

## RESEARCH ARTICLE

# Hope and health-related quality of life among chronically ill uninsured/underinsured adults

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**Abstract**

**Aims:** Uninsured/underinsured individuals with chronic health conditions report low health-related quality of life. Empowerment-based strategies (e.g., hope) may improve the health-related quality of life of uninsured/underinsured individuals with chronic health conditions by enabling them to take charge of their health.

**Methods:** The present study used structural equation modeling to examine the relationships among number of chronic health conditions, the components of hope (i.e., agency and pathways), and the health-related quality of life of 197 uninsured/underinsured adults in the United States living with at least one chronic health condition.

**Results:** Results indicate that number of chronic health conditions negatively impacted health-related quality of life and that agency significantly mediated that relationship.

**Conclusions:** Results from this study can be used to promote health-related quality of life by empowering individuals to take charge of their lives despite their unique contextual circumstances.

**KEYWORDS**

chronic illness, health disparity, health-related quality of life, hope

Certain groups of underserved individuals in the United States (U.S.) experience disproportionate rates of adverse health known as health disparities (Braveman, Cubbin, Egerter, Williams, & Pamuk, 2010; National Center for Health Statistics, 2016; Tan, Chuang, Shirk, Laviana, & Hu, 2016). One such group is uninsured and underinsured adults. Uninsured individuals lack healthcare insurance whereas underinsured individuals have some sort of healthcare insurance but are exposed to financial risk when using these services (Lavarreda, Brown, & Bolduc, 2011). Underinsured healthcare status is defined as out-of-pocket costs that are "equal to or more than 10% of household income or 5% of household income if income is 200% below the federal poverty level" (Schoen, Hayes, Collins, Lippa, & Radley, 2014).

Despite the implementation of the Affordable Care Act (ACA) in 2010, rates of uninsured adults in the United States have continued to rise, from 12.7% in 2016 to 15.5% in 2018 (Collins, Gunja, Doty, & Bhupal, 2018). This translates to 4 million people losing coverage (Collins et al., 2018). Additionally, in 2014, it is estimated that there were 31 million underinsured individuals in the U.S. (Collins, Rasmussen, Beutel, & Doty, 2015). These numbers are alarming, given that it is well-known that insurance coverage is associated with better health outcomes (Centers for Disease Control and Prevention, 2011). For example, uninsured and underinsured individuals experience higher rates of chronic health conditions such as unmet psychiatric needs (Kataoka, Zhang, & Wells, 2002; Reisinger Walker, Cummings, Hockenberry, & Druss, 2015) higher rates of obesity (Axelrod et al., 2018; McQueen, Ghushchyan, Olufade, Sheehan, & Saseen, 2016) compared to their insured counterparts. Additionally, these individuals experience and higher rates of tobacco use (Notaro et al., 2012)—a health risk behavior and a chronic health condition (Tobacco Use and Dependence Guideline Panel, 2008).

These adverse unidimensional health indicators (i.e., indicators that measure one specific dimension of health, such as obesity and tobacco use) are often associated with higher rates of mortality and morbidity (Abdelaal, le Roux, & Docherty, 2017; Carter et al., 2015; Roll, Kennedy, Tran, & Howell, 2013). Uninsured and underinsured individuals are particularly in danger given their higher rates of chronic health conditions and the higher risk of mortality associated with a greater number of chronic health conditions (U.S. Department of Health & Human Services, 2010). Research indicates that the odds of mortality among uninsured individuals, compared to insured individuals, is 0.97–0.71 (Woodhandler & Himmelstein, 2017). While uninsured and underinsured individuals engage in some risky health behaviors (e.g., smoking) that contribute to chronic diseases at a higher rate than their insured counterparts (Centers for Disease Control and Prevention, 2015), the association between lack of insurance status and chronic disease mortality holds true while adjusting for lifestyle factors (Bittoni, Wexler, Spees, Clinton, & Taylor, 2015).

## 1 | MULTIDIMENSIONAL HEALTH

Despite the well-recognized link between unidimensional physical and mental health indicators and mortality and morbidity, organizations such as the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health have drawn attention to the importance of multidimensional health indicators (Forrest, Blackwell, & Camargo, 2018; Slabaugh et al., 2017). Multidimensional measures of health correspond well with the World Health Organization's (WHO) conceptualization of health as "a complete state of physical, mental, and social well-being" (World Health Organization, 1948). Multidimensional measures of health recognize the interplay of various factors that influence health (U.S. Department of Health and Human Services, 2000). Health-related quality of life is a multidimensional measure of health that consists of an individual's subjective appraisal of their physical, mental, and social functioning (Hays & Morales, 2001; Healthy People 2020, 2010). Research suggests that subjective appraisals of health, such as health-related quality of life, can better predict mortality and morbidity than many objective measures of health (DeSalvo, Bloser, Reynolds, He, & Muntner, 2006; Dominick, Ahern, Gold, & Heller, 2002) and that health-related quality of life predicts mortality while controlling for some unidimensional indicators of health (Brown, Thompson, Zack, Arnold, & Barile, 2015).

Therefore, it is concerning that research indicates that health-related quality of life disparities exist (Atel & Cheng, 2016; Fredriksen-Goldsen, Kim, Barkan, Balsam, & Mincer, 2010; McManus, Robert, Albanese, Sadek-Badawi, & Palta, 2014). For example, research indicates that insurance status is negatively associated with health-related quality of life (Bharmal & Thomas, 2005; Smith et al., 2013). Hence, there is a clear urgency to better understand the factors influencing health-related quality of life among underserved individuals (e.g., those who are uninsured and underinsured and living with a chronic illness) to promote health equity.

## 1.1 | The role of empowerment

The WHO recognizes empowerment as a central component to health promotion and stresses the potential role of empowerment in alleviating health disparities (World Health Organization, 1978, 1986). Empowerment is defined as a group-based, developmental process through which marginalized or oppressed individuals gain greater control over their lives and environment, including decisions and actions affecting their health (Maton, 2008; World Health Organization, 2009). A major report published by the WHO concluded that empowerment strategies can produce favorable health outcomes and that empowerment can be an important strategy to promote public health (Wallerstein, 2006). For this reason, empowerment is often considered the “holy grail of health promotion” (Rissel, 1994). The important role of empowerment has been confirmed by recent health promotion interventions. Empowerment-based health promotion interventions among communities disproportionately impacted by health disparities (e.g., Hispanics and African American women) have been successful in improving health indicators (Tucker et al., 2014; Tucker, Smith et al., 2016; Tucker, Wippold et al., 2016b; Tucker, Williams, Roncoroni, & Heesacker, 2017).

Psychology can play a key role in further understanding empowerment among underserved populations. Rappaport (1987) indicated that empowerment was a “phenomena of interest” to community psychology. Rappaport (1981) and (1984) furthered the understanding of empowerment by adding a contextual and dynamic element. Rappaport (1981) defined empowerment as “a process by which people, organizations, and communities gain mastery over their experiences.” Zimmerman (1990) recognized that empowerment functions at multiple levels of analysis, including the personal, organizational, and community levels, though drew attention to the concept of empowerment at the individual level (i.e., “psychological empowerment”). Among the components of psychological empowerment outlined by Zimmerman (1995) were the individual’s belief that goals can be attained, the understanding of resources that inhibit or promote the achievement of one’s goals, and active attempts to fulfill the goals. Despite outlining the components of empowerment, Zimmerman (1995) acknowledged the difficulties in measuring empowerment. Recently, research among community psychologists has focused on the multidimensionality of psychological empowerment (Peterson, 2014). This research has advocated for future researchers to investigate alternative models of psychological empowerment.

## 1.2 | Hope as a mechanism of psychological empowerment

In addition to the components of empowerment outlined by Zimmerman (1995), it has been suggested by other researchers that key components of empowerment include the ability to make meaningful goals, the knowledge in oneself to identify a course of action to achieve that goal, and self-efficacy (Cattaneo & Chapman, 2010; Ibrahim & Alkire, 2007; Sharunga, Mudhara, & Bogale, 2019). Hope is a contextual (Stevens, Buchanan, Ferrari, Jason, & Ram, 2014) and dynamic (Kashdan et al., 2002) state that can play a role in empowerment (Chamodraka, Fitzpatrick, & Janzen, 2017). Hope is the ability to achieve a desired goal (Snyder, Irving, & Anderson, 1991). The hope literature indicates that there are two concepts important in the ability to achieve desired goals—pathways and agency (Snyder, Irving et al., 1991). Pathways are the various routes an individual identifies that will help them achieve their goals, whereas agency refers to the individual’s perception of their ability and motivation to achieve their goals (Snyder, Irving et al., 1991). Therefore, a hopeful person (a) has a desired goal, (b) can identify various routes to achieve the desired goal, and (c) believes that they can achieve their desired goal.

The present study is influenced by the WHO and community psychology’s emphasis on empowering underserved individuals to attain a complete state of health. There is a paucity of research examining hope and health-related quality of life among underserved individuals, particularly uninsured and underinsured individuals living with a chronic health condition. Uninsured and underinsured individuals living with chronic health conditions

experience a number of unique sociocontextual and personal factors impacting their health-related quality of life. Hope may be an alternative, multidimensional model of empowerment. The hypotheses of the present study are that among a U.S. sample of uninsured and underinsured adults living with a chronic illness:

1. The number of chronic health conditions will be negatively associated with health-related quality of life.
2. The relationship between the number of chronic health conditions and health-related quality of life will be mediated by agency.
3. The relationship between the number of chronic health conditions and health-related quality of life will be mediated by pathways.

## 2 | METHODS

### 2.1 | Participants

The participants of the present study consist of 197 adults who self-identified as being uninsured (51.8%) or underinsured (48.2%) and experiencing at least one chronic health condition. The mean age of the participants was 35.73 (standard deviation [SD] = 9.42), and the mean number of chronic health conditions was 2.12 (SD = 1.51).

The race/ethnicity distribution among participants was as follows: 23 (11.7%) self-identified as Hispanic; 1 (0.5%) as American Indian or Alaska Native; 12 (6.1%) as Asian or Asian American; 25 (12.7%) as Black or African American; 159 (80.7%) as Caucasian/White/European American; 2 (1%) as Native Hawaiian or other Pacific Islander; and 2 (1%) as other. Of the 273 participants, 96 (48.7%) self-identified as female; 99 (50.3%) self-identified as male; 1 (0.5%) self-identified as transgender female-to-male; and 1 (0.5%) self-identified as nonbinary. The majority of participants (59.9%) reported having at least a 2-year college degree. See Table 1 for a list of the participant-reported chronic health conditions and Table 2 for additional demographic information.

Participants were recruited from Amazon Mechanical Turk (MTurk)—a web-based resource that allows requesters to post surveys and “Turkers” (i.e., participants) to complete the surveys. MTurk is often used in social science research (Huff & Tingley, 2015; Paolacci & Chandler, 2014). Research on MTurk indicates that MTurkers are more demographically diverse than some traditional samples (i.e., internet samples and college students) and

**TABLE 1** Participant-reported chronic health conditions

	<i>n</i>	%
Diabetes (type 1 and 2)	17	8.6
Arthritis	24	12.2
Asthma	30	15.2
Chronic kidney disease	4	2.0
Chronic obstructive pulmonary disease	5	2.5
Depression	57	28.9
Anxiety	101	51.3
Alcohol abuse	10	5.1
Obesity	37	18.8
Hypertension	28	14.2
Tobacco use	47	23.9
“Other” <sup>a</sup>	41	20.8

<sup>a</sup>“Other” includes chronic illnesses that were entered by participants and appeared once. Examples include lupus, fibromyalgia, and irritable bowel syndrome.

**TABLE 2** Demographic information

	<i>n</i>	%
Gender		
Female	96	48.7
Male	99	50.3
Transgender female-to-male	1	0.5
Nonbinary	1	0.5
Insurance status		
Uninsured	102	51.8
Underinsured	95	48.2
Occupational status		
Employed	164	83.2
Unemployed	33	16.8
Highest level of education		
Less than high school	1	0.5
High school or GED	20	10.2
Some college	51	25.9
Trade/technical school	7	3.6
2-year college	25	12.7
4-year college	79	40.1
Professional/graduate school	14	7.1
Annual income		
Less than \$10,000	27	13.7
\$10,000–\$14,999	16	8.1
\$15,000–\$19,999	14	7.1
\$20,000–\$24,999	17	8.6
\$25,000–\$34,999	38	19.3
\$35,000–\$49,999	36	18.3
\$50,000–\$74,999	36	18.3
\$75,000 or above	13	6.6
Race/ethnicity		
Hispanic	23	11.7
American Indian or Alaska Native	1	0.5
Asian or Asian American	12	6.1
Black or African American	25	12.7
Caucasian/White/European American	159	80.7
Native Hawaiian or other Pacific Islander	2	1.0
“Other”	2	1.0
Last healthcare visit		
6 months or less	54	27.4
>6 months, <1 year	37	18.8
>1 year, <3 years	67	34.0
>3 years	36	18.3
Never	3	1.5

that the data obtained is reliable (Buhrmester, Kwang, & Gosling, 2011; Casler, Bickel, & Hackett, 2013). Furthermore, MTurk can be used to access populations that are not traditionally represented in research because of the difficulty in accessing them (Smith, Sabat, Martinez, Weaver, & Xu, 2015). For example, Turkers (i.e., MTurk participants) are less likely to have health insurance than a nationally representative sample (Walters, Christakis, & Wright, 2018). The inclusion criteria for the present study were: (a) being uninsured or underinsured, (b) having at

least one chronic health condition, (c) residing in the United States, (d) being 18 years of age or older, (e) being able to read in English, and (f) having access to the internet. See Table 2 for additional demographic information.

## 2.2 | Procedure

The present study received institutional review board approval from a large university in the Southeast of the United States. Uninsured and underinsured individuals in the United States were invited to complete the assessment battery via MTurk. Before beginning the assessment battery, the participants were presented with an informed consent document. The informed consent document was the first image to display on the screen of their computer. Participants had to acknowledge having read the informed consent document before they could proceed with the study and complete the assessment battery. The estimated time to take the survey was 6 minutes. Participants received \$0.75 for participating in the study (a rate commensurate with minimum wage for a task of a similar length).

## 2.3 | Measures

### 2.3.1 | Demographic data questionnaire

The demographic data questionnaire (DDQ) is a researcher-created questionnaire that assessed demographic information. The DDQ assessed: (a) insurance status, (b) number of chronic health conditions, (c) gender, (d) occupational status, (e) highest level of education, (f) annual income, (g) race/ethnicity, and (h) time since last healthcare visit. The number of chronic health conditions was measured by providing a list of 11 common chronic health conditions in the United States and asking participants to check any that applied. Following the list of common chronic health conditions, an option was included for participants to enter any chronic health conditions that were not listed. Similar chronic health condition self-report questionnaires have been used in health research (Yamaki, Rimmer, Lowry, & Vogel, 2011), including among publications issued by the CDC (Goodman, Posner, Huang, Parekh, & Koh, 2013; Ward, Schiller, & Goodman, 2014).

### 2.3.2 | RAND-36

It has been suggested that the RAND-36 (Hays, Sherbourne, & Mazel, 1993) is the most widely used health-related quality of life measure (Hays & Morales, 2001). The RAND-36 is a 36-item self-report measure and is composed of eight subscales: (a) physical functioning, (b) role limitations caused by physical health problems, (c) role limitations caused by emotional problems, (d) social functioning, (e) emotional well-being, (f) energy/fatigue, (g) pain, and (h) general health (Hays & Morales, 2001). A common scoring method for the RAND-36 consists of creating two component scores—a mental health component score and a physical health component score (Hays & Morales, 2001; Laucis, Hays, & Bhattacharyya, 2015; Ware, Kosinski, & Keller, 1994). For the present study, an oblique physical health component score and a mental health component score were created from the eight RAND-36 subscales using the technique suggested by Ware et al. (1994). The Cronbach's alpha for the RAND-36 for the present study was .95.

### 2.3.3 | State Hope Scale

The State Hope Scale is a six-item self-report measure designed to assess hope (Snyder et al., 1996). The State Hope Scale is a common measure of hope, having frequently been used in research (Pozzebon, 2010). It is unique in that it appraises an individual's goal-directed thinking (Lopez, Ciarlelli, Coffman, Stone, & Wyatt, 2000). Additionally, the State Hope Scale is responsive to events in the lives of people, as demonstrated by both correlational and causal data (Snyder et al., 1996). The State Hope Scale consists of two subscales, an agency

subscale and a pathways subscale. A sample item for the agency subscale is “At the present time, I am energetically pursuing my goals.” The Cronbach’s alpha for the agency subscale for the present study was .88. A sample item for the pathways subscale is “I can think of many ways to reach my current goals.” The Cronbach’s alpha for the pathways subscale for the present study was .86.

### 3 | RESULTS

Analyses were performed in IBM SPSS version 20 and IBM SPSS Amos 25 (IBM Corp. Released, 2017). Preliminary correlations were conducted in IBM SPSS version 20. See Table 3 for those correlations. Missing data were then analyzed to verify that they were missing completely at random (MCAR) using Little’s MCAR test (Little, 1988) in IBM SPSS version 20. Results indicated that data were MCAR,  $\chi^2(15, N = 197) = 17.60$ ;  $p = .28$ . Once data were determined to be MCAR, a multiple imputation in IBM SPSS Amos was conducted (Schlomer, Bauman, & Card, 2010). A model composed of manifest and latent variables was created. The number of chronic health conditions was entered as a manifest variable. The pathways and agency latent variables were each composed of the three items of the State Hope Scale that correspond with each subscale. These two subscales were allowed to correlate given previous research (Geraghty, Wood, & Hyland, 2010; Snyder, Harris et al., 1991) suggesting a correlation. Additionally, the health-related quality of life latent variable was composed of the physical health component score and the mental health component score of the RAND-36. See Figure 1 for a visual description of the model.

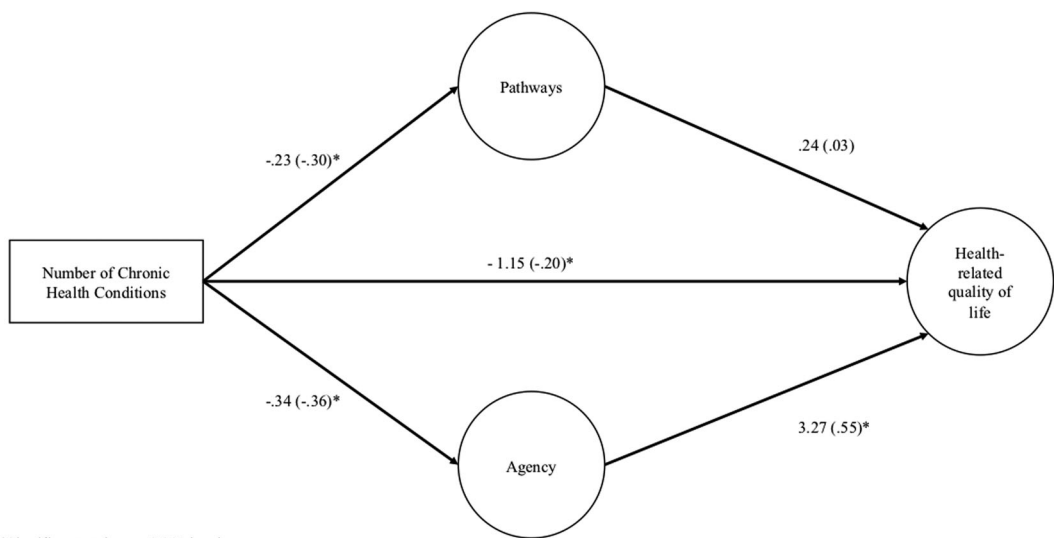
Data were analyzed using structural equation modeling with a maximum likelihood estimation. A bootstrapped sample was used ( $B = 2,000$  samples). Overall, the model was a good fit,  $\chi^2[(23, N = 197) = 26.51$ ;  $p = .28$ ]. Absolute fit indices and incremental fit indices were also used to assess model fit. The root mean square error of approximation (RMSEA = 0.03) suggested an excellent fit (Browne & Cudeck, 1992; Lai & Green, 2016; MacCallum, Browne, & Sugawara, 1996). The following other fit indices also suggested that the model fit was excellent: Comparative Fit Index = .99, Tucker-Lewis Index = .99, Incremental Fit Index = .99, and Normed fit Index = 0.98 (Hu & Bentler, 1999).

Results indicated that number of chronic health conditions was a significant negative predictor of health-related quality of life ( $\beta = -1.15$ ,  $p < .001$ ), pathways ( $\beta = -.23$ ,  $p < .001$ ), and agency ( $\beta = -.34$ ,  $p < .001$ ). Results indicated that agency was a significant positive predictor of health-related quality of life ( $\beta = 3.27$ ,  $p < .001$ ). The relationship between number of chronic health conditions and health-related quality of life was significantly mediated by agency, 95% CI  $[-2.09, -.34]$ . Contrary to the study hypotheses, pathways was not a significant predictor of health-related quality of life ( $p = .83$ ) and thus did not mediate the relationship between number of chronic health conditions and health-related quality of life, 95% CI  $[-.82, .69]$ . The predictors of health-related quality of life (i.e., number of chronic health conditions, pathways, and agency) explained 45.2% of the variance in health-related quality of life.

**TABLE 3** Preliminary correlations

	1	2	3	4	5
Number of chronic health conditions	–	–	–	–	–
Pathways	–0.27 <sup>a</sup>	–	–	–	–
Agency	–0.35 <sup>a</sup>	.75 <sup>a</sup>	–	–	–
Physical health-related quality of life	.42 <sup>a</sup>	.43 <sup>a</sup>	.47 <sup>a</sup>	–	–
Mental health-related quality of life	.52 <sup>a</sup>	.52 <sup>a</sup>	.60 <sup>a</sup>	.88 <sup>a</sup>	–

<sup>a</sup>Correlation is significant at the 0.01 level.



**FIGURE 1** Model of analysis

#### 4 | DISCUSSION

The present study sought to examine the impact of number of chronic health conditions and hope on health-related quality of life among a sample of uninsured and underinsured adults living with at least one chronic health condition. Uninsured and underinsured adults living with at least one chronic health condition are particularly at risk for low health-related quality of life. Hope is a modifiable variable that may be a mechanism to empower these individuals to improve their health. Given the relative intractability (in the United States) of health insurance status and the presence of chronic health conditions, modifiable psychological variables such as hope can be fostered among these individuals to promote their health-related quality of life.

The results of the present study indicate that the number of chronic health conditions endorsed by uninsured and underinsured individuals has a significant and negative relationship with their self-reported health-related quality of life. That is, as the number of chronic health conditions rises, the individual's self-reported health-related quality of life decreases. This finding confirms the results of other similar studies (Brettschneider et al., 2013; Cook & Harman, 2008; Shih & Simon, 2008), though it is noteworthy that the present study examines this relationship among a very specific population. The aforementioned results are concerning and disheartening, given the relative intractability of chronic health conditions and insurance status in the United States, and the impact of health-related quality of life on mortality and morbidity (Abdelaal et al., 2017; Carter et al., 2015; Roll et al., 2013). Though when these results are viewed in conjunction with the other results of the present study, a more encouraging message emerges.

The present study also found that agency significantly mediated the relationship between number of chronic health conditions and health-related quality of life. That is, despite the negative impact of chronic health conditions on health-related quality of life, community psychologists can work to foster agency among uninsured and underinsured individuals living with chronic health conditions to improve their health-related quality of life. This finding is important, given that agency is a variable that can be modified relatively quickly (Feldman & Dreher, 2012). Additionally, this finding is important in light of research indicating that decreases in health-related quality of life are predictive of increased chances of mortality (Kroenke, Kubzansky, Adler, & Kawachi, 2008) and that improvements in health-related quality of life are associated with improvements in mortality (Landman et al., 2010).



Contrary to the hypotheses of the present study, pathways did not significantly mediate the relationship between number of chronic health conditions and health-related quality of life. This statistically nonsignificant result has important implications for health-related quality of life promotion interventions among uninsured and underinsured individuals living with chronic health conditions. Interventions to improve health-related quality of life among a similar sample of individuals would likely benefit from addressing components of empowerment other than pathways (i.e., the knowledge in oneself to identify a course of action to achieve that goal) or in addition to pathways. That is, the ability to achieve positive health-related quality of life among uninsured and underinsured individuals living with a chronic health condition may be more a function of fostering in them a perceived ability and motivation to achieve their goals than a sense of ability to identify ways to achieve their goals.

The present study had noteworthy strengths. First, the present study outlines an empowerment-based approach to health-related quality of life. This empowerment-based approach is particularly significant given the population being studied (i.e., uninsured and underinsured adults living with chronic health conditions) and research's history of assuming a deficits-based approach with underserved populations. This study explores how uninsured and underinsured individuals living with chronic health conditions can take charge of their health despite their present circumstances. Additionally, the present study acknowledges the multidimensionality of health. The conceptualization of health used in the present study corresponds well with the WHO's definition of health. That is, health encompasses more than the absence of disease, but also physical, mental, and social well-being (World Health Organization, 1948). Finally, all the measures used yielded good to excellent Cronbach's alphas (Cortina, 1993).

In addition to these strengths, there are limitations to the present study. First, the MTurk sample used in the present study may draw criticism. One study suggested that the health of Turkers is not representative of the population health of the United States (Walters et al., 2018). Though that study (i.e., Walters et al., 2018) mostly consisted of unidimensional indicators of physical health (i.e., influenza vaccination, smoking, physical activity, and asthma) and one unidimensional indicator of mental health (i.e., depression). Second, the present study relied solely on self-report and cross-sectional data. There is always the possibility that individuals completing self-report measures may paint themselves in an unrealistically favorable manner (DiMatteo, 2004). Though it should be noted that self-report data is often used in health promotion research (DiMatteo, 2004) and that subjective measures of well-being can be as reliable as objective measures of health (Oswald & Wu, 2010). Third, this study employed the State Hope Scale, which has not been validated with diverse populations. The measure was adequate to be used with the present sample (80% Caucasian/White, fairly educated, and above the poverty line), but other measures may need to be incorporated to future research involving more diverse samples. Finally, the present study examines empowerment at one level of analysis (i.e., personal/psychological). Though with that being the case, Zimmerman (1995) notes that examining empowerment at the personal level should not imply that sociopolitical or contextual factors were overlooked. Indeed the present study considers sociopolitical and contextual factors (i.e., adults living with a chronic illness who are uninsured or underinsured), and the authors of the current study acknowledge that all levels of empowerment influence and are influenced by each other.

These results may provide a foundation for future research. For example, future research may benefit from examining the associations of chronic health conditions and hope on health-related quality of life among a community of culturally diverse participants. Although the implementation of the ACA has narrowed the longstanding disparities in coverage between non-Hispanic Whites and racial/ethnic minorities, racial/ethnic minorities continue to be at greater risk of difficulty accessing care and affording healthcare costs. It may be the case that the unique contextual factors experienced by racial/ethnic minority communities impact the mediating role of hope. Empowerment strategies that are community-specific and deviate from a "one-size-fits-all" model may provide a unique opportunity to effectively address empowerment and curb the adverse effects of chronic health conditions on health-related quality of life among racial/ethnic minority communities. Therefore, future research may benefit from including unique covariates in addition to or investigating the relationship of these variables

among racial/ethnic minority communities. This research may also benefit from being intentional about exploring the relationship among these variables among individuals endorsing intersectional identities.

The present study also has important implications for health-related quality of life empowerment strategies among uninsured and underinsured individuals living with chronic health conditions in the United States. Hope may be a mechanism to empower individuals to take charge of their health. Community psychologists seeking to augment hope in a diversity of settings may borrow from the work of Lopez, Floyd, Ulven, & Snyder (2000). These researchers have created a form of therapy called "hope therapy." Community psychologists can build on this therapy by intentionally recognizing and including the sociopolitical and contextual elements associated with hope when seeking to augment hope. There is already a small presence of hope research in the community psychology literature (Stevens et al., 2014) examining the relationship between hope and context. Community psychologists are well-suited to further examine hope on the personal, organizational, and community levels. This holistic understanding of hope can then be used to implement change on various levels. It is well-known that prevention measures that target multiple levels can provide long-term change.

Additionally, the present study has political implications. Community psychologists can work with policy-makers to address contextual variables associated with hope. Stevens et al. (2014) found that approximately 50% of the hopefulness can be attributed to context (e.g., choices, opportunities, and obstacles). Community psychologists can use their expertise to help shape policy that allows for more choices and opportunities and fewer obstacles in the lives of uninsured and underinsured individuals. Although the present study examined empowerment on an individual level, addressing the political implications may foster empowerment on the organizational and community level.

The results of this study can be used by community psychologists to empower uninsured and underinsured individuals living with a chronic health condition to take charge of their lives. The two components of hope, pathways and agency, are modifiable factors that can promote empowerment. Given the worsening health of underserved populations in the United States, such factors may play an important role in providing immediate and future benefits to health-related quality of life. Community psychologists focusing on empowerment-based approaches may play a unique role in ameliorating the impact of health disparities and improving health-related quality of life among uninsured and underinsured individuals living with chronic health conditions.

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