



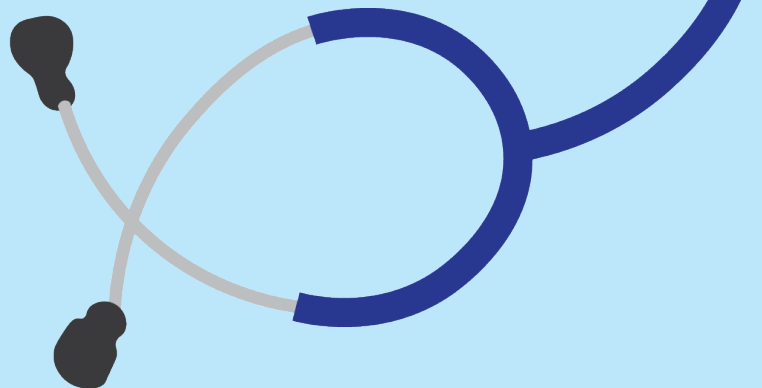
VPHA

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Connecting
The Voices
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Greetings! Welcome to the 2023 spring issue of the Virginia Journal of Public Health. Our journal does not have a predetermined topic agenda but publishes all relevant public health topics, which could assist clinical practitioners, epidemiologists, and other health professionals, to understand and be better equipped to address Virginia's public health challenges.

The first article uses scientific method to investigate flu and COVID-19 vaccine uptake in Southeastern Virginia between December 2020 and March 2021. Findings suggest uninsured patients receiving care at a primary care facility were less likely to be willing to receive flu/COVID-19 vaccinations compared to insured patients attending the same primary care facility. Campaigns to improve vaccination rates may require additional efforts beyond making the vaccines freely accessible to all. Increasing trust in vaccination may be a critical component of future vaccine campaigns.

The second article is a policy perspective about tobacco surcharges and sugar-sweetened beverages taxes. This perspective suggests vulnerable populations are negatively impacted by these taxes. The tobacco surcharge has been found to drive smokers out of the insurance market, making it difficult for them to receive the health care and support they need to quit smoking. Individuals in poverty tend to drink more sugar-sweetened beverages. The surcharges for such beverages exacerbate poverty and potentially health problems. The author implores policy makers to support truly value-added public health interventions.

The third article is a rapid review of the literature and presents collective evidence-based self-care behaviors, practices, and programs for rural Black women to address cardiovascular disease disparities. This paper sheds light to address CVD, the leading cause of death among Black rural women.

Opioid misuse, abuse, and addiction are public health concerns in Virginia. The 4th article presents a quality improvement approach for opioid risk mitigation. This project builds on previous studies using the opioid risk tool ORT-ODU in pain management clinics. This QI project suggests ORT-ODU screening alerts providers of the additional care needed by patients. Authors recommend the implementation of ORT-ODU screening in pain management clinics.

The last article, "Structural barriers to health care access and IPV disclosure in first-generation Latina immigrants" discusses healthcare systems barriers that prevent intimate partner violence disclosure by Latin women. Authors suggest future directions to protect this vulnerable population, which often lacks insurance and faces language barriers.

Stay tuned for our next issue! We invite clinicians, researchers, and other health professionals to help us keep Virginia healthy by sharing their findings!

Happy writing,

Maria, Jen, and Marilyn

Editor: Maria Gilson deValpine, PhD, MSN, RN

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Associate Editor: Marilyn Bartholmae, PhD

Notes from the Field

VJPH welcomes Associate Editor, Dr. Marilyn Bartholmae

Dr. Bartholmae is a United States Navy veteran. She served as a Hospital Corpsman for five years and earned the Good Conduct Medal, 2003, National Defense Service Medal, 2001, and the Global War on Terror Service Medal, 2001.

Dr. Bartholmae received a PhD in Health Services Research from Old Dominion University, a graduate-level certification in Molecular Diagnostics from Old Dominion University, an M.S. in Biotechnology Management from University of Maryland Global Campus, and a B.S. in Biology from University of North Florida. Her research experience is multidisciplinary and encompasses health and scientific fields across various settings including academic, public health department, and hospital settings.

Currently, she is the Co-PI on a funded research project seeking to evaluate the effectiveness of SilverCloud digital mental health therapy in reducing anxiety and/or depression in citizens of Virginia. In addition, she is part of multiple research/quality projects aiming to reduce health disparities.

Save the Date!

**SAVE
THE
DATE**

Virginia Public Health Association's
2023 ANNUAL CONFERENCE
SEPTEMBER 21-22

Reynolds Community College,
Parham Road Campus



**Policy Forum: The Tobacco Surcharge & Sugar-Sweetened Beverage Taxes:
Reconciling Equity and Targeted Public Health Interventions**

Ben Barber
Virginia Public Health Association

Policy Forum: The Tobacco Surcharge & Sugar-Sweetened Beverage Taxes: Reconciling Equity and Targeted Public Health Interventions

By: Ben Barber

Virginia is poised to repeal the tobacco surcharge, an ineffective policy that disproportionately harms low and middle-income Virginians (Small, 2023).

The Patient Protection and Affordable Care Act (ACA), which otherwise strengthened health care access and equity, allows health insurers in the individual and small-group markets to charge smokers up to 50% higher premiums relative to nonsmokers (ACA, 2010). The law's financial assistance does not apply to this surcharge, forcing enrollees to bear the entire cost of the penalty. This provision was a compromise between the ACA's drafters, most of whom opposed the surcharge, and the health insurance industry, which argued that insurers would need to raise premiums on all enrollees if they could not charge smokers higher premiums.

Thirteen years on, it is clear the tobacco surcharge was a mistake. Instead of incentivizing smokers to quit, the surcharge priced many of them out of the insurance market (Dorilas et al., 2022). This had the absurd effect of preventing smokers from accessing the very services that could help them quit. The surcharge also doesn't appear to have much of an effect on health insurance premiums. In fact, Virginia's Joint Commission on Health Care estimates that repealing the surcharge would *reduce* individual insurance market premiums by three percent (JCHC, 2022).

There is a broader lesson, though. The true failure of the tobacco surcharge is that it unnecessarily punished low and middle-income individuals. Smokers tend to have lower incomes than non-smokers.

Consequently, individuals and families who needed the most help were harmed instead.

Repealing the tobacco surcharge is an easy call because the policy doesn't work. However, effective public health policies that disproportionately target lower-income individuals also deserve scrutiny. For example, sugar-sweetened beverage (SSBs) taxes have been shown to reduce sugar consumption, a major driver of the obesity epidemic (Vargas-Garcia, et al., 2017). However, they are regressive, meaning lower-income consumers pay a larger share of their income to the tax than higher earners. Moreover, lower-income individuals tend to drink higher amounts of SSBs, meaning they pay the tax more often (Jiang, et al., 2020).

SSB tax proponents argue that the repressiveness of the tax should be overlooked because the money raised can be directed to programs that benefit poor or minority communities (Krieger, et al., 2021). I am skeptical. The point of the tax is to disincentivize a certain behavior. If it is effective, the funds to support these programs will diminish over time, leaving programs and the communities they serve in limbo. How can a community program succeed if its funding source is designed to disappear?

Second, the poor should not have to pay their way out of poverty. Policymakers should fund community programs and other interventions to address poverty, obesity, tobacco use, and other public health challenges because it is the right thing to do, not because the poor have paid for it via a tax scheme.

Finally, if SSBs are as bad for people as the research suggests they are, then policymakers should ban or at least severely restrict the ability of producers to sell them and consumers to buy them. Americans can't legally buy tobacco products until 18. They can't legally buy alcohol until 21. Of course, an army of lobbyists would mobilize against these measures, but that isn't a good enough reason to pin the burden on the poor, who are too often shut out of policy debates altogether.

The bottom line is that public health professionals should painstakingly scrutinize any public health proposal that disproportionately affects the poor, regardless of their effectiveness. At best, they indirectly encourage small changes in behavior that may have long-term benefits. At worst, they needlessly punish the very people who need the most support. It is our job as public health professionals to advocate for more creative – *and more just* – public health solutions.

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Vaccine Uptake in the Era of COVID-19: Associations Between Willingness to Receive the Influenza and COVID-19 Vaccines

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Vaccine Uptake in the Era of COVID-19: Associations Between Willingness to Receive the Influenza and COVID-19 Vaccines

By: Mutaz Alkalbani, Ritsa Frousios, Matilda Francis, Yousef Beidas,

Jennifer Ryal, Brynn Sheehan

Background

Acute respiratory infections, including seasonal flu, are the eighth leading cause of death in the United States (Healthy People, 2020). The influenza virus, the causative agent of the seasonal flu, is spread through coughing, sneezing, or contact with contaminated surfaces and then touching eyes, nose, or mouth (Keilman, 2019). Each year, the flu causes significant mortality and morbidity, especially amongst vulnerable populations, including older adults, the immunocompromised, and pregnant women (Keilman, 2019). In 2019–2020, the CDC estimated that the number of hospitalizations related to seasonal flu was between 410,000 and 740,000 leading to an estimated 24,000–62,000 deaths (Centers for Disease Control and Prevention, 2019). In addition to the significant mortality and morbidity, there is a tremendous societal cost imposed by the disease, exceeding billions of dollars (Putri et al., 2018).

In an effort to reduce the burden of the seasonal flu on the community and health systems, health authorities developed and implemented vaccination uptake policies. Vaccines against the influenza virus have proven to be cost-effective, particularly among high-risk individuals such as the elderly (D'Angiolella et al., 2018). Despite clear benefits, the uptake of the flu vaccine remains a challenge each year. In 2019–2020, the CDC estimated that the flu vaccine coverage among U.S. adults was 48.4%, an increase of 3.1% compared to the previous

flu season, however still well below the Healthy People 2020 national target of 70% (Centers for Disease Control and Prevention, 2020a; Healthy People, 2020). Specifically in Virginia, flu vaccination rates for adults aged 18 years and older have shown minor improvement from the 50.6% rate in the 2018–2019 season to the 55.7% rate in the 2019–2020 season. However, the rate reduced again slightly in 2020–2021 to 53% (Centers for Disease Control and Prevention, 2021).

Flu vaccination rates have been found to differ by racial and ethnic groups. Black adults have lower vaccine coverage compared to White adults (45.6% compared to 60.9% in the 2020–2021 season) (CDC, 2020a). Interestingly, both Black and White individuals saw a slight increase in flu uptake from the 2018–2019 season to the 2019–2020 season. However, both groups also saw a slight drop from 2019–2020 to 2020–2021. Notably, vaccination rates for Black individuals dropped below that of the 2018–2019 season, highlighting that gains made from the prior season should not be expected in the next without intentional effort to promote uptake. These rates also highlight that an individual choosing to become vaccinated one year is not guaranteed to seek or receive a vaccination in the following year, once again emphasizing the importance of promoting boosters and the need for annual vaccinations. The literature highlights a lack of trust in the healthcare system and greater vaccine hesitancy amongst Black adults as some of the reported reasons for the low

vaccination rates (Quinn, Jamison, Freimuth, An, Hancock, & Musa, 2017).

Similar to the seasonal flu, COVID-19 is a respiratory disease caused by the SARS-CoV-2 virus. COVID-19 was first reported in December 2019 and later declared a pandemic by the World Health Organization in March of 2020. The COVID-19 virus is spread in a similar way as the influenza virus and the disease typically manifests initially with fever, dry cough, muscle pain, and tiredness (Kumar et al., 2020). Most patients express mild symptoms. However, high risk groups such as elderly patients or those with pre-existing conditions can present with severe symptoms and significantly higher mortality (Kumar et al., 2020).

A little more than two years after the declaration of the pandemic, COVID-19 is considered the third leading cause of death in the United States behind cardiovascular diseases and cancer (Ahmad et al., 2021). The FDA approved the first vaccine against COVID-19 under emergency use authorization in December 2021. Early studies showed positive appeal towards receiving the COVID-19 vaccine, with racial discrepancies similar to those seen with the flu vaccine (Kelly et al., 2021). However, data published by the Virginia Department of Health shows a dramatic *decrease* in COVID-19 vaccine uptake in the first half of 2022 in comparison to the same period in 2021. Specifically, on April 1st, 2021, the 7-day average of COVID-19 vaccine doses administered per day was 85,487 compared to the 3,874 doses per day administered on April 1st, 2022 (Virginia Department of Health, 2022).

Nationally, Black adults report reduced willingness to receive the COVID-19 vaccine as compared to White adults (Kelly et al., 2021). Other characteristics

associated with reduced likelihood of vaccine uptake are gender (female), being uninsured, being younger, and not having received the flu vaccine in the previous year (Kelly et al., 2021). Despite the availability of vaccines at reduced cost, or no charge in some instances, the willingness to receive the recommended vaccines remains an issue among people with low income or uninsured individuals (Lu et al., 2015). In the current study, we investigated adult willingness to receive the seasonal flu and COVID-19 vaccines in the ambulatory care clinic setting during the COVID-19 pandemic. We also explored differences in willingness to receive these vaccines across racial groups and insurance status.

Methods

Participants and Procedure

Survey data was collected between December 2020 and March 2021. Adult patients aged 18 years or older, who attended one of two outpatient clinics in Southeastern Virginia during the study period, were eligible to participate. Participants were provided details about the study and were asked to complete an anonymous survey. Interested participants were provided the option of completing the survey electronically through a REDCap link or via paper and pencil. The surveys completed on paper were later entered into the same online database as the electronic survey. The study was reviewed and approved by the local institutional review board at Eastern Virginia Medical School in Norfolk, VA.

Materials

The survey used in the current study was developed after the Quinn et al. (2019) survey assessing vaccination uptake and vaccine hesitancy. The survey was reviewed and revised by a team of physicians and a health services researcher. The final survey

consisted of 24 questions. Participants first completed information about their demographics before completing two sections assessing perceptions of COVID-19 and its potential impact on health, and their history of receiving the flu vaccine. Participants responded to yes/no questions regarding whether they received the flu vaccine in the current and previous seasons and indicated their likelihood of receiving the flu and COVID-19 vaccines, which were measured on a 5-point Likert type scale from 1-*Highly Unlikely* to 5-*Highly Likely*. Notably, at the time of data collection, the COVID-19 vaccine was still under development and not yet authorized for use.

Statistical Analysis Plan

Data was first evaluated using descriptive statistics, with categorical data represented as frequencies and percentages, and continuous data presented as means, minimum, and maximum values, standard deviation, and normality distributions (skewness and kurtosis). To examine the impact of COVID-19 on the likelihood of receiving the flu vaccine, flu vaccination uptake was compared between the 2019-2020 season and the 2020-2021 season. Further, vaccination rates were compared to the reported national rates from previous years. Correlation analyses were then conducted to

examine the association between having received the flu vaccine and the likelihood of receiving the COVID-19 vaccine. Pearson correlations were conducted for continuous variables and Spearman Rho correlations were conducted for dichotomous variables. Finally, group differences were compared between racial groups and health insurance status with having received the flu vaccine (using chi-square analyses) and with the likelihood of receiving both the flu and COVID-19 vaccines (using independent samples t-tests).

Results

A total of 76 participants completed the survey. Participants were primarily Black (54.7%) or White (34.7%). Participants ranged in age from 25 to 86 years ($M = 55.42$, $SD = 17.19$). The average number of times participants received the flu vaccine in the previous five years was 3.57 ($SD = 1.92$). Two participants were previously diagnosed with COVID-19 infection, both of whom said that their disease course was mild, with symptoms lasting more than 14 days but not requiring hospitalization. The majority of participants (49.3%) reported that they were ‘*unsure*’ of the likelihood of them contracting COVID-19. Please see Table 1 for participant demographics and responses to questionnaire items.

Table 1

Participant Demographics and Survey Responses

Categorical Variables	<i>n</i> (%)
Gender	
Female	39 (52.7%)
Male	35 (47.3%)
Missing	2

Race/Ethnicity	
Asian	1 (1.3%)
Black/AA	41 (54.7%)
Hispanic/Latino	1 (1.3%)
Other	2 (2.7%)
Two or More	4 (5.3%)
White	26 (34.7%)
Missing	1
Clinic	
Primary care/insured	51 (69.9%)
Ambulatory care clinic/uninsured	19 (26.0%)
Not Applicable	3 (4.1%)
Missing	3
Insurance	
Medicaid	13 (17.8%)
Medicare	18 (24.7%)
Other	7 (9.6%)
Private/Commercial	17 (23.3%)
Uninsured/Self-Pay	18 (24.7%)
Missing	3
Previously diagnosed with Covid-19	
No	73 (97.3%)
Yes	2 (2.7%)
Missing	1
Likelihood of becoming infected with COVID-19	
N/A	2 (3.0%)
Highly unlikely	7 (10.4%)
Unlikely	13 (19.4%)

Unsure	33 (49.3%)
Likely	7 (10.4%)
Highly likely	5 (7.5%)
Missing	9
Likelihood to receive Covid-19 Vaccine	
Highly unlikely	9 (12.3%)
Unlikely	1 (1.4%)
Unsure	13 (17.8%)
Likely	6 (8.2%)
Highly likely	44 (60.3%)
Missing	3
Main Reason not to receive COVID-19 Vaccine	
Unsure if COVID-19 vaccine is safe	13 (56.5%)
Do not think that COVID-19 will cause significant risk on my health	4 (17.4%)
Other	6 (26.1%)
Received Flu Vaccine in 2019-2020	
No	20 (27.0%)
Yes	54 (73.0%)
Missing	2
Number of times received Flu Vaccine in the past 5 years	
0	12 (17.4%)
1	3 (4.3%)
2	5 (7.2%)
3	1 (1.4%)
4	10 (14.5%)
5	38 (55.1%)
Missing	7

Location of receiving Flu Vaccine	
Clinic/Doctor's Office	25 (47.2%)
Hospital	3 (5.7%)
Other	5 (9.4%)
Store Pharmacy	20 (37.7%)
Missing	23
Received Flu Vaccine in 2020-2021	
No	24 (33.3%)
Yes	48 (66.7%)
Missing	4
Likelihood to receive Flu Vaccine in 2020 - 2021 (If not yet received)	
N/A	2 (8.7%)
Highly unlikely	8 (34.8%)
Unlikely	2 (8.7%)
Unsure	4 (17.4%)
Likely	2 (8.7%)
Highly likely	5 (21.7%)
Missing	53
Main reason for not receiving Flu vaccine	
Unsure if flu vaccine is safe	3 (21.4%)
Unsure if flu vaccine works	3 (21.4%)
Do not think that the flu will cause significant risk on my health	5 (35.7%)
Other	3 (21.4%)
Belief that Flu Vaccine Protects from Covid-19	
No	58 (90.6%)
Yes	6 (9.4%)
Missing	12

Likelihood of Vaccination

The majority of participants (66.7%) had already received the 2020-2021 flu vaccine at the time of data collection. An additional 9% reported that they were likely or highly likely to receive the flu vaccine this season, which is similar to the reported flu vaccination rate of the previous season (73% in 2019–2020). Of those who reported not intending to receive the flu vaccine, the main reasons were the belief that ‘*The flu will not cause significant risk on health*’ and ‘*Concerns about the safety and efficacy of the vaccine.*’

The majority of participants (60.3%) indicated that they were highly likely to receive the COVID-19 vaccine. However, 13.7% indicated they were unlikely or highly

unlikely to receive the vaccine and an additional 17.8% indicated they were unsure. The main reason reported for COVID-19 vaccine hesitancy was ‘*Uncertainty about the safety of the vaccine*’ ($n = 13$, 56.5%).

Receiving the flu vaccine in 2019–2020 was significantly associated with having already received the flu vaccine in 2020–2021 ($r = .713$, $p < .001$). Among those who had not yet received the vaccine, it was highly related to being willing to receive the flu vaccine in 2020–2021 ($r = .691$, $p < .01$). Having received the flu vaccine in 2019–2020 and having received the flu vaccine in the current 2020–2021 season, were both correlated with the likelihood of receiving the COVID-19 vaccine ($r = 0.546$, $p < .001$; $r = 0.545$, $p < .001$, respectively). See Table 2.

Table 2

Bivariate Correlations between Flu and COVID-19 Vaccination Variables

	1.	2.	3.	4.	5.
1. Flu Vaccine19-20	--	.713**	.824**	.691*	.546**
2. Flu Vaccine 20-21		--	.606**	.	.545**
3. Flu Vaccine-5yr			--	.794 _a **	.640 _a **
4. Flu Vaccine Likely				--	.614 _a *
5. COVID Vaccine Likely					--

Note: No correlation could be computed for variables 2x4 because those who already received the vaccine did not answer this item. *a* = Pearson correlation; all other results are based on Spearman rho correlation. * $p < .01$. ** $p < .001$.

Group Differences by Race and Insurance Coverage

Race

Given the limited number of respondents who identified as races other than Black or White (<10), group differences

by race compared Black and White respondents only and others were excluded from analyses. A chi-square test revealed no significant differences between Black and White participants regarding whether they had received the 2019-2020 flu vaccine ($\chi^2 = .073$, $p = .787$). Specifically, 70% of Black

participants and 73.1% of White participants reported having received the flu vaccine. Similarly, race was also not significantly related to having received the 2020-2021 flu vaccine, ($\chi^2 = 2.54, p = .111$), with 56.4% of Black participants and 76% of White participants having already received it. For those who had not yet received the 2020-2021 flu vaccine, an independent samples t-test revealed that intentions to receive the flu vaccine did not differ by participant race, $t(18) = -.426, p = .675$, [95% CI -2.12, 1.41], (White, $M = 3.00, SD = 1.79$; Black, $M = 2.64, SD = 1.69$). Regarding the COVID-19 vaccine, White participants reported greater intentions to receive the vaccine ($M = 4.36, SD = 1.38$) compared to Black participants ($M = 3.73, SD = 1.38$). However, this did not reach statistical significance, $t(63) = -1.81, p = .076$, [95% CI -1.34, .07].

Insurance Coverage

A chi-square test revealed that in the 2019-2020 season, a greater percentage of participants covered by medical insurance received the flu vaccine (78.4%) compared to the percentage of uninsured participants who received the vaccine (50%) ($\chi^2 = 5.23, p = .022$). Similar trends were observed in the 2020-2021 flu season, with 35 of 50 (70%) insured participants having received the flu vaccine compared to 8 of the 17 (47.1%) uninsured participants, although differences did not reach statistical significance during this season ($\chi^2 = 2.90, p = .088$). Independent samples t-tests revealed that for those individuals who had not yet received the 2020-2021 flu vaccine, insured patients reported greater intention of receiving the flu vaccine ($M = 3.29, SD = 1.64$) compared to uninsured patients ($M = 1.57, SD = 0.98$), $t(18) = 18.17, p = .008$, [95% CI .513, 2.916]. Greater intention to receive the COVID-19 vaccine was also reported by insured ($M = 4.12, SD = 1.32$) compared to uninsured

participants ($M = 3.50, SD = 1.65$). However, this did not reach statistical significance, $t(66) = 1.59, p = .12$, [95% CI -.16, 1.40].

Discussion

Despite nationwide efforts to promote the uptake of the flu vaccine, the percentage of the U.S. population that is vaccinated remains below goal, with variation between race and ethnic groups (Rouw et al., 2020). The current study sought to examine flu and COVID-19 vaccination uptake intentions among a convenience sample of patients attending two clinics in Southeastern Virginia, and explore differences in this region by race and insurance status.

Compared to the national average, current study participants from Hampton Roads, VA indicated a much greater flu vaccination rate and intentions to receive the upcoming season's flu vaccine. The majority (66.7%) of participants had already received the flu vaccine at the time of the study, and many of those who had not yet received it were planning on receiving the vaccine (21.7%). This is much higher than the national average in current and previous flu seasons (48.4% and 59% in 2019-2020 and 2020-2021 flu seasons, respectively) (CDC, 2020b). As health fears increased during the COVID-19 pandemic, it may be that individuals wanted to be proactive about protecting their health. Those who had received the flu vaccine in the past, or had considered receiving it, were likely highly motivated to seek the flu vaccine in the 2020-2021 season. An individual who consistently received the flu vaccine in previous seasons likely more strongly endorses the vaccine's efficacy and safety, which may explain the strong association between previous vaccinations and the likelihood of receiving the flu vaccine in the upcoming season. This is consistent with previous studies suggesting that vaccine effectiveness and adverse

effects, in addition to perceived severity of the disease, are major factors in determining an individual's willingness to receive vaccines (Doornekamp et al., 2020).

The study also examined the association between receiving the flu vaccine and the intention of receiving a COVID-19 vaccine. Overall, there appears to be a strong association between having received, or the likelihood to receive, the flu vaccine and the likelihood of receiving the COVID-19 vaccine. This finding could be explained in several ways. First, individuals who received the flu vaccine during this or previous seasons could have easier access to healthcare services. The participants in the current study were patients who were present at a medical clinic to receive healthcare. These individuals may inherently be more likely to take proactive care of their health or be reminded by a provider about the importance of receiving their vaccines, more so than individuals who tend to not attend health clinics or healthcare appointments. Second, individuals who received the flu vaccine in previous seasons may do so because they perceive themselves to be at increased risk of complications from the season flu, due to older age or other health-related factors (Kumar et al., 2020). Although the same protective measures could apply to intentions to receive the COVID-19 vaccine, recent literature suggests otherwise. Kelly et al. (2021) found that although older individuals reported greater willingness to receiving the COVID-19 vaccine, individuals with underlying medical conditions and/or comorbid conditions were *not* more likely to get vaccinated for COVID-19 than those at low risk. This apprehension may be due to the relatively recent development of the COVID-19 vaccine compared to the flu vaccine and concerns about safety of the vaccine itself.

The study found no statistically significant differences in the likelihood to receive either the flu vaccine or COVID-19 vaccine between White and Black respondents. However, White individuals reported slightly higher intentions of receiving the COVID-19 vaccine compared to Black individuals. Similar studies have shown hesitancy in receiving the flu vaccine among the Black population related to distrust in the healthcare system (CDC, 2021; Freimuth et al., 2017; Quinn, Jamison, Freimuth, An, & Hancock, 2017). The willingness to receive the COVID-19 vaccine is also likely more complex to interpret given the politicization of the vaccination process (Kreps et al., 2020). The media and social media platforms have been major sources of misleading information that have likely promoted hesitancy among the public, particularly among those with an existing distrust of the healthcare system (Wilson & Wiysonge, 2020).

The study revealed that participants with medical insurance were more likely to report having received the flu vaccine in the previous 2019-2020 season compared to uninsured patients. With the cost of healthcare in the United States on the rise and the lack of universal health care coverage, there remains a large number of adults who are in need of quality and affordable health care (Osborn et al., 2016). In December 2020, the federal government developed a plan to provide the COVID-19 vaccine for free, regardless of health insurance. Similarly, many programs have been developed over the years to offer the seasonal flu vaccine for free or at a reduced cost. Despite these efforts, vaccination coverage among uninsured individuals remains lower than those who are medically insured (Lu et al., 2015). Lack of knowledge of the availability of vaccines at no cost is likely a contributing

factor. Interestingly, uninsured participants in the current study were seen in a primary care clinic with comparable access to healthcare services as those with health insurance. Still, these participants were less likely to receive the flu vaccine.

Vaccines against COVID-19 have shown great efficacy in mitigating the effects of the pandemic on the population and healthcare systems. However, as new variants of the virus continue to appear, there is a need for booster doses to maintain adequate protection against the virus, similar to the annual flu vaccine. Accordingly, more efforts are needed to promote vaccine uptake, especially while the rates of vaccine uptake are dropping. Addressing the main reasons behind vaccine hesitancy is essential to increasing vaccine coverage. This includes raising the awareness of the safety and efficacy of the flu and COVID-19 vaccines in communities with low vaccine uptake through public media platforms, including more diverse participants in studies conducted on the safety and efficacy of the vaccines, especially Hispanic, Black and women participants, in addition to making these studies available to the public with easy access to help improve the public trust in healthcare systems.

Limitations

The study is limited in terms of generalizability outside of Virginia but, due to the diversity in the sample population, findings can likely be generalized to regions across the state. It should be noted that participants were recruited in primary care clinics where they directly interact with healthcare providers and have greater access to healthcare services. Additionally, the mean age of participants was 55 years old. Given that older individuals have different perceptions of their health than younger individuals, vaccine uptake and related

intentions likely differ by age group. The difference in attitudes in vaccine uptake in this study should be interpreted with caution, as it did not reach statistical significance. It is imperative to continue to assess these potential differences in other regions as more Virginia patient data become available and more information about the vaccines becomes known.

Conclusion

The current sample of patients from Hampton Roads, VA reported high intentions to receive the flu vaccine compared to the national average. There were also strong positive correlations between receiving the flu vaccine in previous seasons and willingness to receive the flu vaccine and a COVID-19 vaccine in the upcoming season. Racial differences suggest that there is likely greater hesitancy among Black patients, though differences did not reach statistical significance. Novel findings suggest that the insured population is more likely to have received the flu vaccine in the 2019-2020 season despite comparable access to healthcare services and vaccine availability, suggesting the need for improved awareness of vaccine availability in the Hampton Roads region. Furthermore, although the majority of patients in this region of Virginia reported high likelihood to receive the COVID-19 vaccine, those who are vaccine hesitant emphasize a concern for the safety of the vaccine as the primary reason for hesitancy. This is an important target area for healthcare providers to discuss with their patients. The current study and similar studies that continue to investigate vaccine hesitancy are integral to understand vaccination intentions and predictors of uptake, particularly when annual vaccine and boosters are needed to promote herd immunity. Overall, this study adds to the growing body of literature on vaccination uptake during a time in which

willingness to receive a vaccine can be the difference between life and death.

Recommendations

Findings in the study suggest that while some populations may indicate greater intentions to receive the flu vaccine in the setting of the COVID-19 pandemic, more efforts are needed in upcoming flu seasons to

reach goal coverage. Increasing trust in the vaccine's efficacy and safety are major contributors to effective vaccine promotion. Larger scale studies are recommended to further investigate the difference in the willingness to receive flu and COVID-19 vaccines among different racial groups and greater effort should be taken to improve vaccine communication for trust building.

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**A Rapid Review of the Literature:
Cardiovascular Disease Preventive Practices and
Rural Black Women**

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A Rapid Review of the Literature: Cardiovascular Disease Preventive Practices and Rural Black Women

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Introduction

Cardiovascular disease (CVD) accounts for more U.S. deaths annually than all forms of cancer and chronic lower respiratory disease combined (Tsao et al., 2022). Black people have the highest prevalence of CVD, are more than twice as likely to die from heart disease, and are most likely to have modifiable clinical risks factors such as high blood pressure, diabetes, and obesity than any other race (Ard et al., 2017; Dickson et al., 2013; Foley et al., 2012; James et al., 2018; Juan, 2014; Scarinci et al., 2014). People living in rural areas in the U.S. suffer disproportionately from preventable diseases (Befort et al., 2012; Foley et al., 2012; Yang et al., 2012). Not surprisingly, Black women are at a higher risk of preventable chronic illnesses than their White counterparts (Ard et al., 2017; Dickson et al., 2013; Foley et al., 2012; Juan, 2014; Scarinci et al., 2014; D. R. Williams, 2008). Rurality escalates the figures further, making rural Black women especially vulnerable to CVD.

The intersections of social determinants of health (SDOH) and gender-related sociocultural experiences and practices beyond geography and location complicate rural Black women's vulnerability (Juan, 2014; Zahnd et al., 2021). These intersecting factors require multifaceted interventions for lifestyle modification to prevent and manage CVD and the related risks factors (Eckel et al., 2014; Lloyd-Jones et al., 2010; Seguin et al., 2015; Siegel et al., 2012; Smith et al.

2011). However, such interventions are often not rural and cultural-sensitive or accessible to rural Black women because of the lack of resources (Dickson et al., 2013; James et al., 2018) and the stresses related to structural racism (Juan, 2014; Taylor-Clift et al., 2016). Consequently, the geographic determination of health status, similar to that seen in Murray's Eight Americas (Murray et al., 2006) and the conception that where one lives could influence how long they live (Barber et al., 2016; White et al., 2008).

There is an increasing need for evidence-based practice guidelines to address CVD and other health disparities among rural Black women, as is found in the U.S. Preventive Services Task Force website

(<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation->

[topics](#)). In 2019, Congress passed Bill H.R. 4004--Social Determinants Accelerator Act of 2019, which supports the development of strategies that improve the health outcomes of vulnerable populations without denying them services (Social Determinants Accelerator Act of 2019). The guidelines could be relevant, frequently updated, pre-appraised evidence easily retrieved in practice to improve rural Black women health outcomes and address disparities. However, to our knowledge, such research-based guidance needs to be present. In this rapid review, we aimed to provide a comprehensive collection of evidence-based and promising self-care practices and programs to address the CVD disparities due

to race, gender, geography, and other SDOH. Additionally, we wanted to report and discuss evidence-based programs that provide best practices for rural Black women with CVD. The results of this rapid review point to a lasting and correctible reason for the disparity: there needs to be more-documented evidence.

Background

According to the United States Department of Agriculture, Economic Research Service, Black/African American people make up 7.8% of the rural populations and live in counties with high and persistent poverty rates (<https://www.ers.usda.gov/data-products/chart-gallery/gallery/chart-detail>). Approximately 58.8% of U.S. Black women have some form of CVD or risk factor (Tsao et al., 2022). Cardiovascular disease is the leading cause of death among Black women (23.1%), with elderly rural women often dying within weeks of a heart attack (Benjamin et al., 2019; Brundisini et al., 2013; James et al., 2018). Accessible, evidence-based lifestyle modification strategies for risk reduction and CVD prevention, such as self-care, can address these disparities (Juan, 2014; Lloyd-Jones et al., 2010; Taylor-Clift et al., 2016; Zahnd et al., 2021). Unfortunately, self-care programs are often inaccessible to rural residents due to geographic inequities, lack of care coordination, and general lack of resources and healthcare services attributed to the rural SDOH (Brundisini et al., 2013; Choshi MM et al., 2020; Valencia HE et al., 2011). Most recommendations for appropriate self-care behaviors, such as engaging in physical activity and healthy food choices, are not sensitive to rural Black women's culture; therefore, they are not beneficial for this vulnerable population (Eckel et al., 2014; Goff et al., 2014; Perel

et al., 2015; Smith et al., 2011; Vanstone et al., 2013).

Rural Black women face challenges of access to healthy foods, safe and affordable recreation facilities, and primary and specialty healthcare providers (Befort et al., 2012; Brundisini et al., 2013; Dickson et al., 2013; Juan, 2014; Vanstone et al., 2013). Researchers reported that the female gender and low socioeconomic status decrease rural Black women's chances of referral to a cardiac specialist or cardiac rehabilitation services (Juan, 2014; Williams, 2008). Additionally, rural and remote living strongly isolate rural Black women from social networks that protect against debilitating chronic stress, which is a predisposing factor to CVD risks such as high blood pressure and diabetes. Structural racism in public health and healthcare practice policies perpetuates these risk factors (Ebong & Breathett, 2020).

Culture also plays a role in developing and perceiving self-care practices in ethnic minorities with chronic illnesses (James et al., 2018; Siegel et al., 2012). Most often, Black people perceive and experience bias in the health care system and its delivery of care (Williams et al., 2014). Therefore, they delay seeking care until their disease has advanced, often resulting in higher levels of debility and increased treatment costs. Regardless of these known factors, public health leaders often overlook rural racial and ethnic minorities' needs when allocating resources (James et al., 2018). Most studies compare rural and urban variations, ignoring the racial and ethnic differences within rural communities (Vanstone et al., 2013; Williams et al., 2004). Health providers and policymakers must consider rural Black women's gender-related sociocultural experiences, practices, and health perceptions when developing self-

care programs (Dickson et al., 2013; Foley et al., 2012; Juan, 2014).

Methods

We followed the Virginia Commonwealth University's Rapid Review Protocol to define and refine the research question. Therefore, the PICOT (population, intervention, comparison, outcome, and time) question is the self-care behavior, practices, and programs for rural Black/African American women with CVD. James Madison University Library databases, PubMed, CINAHL, Web of Science, PsycInfo-Embase, and Scopus, were searched for studies published between 2010-2022. The researchers also hand-searched the reference lists from the retrieved peer-reviewed articles to identify additional articles that matched the inclusion criteria.

The databases were initially searched using Medical Subject Headings (MeSH), but the results were limited. The advanced search feature was used with these terms: rural, Black, African American, women, female, heart disease, and cardiovascular disease/s, which generated 2,688 citations. Additional filters included articles, humans, English, open access, and peer-reviewed journals, which generated 288 articles. Systemic and integrative reviews and studies not done in the U.S. were excluded. Six additional articles were found in the grey literature at <https://clinicaltrials.gov/>.

Two reviewers (authors) independently and manually screened the articles using the titles and the abstracts. Three articles were identified from the databases and the grey literature that met our inclusion criteria. Two articles considered promising but only meeting some criteria are also discussed. See

Figure 1 for an overview of the search strategy for this rapid review.

Inclusion criteria, based on our PICOT question: Population included rural and remote Black/African American women ages 18 and older with CVD in the United States. Interventions included studies investigating programs on self-care behaviors to prevent or manage CVD and the risk factors thereof. Comparison studies were included whether they did or did not have comparison groups. Outcomes were strategies researchers used to engage rural women and their facilitators, challenges, barriers, and contextual factors.

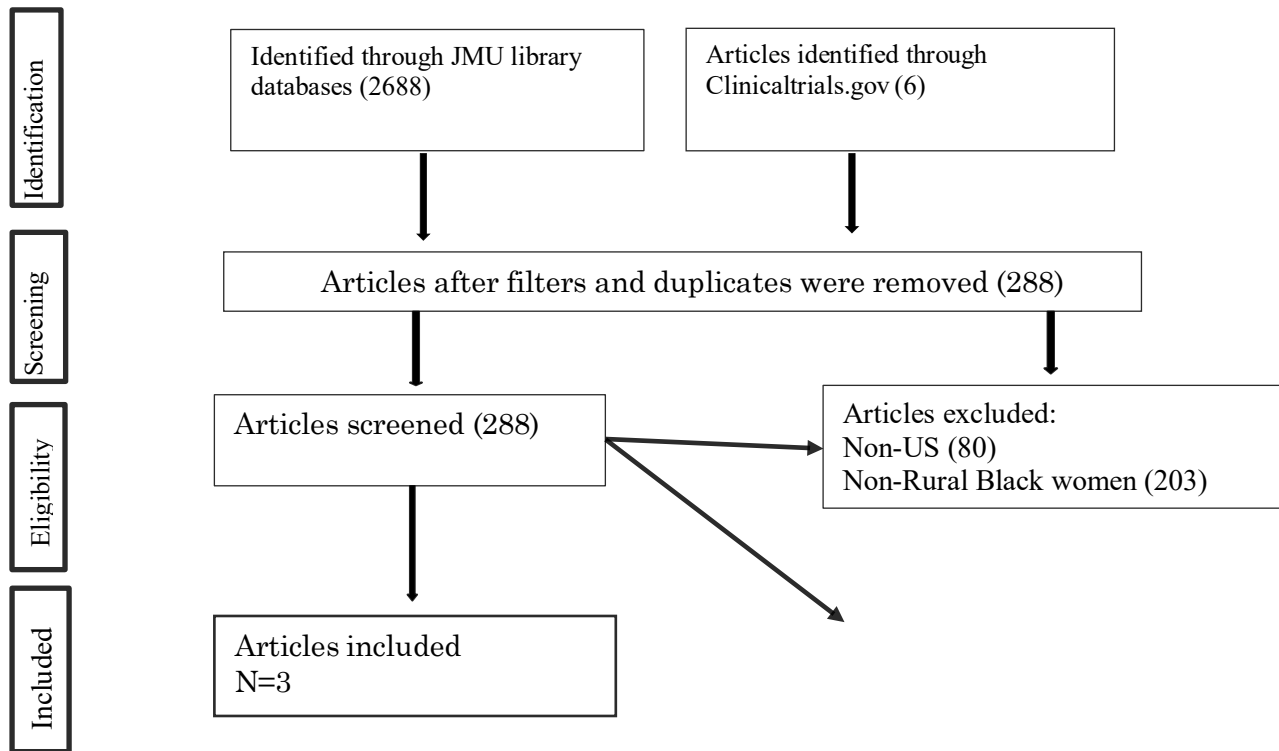


Figure 1: Flow diagram of the search strategy

Promising articles (2)

Quality Appraisal and Evidence Synthesis

Selected studies were synthesized and reviewed to summarize the evidence-based and promising self-care practices and programs to address the CVD disparities in rural Black women. The findings were examined for study design, purpose, sample size, procedures, and findings (See Table 1).

Rural Black women were notably affected by CVD and its risk factors, and there is a knowledge gap regarding which interventions work (Parra-Medina et al., 2011). The three studies included in this review that met all criteria were experimental randomized controlled trials. Two addressed obesity in rural Black women (Ard et al., 2017; Foley et al., 2012); one promoted physical activity and healthy eating (Scarinci et al., 2014).

Ard et al. (2017) used an intervention to increase weight loss. Foley et al. (2012) used an online interactive intervention to prevent overweight rural Black women from gaining weight. All of the studies acknowledged the underrepresentation of rural Black women in intervention development and research, which could contribute to CVD disparities. The authors recommended additional research using different approaches to develop self-care behaviors programs for rural Black women CVD prevention.

Collaborative institutional-community partnerships may be the best route to combating the health disparities and inequities experienced by rural Black women (Ard et al., 2017; Scarinci et al., 2014). Researchers from the University of Alabama Birmingham reported they had an excellent infrastructure to establish relationships with rural communities from the beginning of the study (Ard et al.,

2017; Scarinci et al., 2014). They partnered with community members to identify and address priority problems and to develop and implement interventions. Through these partnerships and community involvement, the researchers could reach rural Black women, whom they might have yet to be able to access.

Ard et al. (2017) tested the effectiveness of an adapted Journey to Better Health (JTBH) weight loss intervention delivered by community health advisors. The JTBH was developed based on Black women's weight-related beliefs on body image. Black women may be comfortable with a body that is curvy or heavy. Because of these beliefs, the community health advisors participated in identifying the problem and weight loss intervention, developing a research proposal, and adapting the program until the testing and implementation stage. The researchers trained community members to administer the intervention. In studies where community members administered the intervention, participant retention and attendance at intervention sessions were considerably higher than those that used health professionals or non-community members to administer the interventions. Participants in the intervention achieved average weight loss, which was attributed to the use of lay community health advisors who understood them.

Scarinci et al. (2014) also used a specific method selected by the community to test the efficacy of a culturally relevant intervention to promote healthy eating and physical activity among rural Black women. Participants advised researchers not to designate the program as a "weight loss" intervention because rural Black women do not take the idea in a positive way. Because of this negative connotation towards weight loss, researchers did not measure weight, *per se*; they measured

how often participants engaged in weekly physical activity, consumed fruits and vegetables, or consumed fried foods. After 12 months, participants increased their consumption of fruit and vegetables, decreased their consumption of fried foods, and increased physical activity to four to five times per week. At the 24 months follow up, participants had decreased physical activity. However, some were able to maintain their healthy eating styles. These intermediate measures were successful, and the authors attributed this to the adopted change in culturally appropriate concepts.

Beyond the sociocultural experiences of Black women in general, both the Ard et al. (2017) and Scarinci et al. (2014) studies highlighted specific geographic challenges faced by rural Black women: remoteness, isolation, lack of recreational facilities and safe sidewalks to engage in physical activity, and lack of healthy foods. These challenges, consequently, lead to increased obesity, CVD, cancer, and other chronic illnesses (Ard et al., 2017; Scarinci et al., 2014). Lack of nutritional and physical education also hinders self-care behaviors for CVD prevention.

Despite a promising study plan and some evidence of efficacy, the Shape program to prevent weight gain in overweight and class one obese Black women did not report meaningful outcomes after 12 months (Foley et al. 2012). This study was somewhat complicated to interpret. The study enrolled rural Black women with a body mass index (BMI) between 25 and 34.9kg/m² with a primary goal of maintaining or not gaining weight over 12 months. The reason behind the specific BMI was that Black women, in general, preferred heavier body weight. The researchers used an interactive obesity

treatment approach to produce weight change through the modification of routine obesogenic lifestyle behaviors, such as consuming five or more fruits and vegetables per day, no fast food or sugary beverages, and walking 7,000 steps a day (Foley et al., 2012). The authors did not clearly explain the impact of the different aspects of the Shape program on their goals. The latest published study by the same researchers alluded to the success of the Shape program in the prevention of weight gain in Black women; however, the article only published one aspect of the program, moderate-vigorous physical activity (Greaney et al., 2017). This study (Greaney et al., 2017) was not specific to rural Black women.

Although specifically designed for rural Black women, the Foley, et al. (2012) study was not community-based and did not appear to address challenges particular to rural geography and rural Black women's cultural and linguistic preferences. The lack of success of the intervention cannot be conclusively laid at the feet of the technology; however, studies of Black women highlight the cultural importance of human contact and social interactions (Dickson et al., 2013; Scarinci et al., 2014). Both Ard et al. (2017) and Scarinci et al. (2014) studies attributed the particular importance of community participation to their success.

“Promising” Studies

One study proposal and one completed study found in the literature merit mention here. The Strong Hearts, Healthy Communities program (Seguin et al., 2015) proposed a randomized controlled trial comparing a community program to a minimal control intervention (Strong Hearts, Healthy Women) to address chronic disease risk among rural women. While the proposal was well-

designed, appeared to be culturally relevant, and the community informed the study by community participation, the study results were not in a follow-up literature search. In addition, the proposal did not meet the criteria for Black women specifically. The Heart Healthy and Ethnically Relevant Lifestyle Trial (Parra-Medina et al., 2011) was an evidence-based, community-appraised program to address physical activity and diet in Black women but did not examine rural Black women specifically. The study was a randomized controlled trial comparing the standard care intervention to a comprehensive intervention to increase moderate-vigorous physical activity and decrease dietary fat intake (Parra-Medina et al., 2011). Both physical activity and dietary fat intake were improved at six months (although confidence intervals were wide), and 12-month comparisons of experimental groups were either insignificant or less significant than at six months. Both studies mentioned here show that robust study designs, culturally relevant interventions, and community participation and will be worth following in the future.

Table 1: Summary of Studies of Self-care Practices to Prevent Cardiovascular Disease.

Authors/Citation	Study Design	Purpose	Sample	Procedures	Results
Ard et al., 2017	Cluster Randomized control trial	To test the effectiveness of an evidence-based behavioral weight loss intervention delivered by community health advisors to African American women in the rural South	409 African American women age 30 to 70 years (Intervention N=154, control N=255)	Compared evidence-based behavioral weight loss program augmented with community strategies to support healthy lifestyles (Weight Loss Plus) with weight loss program alone (Weight Loss Alone)	Participants lost 3.2kg in Weight Loss Plus and 2.2kg in Weight Loss Only.
Foley et al., 2012	Randomized control trial	Weight gain prevention intervention among overweight and Class 1 obese Black female patients in a primary care setting (The SHAPE Program)	194 Black women (Age 25 to 44years)	Compared 12 months of tailored obesogenic behavior change goals, self-monitoring via interactive voice response phone calls, tailored skills training material, 12 counseling calls with a registered dietitian, and a 12 months YMCA membership with usual care	No results reported
Scarinci et al., 2014	Cluster Randomized Control trial	Examine the efficacy of a community-based, culturally relevant intervention to promote healthy eating and physical activity among African American (AA) women between the ages of 45–65 years, residing in rural Alabama.	565 African American women age 45 to 65 years	Evaluated two interventions: (1) promotion of healthy eating and physical activity (healthy lifestyle), and (2) promotion of breast and cervical cancer screening (screening).	A decrease in the consumption of fried food and increase in fruits and vegetable intake and physical activity for healthy lifestyle group.
Promising Studies					
Seguin et al., 2015	Proposal -- Randomized control trial	To compare a multi-level, community program (Strong Hearts, Healthy Communities) with a minimal intervention control program (Strong Hearts, Healthy	Not specific to rural Black women Rural underserved community members will		Study protocol: no results.

		Women).	be recruited		
Parra-Medina et al., 2011	Stratified randomized control trial	To evaluate a culturally appropriate theory-based lifestyle intervention targeting physical activity and dietary fat intake among African American women at high risk for cardiovascular disease.	Not specific to rural Black women 266 low-income African American women aged 35 years and older	All participants received the standard care intervention during their appointment: motivational, stage-based behavioral counseling from their primary care provider; nurse-assisted goal setting; a community resource guide featuring free or low-cost programs and facilities; and ethnically tailored educational materials. Comprehensive intervention participants received standard care plus the following: 12 motivational, stage matched, ethnically tailored newsletters over 1 year; an in-depth, introductory telephone call; and up to 14 brief, motivationally tailored telephone counseling calls from research staff over 1 year.	The comprehensive intervention group showed significantly greater improvements (reduction in risk score) over time than did the standard care group for the DRA total score and for the meat and the dairy products and eggs subscales.

Discussion and Recommendations

In this rapid review, the authors aimed to provide a comprehensive collection of evidence-based and promising self-care practices and programs to address the CVD disparities due to race, gender, geography, and other SDOH. Self-care is an essential component for CVD prevention for people in general. However, evidence-based self-care programs may not be easily accessible or culturally sensitive to rural Black women (James et al., 2018; Parra-Medina et al., 2011; Scarinci et al., 2014). The literature was searched based on the following PICOT question: self-care behaviors, practices, and programs for rural Black/African American women with CVD. There is minimal documented evidence-based self-care practices and programs for this population. The U.S. public health and health care systems need help with the intersections of SDOH and gender-related sociocultural experiences and practices impacting rural Black women's CVD outcomes (Zahnd et al., 2021). From this minimal set of studies, a few tentative conclusions and future directions for research and intervention are derived. First, CVD has several modifiable risk factors, obesity being one of them, such as diabetes, high blood cholesterol, high blood pressure, and smoking. Undeniably, obesity is associated with multiple chronic diseases and multiple CVD risk factors among rural women (Havranek et al., 2015; Murray et al., 2006; Yang et al., 2012). Weight, taken in isolation and interventions aimed only at obesity are likely inadequate.

Second, rural Black women's cultural beliefs impact their perceptions of obesity (Ard et al., 2017; Foley et al., 2012; Scarinci et al., 2014). The development of JTBH intervention (Ard et al., 2017), not using the "weight loss" phrase in the

program (Scarinci et al., 2014), and only enrolling rural Black women with BMI between 25 and 34.9 kg/m² in the study (Foley et al., 2012) were all reported to be based on some form of weight-related beliefs among Black women. These beliefs, not exclusive to rural Black women, but to Black women in general, include a preference for bigger body size, cultural acceptance of obesity, and dissatisfaction associated with thinness. Body image and attractiveness in Black women are not associated with being thin but with heavier or curvier weight.

Third, poor access to health care services and health-promoting interventions contribute to health disparities among rural Black women. Although the Foley et al. (2012) study did not mention this specifically, the use of an online interactive obesity intervention to enhance moderate physical activity may have been intended to increase access to resources for rural women. More critically, racism underlying the structures of American society (including health care) is not addressed in randomized controlled trials of single, uncomplicated risk factors for CVD prevention. Rural Black women experience multiple challenges from these inequitable systems, including constant exposure to chronic stress (Zahnd et al., 2021).

An essential feature of the Ard et al. (2017), Scarinci et al. (2014), Parra-Medina et al. (2011), and Seguin et al. (2015) studies (but not the Foley et al. (2012) or Greaney et al. (2017), the Shape program studies) was that they were all community-based studies. Disparities in services and underlying racism will not be solved by only ensuring rural Black women are active participants, advisors, and evaluators in any study involving them. However, their inclusion will go a long way to ensuring culturally mistaken

confounders are excluded from studies and, more importantly, will ensure a socially just research agenda.

Limitations

The inequities that produced the CVD disparities in rural Black women contribute to the limitations of this review and the studies appraised. There is very minimal evidence documented for self-care behaviors, practices, and programs for CVD prevention for rural Black women. There were only three studies that fit the inclusion criteria for our PICOT question. There needs to be more attention to disadvantaged populations' problems to ensure an adequate research base to solve those problems. In addition, the need for self-care programs to prevent CVD and manage risk factors in rural Black women may be confounded by a lack of attention to culturally appropriate interventions.

More traditional research limitations include obesity being the only clinical risk factor considered by these studies, allowing only a narrow application of findings. Also, the studies looked at only decreased physical activity and healthy food consumption related obesity. Although the participants demographics were not discussed in the results of the studies reviewed, they are worth mentioning here as they can be limitations, especially for this specific population. First, the age of study participants varied (24-45 in Foley et al., 45-65 in Scarinci et al., and 30-70 in Ard et al.). Age may affect diet and exercise outcomes, making these studies non-comparable or affecting generalizability to a different aged population. Second, most women in these studies had graduated from high school or had a college degree and had incomes above the poverty level. Education and economic stability are social determinants of health (Goff et al., 2014; Havranek et al., 2015; Smith et al., 2011). Those with more education and higher

income have better access to care, may engage in more health-promoting activities, and may be thinner and generally more resourceful than their less advantaged counterparts. Considering these aspects, these studies may only include some rural Black women who live in poverty.

Conclusions

Cardiovascular disease is the leading cause of death among rural Black women. Self-care is an essential component for CVD prevention and risk management. In this rapid review, we aimed to provide a comprehensive collection of evidence-based self-care behaviors, practices, and programs for rural Black women to address the CVD disparities. Unfortunately, there is minimal documented evidence for effective interventions. Culturally appropriate evidence-based self-care programs are not easily accessible to rural Black women, the population that needs them the most.

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**Examining Opioid Risk Mitigation Practices in a Rural Pain Management Clinic: A
Quality Improvement Project**

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Examining Opioid Risk Mitigation Practices in a Rural Pain Management Clinic: A Quality Improvement Project

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The United States (US) has the highest usage of opioids globally, leading to significant opioid-related deaths and a public health crisis (National Institute on Drug Abuse [NIDA], 2022). According to the Centers for Disease Control and Prevention (CDC, 2021), 91,799 people in the U.S. died from opioid-related overdoses in 2020. Addictions to prescription opioids and overdoses have led to increased mortality rates that exceed HIV-related mortality and motor vehicle accidents (Rudd et al., 2016).

Opioid misuse, abuse, and addiction are concerning public health issues in Virginia. Drug addiction is on the rise in Virginia and causing an increase in multiple public health issues, including blood-borne infections (Hepatitis C) and overdoses (Virginia Department of Health [VDH], 2021). In Virginia, 1,193 drug overdose deaths involved opioids in 2018 (NIDA, 2020). Opioid-related emergency room visits and overdose deaths are rising locally. In 2020, Virginia had 1,478 overdose deaths, a 17% increase from 2019, and hospitals recorded 9,901 emergency room visits, a 33% increase from 2019 (VDH, 2021). Given the national and local opioid crisis, providers must understand opioid use disorder and related clinical guidelines and apply this knowledge to their specific area of practice to better ensure patient safety. Thus, this quality improvement project addressed the following question with providers in a rural pain management clinic: “Will implementation of the ORT-ODU as a screening tool in adult who meet inclusion criteria result in 80% of eligible patients being screened by the second iterative plan-do-study-act (PDSA) implementation cycle?”

Background

Several diagnostic and general terms are important to understanding the opioid crisis. “Opioid misuse” is the use of an illegal drug or using a prescription medication in a manner other than as directed by the prescriber (Agency for Healthcare Research & Quality, 2019; CDC, 2021). This may include taking a higher dose, more often, or longer than prescribed (Agency for Healthcare Research & Quality, 2019; CDC, 2021). Addiction is a disease that affects a person’s brain and leads to the inability to control the use of a drug or medication. Symptoms can include intense urges for that drug or medication. The preferred term for addiction is substance use disorder (SUD) (CDC, 2021) and when referring to opioids, the preferred term is opioid use disorder (OUD). OUD is a specific type of SUD characterized by a problematic pattern of using opioids resulting in distress or significant impairment (CDC, 2021).

The national problem of opioid misuse is widespread and complex. Approximately 10.1 million people aged 12 years and older misused opioids in 2019, and 9.7 million misused prescription pain relievers (US Department of Health and Human Services, 2021). A summary article highlighted many identified risk factors for opioid misuse and OUD, including the inability to function, exaggeration of pain, poor social support, stress, trauma, and mood swings (Webster, 2018). The author also identified risk factors related to the healthcare system, including healthcare provider prescribing practices.

Unsafe opioid prescribing is a vital provider factor related to the SUD problem in the U.S. An explanatory longitudinal cohort study identified that a higher prescribed opioid dose was strongly associated with opioid-related death (Gomez et al., 2011). Moreover, a study of opioid treatment dosing guidance demonstrated significant declines in doses prescribed, suggesting that baseline dosing was higher than needed (Sullivan et al., 2016). Finally, variations in opioid-related death rates of different states indicate that state laws related to prescribing practices of healthcare providers are relevant to patient outcomes (Morbidity and Mortality Weekly Report, 2019). According to Volkow et al. (2019), efforts to address the opioid crisis must include prevention programs and focus on risk factors of opioid misuse and OUD, as well as inappropriate prescribing.

In a rural Virginia pain management clinic, no screening protocol for patients on chronic opioid therapy existed. Thus, given this national and local problem, this quality improvement project aimed to screen 80% of eligible patients. Prior to implementing the project and addressing the clinical question, a review of the literature was completed.

Opioid Clinical Guidelines

In 2016, the CDC issued 12 evidence-based guidelines covering such topics as when to initiate or continue opioids, best practices for prescribing specifics, treatment goals relative to risks, and discussing opioid-related risks with patients (Dowell et al., 2016). The CDC also recommended that prescribers who manage chronic opioid therapy screen patients for misuse, abuse, and risk for opioid-related harm. However, when the CDC issued the guidelines in 2016, insufficient evidence existed to determine whether screening tools effectively reduced harm. Thus, the guidelines did not recommend specific tools or implementation strategies, such as screening frequency.

Moreover, the guidelines are less helpful for some practice settings, such as pain management clinics. For instance, the guidelines have been less practical for providers managing complex and often long-standing patient pain, as described in the next section.

The CDC developed their 2016 guidelines for primary care providers, and pain management specialist providers considered them controversial. These guidelines were not intended for pain management providers treating chronic pain patients already managed with chronic opioids, as these patients often benefit from the high doses, as evidenced by improved quality of life and pain control (Downes et al., 2018). For example, higher morphine milligram equivalents (MME) are correlated to increased opioid-related risks, including respiratory depression. For this reason, the 2016 CDC guidelines recommended limiting prescribed doses to 50 MME, with a maximum of 90 MME per day for most patients and no limits per dose. However, it is sometimes challenging to achieve these limits when managing individuals with chronic pain, as these patients have often failed conservative treatments or interventional injections and may not have been eligible for or responded to surgery (Downes et al., 2018). Moreover, these patients may require higher opioid doses to maintain function and quality of life, making the CDC's MME recommendations infeasible for this population (Downes et al., 2018). Given the specific needs of the pain management patient group in terms of higher doses and lack of other treatment options, it is vital to monitor this population for opioid risk as part of their treatment plan.

Opioid Risk Screening in Pain Management

Evidence to support risk screening in pain management is relatively new. A 2017

systematic review found a lack of high-quality evidence to guide pain management clinics to treat patients with chronic pain and opioid misuse, and the authors specifically cautioned about inconsistencies with screening tools (Voon et al., 2017). Since 2017, there has been growing support and evidence available to guide opioid risk screening in pain management clinics and more generally. For instance, Cheatle et al. (2018) conducted a prospective study examining the process of screening patients before prescribing opioids for chronic pain. The researchers found that aberrant behavior is low in pre-screened patients with no history of a SUD, minimal psych history, and good social support. In a community study, Strand et al. (2019) created a community pharmacy toolkit to prevent opioid misuse, including the opioid risk tool (ORT). The pharmacists who implemented the toolkit valued having an objective measure of potential misuse and reported improved patient conversations (Strand et al., 2019). Thus, within the last five years, evidence has grown to support screening.

Specifically, there is evidence for using the ORT and a revised version of the ORT, the ORT-ODU. A longitudinal study of four screening questionnaires concluded that providers should use the ORT to screen patients before beginning opioids (Vargas-Schaffer & Cogan, 2018). Cheatle et al. (2019) further studied the ORT and tested a revised version that removed the question regarding pre-adolescent sexual abuse for patients with chronic nonmalignant pain (CNMP) on long-term opioid therapy. The same authors examined a 10-item weighted scale including the pre-adolescent sexual abuse question, a nine-item ORT without the pre-adolescent sexual abuse question, and a 9-item unweighted scale with yes or no responses. Their analysis showed that the patient's age, personal and family history of substance abuse, and psychological disease

determined the risk level without including the pre-adolescent sexual abuse question (Cheatle et al., 2019). The authors found that the ORT could discriminate between patients with and without OUD ($OR = 1.624$) and that removing the item about sexual abuse produced similar results ($OR = 1.648$). Cheatle et al. (2019) reported Cronbach's alpha (CA) of .72 and .73 in two respective samples. When they tested an unweighted version of the ORT without the question about sexual abuse, it produced stronger results ($OR = 3.085$, 95% CI [2.725, 3.493], $p < .001$) than the original ORT and the weighted ORT without the question about sexual abuse. Since removing the item about sexual abuse simplified the process and produced similar results, the researchers considered the ORT-ODU a superior tool (Cheatle et al., 2019). Given the complexities of the pain management patient population and growing evidence to support screening for opioid misuse risk, it is reasonable for pain management clinics to initiate screenings using the ORT-ODU. Screenings will give providers additional knowledge to make clinical decisions and establish a baseline for future patient assessments.

A theoretical and implementation framework further supported this project. Lewin's (1974) unfreeze-change-refreeze change management model guided this project. Unfreezing prepares an organization for change, the change occurs, and once people are ready to embrace the change, refreezing occurs (Lewin, 1947). The Institute for Healthcare Improvement's (2022) model for improvement and Plan-Do-Study-Act (PDSA) approach provided the implementation framework for this two-cycle project (IHI, 2022).

The primary objective of this quality improvement project was to implement an evidence-based risk screening tool in patients receiving long-term oral opioid therapy in a rural pain management clinic to improve the

identification of patients at high risk for opioid misuse and abuse. Each PDSA cycle lasted three weeks with the primary aim of describing the risk level of screened patients and the secondary aim of quantifying the number/percent of patients who met eligibility criteria. PDSA Cycle 1 specifically aimed to identify barriers and levers to implementation of the ORT-OD. The goal was to screen 80% of eligible patients for opioid risk in Cycle 2. The following methods supported achieving the aims.

Methods

This project took place in a local, rural interventional pain management clinic staffed by five providers: one medical doctor (MD), one doctor of osteopathic medicine (DO), two physician assistants (PA), and one nurse practitioner (NP). Two to four providers see patients in the clinic daily and providers rotate to complete procedures and to other offices in the health system. The practice sees an average of 1,000 patients monthly; 260 of these patients are treated in the procedural suite.

Intervention

This project was a quality improvement project with a primarily quantitative design augmented by narrative feedback about implementation. The Institutional Review Board at James Madison University and the participating institution approved the project before the interdisciplinary team implemented an addiction risk screening tool.

ORT-OD Description

The implemented screening tool was the ORT-OD, a brief questionnaire easily self-administered by the patient within one to two minutes and used with permission from the developers. The ORT-OD is a nine-item instrument that asks yes or no questions about family history of substance abuse (alcohol, illegal drugs, and prescription drugs),

personal history of substance use (alcohol, illegal drugs, and prescription drugs), age (16 to 45 years), and history of psychological diseases (attention deficit disorder, obsessive-compulsive disorder, bipolar, schizophrenia, and depression) (Cheatle et al., 2019). Patients can score from 0-9, and their total scores are summed, with a score of ≤ 2 indicating low risk and ≥ 3 indicating high risk (Cheatle et al., 2019). Psychometric testing of the ORT-OD is robust with a sensitivity of .854, a specificity of .851 (both high), and strong negative and positive predictive values, .914 and .757, respectively (Cheatle et al., 2019). The ORT-OD was implemented over two PDSA cycles lasting three weeks each.

PDSA Cycle 1

Procedures (Cycle 1). During PDSA Cycle 1, the interdisciplinary team implemented the ORT-OD with one provider whose patients met the inclusion criteria. The inclusion criteria consisted of adult patients (age 18 and older) who presented with CNMP and received chronic opioid therapy (≥ 6 months) during the study period. The primary investigator (PI) reviewed the participating provider's schedule daily with the nurses and front desk staff to identify eligible patients. The front desk staff and all nurses were given a list of eligible patients. The registration clerical staff gave an ORT-OD paper form to each patient that met the criteria at check-in. No patient identifiers were used on the form.

The nurse rooming the patient collected the form, verified it was complete, and gave it to the provider for review. Similar to other intake paperwork, if the form was incomplete, the nurse asked the questions and completed the form, noting this on the document. After the visit, the nurse placed the form into a securely locked box at the nurses' work area and the PI collected the forms daily. The PI kept records of the

provider's total number of patients seen that day, the number of eligible patients seen, and the number of completed ORT-OD forms at the end of each day. The PI collected and noted feedback from staff, the implementing provider, and the participating patients during and at the end of the first three weeks. The first PDSA cycle ended with an email to all providers, nursing staff, and clerical staff describing the results of Cycle 1. During this phase, the team noted early successes and approved the process, which increased the likelihood that the unfreezing of prior

behavior occurred, a necessary step for change according to the theory (Lewin, 1947).

PDSA Cycle 1 Sample. All patients scheduled to see the participating provider and who met the inclusion criteria (Table 1) received the ORT-OD form for completion. One of the aims of PDSA Cycle 1 was to determine the number of eligible patients. This information allowed for better planning for Cycle 2.

Table 1

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Adults aged 18 and older	Not prescribed oral opioids
Long-term (≥ 6 months) oral opioid therapy	Pain related to cancer
Chronic non-cancer pain	Short-term (< 6 months) opioid therapy

PDSA Cycle 2

Procedures. During PDSA Cycle 2, the PI and the interdisciplinary team implemented the ORT-OD with four providers whose patients met the same inclusion criteria used in Cycle 1. The four providers included in this study (1 MD, 1 DO, and 2 PAs) treat chronic pain and prescribe oral opioids. The NP in the group was the PI. Patients seen by the NP were excluded to minimize bias. All patients seen by the four providers who met inclusion criteria were given the ORT-OD for completion. The ORT-OD was implemented in the same manner as PDSA Cycle 1. The only procedural change was that a number indicating the provider seen was added to

each completed ORT-OD form. Implementation dates were adjusted to accommodate days the clinic was closed for holidays. Related to the theory of change, the final phase is refreezing, when the goal is to sustain the change, becoming a new habit (Lewin, 1947). At the end of PDSA Cycle 2, the PI shared the results and presented recommended plans to maintain the change.

Analysis

The PI analyzed data at the end of Cycles 1 and 2. The PI entered data collected from the ORT-OD forms and implementation data into a spreadsheet and calculated the total number of patients seen, number and percent of eligible, and screened patients. The risk level was calculated for

each screened patient, and then rates and percentages were calculated to describe the risk level of the screened group. The PI made these calculations for each cycle and for the project total. De-identified qualitative data were analyzed using qualitative descriptive methods.

Results

During the project implementation period, the four participating providers saw 544 patients. In PDSA Cycle 1, the participating provider saw a total of 118 patients, and the four participating providers in Cycle 2 saw 426 patients. Of the 544 total patients, 78 (14% of the total) met the inclusion criteria (18 years of age or older, ≥ 6 months oral opioid therapy, and chronic non-cancer pain diagnosis). All 78 patients who met the inclusion criteria (100% of eligible) completed the ORT-OD screening. The nurse completed two ORT-OD forms during telehealth visits where there is no protocol for completing intake paperwork individually. One ORT-OD form was completed verbally during the office visit with a patient that did not complete it as part of the intake paperwork. If this person is excluded from the screening rates, the completion rate is 99% of eligible patients. Therefore, the project met the goal of

screening greater than 80% of eligible patients by Cycle 2.

ORT-OD Responses by Item and Reliability

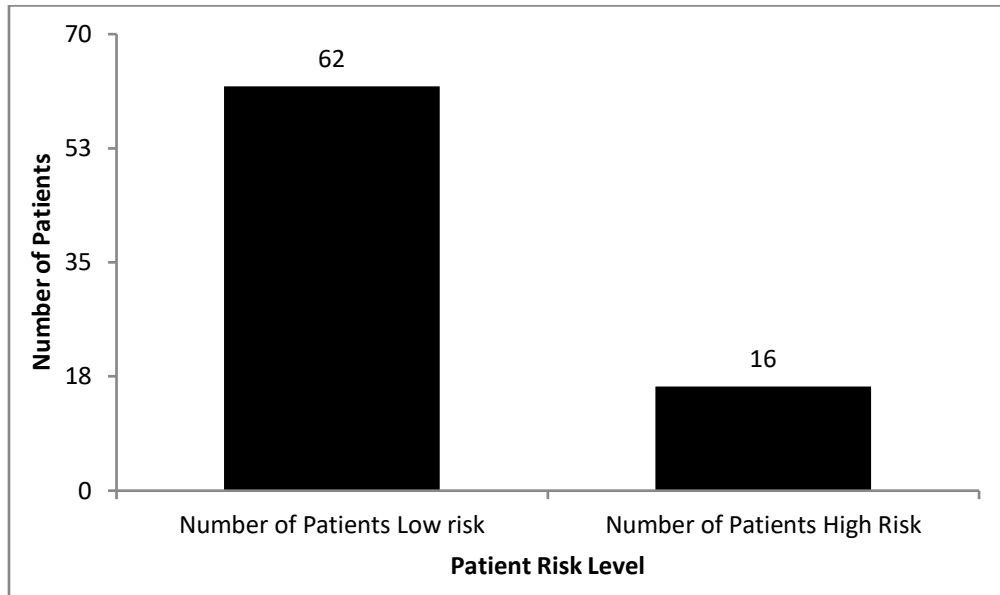
A total of 78 patients completed the ORT-OD. Of those, 26 (33%) had a family history of alcohol abuse, nine (12%) had a personal history of alcohol abuse, 10 (13%) had a family history of illegal drug use, four (5%) had a personal history of illegal drug use, 12 (15%) had a family history of prescription drug abuse, and four (5%) had a personal history of prescription drug abuse. Of the 78 patients screened, six (8%) fell into the high risk age range of 16-45, 16 (21%) had a history of psychological disorders other than depression (attention deficit disorder, obsessive-compulsive disorder, bipolar, and schizophrenia), and 36 (46%) had a history of depression. In the current study, our CA was 0.65. CA for this sample would be slightly higher (0.66) with the item regarding age removed.

Number of Patients Screened by Risk Level

Of the 78 patients that were screened during the project, 16 (21%) were high risk and 62 (79%) were low risk (see Figure 1)

Figure 1

Number of Patients by High- and Low-Risk Designation



Implementing the intervention with one provider in Cycle 1 resulted in five patients over three weeks being identified as high risk. Implementing the intervention with four providers in Cycle 2 resulted in 11 patients being identified as high risk. The

screening identified a total of 16 patients (21% of screened patients, 3% of total) as high risk throughout the 6-week intervention. Table 2 provides a week-by-week breakout of the high-risk patients identified through screening.

Table 2

Number of Screened Patients Identified High Risk by Week

Screening Period	Number (% of screened that week) of Patients Identified as High Risk
Week 1 Cycle 1	1 (33)
Week 2 Cycle 1	3 (43)
Week 3 Cycle 1	1 (33)
Week 4 Cycle 2	3 (27)

Week 5 Cycle 2	2 (12)
Week 6 Cycle 2	6 (16)
<hr/>	
Total (% of total)	16 (21)

Barriers and Levers

The interview data revealed two barriers related to implementing the ORT-OD screening form. First, one day during PDSA Cycle 2, a float nurse worked in the clinic. That day, the nurse did not give five ORT-OD screening forms to the provider for review but instead gave them directly to the PI. Second, one provider was less interested in reviewing the ORT-OD screening forms.

A lever of this project was that the providers and staff were overwhelmingly supportive of the implementation during the project. Three providers stated they were especially interested in using the ORT-OD results to inform their practice. The providers also noted that the ORT-OD was helpful because it establishes a baseline that can be used to evaluate changes in patient status over time.

The project raised several implications for future implementation. During the interviews, the PI and providers discussed frequency of screening. Providers and staff reported they supported implementing the ORT-OD screening form at least annually in patients receiving chronic opioid therapy. Providers also noted that they needed to take time to calculate their patients' risk level by looking at the individual responses. While the calculation was simple, a future improvement would be to have the risk score calculated for the provider.

Discussion

This quality improvement project builds on prior evidence that suggests it is feasible to implement ORT-OD screening in a pain management clinic (Downes, et al., 2018; Vargas-Schaffer & Cogan, 2018). Other studies about chronic opioid therapy focused on assessing risks only at the initiation of opioid use (Dowell et al., 2016). The response rate in this study exceeded the benchmark of 80%, which suggests that patients in this sample were willing and able to complete such screening. Exploring staff and provider attitudes further supported that this evidence-based opioid risk screening tool is implementable with patients receiving chronic oral opioid therapy. Almost one-quarter (21%) scored in the high-risk range. This information would have been unknown to providers before this project. These findings suggest that ORT-OD screening gives providers additional clinical knowledge for care. Implementing the ORT-OD in pain management clinics is therefore recommended.

Regarding the paper format of the ORT-OD used in this study, staff and providers identified a few barriers to implementing the ORT-OD in paper format. Whether a digital format would be more straightforward or challenging to implement is unknown. One potential benefit of the digital format would be that the risk score would be calculated automatically and recorded as part of the medical record for comparison. Moreover, digital screening may also address the issue of float staff not knowing and following the exact process.

Providers identified screening frequency as an important consideration. Evaluation at one point in time is a limitation as noted in the Cheatle et al. (2019) study, as there may be events that occur after the one-time evaluation that could contribute to OUD at a later time. Cheatle et al. (2019) suggested that screening could also potentially take place during the initial visit and when opioid medication changes are initiated. Additional research is needed to understand the ideal frequency of screening and how the specific modalities affect risk screening. Given the benefits of identifying previously unknown high-risk patients, an additional PDSA cycle in the study clinic should implement the screening tool in the electronic health record (EHR).

Limitations

This project was conducted in a small, local pain management practice. Implementation was studied over six weeks using paper screening, limiting the potential applicability of these specific findings in other settings. The clinic plans to sustain and expand the screening, which will likely include implementation in the EHR. This project gathered no information, beyond informal feedback, about whether the pain management providers used the information gained through the ORT-OUD screening. Although the ORT-OUD identified similar rates of high-risk patients in this project as seen in previous research, it is impossible to assess whether this project's screening potentially missed some high-risk patients or if patients responded accurately to the questions. More research is needed to determine if providers use this screening information in practice decisions and how those changes ultimately affect patient outcomes.

CA is a measure of internal reliability and estimates reliability of responses to questionnaires. The ORT-OUD CA for this

sample was .65, which is lower than previous samples and lower than the benchmark of .70 for a "good" CA (Lavrakas, 2008). However, it may be less relevant whether the ORT-OUD measures a consistent construct than whether each item individually measures a known risk factor and the total provides a clinically relevant understanding of those risk factors. Further, the ORT-OUD screening form asks dichotomous yes or no responses. The use of CA is convenient but is limited in testing the reliability of tools with dichotomous values (Napolitano et al., 2013).

The CA brings up an interesting point about age in our sample. The lower CA in this sample may be because of an age difference between the project sample and prior ones, although removing the question about age would only minimally elevate the CA in this sample. Although this study did not assess the participants' specific age, 92% of participants in this sample were over 45. Our sample was likely older than others who validated the ORT-OUD as a screening tool and reported a mean age of 40 (SD 10.92) for those who screened positive, and a mean age of 54 (SD 12.65) for those who screened negative (Cheatle et al., 2019). Yet, a clinically important number and percent of patients screened positive in our sample, suggesting that the ORT-OUD tool is clinically relevant. It is possible that the demographics of addiction risk are changing or that risk factors by age are different for those being treated with opioids for CNMP. This could be explored in future research. Despite these limitations, the project accomplished the stated aims and identified important implications for practice based on the clinical significance of the results.

Implications for Practice

This project supports the use of the ORT-OUD as a screening instrument in the pain management setting, as the ORT-OUD successfully identified a clinically significant

number of high-risk patients in this setting. Specifically, opioid risk screening should be part of care for patients receiving chronic opioid therapy for CNMP. Those who wish to implement the ORT-ODU in clinical practice should plan for and iteratively evaluate screening frequency. Lewin's theory of change is a helpful theory for guiding the implementation of the ORT-ODU in this setting.

Conclusion

Opioid risk screening as part of a comprehensive evaluation to identify patients at high risk for opioid misuse and abuse is an evidence-based practice for several populations, including those treated for chronic pain (Vargas-Schaffer & Cogan, 2018). The lack of opioid risk screening is a problem in many practices, including pain management (Downes et al., 2018). Given

this problem, this project aimed to implement an evidence-based opioid risk screening tool, the ORT-ODU (Cheatle et al., 2019), in a rural pain management practice. The project completed two PDSA cycles implementing the ORT-ODU screening tool with eligible patients, identifying high-risk patients who would have otherwise not been identified.

Implementing an opioid risk screening tool in patients receiving chronic oral opioid therapy can identify high-risk patients, potentially improving outcomes. These findings can guide future practice in the pain management clinic where the project took place. The results may also change care in the complicated health system and serve as an example to other clinics looking to implement the evidence-based ORT-ODU in their practice.

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**Structural Barriers to Health Care Access and IPV Disclosure in
First-Generation Latina Immigrants**

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Structural Barriers to Health Care Access and IPV Disclosure in First-Generation Latina Immigrants

By: Schminkey, Elkins, Jagiello, Annan, Robinson, Metzler Sawin

Introduction: Background and Purpose

One of the Healthy People 2030 goals is to improve access to comprehensive health care services (Office of Disease Prevention and Health Promotion [ODPHP], n.d.). For the one in four women in the United States who identify as Latina (United States Census Bureau, 2020), this is a lofty goal. Latinas are more likely to be uninsured than any other group of women in the United States (Keisler-Starke & Bunch, 2020), making access to health care a significant issue for this group. These women are less likely to have an ongoing relationship with a health care provider and worry more about medical bills than their non-Latina counterparts (OASPE, 2021). Aside from the policy level issues that affect access, entering appropriate services in a timely manner can be difficult for many of these women (Schminkey et al., 2019).

Latina/Latino and Hispanic are terms that are often used interchangeably despite their different meanings, Latina denotes a woman of Latin American descent or origin, while the term Hispanic denotes Spanish speakers including those who are not from or descended from people living in Latin America (Austin & Johnson, 2012). It is important to note that many immigrants from Spanish-speaking countries do not primarily speak Spanish; rather, they speak indigenous languages other than Spanish as their first language (Casanova, et al., 2016). Both terms appear in the literature and thus both appear in reference to other literature, even though our study population was exclusively Latina.

There are significant, persistent health risks in Latina communities in the United

States (Boen & Hummer, 2019; Velasco-Mondragon, et al., 2016). Rates of diabetes and obesity are increasing for Hispanics (Velasco-Mondragon, et al., 2016). Severe maternal morbidity is more likely in Hispanic people than White people (Fingar, et al., 2018). In addition, there is a greater burden of both functional limitations and depressive symptoms in Latina communities than in the general population (Boen & Hummer, 2019). Disturbingly, there are discrepancies between the reported rates of abuse disclosure in Latina populations: a recent review found prevalence of abuse ranged from 1-83% (Gonzalez et al., 2020). The association between intimate partner violence (IPV) and poor health outcomes is well established (Chandan et al., 2020; Bacchus et al., 2018). Reports of increased risk of poor physical and psychological health in abused Latina women makes it clear that women experience disproportionate adverse consequences when they are abused. Furthermore, the authors' experiences in clinical practice demonstrate significantly less IPV disclosure in Latina populations in suburban health department settings than would be expected, particularly among recently arrived immigrants, corroborating findings from Zarza and Adler (2008) on disclosure rates for Latina populations in New Jersey. This lack of disclosure of violence highlights both a lack of understanding among practitioners and researchers regarding the screening tool validity and a gap in care access for the Latina women who currently experience abuse or have experienced abuse in the past.

These rates of chronic disease, disability and abuse suggest that it may be more difficult for Latinas to access care. Given that

Latino immigrants in the United States comprise the fastest growing percentage of the rural population in the United States (Lichter & Johnson, 2020), outreach from the health care sector to this growing population needs to be strategic and must address the structural challenges that impede help-seeking from the health care system. The aims of this paper are two-fold: to describe the structural barriers faced by Latina women in rural areas of the eastern United States as they attempted to access the health care system, and, once they gained access, to identify barriers to IPV disclosure.

Methods

Study Design

The study adopted a Heideggerian interpretive phenomenological approach to thematic content analysis. This allowed the researchers to capture the experience of rural Latina women who were first-generation immigrants to the United States as they navigated the health care system and were questioned about IPV by their health care providers. We sought to recognize our bias as health care workers and identify components of the interview in which we made judgments and assumptions.

Recruitment and Sampling

The University of Virginia Institutional Review Board approved the study recruitment process and interview protocol. Informed consent was obtained from study participants, and participants were offered a twenty-dollar gift card for completing the interview. The participants were recruited

over a six-month time frame using a purposeful convenience sampling strategy from advertisements placed in a convenience store serving the Latina community, and then concomitant snowball recruiting. All participants were selected to participate in the study if they met the following criteria: age 18-65, female, and of first-generation Latina families. Women were interviewed either in private homes or in a location that afforded privacy and was agreeable to the participants. The participants chose whether they preferred to be interviewed in Spanish or in English.

Data Collection

Nine women were interviewed using a semi-structured approach by one of the researchers at a location of the participants' choosing (Table 1). If Spanish was her preferred language, a Spanish-speaking researcher conducted the interview in Spanish, which was later transcribed into English. Interviews ranged from 60-105 minutes in length. Reflexivity was necessary during portions of the interviews as some of the women discussed personal suffering, problem relationships, and vulnerabilities in seeking out health care in an unfamiliar system.

Four of the interviews were conducted by native Spanish speakers, both first-generation immigrants. The interview transcripts were sent to two Spanish translators for verbatim translation with each translator working independently. Afterwards the transcripts were reviewed by the original interviewers for accuracy.

Table 1

Summary of semi-structured interview guide questions

Primary Questions	Examples of Probes
Can you tell me about an experience accessing the health care system here?	Probe for specific experiences patients have had in getting healthcare. Probe for details regarding how they understood the process, the emotions they experienced, and their sense of how well they were cared for.
What kinds of difficulties have you encountered accessing health care?	Probe for specifics such as transportation, communication issues, payment issues, continuity of care.
What has helped make getting health care easier?	
Is most of your care received at the hospital emergency room/urgent care facility, or from a clinic or private office?	Probe for reasons why this is the site of most of their care.
Can you tell me about the experience of being enrolled or registered for care in these facilities?	Is there one experience that sticks out to you? How did you feel about the process?
Have you ever been asked about whether or not your family relationships and intimate relationships are difficult, if you have troubles, or if you have concerns about whether the relationship is healthy when you are in a health care encounter?	If so, can you tell me about how you felt about that? Did you answer truthfully? Why or why not? Depending on answer, may follow with a direct question about whether they have been screened for intimate partner violence.

Data Analysis

Following the initial read-through of each transcript, the researchers created reflexive notes about the overarching themes of the interviews as well as possible areas of

bias. The analytic process started with eclectic coding as an initial, exploratory technique, followed by code mapping (Anfara et al., 2002). The researchers used eclectic coding initially to identify

phenomena in the interviews and compare them to other participants as well as to what is currently understood about Latinas' access to health care.

The second stage of the coding process was code mapping. Anfara et al. (2002) illustrated how initial codes can progress through several iterations of analysis. The first iteration included organizing the codes into a full list of all the codes used and then condensing them into central themes. Initial codes identified by the researchers were categorized into clusters of codes that could be linked and become our reduced central themes. The emerging themes were then subjected to theoretical coding, as the data was examined in terms of these new themes, rather than chiefly in descriptive terms. Although all participants were invited to review the interview transcripts and given the opportunity to provide further comments, only one participant chose to examine the transcript and clarify her thoughts with the research team.

As a team of health care and service providers, we recognized ourselves as social beings who bring our own previous experiences to the data analysis and interpretation. These experiences help us better understand the processes of interest but also create an inherent bias. Personal bias of the researchers was explored through journaling and memo writing during the data collection and analysis portions of the study. During analysis, we explored how our health care experience and IPV-related experiences influenced the data analysis.

Results

Seven participants in our study disclosed a history of IPV or current abuse during their interviews and two did not. One who did not report a personal history of abuse had witnessed it in her family of origin. Our analysis identified several salient themes that represent de facto structural barriers to both

care access and abuse disclosure. The overarching theme of "searching for dignity" is indicative of the women's need to be treated as though they are worthy of honor and respect. The interview narratives describe Latina women's experiences of care seeking and shed light on this ongoing search for dignity, which can be related to several emergent themes. Four sub-themes were identified which defined the experience that the participants reported while seeking health care and being screened for abuse. The subthemes were *no confianza* (lack of trust), having a voice, being marginalized, and navigating a dysfunctional system.

Searching for Dignity

Latina women's perceptions of being treated with dignity within the health care system was impacted by their belief that they were treated differently because of race or socioeconomic status. This perception contributes to an inherent lack of trust and sense of vulnerability within the health system. The perceived racism was often related to a language barrier or lack of resources to overcome the language barrier. "I think about those people, who don't know the language and you just do to them whatever, but yes, I do change the doctor because of the wait and the way they treated us" (108, p.2). The language barrier, or even an assumption of language barrier on the part of health care personnel, often intersects with a person's difficulty navigating the health care system, paying bills on time, and understanding directions or printed material. One woman said:

I have found many times that they are racist. They don't give sufficient information to the patient, and I always feel they are trying to hurry me every time I go, or something in what is the service is missing. Information is always missing. (102, p. 2)

The same participant later talks about trying to obtain health care without insurance and the belief that she was not receiving the same treatment as others due to her insurance status.

...the service when there is no health insurance is poor. They put you at the bottom of the list and they have always been telling me, 'There are services we can give you, but I don't think that you will be able to pay.' And I asked myself, 'how do you know that I cannot pay for them?' She did not even tell me what is the service, what is the cost? Only because she has seen my [socioeconomic report], she assumes I would not be able to pay... (102, p. 3)

Women discussed not being able to pay their bills due to the fact that the bills are written in English, and they did not understand how or where to pay. This creates a belief that the system is not designed to help them, and their lack of health system literacy leads to a sense of vulnerability among our study participants.

It's hard even with insurance because language barriers, documents sent in English by mail, and bills sent in English. They can keep sending, but when they go to collection you still don't understand them. You get forms from the doctor in English, how are you supposed to fill them out? (101, p. 1)

When these women encounter barriers in scheduling appointments, or navigating payment systems, and feel treated with disrespect, they already have the impression that the health care system is itself abusive. These experiences identify for them that this is an unsafe environment for them to further

expose vulnerabilities in their psychosocial life such as intimate partner violence or sexual abuse. These participants' perception of being undervalued is explicated by the four sub-themes no confianza (lack of trust), having a voice, being marginalized, and navigating a dysfunctional system.

No Confianza

Confianza is a Latin American concept that embodies both trust and a sense that both parties in a relationship will look out for each other. When confianza is present, there is not only mutual honesty in sharing information, but each person feels obligated to bring their best to the relationship. Lack of trust in health care providers and their office staff can be a structural barrier to care and full disclosure of information. The issue of no confianza was heard throughout the interviews and describes the participants' lack of trust in their health care providers as well as the entire health care system. Their unwillingness to trust the providers was predicated on their perception that office staff and providers did not trust them with complete information. This sub-theme, no confianza, represents women's impressions of the inability of their health care provider to care for them as individuals. The belief that the provider is just "reading questions from a screen" made them feel like they are just a job to the health care provider" and that the provider did not "really care about them as a human" (101, p. 5). That sense of not caring made them hesitant to trust and be vulnerable due to the perceived lack of empathy. It also contributed to their impression that it was not important to answer sensitive questions honestly, as their complaints were not heard or were dismissed.

The participants shared many examples of what they perceived to be lack of caring by the health care workers they encountered. Several participants stated that they did not "know" their provider and would

not disclose personal details about their history with them. This was particularly noted when they were asked to complete an IPV survey at the beginning of a health care visit. They were surprised to be asked those questions and did not always feel comfortable answering them (104). One participant reported that she did not complete it and “would just try to keep the form under the other papers and if they don't ask [her] to complete it then [she] would just skip it” (101, p. 13). Another reported that, “I told them ‘No’ [to all the questions] because it’s not a topic you can discuss with the whole world” (103, p. 4).

The failure to promote trust was perceived by most participants. This was reinforced by the sense of being rushed by the health care provider through an overly structured visit. “They don’t give sufficient information to the patient, and I always felt that they are trying to hurry me every time I go, or something is missing. Information is always missing” (102, p. 1). Another participant believed that there was a lack of transparency stating, “If I want to know something... if I want a copy of my xray... I have to ask. They don’t show me. They don’t speak or offer me a copy. They do just what they need to do” (108, p. 3). Dissatisfaction with the length of the healthcare visit was a frequent concern. Participants reported that health care providers walked out the door while they still had questions, dismissed questions or complaints, and did not have time to spend with them. “They say, ‘do you have any questions?’ but at the same time they are closing the conversation. Then, even though you have questions, it is too late” (102, p. 3). The Latina women discussed the need for thorough communication to build trust, and that 10-15 minutes was not enough time during one appointment.

Having a Voice

Difficulty with communication is a major structural barrier. The ability to speak and understand is of utmost importance in a patient – provider relationship. This communication is essential in building trust as well as establishing a healthy and safe environment for the patient. The Latina women in this study all believed that they encountered barriers at one time or another in receiving care because of their cultural heritage and language. Many found that they had difficulty finding a Spanish-speaking practitioner or obtaining an appointment with one. Those who could not secure a Spanish-speaking health care provider or who sought care in an emergency room or clinic encountered communication barriers that negatively impacted their confidence in their providers.

Some who had limited English language skills were offered interpreters for translation, but as one participant said, “Interpreters are not enough” (103, p. 2). One woman reported that she has “some” English skills, so no interpreter was used; this resulted in her having a poor understanding of what the health care provider told her. The ability to be understood was further complicated by the lack of written Spanish text used for communication. This can be particularly frustrating when trying to read information in the office or sent to the home, interpreting test and radiology results, and taking care of billing issues. Once, the provider visit was concluded because no interpreters were available and no one in the office was able to translate. One woman stated that the “interpreter is only there during the consultation. They are not there to help with the bill or the results, but I didn’t want to bring my family member to help me” (103, p. 2). Another stated in her interview that she had “to be paying someone who can translate for me from my own pocket who is of legal age and knows how to speak the

language well,” (106, p. 3) in order to deal with the health care system outside the exam room.

Participants explained how their communication difficulties both contributed to their own loss of power and control in health care situations, and to how sometimes communication policies and strategies utilized by providers and office staff exerted power and control in ways that discouraged full patient disclosure during their visits.

Being Marginalized

Being marginalized was another sub-theme identified as a structural barrier, which included experiences of racism and implied bias as well as the lack of respect from health care providers and staff. One woman, while attempting to register for care at a provider’s office, experienced the feeling of being marginalized, stating, “they treat you like you are an invader in this country” (106, p. 5). A second woman said, “I have found many times they are racist” (102, p. 2). A third woman said, “I just feel like you know, discriminated... I don’t feel, myself, that they treat you right.... You can tell that when they see the Spanish people, you just see the change in the way they feel and treat you” (108, p. 2). In addition to overt racism, one participant noted bias in disparate medical care when she compared her treatment to other non-Latina patients.

I had a co-worker who had the same surgery and she told me how they treat her and how they explained it to her; but for me, I need to ask, ask, if I want to know something I need to ask. If I want a copy of my x-ray or something, about my knee. I have to ask. They don’t show me. They don’t speak or don’t offer me a copy.... No matter who is coming to see them, they need to be equal, you know, for everybody. (108, p. 3)

These experiences of being marginalized are critical contributors to these women’s perception that their human dignity was not recognized or respected.

Navigating a Dysfunctional Health Care System

Obtaining health care in what our participants saw as a dysfunctional system was noted to be a laborious and confusing process. The dysfunctional system described by participants was itself a major structural barrier to care. Multiple factors, such as health care system literacy, the lack of financial transparency, gatekeepers denying access to care, the extensive wait times to both obtain an appointment and while sitting in waiting rooms contribute to the sub-theme of navigating a dysfunctional system. The women expressed frustrations at receiving bills in English and for amounts that were higher than the initial quoted cost. Lack of ability to pay for care or the assumption that patients did not have the resources was a concern for some women. Unfamiliarity with health insurance led another woman to be bewildered when she had a co-payment after visiting her provider.

Understanding how to navigate the health care system itself was difficult for the women in this study. This was most apparent with gatekeepers and/or telephone conversations. One woman related this incident:

“The ultrasound, when the test came back, I just get a phone call from a nurse saying, “the test is negative.” I say, “what are we testing for?” And she says, “I don’t know, the doctor didn’t tell me.” I say, “can we ask the doctor?” and she says, “no way, he’s in appointments” (101, p. 4).

After an Emergency Department (ED) visit, another woman was told to follow-up

with her doctor's office for care. She did not get that follow-up because the only access points into the system she was aware of were the ED and her obstetrician/gynecologist's office. Doing as instructed, she called that office for an appointment and was told, "we don't take care of that problem here," and the receptionist hung up the phone without directing the woman to another resource for care (103, p. 10).

The timeliness of the health care visit was another obstacle in navigating the health care system. Women stated that despite having a scheduled appointment, they were frustrated and confused when they had to wait to be seen. One woman stated, "And you have to take time from work, and your boss expects you when you told them what time your appointment was, and you know it is a lot of time to wait" (108, p. 2). Participants identified that their time was not valued in the same way as the health care practitioners or English-speaking patients who were apparently seen more quickly.

Summary

Throughout this study, participants described routinely experiencing several interconnected barriers to care that illustrated to them that they were not in a safe care environment for disclosing IPV and other sensitive health information. The conditions that created a lack of trust and confidence in their care providers, communication barriers, the experience of being marginalized, and the dysfunctional system coalesced in ways that left these women feeling as though their basic human dignity was not acknowledged. The participants felt their care was disjointed; thus, they did not disclose sensitive information to providers. They described waiting and searching for a place within the health care system where they felt their common humanity and dignity to be recognized and respected. The onus is not on the patient but upon those who comprise the

system: health care organizations, administrators, and providers, to ensure that patients who are the most vulnerable can trust, communicate, and successfully navigate unfamiliar systems in ways that build their confidence in and capacity to utilize the health care system to maximize their health.

Discussion

The study participants all had a basic need and desire to be treated with dignity and respect. When this did not happen, it created a barrier to both health care access and IPV disclosure for these Latinas. Whether they were still seeking a health care provider or choosing to disclose or withhold information about their safety in intimate partner relationships, participants reported being assailed rather than supported in their search for health care. Until human dignity is affirmed in these interactions, basic expectations for a therapeutic relationship will not be met, which means our participants will not provide candid answers to IPV screening questions or report unsafe environments to providers who may be able to provide resources and assist with strategies to help them move towards safety. The basic principle of esteem is found in Maslow's Hierarchy of Need (McLeod, 2020) and includes respect as well as dignity. Dignity is derived from being treated with respect (Zirak et al., 2017) and is an expectation of all client interactions in a health care relationship (Barclay, 2016; Beach, et al., 2017). Barclay (2016) and Beach et al. (2017) both found that individuals reported the perception of being respected and having dignity when their providers engaged with them and were transparent in their interactions. This was reported as missing by the women in our study.

Further, in other studies, Hispanic individuals reported having dignity and respect when their providers were honest,

prompt, maintained eye contact, acknowledged family members, did not rush them in their interactions, respected their privacy, and sought to build a trusting relationship (Barclay, 2016; Beach et al., 2017; Bridges et al., 2021; Roncoroni et al. 2021; Williams et al. 2016; Zirak et al., 2017). Unfortunately, the experiences reported by the women in our study did not reflect the efforts of health care providers to provide dignity and respect as suggested in the literature.

Women in our study did not always report their history of or ongoing IPV to their providers. Alvarez and Fedock (2019) found that while Latina women are not more likely to experience IPV, they are less likely to report it. The decision to report abuse and IPV to providers is influenced by the perception of being treated with dignity and respect (Alvarez & Fedock, 2019; Burnett et al., 2016). The perception of a lack of respect and dignity was a factor in the women in our study failing to disclose abuse and traumatic experiences. It is crucial for individuals to believe that they are respected and treated with dignity to provide the safe space to reveal abuse or IPV, but it is also crucial following disclosure (Burnett et al., 2016). Further, the judgmental response from providers and staff can shut down conversations instead of facilitating diagnosis and treatment of Latinx patients (Lightfoot et al., 2019). Hymal et al. (2018) reported that implicit bias and ascertainment bias, defined as, “looking for what one expects to find only in patients where they expect to find it and not in other patients,” (p. 198) obstructed the discovery of trauma and abuse in patients. While providers are aware of the need to build a strong rapport with patients that would provide dignity and respect during interactions, many identified that time constraints and language barriers impacted their ability to do so successfully (Portnoy et al., 2020). Those same barriers

reported by providers were noted by the women in our study which caused them to feel disrespected and lacking dignity.

The overarching theme of “searching for dignity” by the women in this study aligns with previous literature. The intersection of four sub-themes contributed to their sense that they had not yet found a health care home in which they were treated with respect and dignity. These sub-themes are discussed individually below.

The lack of trust in their health care providers identified here as “*no confianza*” negatively impacted the participants’ satisfaction in their care as well as their willingness to disclose what they believed to be personal information. This is not novel to the Latina population. Distrust of health care providers by persons from different racial and ethnic groups and of providers is found in the literature with the level of trust between provider and patient impacting outcomes (Birkhauer et al., 2017; Mouslim et al., 2020). Further, Beach et al. (2017) identified that Caucasian, Black, and Latino patients all equally reported the need to be treated with respect with the perception of being disrespected impacting their ability to build trusting relationships with their providers. Trust was also impacted in our study by the perception of a lack of caring by the provider. This lack of caring was exemplified by providers not being respectful of the participants’ time, not providing enough time for the participants’ questions, and dismissive behaviors such as poor eye contact and talking to the computer screen. These same qualities are described in the literature with authors also adding that exposure to unfriendly office staff, being provided with information about their visit, and concerns that the provider is not “hearing” what they are saying decreased the level of trust in Latina patients (Amirehsani et al., 2017; Beach et al., 2017; Choi et al.,

2016; Magana, 2020; Vargas Bustamante et al., 2019; Williams et al., 2016).

In this study, the lack of trust further impacted the participants' willingness to disclose sensitive information about IPV. Williams et al. (2016) also identified that for Latina women in their study, the perception of rapport and trust in their provider was essential before disclosing any experiences of IPV. A study by Burnett et al. (2016) not specific to Latina women supported this finding, adding that women from rural settings who have been treated with dignity and respect both before and after disclosure of IPV were more likely to be open about their experiences. Unfortunately, few other studies have explored trust as a barrier to sharing experiences with IPV in rural Latina women in the U.S. A great deal of literature explores the methods used to conduct the IPV screening although studies specific to the Latina population are lacking. There is also much literature that supports the need for a trusting relationship between health care professionals and Latina women to improve patient satisfaction; however, there is a dearth of literature that focuses on the need for a trusting, respectful relationship as a Latina cultural consideration for sharing sensitive information with health care professionals.

The second theme, "*having a voice*," identifies the importance of the patient's ability to communicate with the health care provider, especially for those in unsafe environments. In this study, the perception of not being "heard" by their provider was a common theme. Language is often perceived as a barrier to building trust for Latinx persons (Amirehsani et al., 2017; Choi et al., 2016; Gonzalez et al., 2018; Vargas Bustamante et al., 2019). Latinas from our study were very clear that the breakdown in communication began before they even saw their provider. This same theme is found in other studies with patients having difficulty in making appointments due to the lack of

Spanish-speaking office staff as well as the failure of the provider to offer required patient information forms and discharge instructions in Spanish (Calo et al., 2015; Sawin et al., 2017; Steinberg et al., 2016; Topmiller et al., 2017; Torres-Aguilar et al., 2016).

The inability to discuss concerns and respond to questions can be frustrating and depersonalizing (Vargas Bustamante et al., 2019). The women in our study sought out Spanish-speaking providers but few were available and those they located were not taking new patients. Steinberg et al. (2016) also identified that Latinas in their study preferred a Spanish-speaking health care provider but often had to settle with alternative methods of communication. Offices did not always provide interpreters for the women in our study; aside from not being standard of care, expecting family members to attend visits and interpret is an invasion of the patient's privacy and inhibits their ability to honestly answer sensitive questions. The inability to converse directly with a provider in either case affects a woman's ability to address the questions related to their experience with IPV.

The use of interpreters to aid the health care provider to communicate with their patients is recognized as a convenient alternative to Spanish-speaking health care providers; however, the participants in our study did not always find the practice to be helpful. Several issues are associated with interpreters. As in our study, other researchers learned that the lack of availability of interpreters for many offices was an obstacle to communication with health care providers (Calo et al., 2015; Schminkey et al., 2019; Wilson, et al., 2015). One participant in our study questioned if she would have to pay out of pocket to bring her own interpreter. She did not have to resort to this; however, participants in a study by Steinberg et al. (2016) did. There can also be

long wait times associated with the use of interpreters if more than one Latina patient is waiting, which further impacts the perception of being heard and building trust with the Latina population (Calo et al., 2015; Cheng et al., 2018; Magana, 2020).

The use of an interpreter can also impact the level of trust between the patient and provider. Women in our study were hesitant to disclose personal information through an interpreter. Allison and Hardin (2020) found that using interpreters could also impact the building of trust between the Latino patient and their provider when social niceties such as small talk, apologies, words of empathy, and humor were not included in the translation. The accuracy of the translation was also questioned by Latina participants in our study; they were unsure if what they were saying was accurately or completely communicated. Other studies have had similar findings (Lightfoot et al., 2019; Steinberg et al., 2016; Vargas Bustamante et al., 2019). Furthermore, Vargas Bustamante et al. (2019) found that patients perceived that they received incomplete information when using interpreters, negatively impacting adherence to treatment. Steinberg et al. (2016) also identified this, as well as Latinas reporting distrust of interpreters even if they had personally had little or no experience with using an interpreter. If the use of an interpreter is in question by the Latina population, then it is doubtful that they will disclose sensitive details required by the IPV screening. As noted in our study, participants provided safe and negative answers to IPV questions rather than attempting to report IPV through an interpreter. Ultimately, as found by Sawin et al. (2017), a barrier to IPV intervention is impacted by the language barrier between the Latina patient and the provider.

“Being Marginalized” was the third common theme that emerged from our data. Experiences of discrimination were often

described by the Latinas in our study. This perception of discrimination is reflected in other studies of Latinos as they seek health care in the U.S. (Becerra et al., 2015; Calo et al., 2015; Gonzalez et al., 2018; Schminkey et al., 2019). Being marginalized has potential negative consequences on health outcomes. Calo et al. (2015) suggested that this perceived discrimination leads to reduced levels of health care utilization including a hesitance to seek care and the reluctance to complete treatment when care is eventually obtained. Becerra et al.’s (2015) secondary analysis of over 4,000 surveys of Latinos suggested that participants’ perceptions of discrimination in encounters with the health care system led to dissatisfaction with care, instances of delays in care, and reluctance to follow or complete treatment recommendations. Further, Beach et al. (2017) reported that Latinos believe that they received unequal treatment compared to non-Hispanic patients. Amirehsani et al. (2017) and Gonzalez et al. (2018) noted many of the same themes regarding Latino perceptions of discrimination in the health care system, including delays in care or a failure to seek care altogether. Lightfoot et al. (2019) identified that some Latinos felt judged by their providers. Another study by Wilson et al. (2015) added that feelings of shame and embarrassment were experienced by Latinas reporting IPV. The sense of being discriminated against, judged, or shamed can severely impact a victim’s willingness to disclose experiences of IPV with their providers. The belief that they were being discriminated against led to similar disruptions in care from the Latinas in our study, impacting the participants’ willingness to disclose sensitive information during visits and becoming a barrier to reporting IPV disclosure.

The participants in this study shared experiences of *“Navigating a Dysfunctional System.”* Critics across the political spectrum

have described the U.S. health care system as dysfunctional (McAneny, 2018; Abendshien, 2019). These critics point to the high cost of care, complex coverage issues, access to care, disparities in care, governmental regulations, care fragmentation, short visit times, and the limited number and geographical availability of primary and specialty care providers (Abendshien, 2019). These issues can be intensified when seeking health care in rural areas. In 2018, the then president of the American Medical Association, Barbara McAneny (2018), bluntly stated at a national meeting that the system itself “often gets in the way of actual health care.” The system is even more complex when the person seeking health care has both poor English skills and limited knowledge of the health care system.

Complicated payment systems were noted by the Latinas in our study to be a structural barrier. This sentiment was congruent with findings from other research (Becerra et al., 2015). Steinberg et al. (2016) and Topmiller et al. (2017) found the cost of health care to be a significant barrier. Lacking funds to pay for care or being uninsured was another barrier to both seeking or obtaining health care (Lightfoot et al., 2019; Schminkey et al., 2019). Additionally, difficulty understanding and traversing multiple payment structures was found by Leon et al. (2020). Our study adds that even the perception by health care system employees that you lack funds to pay is itself a barrier to care.

Navigating the office visit itself can result in patient frustration and contribute to negative patient outcomes. Researchers have noted that challenges making appointments, long periods sitting in waiting rooms followed by brief provider visits (Oguz, 2019), awkward information gathering and screening by providers and office staff, lack of translators, and insufficiently clear discharge instructions are common complaints voiced by Latino patients

(Amirehsani et al., 2017; Calo et al., 2015; Schminkey et al., 2019). Many of these complaints were similarly voiced by our participants. Our study affirms the work of Portnoy et al. (2020) that found these struggles can be impediments to building engaged and honest relationships between patients, providers, and clinic staff that are crucial to providing a space for women to share their experiences with IPV.

Maneuvering through the health care system left many of our participants with a sense of powerlessness and loss of agency. Other researchers (Burnett et al. 2016; Gonzalez et al., 2018; Martinez et al., 2015) also found these beliefs expressed by marginalized patients in health care. Especially when a patient is naive to the health care system, they may not recognize the system itself is dysfunctional; their experience of dysfunction can feel personal. Navigating a dysfunctional health care system directly contributes to no *confianza*; the experience leads to frustration and discouragement, impacting a person’s trust in their providers and the health care system and interfering with disclosures that are critical to maximizing the patients’ safety and health.

Limitations

Our participants reside in rural Virginia; these findings may not be generalized to Latinas in other rural areas. There could be a selection bias present, in that women who volunteered to be interviewed may have experiences that are fundamentally different from those who did not volunteer. The single interview itself may be considered a limitation. A second interview with participants may possibly have engendered a deeper level of trust, allowing further disclosures. Although member checking was offered to participants to validate the credibility of the results, only one participant chose to review her transcript. This also may have impacted the results. Additionally, the

interviews were conducted by four interviewers, which given the nature of the semi-structured interview format, may have led to differently-biased follow-up questions being asked.

This study identifies a unique set of structural barriers to the delivery and receipt of health care for rural Latina immigrants. These barriers help account for the wide discrepancy in reported rates of IPV in the Latina/Hispanic population in the United States. Taken together, these findings suggest that the perceived lack of dignity on the part of these Latina immigrants affects their entire health care experience.

Recommendations

There is clearly a need for health care providers/organizations to explore with the communities they serve each other's beliefs about appropriate care, and understandings of how to access care. A shared agenda of mutual trust and understanding needs to be developed within local care systems to provide dignity in health care. This must include strategies to pull the newest community members in from the margins and coach them on how to navigate the system appropriately. Ten or fifteen-minute appointments with culturally sensitive providers will not suffice when multiple indignities have been suffered enroute to the exam room. That these women in our study did not feel comfortable talking about IPV or disclosing their safety status with their providers is a systemic, not an individual level issue.

Solutions to these structural issues need to be developed and evaluated on organizational and systems levels. One approach is Trauma and Violence Informed Care (TVIC), which is aimed at addressing health inequities and structural violence such as that experienced by the women in this study. TVIC shows promising results improving trust and encouraging disclosures

of violence when caring for women in indigenous communities (Cullen, et al., 2022).

There are four principles to be followed when an organization refocuses their care delivery utilizing a TVIC approach (Wathen & Mantler, 2022). First, staff and providers receive trauma awareness education to increase their understanding of the unique histories and present circumstances of their patients and staff. Second, steps are taken to transform the clinical environment into a safe care space. Third, relationship building becomes an organizational priority, promoting shared decision-making and collaboration among patients, staff, and providers. Fourth, both organizational policies and individual patient care plans are driven by an understanding of the patients' strengths and abilities.

Conclusion

This study identifies unique structural barriers to the delivery and receipt of health care for rural Latina immigrants. These barriers help account for the wide discrepancy in reported rates of IPV in the Latina/Hispanic population in the United States. Taken together, these findings suggest that the perceived lack of dignity on the part of these Latina immigrants affects their entire health care experience. The onus is not on the patient but upon those who comprise the system: health care organizations, administrators, and providers, to ensure that patients who are the most vulnerable can trust, communicate, and successfully navigate unfamiliar systems in ways that build their confidence in and capacity to utilize the health care system to maximize their health.

Despite multiple failures during continued interactions with the health care system, the Latina women in our study, and perhaps in other communities, continue to hope that their search for dignity and

understanding will one day be fulfilled. Health care providers must be willing to examine individual and systemic assumptions and practices from initial contact through ongoing case management

through a more equity-oriented lens to form partnerships that will provide this population with more satisfying and comprehensive care.

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