



RESEARCH ARTICLES

Georgia Health Care Providers' Experiences With Community Public Health Clients

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Community health and human services workers play an integral role in communal public health. They are especially integral to meeting the needs of patients who are often on the margins of society. While we often conduct research from the perspective of the end-user – the patient or the client – we do not hear the voices of health and human services professionals with the same regularity. The purpose of this study is to examine the healthcare needs of public health patients from the perspective of community health providers in two Georgia counties. Through this case study, utilizing qualitative data garnered through three focus groups with the local public health department's employees and affiliated human services providers as part of their quintennial Community Health Needs Assessment (CHNA), we call attention to several individual and systemic issues providers have identified as worthy of concern. These include health seeking information and behaviors of their clients, as well as the role of health insurance and health access for improved physical, mental, and sexual health. Systemically, providers identify the challenges of status, stigma, and consumer perceptions in the access and quality of care certain segments of the population receive and how provider bias can impede wellbeing. Although the CHNA data collection took place prior to the COVID-19 pandemic, our examination of the data took place during the height of the pandemic. As such, in this paper, we also provide practical implications and future directions for public health and human services providers who have endured the pandemic and sought to meet their patients' needs during unprecedented circumstances.

Without the proper access to health care and health education, marginalized communities in the United States face significant health disparities due to a lack of knowledge about health-related issues such as mental health, sexual health, and appropriate nutrition as well as inadequate or non-existent health care insurance (Ferreti et al., 2020). Therefore, they often do not receive the care they need to maintain a healthy lifestyle while avoiding preventable diseases

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and suffering (Ruiz & Praetorius, 2016). Perpetual unhealthy living can lead to persistent negative health in a feedback loop, making it difficult to live a healthy lifestyle such that negative outcomes accumulate (Connell et al., 2019).

Health care providers are the warriors on the front lines addressing the issues that individuals face and because of their expertise, they can provide life-enhancing and life-saving care. Their role in the human services profession is paramount to ensuring the health and wellbeing of their fellow community members. By helping some of the most vulnerable populations in the country, health care workers have the opportunity to alleviate disparities, but these professionals are in dire need of resources and support.

The findings from this article were collected before the pandemic; the authors sought to understand the experiences of health care providers who served low-income and minority patients in community public health settings. To do so, we reviewed the empirical literature as well as gray literature to identify and understand the challenges low-income communities encounter when seeking health-related services. We found that much of the research is positioned from the perspective of the patient, while limited research is centered on the health care providers and the challenges *they* observe. Therefore, in partnership with the local community public health department, we engaged in a series of three focus groups with public health providers to identify what they saw in their patients. Our findings indicate that providers are concerned about both individual and institutional, or systemic, issues impacting their clients. These findings emerged from data collected prior to the COVID-19 pandemic; however, in our discussion, we situate these findings within the current and unfolding context of the pandemic knowing that these concerns have become more pronounced.

Moving forward, the next section provides research about the difficulties faced by low-income individuals and certain minority groups when navigating health-related services. The methods section follows. The results section details the outcomes from the focus groups and the main themes that emerged. This is followed by a discussion of the main themes and suggestions on how to appropriately address them, so that health care providers can be better informed in addressing their patients' needs. Rounding out the article are limitations, implications, and concluding remarks. This article is offered with great hope that health and human services providers will use the findings to better serve their low-income and minority patients by creating more equitable and inclusive practices, thus reducing risks, and creating healthier communities for all.

Analysis of the Literature

Health-seeking Information and Behaviors

Education and information can make the difference between whether people engage in healthy or risky behaviors. Research shows that certain minority and low-income groups often lack vital health information, pointing to the need for comprehensive health services to address the problem. Pastuszak et al. (2017) found that in a group of African American and Hispanic males,

80% were convinced their risk of contracting a sexually transmitted infection (STI) or human immunodeficiency virus (HIV) was low, yet they lacked the sexual and reproductive health knowledge regarding safer sex practices that would make this likely. Focusing on Latinos, Ruiz and Praetorius (2016) found that men were likely to seek information about diabetes from loved ones rather than health professionals. Latino men often did not have a culture of prevention (Luquis, 2019) and a study of African Americans found that gender norms made men less likely to seek health care because men perceived help-seeking behavior as feminine (Connell et al., 2019). Connell and colleagues noted that African Americans found the stigma surrounding mental health issues and reaching out for help to be a deterrent for seeking care (Connell et al., 2019). Evidence suggested that stigma also played a role in resistance to obtaining a COVID-19 test, especially among recent immigrants (B. L. Perry, 2021). Finally, Zimmerman (2018) found that low-income women sought reproductive health information both informally and formally. Specifically, Zimmerman found a “two-step information-seeking process...in which women most often seek personal or informal sources first and clinicians second” which was a new, yet important finding recently uncovered within the literature (p. 78).

Health Insurance Eligibility and Affordability

Healthcare providers can also be crucial sources of guidance on health insurance-related issues, which had implications for groups likely to be uninsured or underinsured, especially individuals who are low-income (Larson et al., 2020). Other factors predicted the likelihood of being under- or uninsured. For example, Hatch et al. (2016) found that among those eligible for Medicaid, being male and Hispanic-identifying and Spanish-dominant speaking, independently predicted the likelihood of not participating in a health insurance program. Hasstedt et al. (2018) found that 54% of immigrant women in the U.S. compared to only 25% of U.S.-born women, lacked health insurance. Reasons immigrant women did not seek coverage included their immigration documentation status, unfamiliarity with navigating the health system, and the expenses associated with obtaining health care (Hasstedt et al., 2018; Rodriguez et al., 2020).

With little-to-no coverage, out-of-pocket health expenses can add up. Specifically, “more than 40 percent of low-income Americans spent more than 5 percent of their incomes” to cover such expenses in 2010 (Kwon et al., 2018). Relief measures such as the Affordable Care Act were implemented to help low-income individuals and because of this, state and federal marketplaces opened allowing more individuals to be insured (Larson et al., 2020). However, a study involving community health centers found that individuals in states that did not implement Medicaid expansion had to rely on private/marketplace coverage compared to those in expansion states (Larson et al., 2020). They also paid more in health care visits and were more likely to show seasonal variation in their visits than their peers in expansion states (Larson et al., 2020). In other words, for those who are uninsured or underinsured, state of residence can

affect access to care (Rudowitz et al., 2023). As seen during the pandemic, the type of health insurance one has can also have significant impacts on health-seeking behaviors and medical visits, with those having private insurance more likely to make hospital visits (Schenker et al., 2022).

According to health care providers, minority groups experience many disparities. Ferreti et al. (2020) noted that young Latinas in Alabama struggled to find access to health care, including birth control. Hasstedt and colleagues (2018) found that foreign-born women were less likely to receive information regarding contraception than U.S.-born women. They also found that when immigrant women sought information and services, they were more likely than U.S.-born women to utilize the resources of publicly funded sexual health centers (Hasstedt et al., 2018). When such centers do not exist or are not well-equipped to serve immigrant, non-English speaking, and low-income populations, information and services may be hard to obtain.

Davids and colleagues (2020) found that the establishment of a public health center in Hampton, Virginia, by medical students from Eastern Virginia Medical School that was culturally and linguistically tailored for the uninsured Hispanic population notably improved access. Another example is the Live Better initiative, through multisector partnerships in Santa Cruz County, Arizona, to educate the Hispanic population on diabetes management in Spanish and English (Kunz et al., 2017). Luquis (2019) noted that the establishment of health care centers tailored to meet the needs of a target population helped initiate the process of preventive health care by those populations targeted. This includes not only targeting potential patients based on their ethnicity, race, language, and immigration status, but also among rural communities and the importance of having rurally based health centers and initiatives.

Kunz et al. (2017) emphasized the important role practitioners and policy makers play in elevating and addressing the unique needs of rural communities (Blaga et al., 2019). James et al. (2017) found that racial and ethnic minority populations in rural areas generally lacked access to health care and had significant health challenges. For example, immigrant children were extremely likely to be uninsured, despite the fact that they were eligible for public health insurance if their parents could not obtain private alternatives; and access to insurance was a significant barrier parents faced in providing for their children (Leon et al., 2020). Thus, interpretations of aggregated population data may obscure the heightened disparities within marginalized populations.

Mental Health Needs and Stigmatized Populations

With regards to mental health awareness and the utilization of mental health services, disparities have been reported due to high costs and low levels of access (Planey et al., 2019; Selby-Nelson et al., 2018). For both cost and cultural reasons, African Americans and Afro-Caribbeans vastly underutilize such services (Evans & Sheu, 2019). In a study of urban seventh graders in the south-central U.S., Giano et al. (2020) found that Latinx individuals often exhibited depressive symptoms because of their or their family's immigration

status. These examples reflect deep seated stigmas associated with seeking help, the inability to access and pay for help, and limitations in social networks to normalize mental health needs (Planey et al., 2019).

In a study of Latino immigrants in Baltimore, many of whom were fleeing from violence in their home countries in Central America, Bucay-Harari et al. (2020) found that in a program that served uninsured patients without regard for documentation status, mental health disorders were a growing cause of visits. A study of Latinos' access to online mental health support services found that usage rates amongst Latinos were lower than within the general U.S. population because of the cost of treatment, lack of English fluency, and limited internet access (Parra-Cardona & DeAndrea, 2016). However, Walton et al. (2022) found that ongoing communication between a child's pediatrician and a mental health provider were important determiners for better mental health for low-income patients, especially for child wellbeing.

While mental health concerns impact all members of society, studies have shown that mental health issues tend to affect members of sexual and gender minority communities at a greater level (Bränström et al., 2022; Jenkins et al., 2022; Kerr et al., 2022; Pease et al., 2022; N. S. Perry & Nelson, 2022; Pharr et al., 2019; Tabler et al., 2019; Tuthill et al., 2017). After examining the variation in health status and behavior for gay, lesbian, and bisexual men and women who identified as minorities, Tuthill et al. (2017) reported that lesbian and bisexual women of all racial and ethnic identities experienced greater health and behavioral disadvantages. Black lesbian and bisexual women reported more smoking and Black lesbian women also had higher odds of obesity when compared to Black heterosexual women (Tuthill et al., 2017).

When studying Asian American-Pacific Islander lesbian and bisexual women, their odds of smoking were four times higher than for their heterosexual counterparts (Tuthill et al., 2017). In addition to higher incidences of smoking, Pharr et al. (2019) reported higher levels of depression and heavy/binge drinking among the lesbian and bisexual women, in general, in comparison to their heterosexual counterparts. Similarly, Bränström et al. (2022) researched the prevalence of mental health problems amongst Sexual Minority Individuals (SMIs) across age groups and discovered that sexual minority status was strongly associated with depression across the life span, but most strongly related anxiety especially between 16 and 45 years of age. The authors also found that SMIs had greater odds of receiving treatment for depression in comparison to heterosexual individuals (Bränström et al., 2022).

While many studies explored the impact of depression and health related stigma upon SMIs (Pharr et al., 2019; Tabler et al., 2019), based on a univariate analysis, transgender individuals screened positive for depression more often and expressed feeling less accepted by their medical providers in comparison to their cisgender counterparts (Jenkins et al., 2022). Similarly, non-heterosexual individuals were likely to screen for depression in comparison to their

heterosexual counterparts (Jenkins et al., 2022). Yet, the experiences of gendered SMIs in rural communities were generally overlooked (Jenkins et al., 2022).

Regarding younger populations, Kerr et al. (2022) examined prevalence of mental health problems and suicidal thoughts and behaviors amongst college students and discovered that, compared to cisgender women, transgender women experienced more anxiety. Furthermore, transgender women reported more than double the odds of self-harm, suicidal ideation, and suicidal attempt in comparison to cisgender women (Kerr et al., 2022). Lastly, pansexual students seemed to have the highest rates of self-harm and suicide ideation indicating that SMI college students are at great risk for self-harm, which could be due to the sense of a lack of belonging and connection (Kerr et al., 2022). These findings reveal the disparities in access to health care, preventative health, and health risk behaviors among SMIs in the U.S. and how they intersect with mental health and wellbeing.

Health Provider Biases

While health care workers perceived themselves to be bias-free and in alignment with their patients' needs, another barrier to care among minority groups was the sense that health care providers may be biased (Connell et al., 2019). Indeed, this mismatch made it more difficult to change providers' biases. For example, Hobster and McLuskey (2020) found that transgender individuals often had negative encounters with health care providers because of discrimination based on their identity. This in turn had a negative impact on their likelihood of returning to receive medical care.

On a similar note, lesbian and bisexual women were less likely to undergo a pap smear test or a mammogram because they felt "vulnerable, discriminated against, and stigmatized" about revealing their sexual identity to their health care providers; this is especially true among bisexual women (Pharr et al., 2019, p. 727). However, bisexual women were more likely to have been tested for HIV when compared to both lesbian and heterosexual women (Pharr et al., 2019).

Regarding the impact of HIV/AIDS upon the mental health of lesbian, gay, and bisexual individuals, Tabler et al. (2019) examined the role of social support and perceived discrimination upon symptoms of depression within sexual minorities. The results demonstrated that perceived discrimination was associated with depressive symptoms amongst sexual minorities, at a statistically significant level (Tabler et al., 2019).

Each of these issues on their own is an area of concern, collectively, they are of paramount importance as community and public health providers and officials seek to improve community public health and wellbeing.

Methodology

Our efforts to understand community public health are broad and emanate from high-quality data pooled from diverse public and private sources through qualitative and quantitative inquiry within two north central Georgia counties.

In the present study, the authors explored the experiences of health care providers who served low-income and minority patients in community public health settings to better understand how these patients navigated the various health obstacles they faced. This work was part of a larger community-based participatory research project with a public health department located in the north central part of the state, which partnered with a local comprehensive university to conduct its quinquennial Community Health Needs Assessment (CHNA).

CHNAs refers to a “health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis” (CDC, 2018). These local, state, or other geographically defined areas identified as “a community” and their respective community leaders, stakeholders, and residents were sought for all phases of community health improvement. Through increased transparency, CHNAs increase the likelihood of community participation, and accountability, which improve community health interventions and innovations.

In this paper, we present the findings specific to three focus groups with health care providers in the two counties that the public health department serves as one entity. The two counties are adjoining with one being labeled a rural county and the other an urban county. County health and human services providers in both settings who work with and in conjunction with the public health department were assembled. They were invited to participate due to their direct employment in county-wide public agencies that provide public health services or as community partners that work with public health clients on a referral basis from the county.

The focus groups were held during their monthly recurring stakeholder meetings to discuss trends, troubleshoot issues, and provide shared training and support. During the focus group sessions, health providers were provided a catered lunch in appreciation of their service and steadfast efforts. As part of the luncheon, a short program was delivered by the CHNAs leadership and the partnering university who were conducting the study. For two hours, two university faculty facilitated the focus groups. Accompanying them were three trained human services and social work students who served as observers and note-takers throughout the session. In total, twenty-five health providing entities were represented in the recorded and transcribed focus groups.

Once the transcriptions were complete, the faculty and students crosschecked their notes with the transcripts to ensure accuracy. The focus groups aimed to identify issues; through the collaborative participation of diverse health care providers from both counties, the goal was not only to identify and analyze, but also to prioritize and address the currently existing, unmet needs. It was with this in mind that the team developed a color-coding structure to identify major and minor themes. To do so, the research team engaged in thematic analysis of the extracted color-coded transcripts. Each author received training and instruction on the way to conduct a thematic analysis. Collectively, we practiced on shared portions of the data to increase

familiarity and illustrate inter-rater reliability. Next, each author independently reviewed and coded the data. Even though an initial set of codes was provided, the authors were encouraged to identify additional themes based on the research they had completed. At this point, the team gathered for several sessions to compare the established codes and include new ones. In the final step, identification and clustering of major and minor themes took place.

The findings within these two north central Georgia counties, which are part of the Atlanta Metropolitan Statistical Area, are consistent with barriers experienced by public health and human services providers serving low-income residents and households in other parts of the U.S. Moreover, with the onset of COVID-19, the issues we identified became even more salient as the difficulties and disparities became more pronounced. Therefore, although our data was gathered prior to the COVID-19 pandemic, we sought to highlight the critical importance of community health plans and interventions, considering recent events and the implications that they had on health and human services providers.

Research Findings

The findings are divided between individual health issues and systemic issues encountered by patients, as stated by their health care providers. The findings are listed in the relevant sections based on the prevalence among providers' responses and concerns for their patients. Sexual and mental health were the prevailing concerns shared by providers. Although not as pervasive, nutrition was a third theme that resonated with public health providers and thus those findings are also shared in the health and wellness section. This is followed by health insurance and biases in patient care in the institutional and systemic issues section.

Individual Health and Wellness

Sexual Health: Understanding the Importance of Prevention

Health and human services providers felt it was difficult to discuss the prevention of STIs generally, and HIV specifically, with their low-income patients. One health care provider explained:

In my eyes, prevention is always hard to push. You know, it's hard to prevent people, because remember, you know, they don't want to be out financially [such as for the cost of condoms] or doing things and then you have to teach and so you know, they're not going to come for teaching. But they will come for testing.

The prevalence of these feelings led one public health center to reorient their sexual health education programming as part of their larger life skills courses. One participant noted:

We have life skills classes every week (for our housing clients) and one of the topics that we do cover is HIV testing, so we do have a professional come out and then she will do the first week as

an education and then the next week they actually do the free testing for them. They also have someone who comes out from [the counties'] public health [department], so we have different courses that we do teach them and educate them.

Some of the public health clinics within the network offered free HIV and STI testing, and participants felt that these services had been successful in attracting patients who needed testing. As one participant said, “Yeah, almost like, if you build it, they will come: If you have a free STI test or low cost, they will come.” However, these same testing services did not provide prevention treatment or instructional support, and they also did not give condoms to patients. Yet, health care providers consistently voiced that “free services such as condom distribution and testing seemed to be what patients wanted.” Clinics that do provide condoms typically only distribute them to adults. When these services were provided, providers indicated it was highly transactional and an efficient way to prevent unplanned pregnancies and STIs. Ironically, providers admitted that there had been an increasing number of adolescents with HIV and STIs, which was an indication that their transactional approach was not efficient or effective. Providers stated that although patients did not see a need for greater sex education and outreach, especially in terms of delaying sex and ways to engage in safer sex practices, it was becoming increasingly apparent that those who did not have health insurance or money for birth control would benefit from it.

Mental Health: An Under-resourced Public Health Ailment

Mental health issues were prevalent among many of the low-income individuals treated by the providers. These issues spanned all age groups and over time have become more difficult for U.S. public health clinic settings to meet or treat their patients. One participant said:

[M]ental health is one of our biggest challenges. I would even say it's even higher than physical health and dental care. Our emergency room is overcrowded with behavioral health patients without anywhere to access for their long-term care and stabilization.

For all the patients seeking help in the clinics, participants were conscious that many had avoided seeking help, or only sought help when in crisis. They attributed this to the negative stigma attached to those who suffer from mental health issues, lack of insurance with mental health coverage, and unfamiliarity with the health care system overall. In the absence of ready professional help, patients can be left with few options. A participant said, “[Patients] are primarily self-medicating if they're dealing with mental health issues.”

One of the counties from our study does provide mental health treatment for a minimal fee to a specific group of patients: substance abuse treatment for mothers with children up to age three. One participant who worked in this program noted the obvious problem, women with older children have no

access to it or those that do have it age out of the program. They said, “we have to catch the younger ones, [with] the hope that we can break that parental substance abuse issues that are going on [before their children no longer qualify for them].” The limitations of the program were clearly a problem.

Nutrition: Healthy Eating Challenges

Although not as prevalent, participants reported that patients had little knowledge of healthy food choices or cooking methods, which in turn had a negative effect on individual well being, contributing to diabetes, obesity, and other health-related issues. One participant said:

I’ve found a lot of these young parents, they don’t know how to cook, they don’t know what it is to go to the store and buy food, a pack of dry beans. They have no idea how to cook that. Vegetables, they have no idea how to cook vegetables.

[Others] acknowledged that information was not the only problem. One participant highlighted the problems of access:

[A] large percentage of people [I treat] do not have a car and do not live within two miles of a grocery store with fresh produce. And so, I’m assuming that most of their food comes from convenience stores, fast food, etc., etc., not Publix [grocery store].

In light of these individual experiences as related by health and human services providers within community public health settings, we realize that there are social forces at work.

Institutional and Systemic Issues

Aside from health and wellness issues, participants discussed certain systemic issues their patients faced. Insurance and biases encountered were the main themes found in this section.

Health Insurance: Going Without and Still Not Getting By

Many health care providers noted the impact of lack of insurance among their patients, referencing self-medication, emergency room visits, and deferred care for illness and injuries. Specifically, a participant said:

I work with children and their families and most of them that we see either self-medicate or they’ll go to the emergency room for any type of illness, or they just won’t do anything at all. The only people in the family that may go to a doctor are the children. As far as the adults, very few of them have insurance.

Providers overwhelmingly indicated that children were more likely to receive health care services. This was because of the Georgia Department of Community Health’s PeachCare for Kids, the state’s children health insurance

program, increases access to affordable health insurance. But for low-income and homeless adults in parts of north central Georgia, this is not an option. A participant noted that most of their adult clients:

...will access the emergency room, because they don't qualify for Medicaid, but their children do have Medicaid. So, if they're low-income and they have just a little bit of income, the Medicaid cuts off for them, so they're referred to the emergency room.

Consequently, even those with insurance are often underinsured, with high deductibles, which only adds to the perpetual struggle that many patients of the health care providers in this study faced. And these patients are generally low-income which makes it difficult for them to afford such high deductibles.

Consumer Perceptions: Poor Customer Service and Communications

When individuals did seek care at public health clinics, they faced frustrations due to poorly managed customer service operations. Community and public health providers, which were the participants in these focus groups, were well aware of this, and they said that the use of voice recordings instead of people answering phones has led to misunderstandings and confusion. One participant noted:

Encountering an actual person, I mean, that's part of making [health care] user-friendly is that [patients] don't spend an hour pushing the wrong button and going to and not knowing like, what, I don't know why I'm calling. You know, and trying to navigate that but to like actually get to speak to a person.

Some human services participants acknowledged that their clinics had outdated websites with incorrect phone numbers and intake hours. They said this can be profoundly discouraging to potential patients, who felt that such problems indicated the providers employed by a clinic did not care about them. One participant stated:

You go to the website and that's not their phone number anymore, that's not their intake hours anymore, and then you're calling somebody to try and figure out what they are, but you can't, and it's frustrating for me [meaning for patients], and [as a consequence people decide] I don't need the services, you know. So, too, they're going to give up and they do give up because [they feel], what's the point? Because [sometimes they've] been on the phone for an hour and a half and [they] still haven't talked to anybody.

Not only is it important that clients have the opportunity to speak to a human being during intake, but it is important that this person be able to meet patients' linguistic and cultural needs. Focus group participants noted how important this was to them. Even those clinics that had bilingual staff did not

have enough personnel to cover the need. One participant said that their clinic was “fortunate enough” to have two bilingual clerical staff, and that “they will go out with the nurses to visit our Spanish clients and address them at their needs,” but that two staff members was insufficient. This participant’s clinic sometimes called these staff members at home to have them translate “on the fly”, which was both an inconvenient process and unsettling for the patient and the health care provider, and an infringement on the bilingual staff members’ personal time.

Even clinics that have a number of Spanish speakers on staff may struggle. A participant explained:

We have to hire a pool of people who can speak Spanish and I have my schedulers make sure there’s someone always there, [but,] like, yesterday we did not have one. And we got 12 calls yesterday of people asking is there someone there who speaks Spanish, and we didn’t have anyone. So, we had to call her at home and have her interpret. So yeah, that’s a need and some providers don’t have [translation services], you know, and so you in fact shut out that community.

This has become an area of increasing concern, since Spanish and Korean are the two most common languages spoken in the home beyond English within Georgia, and with increasing levels of migration and diversity in the state, the public health community is not able to adequately respond, which could become a public health crisis unto itself.

Stigmatized Identities: Those on the Margins Feel Further Marginalized

In the case of low-income and undocumented immigrants, participants felt that structural issues made it difficult for them to provide care. Health care providers in the two counties from this study stated that funders did not perceive that poor people lived in the urban county, and therefore clinics did not need to take measures to provide for these individuals based on their unique health care needs. A participant explained:

And really just, there’s this perception that [our] county doesn’t have poor people...I come across that all the time. You know, we have homeless college students. I have a student [as a patient] who’s sleeping in his car right now. I have [another patient] who’s sleeping in an extended stay [hotel]. And those are just the ones that I know about, and people hear that, and they’re baffled by [it]. [They wonder,] how you can be in college and be homeless? ... There’s just an attitude like, that doesn’t affect us, and so to me, that’s also just changing attitude and making people more aware and realizing that like, this is real life.

Participants also noted that some individuals are afraid to seek care because of fear of being reported to the authorities based on their immigration status. They typically do not trust the health care providers at the government-sponsored public health clinics and therefore, turn to self-medication. As a participant noted:

We also find that the children may be born here in the United States and are considered U.S.-citizens, but their parents are not. Some of them are very hesitant to open up to us because of that. One thing that we have to be sure that they understand when we go to see them is that we are not [immigration enforcement officers], we are not [Georgia Division of Family & Children Service]. We are here to address your needs, whatever that need may be, and we will provide you with as many resources as we can in the community.

By contrast, focus group participants seemed not to be aware of the need to provide care tailored to LGBTQ+ persons. They responded to questions about this equally diverse and underserved population, by speaking specifically about transgendered people. This could suggest that providers may not be conscious of the distinct health needs affecting other LGBTQ+ people.

Discussion and Recommendations

Based on the public health and human services providers' statements, as well as previous studies, we can conclude that lack of education contributes to the health disparities of marginalized groups, who make up the bulk of the patients serviced by community public health professionals in this study. Participants noted that their patients were typically uninformed about healthy lifestyle choices and lacked access to care and resources to address such choices. Oftentimes, patients seek informal means of gathering information about health care choices (Zimmerman, 2018). However, interventions and informational sessions by health care providers can benefit patients (Lachance et al., 2018) and have been found to be effective at changing habits (Hoffman et al., 2017). Ultimately, it is up to the patients to change their own behaviors, but if they do not take the proper precautions to live healthier lives because they lack the knowledge, they put themselves at greater risk of illness (Connell et al., 2019). This can incur costs that imperil financial solvency and cause disability that makes it difficult to work and achieve upward mobility (Connell et al., 2019).

County health and human services providers recognized that low-income individuals typically did not have easy access to healthy foods or groceries that offered a balanced, nutritious diet. Such food insecurity can be detrimental for this group (Blancato & Whitmire, 2021). Cooking and dietary education initiatives are often lacking for low-income individuals, and this can compound the risk of poor eating habits, which can cause serious health issues (Mangadu et al., 2017). If health care providers can train patients on how to properly prepare food and which foods contribute to a healthier lifestyle, they may

be able to make a difference in health outcomes of their patients. However, nutrition education is enhanced with extended engagement. One approach to reducing food insecurity and community wellbeing is through the implementation of two-generation initiatives that pair up youth and the elderly in community garden initiatives. Mangadu et al. (2017) found that community gardens had a discernable impact on mitigating these factors; Knapp et al. (2019) came to a similar conclusion, whereby school-based garden programs had positive impacts on a community wellbeing. Children who participated in these school-based programs not only learned about nutrition and food preparation, but they were also able to share that knowledge to their family members at home, thus creating the potential to change eating habits at the individual, familial, and eventually community levels (Knapp et al., 2019).

Sexual education is needed to help stop unwanted pregnancies and the spread of STIs (Ferreti et al., 2020). Among the participants' patients in this study, willingness to engage in STI/HIV testing was common, but they were not interested in using condoms. Lack of sexual education can be common among certain groups (Pastuszak et al., 2017), and individuals may be resistant to such information, but health care providers should seek opportunities to educate their patients on choosing safer sex practices. This could be done through community outreach programs, social media campaigns, and even knowledge sessions when the individual comes in for testing. Formal informational avenues such as these may be beneficial since low-income patients oftentimes seek informal paths for gathering medical advice (Zimmerman, 2018).

Mental health awareness and education are needed but they are insufficient within certain parts of north central Georgia. Findings aligned with other research and indicated that, those in need can be dissuaded, due to the cost as well as stigma, associated with seeking help (Planey et al., 2019). In some communities, such as the ones within this study, mental health professionals are scarce, resulting in a lack of care for vulnerable individuals (Selby-Nelson et al., 2018). In immigrant communities, mental health issues can arise due to immigration status (Giano et al., 2020; Rodriguez et al., 2020). Therefore, mental health concerns for groups outlined in this study are real and the providers recognized the need for long-term care for such health-related issues, but they had no resources to provide it or places to refer the patients in need. As such, if professional help from psychologists, psychiatrists, and social workers could be available onsite to address mental health issues this could be beneficial, specifically for north central Georgia. Ultimately, it is important to maintain ongoing communication between doctors and mental health providers to ensure the patient receives the appropriate mental health care (Walton et al., 2022).

Health care needs became a secondary concern to priorities such as rent, food, and clothing for the patients of the participants in this study. Also, out-of-pocket health expenses for low-income individuals can add up (Kwon et al., 2018). The lack of health insurance or unfamiliarity with the health care

system may be some of the reasons that patients from this study were primarily interested in being tested for health conditions and treating them, rather than obtaining education on preventative measures. If health care providers can provide proactive guidance and if they can find ways to engage their patients in preventative measures, they may be able to significantly lessen their suffering. However, they must be able to gain the trust of patients who may be skeptical of authority figures (B. L. Perry, 2021). For undocumented immigrants, this difficulty is particularly acute because of the ever-present fear of deportation (B. L. Perry, 2021; Rodriguez et al., 2020).

Improved customer service is important, especially regarding the virtual health guidance that emerged during the pandemic (post-data collection for this study), but access to such care may be limited if individuals do not have the resources for accessing such care (Valenzuela et al., 2020). Tied to this, there is a dire need to meet patients' linguistic and cultural needs, according to this study. There is a severe need for Spanish-speaking health care providers, and virtual care often does not include such interpreters, which can affect health care access for people whose preferred language is not English (Valenzuela et al., 2020).

Many respondents noted the lack of resources and understanding for minorities, especially those who did not speak English or who identified as LGBTQ+. This, in turn, made those patients less likely to seek help for their health-related issues. Evidence shows that negative encounters do happen because of practitioner biases regarding patient identity (Hobster & McLuskey, 2020). Perhaps health care providers could undergo multicultural and diversity sensitivity training to help ensure they are informed of the issues minority groups contend with on a daily basis. This knowledge could allow them to serve as allies for their patients by offering more inclusive health care.

Research Limitations

The focus groups utilized in this study only included the input from community public health and human services care providers from two counties in north central Georgia. Because of this limitation, findings should be generalized with caution. The responses provided in the focus groups typically related to immigrant and low-income individual patients, as these segments of the population are well represented in the north central region of the state. Consequently, not all patient groups were represented, and for those represented in this study, they may not be reflective of immigrant and low-income populations writ large. Finally, the data collection for this research was conducted prior to the onset of COVID-19. However, the analysis of the findings was done during the pandemic in preparation for the quinquennial community health needs assessment. Therefore, the original findings provide a snapshot in time, whereby the pandemic magnified the challenges already being experienced by public health clients as observed by their health care providers in community public health settings.

COVID-19: A Much-Needed Spotlight on Public Health Provision

The health issues low-income and marginalized groups encounter existed before COVID-19, but the effects on these individuals and groups were further exacerbated due to the pandemic (Sycamore, 2021). For reasons such as immigration status and U.S. residency in multi-generational households, employment in essential work, certain underlying health conditions, and lack of access to care, inequities existed. Specifically, there was evidence of “clear inequalities in exposure to infection, and the ability to socially distance, and in who will bear the brunt of the longer-term negative impacts” for low-income individuals and certain minority groups (Allen & Allwood, n.d.; Dorney-Smith, 2021, p. 61; Hill et al., 2021).

Even with supposed ease of access to health care providers through telehealth measures, certain groups were excluded. Specifically, utilization of this type of care can be limited due to insufficient patient technology access and the fact that “Non-English-speaking families...[found] difficulty accessing instructions to virtual care and limited interpreter services on virtual care platforms” (Valenzuela et al., 2020, p. 840). Also, some groups associated stigma with COVID-19, which gave them the fear of others knowing they might be infected. Perry found that “recent immigrants (30%) were nearly four times as likely as nonimmigrants (9%) to report that a person should be afraid to tell other people if they test positive for COVID-19” due to its possible social and legal consequences (2021, p. 780).

Among recent immigrants, the general view was that a positive test could label one as an outsider in the community (B. L. Perry, 2021). Tied to this, they may view getting tested and reporting one’s results as meaning an interaction with authorities, which could have a negative outcome such as deportation for undocumented immigrants (B. L. Perry, 2021). Finally, people in more vulnerable groups typically made fewer medical visits during the pandemic. According to Schenker et al. (2022, p. 30), in a study of health care providers,

patients who completed any visit during the pandemic were younger, more likely to be White/Caucasian or Asian and less likely to be Black/African American or Latinx, more likely to be English speaking, less likely to request an interpreter, and more likely to have private insurance.

As this research was gathered from a public health department, whereby a large urban county was partnered with an adjacent rural county to provide public health services, we would be remised if we did not state how the issues prior to and during the pandemic were likely worse in rural-only county public health department settings. Kunz et al. (2017) highlighted the need for practitioners and policymakers to consider rural populations when examining health disparities, which can often be magnified in these communities (Blaga et al., 2019). James et al. (2017) found that racial and ethnic minority populations

in rural areas generally lacked access to health care and had significant health challenges. Thus, interpretations of aggregated population data may obscure the disparities among and between various marginalized populations.

As the COVID-19 pandemic aggravated existing health care disparities amongst minorities, Perry and Nelson (2022) aimed to better understand the use of mental health care amongst adolescent (cisgender) SMIs. The authors learned that while approximately 40% of the youth reported having received treatment for mental health concerns throughout their lifetime, only 20% of the youth reported receiving treatment for mental health during the COVID-19 pandemic. Perry and Nelson's (2022) findings highlight the gap in mental health care amongst SMI resulting from the systemic barriers to adequate health care services available during the COVID-19 pandemic.

As seen during the pandemic, access to and the type of insurance coverage had an impact on medical visits. For example, those with private insurance were more likely to make hospital visits during this time (Schenker et al., 2022). Such lack of insurance or quality of insurance, along with lack of health literacy or basic English fluency, fear of authorities, fear of stigma from having COVID-19, all contributed to the health disparities felt by marginalized groups during the pandemic. These inequalities during the pandemic, coupled with the pre-existing disparities encountered by these vulnerable and indigent populations pre-pandemic, highlight the need for public health service providers to reevaluate if, when, and how they design and deliver their services and programs.

Future Directions for Public Health and Human Services Professionals

Since this study focused on community public health and human services professionals, within a specific location of Georgia, future research is necessary pertaining to the health care needs of other marginalized communities and the ways that health care providers address such needs. Despite the stated and additional limitations of the study, we believe the findings will encourage those in the health and human services professions to reconsider how their services are designed and delivered to produce better alignment between provider-patient outcomes. The pandemic has only intensified these disparities. Thus future research is necessary on COVID-19's impact on public health provision for low-income clients and how changes made during a period of great disruption may present growth opportunities for systemic change. Lastly, it is vital that health care providers receive the necessary resources to adequately address the abovementioned concerns and provide all health care patients with a sense of respect and human dignity.

Conclusion

The health providers in this study highlighted health-related issues faced by certain marginalized groups. Lack of sexual and mental health access and awareness, lack of a nutritious diet, lack of insurance or being underinsured, negative consumer experiences, and biases encountered were the main themes that emerged from the data. During the COVID-19 pandemic, health care

workers were on the frontlines, aiding and assisting vulnerable groups more than ever before. Through their expertise, guidance, and compassion, health and human services providers can make the difference between life and death. We all bear the responsibility to care for one another, and it is important to remember that, regardless of one's background, identity, or socioeconomic status, individuals generally want healthy communities and encounter shared health risks (Parment et al., 2017). The authors hope that by shedding some light on what providers experience and how they perceive the health challenges, both before and during the pandemic, we can collectively work toward creating healthier communities.



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