & DeHaven, 2021; Gerber et al., 2013; R. Jones & Lacroix, 2012; Miranda et al., 2003; Pekmezaris et al., 2019). (Banks-Wallace, 2000; P. H. Collins, 2002; Crenshaw, 1989)
What would you like to share with healthcare providers about the experience of telehealth to help other Black women?	R2, R4	(Crear-Perry et al., 2021) (Anderson et al., 2019) (Seto et al., 2019) (Qiao et al., 2015) (Obey, 2009) (Banks-Wallace, 2000; P. H. Collins, 2002; Crenshaw, 1989) (Alinia, 2015; P. H. Collins, 2002, 2015) (Alinia, 2015; Carastathis, 2014; Gopaldas, 2013).