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Georgia Government Leaders' Lived Experience Creating and Implementing Health Equity Policies

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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Tracy Michele Clopton

MSW, University of Pennsylvania, 1995

BS, Slippery Rock University of Pennsylvania, 1987

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Public Policy and Administration

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Abstract

Georgia’s racial and ethnic minority communities have a continual problem of disproportionately worse health outcomes, including higher chronic disease and behavioral risk factors, compared to their nonminority counterparts. The average cost per year for chronic disease between 2016 and 2030 could be $64.6 billion in medical costs and $26.8 billion in lost employee productivity for Georgia. The purpose of this study was to explore the lived experience of Georgia legislators and health program staff to determine policy solutions to reduce chronic disease and behavioral risk factor disparities in the racial and ethnic minority population. The theoretical lens for the study was Habermas’s theory of communicative action that advocates public dialogue for determining optimal actions to overcome social oppression. This study may contribute to continued public dialogue on the pursuit of legislation and program policies to eliminate racial and ethnic minority health disparities. Data collection took place through qualitative online surveys and semi-structured interviews with 11 legislative and health department program participants. For analysis, structural and thematic codes were determined from participant interview transcripts. Findings indicate a need for appropriate state legislative policies to support health improvement, and the ability to address the social determinants of health through health programs exists at various levels. Since initiating the inquiry, the Georgia General Assembly allocated additional funding that could impact the social determinants of health. Participants also expressed the need for additional funding based on their lived experience working towards health equity for racial and ethnic minority Georgians.

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Dedication

I thank God for the gift of compassion and desire to pursue equity for persons most in need. I will continue seeking God's help to "do nothing from selfish ambition or conceit, but in humility count others more significant than yourselves…each of you look not only to his own interests, but also to the interests of others" (Phil. 2:3-4, English Standard Version).

I thank my mother, Dolores E. Clopton, for her lifetime commitment to building my character, and my father, George L. Clopton, whose memory of assuring encouragement lives on in my spirit. I will always love you both for your tireless support and love in every way possible.

I am grateful to the Georgia Legislator and Health Official participants for their inspirational courage. Georgia state residents are blessed by your work and commitment. I am also thankful to my mock interviewees and validity reviewers for their help and commitment to public health.

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To all my supportive extended Hyatt and Lampkins family, Farrell, PA community, Ohio colleagues, friends, coworkers, and associates, your kind words were music to my ears. As the African Proverb says, you gave me the ability to keep dancing as the dissertation music changed going forward. I am fortunate to have you in my life; may you all be blessed.

The work is in memory of U.S. Secretary of Health and Human Services, Margaret Heckler (1931–2018). She showed us that health improvement is an apolitical human concern.

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Chapter 1: Introduction to the Study

Introduction

Georgia's racial and ethnic minority population, including racial and ethnic minorities in rural locations, have a historical problem of disproportionately poor health outcomes, including higher chronic disease and behavioral risk factor (e.g., diabetes or physical inactivity) rates, compared to their nonminority counterparts. For all Georgia racial and ethnic minority communities, the prevalence rate for Type 2 adult diabetes is greater compared to non-Hispanic Whites. For example, in 2012, the non-Hispanic White rate was 8.4% compared to the rates for non-Hispanic Blacks at 12.8%; Hispanics at 9%; and the combined Asian, Native Hawaiian/Pacific Islander, American Indian/Native Alaskan, and multiracial communities at 9.8% (Georgia Department of Public Health, 2012). More recently, the Henry J. Kaiser Family Foundation (2017b) reported the diabetes death rate for Blacks was at 37.5 per 100,000 population versus 19.2 for Native American, Alaska Native, Pacific Islander, and Asian populations and 19.6 for Whites.

Corroborating the data mentioned previously, chronic disease and behavioral risk factor disparities were captured in the seminal 2008 Georgia minority health report for racial and ethnic minority residents. For instance, Georgia Blacks and Hispanics/Latinos, compared to their White counterparts, experienced higher death rates from cancer, heart disease, HIV, and diabetes, in addition to having unequal health insurance coverage (Georgia Department of Community Health, 2008). Compounded by poverty, the report further indicated the urgent need for relief in rural communities (Georgia Department of Community Health, 2008).

I conducted a qualitative inquiry to have a better understanding of and determine solutions to Georgia’s persistent racial and ethnic minority health disparities. The purpose was to determine the lived experience of Georgia state legislators and health department officials working to pass and implement policies to eliminate racial and ethnic minority health disparities. Their recommendations could possibly improve health outcomes.

In Chapter 1, I provide background by describing Georgia’s racial and ethnic minority health disparities through national and Georgia-specific data. Additionally, I provide information on healthcare costs and insurance coverage challenges related to health disparities and national and Georgia-specific efforts to address health insurance coverage access. In addition to the background, this chapter includes the problem statement, study purpose, research questions, theoretical foundation, nature of the study, definitions, assumptions, scope and delimitations, limitations, significance, and a summary.

Background

Black male health and life expectancy has not traditionally been equal to or better than their White counterparts. According to the Centers for Disease Control and Prevention (CDC, 2018b), the national Black male colon and rectum cancer incidence rate in 2011–2015 was 53.9 per 100,000 versus 44.1 for White males. For prostate cancer deaths in 2016, Black males had a rate of 37.9 per 100,000 population compared to 18.2 for White, non-Hispanic males and 18.1 for the nation (Healthy People 2020, 2017b). These are two national examples from a larger pool of evidence of unequal health burdens in racial and ethnic minority communities.

Nationally, disproportionate racial and ethnic minority population health outcome burdens cost taxpayers billions of dollars in addition to the toll on quality of life and premature death (Gaskin, LaVeist, & Richard, 2012). Health insurance coverage is a way to reduce costs associated with health burdens (Shi et al., 2017; University of Wisconsin Population Health Institute, 2018). Insurance can give residents access to routine healthcare for disease prevention and potentially mitigate the adverse effects of diseases and risk factors that could improve life quality. Approximately 267,000 Georgians cannot access private insurance and do not qualify for Medicaid (Henry J. Kaiser Family Foundation, 2019b). The uninsured rate among different racial and ethnic minority persons in Georgia ranges from 12% to 34%, while the state and national rate is 16% and 11%, respectively (University of Wisconsin Population Health Institute, 2018). These Georgians lack a system for affordable health coverage.

Understanding the scope of health-related inequality in Georgia is important if social change is sought. If every Georgia resident had an equal opportunity to be healthy, an estimated 5,600 deaths would be preventable annually (University of Wisconsin Population Health Institute, 2015). Racial and ethnic minority groups are a significant part of the population in Georgia, and the percentage is growing. Approximately 47% of Georgia’s population in 2015 belonged to a racial or ethnic minority group (U.S. Census Bureau, 2015). Georgia could benefit from a health disparity elimination policy to give all racial and ethnic minorities as well as rural populations in need the opportunity to have healthcare. Doing so could reduce state and personal costs and improve quality of life.

Historically, state government health leaders have grappled with how to remove or decrease racial and ethnic minority and rural health disparities. To overcome the health disparity challenge, the Commonwealth Fund's recommendations from a state legislative policy and public health practice perspective were grounded in previously documented efforts from various state leaders seeking to address racial and ethnic minority disparities significantly (McDonough et al., 2004). These recommendations came approximately 20 years after the pioneering 1985 Heckler report from the U.S. Department of Health and Human Services' documented racial and ethnic minority health disparities in the United States (Heckler, 1985). Considering the minority health disparity evidence documented since 1985, it is appropriate that President Barak Obama offered state public health leaders a way to close health coverage gaps through Medicaid expansion under the Patient Protection and Affordable Care Act of 2010 (ACA).

The 2016 presidential election ushered in a political shift. Initially, Congress planned to offer a limited reversal of ACA through budget reconciliation without specifics for a full coverage replacement policy (Blumberg, Buettgens, & Holahan, 2016). In March 2017, the proposed American Health Care Act (AHCA) was released with provisions removing financial support for ACA's Medicaid expansion (Henry J. Kaiser Family Foundation, 2017a). However, on March 24, 2017, there were not enough votes in the U.S. House of Representatives to pass the AHCA, and the bill was terminated (Reilly, 2017). By May 4, 2017, an AHCA bill passed the U.S. House of Representatives, and the people of the United States are still waiting for the U.S. Senate to create its version of the bill to repeal and replace ACA (Independent Health Association, 2019). On

December 14, 2018, a Texas U.S. District Judge ruled that ACA was unconstitutional; nevertheless, the law will remain intact while under decision appeal (Goldstein, 2018a).

Georgia did not expand Medicaid under the ACA, but state legislators have continually made efforts to do so as well as to offer legislation in support of achieving health equity. Although interest in expanding Medicaid appeared to fall along political party lines, there were no committee membership boundaries for sponsoring and cosponsoring such legislation among persons outside of the Health and Human Services Committee. Some of the most vocal and ardent supporters of Medicaid expansion for Georgia emerged from servants on committees, such as, but not limited to, Appropriations, Governmental Affairs, or Industry and Labor. On January 31, 2017, Georgia Representatives Abrams, Trammell, McGowan, and Gardner introduced House Bill (HB) 188, called the Expand Medicaid Now Act (Georgia General Assembly, 2017-2018c). Likewise, on January 23, 2017, Senate Bill (SB) 7, proposed by Georgia Senators Forte, Jackson, Parent, H. Jones II, E. Jones, and Henson, was released to secure funds for "obtaining federal financial participation for medical assistance payments to providers of Medicaid expansion under the federal Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010…" (Georgia General Assembly, 2017-2018a, para. 2-5).

Despite introducing Senate Resolution 595 to reject ACA through the Health and Human Services Committee to "…return health care decision making power back to the state of Georgia…" (Georgia General Assembly 2015-2016b, para.1-2), other officials in the Georgia General Assembly have persistently continued to sponsor or cosponsor legislation that could potentially help reverse excessive health burdens of racial and ethnic minority groups and rural communities. Examples included HB 669 to expand Medicaid under ACA (Georgia General Assembly 2017-2018d); HB 177 to ensure that English as an official language was not an unintended barrier to public services, inclusive of health (Georgia General Assembly, 2017-2018b); HR 226 to express the need to provide health coverage for persons unable to afford the costs but not qualified for Medicaid (Georgia General Assembly, 2015-2016a); HR 746 to encourage the General Assembly to enact policies allowing Georgians to flourish, focusing on health (Georgia General Assembly, 2015-2016c); HB 823 to expand Medicaid under ACA (Georgia General Assembly, 2015-2016d); and SB 368 to have the state provide financial assistance for health coverage in partnership with qualifying persons who could also contribute partial funds towards health care coverage (Georgia General Assembly, 2015-2016e). The bill and resolution repetition further confirmed the governance challenges associated with securing state legislation to protect and improve health, particularly for persons experiencing disproportionate health burdens.

State governance does not operate in isolation, and the national milieu can serve as an influence. I learned from one legislator participant that the political instability of Medicaid expansion has been a reason for legislators' resistance to expanding Medicaid in the Georgia General Assembly. However, the Medicaid expansion provision of ACA appears to have a sustainable track record for three reasons. First, healthcare remains a major issue statewide and nationally (Hart & Bluestein, 2019; Vazquez, 2019). Second, during the 2018 midterm elections, three states passed ballot measures to expand

Medicaid in traditionally Republican states (Goldstein, 2018b). Third, since 2009, ACA has endured over 50 amendment and repeal votes in Congress (Berensen, 2017). By early spring 2019, President Trump stated the Republican Party would gain a reputation for addressing healthcare, but so far, this has not come to fruition (Vazquez, 2019).

Beyond the Georgia and national legislative obstacles referenced above, the literature review I conducted also revealed challenges, particularly in the southern United States, including Georgia, in the attempts to pass health policies that would help to reduce the disproportionate health burdens among racial and ethnic minority and rural communities (Burki, 2015; Pandey, Cantor, & Lloyd, 2014; Rose, 2015). To impact equitable and positive social change, I gathered the experiences and recommendations of Georgia state employees and elected officials for addressing racial and ethnic minority health disparities. State and national health policy makers could find the study results informative. Most importantly, with this study, I sought to gain insights regarding solutions to poor health outcomes among the Georgia residents most in need of health improvement.

Literature Review

The focus of my review of the extant literature was state policies created to reduce chronic diseases and behavioral risk factors resulting in continued health outcome disparities. My search also yielded information on nationwide state legislature bill introduction and passage. Young, Pollack, and Rutkow (2015) conducted a study to analyze legislative action to address racial and ethnic minority disparities. Their study served as a basis for my inquiries into eight states and Georgia to learn more about state policies to address health inequities. The states looked at for this study were Arkansas, California, Florida, Illinois, Maryland, New Jersey, New Mexico, and New York. In addition to Young et al.'s study, the literature search also revealed information about the work outcomes of state legislative policy makers and health department practitioners related to pursuing health equity (McDonough et al., 2004; Stamatakis, Lewis, Khoong, & LaSee, 2014).

My search also led to examples of specific strategies for achieving health equity at the federal, state, and local levels. Results included health equity action frameworks, local approaches to public health disparity removal, and pursuits of health equity in healthcare delivery (Beadle & Graham, 2011; Belasco, Gong, Pence, & Wilkes, 2014; Raphael & Brassolotto, 2015; Saldaña-Ruiz, Clouston, Rubin, Colen, & Link, 2013).

There was a gap in the literature related to the experiences of Georgia state government employees working to eliminate racial and ethnic minority health disparities. Additionally, researchers had not asked legislators and state employees for solutions to reversing the health disparity trends in Georgia within the context of the concepts found in the literature review. A substantial amount of empirical literature included analytical commentary and quantitative inquiries. Qualitative studies reflected insight from communities affected by a health challenge or healthcare providers' views on patient management. Therefore, my inquiry was Georgia-specific and conducted to understand the personal perspectives of state employees and legislators on health equity.

My study was necessary to inform health equity advocacy and public health policy action. Recommendations could help improve health outcomes among racial and ethnic minority communities in Georgia that are experiencing poverty and who bear the disproportionate burden of persistent chronic diseases and behavioral risk factors. The program areas of interest were health promotion, health equity, cancer, obesity/nutrition, diabetes, heart disease and stroke, rural health programs, and refugee health.

Problem Statement

Reflecting a national crisis, there is a problem among the racial and ethnic minority populations in Georgia, particularly among persons living in poverty. Despite the release of the seminal *Georgia Health Equity Initiative Health Disparities Report* in 2008 (Georgia Department of Community Health, 2008), a disproportionate burden of chronic diseases and behavioral risk factors result in costly health outcome disparities for racial and ethnic minority populations (i.e., African Americans, Hispanics/Latinos, Asian Americans, Native Hawaiians/other Pacific Islanders, and American Indians/Alaska Natives) in comparison to their White counterparts. The report by the Georgia Department of Community Health (2008) provided evidence of racial and ethnic minority health disparities at the county level. The purpose of the report and of providing county-level health status ratings was to encourage county-level partnerships to use the best strategies to improve health outcomes according to county-specific needs. In addition to statewide public education about the report, the Georgia Department of Community Health, where the Office of Minority Health existed at the time, released funds to communities for health equity programs.

In the United States, there is consensus among public health practitioners that the racial and ethnic minority health disparity problem is current, relevant, and significant.

There is an ongoing gap in comparatively positive health outcomes among racial and ethnic minority communities; persons affected by mental and behavioral health challenges; and persons within the lesbian, gay, and bisexual community (Novick, 2016). Canadian researchers have also affirmed the difficulties involved in improving health outcomes through local and regional public health system services and, consequently, offered potential solutions (Cohen et al., 2013; Raphael & Brassolotto, 2015). Ottersen et al. (2014) corroboratively documented governance dysfunctions globally that lead to unequal power distributions linked to the inability to address the social determinants of health (SDOH) associated with poor health outcomes. Not only is addressing racial and ethnic minority health disparities a challenge in the United States, but global evidence exists confirming that government leaders wrestle with how to improve health outcomes among populations with disproportionately poor health (Marmot, 2007; Ottersen et al., 2014).

Since 2013, researchers have quantitatively and qualitatively confirmed the public health challenge that results from racial and ethnic minority health disparities. The policy literature on the racial and ethnic minority health disparity under inquiry reflects five concerns. First, the state legislative bills most likely to pass are intended to inform the public rather than require significant resources or action (Young et al., 2015). Multiprogram collaborative actions or socioeconomic consideration bills to improve health outcomes were not prevalent (Young et al.). Second, the southern United States commonly has a more persistent racial and ethnic minority chronic disease health disparity burden (Alexander, Alfonso, & Hansen, 2015; Burki, 2015; Logan, Guo, Dodd, Muller, & Riley, 2013). The third health policy concern is the lack of comprehensive or preemptive statewide tobacco policies that threatens to disproportionately expose minority and service-wage earning communities to secondhand smoke, leading to greater health burden risks (CDC, 2018a; Chandora, Whitney, Weaver, & Eriksen, 2015; Mowery, Babb, Hobart, Tworek, & MacNeil, 2012). The fourth policy concern was most southern states, including Georgia, had not used Medicaid expansion governance powers through ACA (Henry J. Kaiser Family Foundation, 2019a; Rose, 2015). Arkansas was a lone positive example in the southern region in terms of how and why to expand Medicaid under ACA on behalf of youth and adults disproportionately burdened by chronic health conditions (Thompson, Wilson, Allison, & Beebe, 2014). Rather than traditional Medicaid expansion, through the 1115 waiver, Arkansas policy makers used private insurance systems to offer similar healthcare access to residents needing coverage (Thompson et al., 2014). As the AHCA or possibly other similar replacement plans linger in uncertainty, state policy makers who passed the ACA are swiftly recognizing financial benefits from Medicaid expansion (Bachrach, Boozang, & Lipson, 2015; Harker, 2018; Searing & Hoadley, 2016). The fifth area was putting policies in place to address the health coverage needs of immigrant communities (both undocumented and legal), either through state government or the ACA; furthermore, researchers showing escalating “Medicaid patient [hospital] admissions and Emergency Department (ED) visits after Medicaid Expansion” for 1 year heightened awareness of the need to continue monitoring primary care provider gaps (Barakat et al., 2017, p. 10; Nguyen, Choi, & Park, 2015; Sanchez & Sanchez-Youngman, 2013; Tshiswaka, Whembolua, Conserve, & Mwamba, 2014). The five areas of concern reflect a variety of health needs for which there is an opportunity for the study participants’ recommendations to be impactful.

There was a gap in the current research literature regarding understanding the lived experience of working to eliminate racial and ethnic minority health disparities in the Georgia state health departments and legislature. Additionally, the public health policy community can benefit from government employees’ recommendations for improving chronic disease and behavioral risk factor health outcomes. Consequently, I undertook this inquiry to determine the public health disparity elimination actions that would move the state and nation closer to health equity.

Purpose of the Study

There were two purposes for this phenomenological study. The first purpose was to explore the perceptions and experiences of Georgia staff persons from state and local health departments regarding implementing policies and policy programs to eliminate chronic disease and behavioral risk factor disparities among racial and ethnic minority populations. The second purpose was to understand the views and experiences of Georgia health legislation decision makers with creating and passing state legislation to eliminate racial and ethnic minority health disparities. My inquiry revealed what both state leadership groups believed needs to be done to address Georgia’s racial and ethnic minority health disparities through policy and practice solutions.

Research Questions

The following research questions guided this study:

Research Question 1: What is the Georgia Health and Human Services Committee legislators’ lived experience in creating and passing state legislation to eliminate racial and ethnic minority health disparities?

Research Question 2: What is the Georgia Department of Public Health and Department of Community Health employees’ lived experience in implementing policies and policy programs designed to eliminate chronic disease and behavioral risk factor disparities among racial and ethnic minority populations?

Theoretical Foundation for the Study

This study was grounded in the theory of communicative action within the critical theory concept advocated by German social philosopher, Jürgen Habermas. Influenced by Marxism, the second-generation Frankfurt School philosopher offered principles for understanding the processes for overcoming social oppression within the context of dialogue grounded in integrity and proactivity (Corradetti, 2011). I will more thoroughly address major theoretical propositions in Chapter 2 but will briefly discuss three observations in this section: (a) government can be a deterrent to open social discourse, (b) public dialogue is essential for determining favorable courses of public action for social challenges, and (c) public discussion can result in social freedoms for marginalized populations. The theory of communicative action was a suitable theoretical foundation for this study because it supported the contribution of the voices of government employees to the public dialogue regarding how best to address racial and ethnic minority health disparities in Georgia. Within the context of the theory of communicative action and through research questions, I sought answers to what is currently being done to close the Georgia health disparity gap and obtained insight into the experiences of performing work in the Georgia state government to eliminate disparities. Finally, within a public discourse context, I used research and interview questions (IQs) to give employees an opportunity to recommend solutions to the public health problem, which may lead to a policy change resulting in improved health outcomes among racial and ethnic minority populations.

Nature of the Study

My rationale for choosing a qualitative phenomenological design was the need to explore and obtain a better understanding of the lived experiences of state government employees working in Georgia's state and county health departments and legislature in the public health policy and practice arenas. I also intended to learn how the experiences could offer policy and practice solutions to eliminate racial and ethnic minority health disparities. The qualitative online survey and face-to-face semi-structured interview approach offered the best opportunity for participants to give their perspectives and contribute to the dialogue for reversing the health inequity trend among racial and ethnic minorities in Georgia, including racial and ethnic minorities in rural locations.

I sought data from program staff with a minimum of 1.5 years of experience working in state and county health department programs. The Georgia chronic disease and behavioral risk factor programs were either state or federally funded to help eliminate racial and ethnic minority health disparities. Health department staff members were given a small incentive for their online survey completion or in-person transcript reviews.

I also collected data from Georgia Senate and House of Representative General Assembly members. All participants had at least 1.5 years of service in the Georgia state legislature working to pass legislation beneficial for racial and ethnic minority and rural health disparity elimination. There was particular interest in the Senate Health Care Delivery Subcommittee and the Health and Human Services Committee due to their responsibilities for health care and social services. Legislator participants did not receive incentives.

I collected data through an online survey system called SurveyGizmo and in digital, audio-taped, semi-structured, in-person interviews. The online survey responses and audio transcripts were coded based on literature review key concepts and analyzed for common work experiences and health disparity elimination recommendations to inform racial and ethnic minority health disparity trend reversals. Data saturation dictated the final number of interviewees for the state legislature; however, access to participants reflected the final number for health department staff.

Definition of Terms

Health disparity: Inferior health among persons who are in a lower socioeconomic status regardless of race or ethnicity; among persons within racial and ethnic minority population groups; or among persons in various other populations based on age, mental health status, physical ability, or sexual orientation who experience social and economic obstacles (Braveman, 2014).

Health equity: A lack of differences in health outcomes due to social position (CDC, 2019a).

Health inequity: Differences in health outcomes based on unjust global governance powers (Ottersen et al., 2014).

Lifeworld: Citizens' personal and public lives (Leanza, Boivin, & Rosenberg, 2013).

Patient Protection and Affordable Care Act of 2010 (ACA): A federal provision for states to extend Medicaid health coverage to persons in poverty (i.e., $17,236 for one person in 2019) who do not have healthcare insurance (Henry J. Kaiser Family Foundation, 2019b).

Risk factors: Behaviors or environmental circumstances that raise the probability for disease, such as tobacco use, high blood pressure, and physical inactivity (New York State Department of Health, 2017).

Social determinants of health (SDOH): Social, physical, and economic influences on health outcomes (Rudolph, Caplan, Ben-Moshe, & Dillon, 2013).

Assumptions

Assumptions are study circumstances researchers believe to be true but cannot influence (Simon, 2011). I assumed that study participants would be candid in their responses regarding their experiences working to achieve racial and ethnic minority health equity or their recommended solutions for poor health outcome reversal. Another assumption was that employees would be willing to contribute toward a social change public discourse through participating in this study regardless of the socially challenging nature of the topic. Wargo (2015) suggested this type of assumption indicates that participants have no hidden agenda and will contribute sincerely. Consequently, I took the necessary care to preserve participants' identities at all costs to allow the freedom for thoughtful expressions (see Simon, 2011).

Scope and Delimitations

The scope and delimitations of a study are the confines a researcher places on the inquiry, such as the topic, research questions, or participant recruitment criteria (Simon, 2011). The specific aspects of the research problem addressed in my study included the key concepts from the literature review, such as determining the health equity frameworks used to inform policy work, passing state legislation to address excessive human suffering, and making recommendations to improve health outcomes. I chose these focus areas to reflect the work public health leaders were pursuing to improve the health statuses of rural communities and racial and ethnic minority populations in the United States. The study population included Georgia state representatives and senators as well as chronic disease and behavioral risk factor program consultants, managers, and directors in state and county health departments. I had particular interest in the Health Care Delivery Subcommittee members based on the connection to healthcare access through the ACA or state health coverage, which was stated repeatedly in the literature. The study population included six Georgia elected officials and five Georgia Health Department officials. A large number of Georgia elected officials pursuing health equity related legislation unexpectedly served on committees other than the Health and Human Services committee. Study outcomes have the potential to foster transferability among persons working in public service regardless of the geographic location, the population-specific focus, or the entity type (e.g., nonprofit or government). Pursuing health equity for marginalized communities may expose common experiences and hardships among practitioners, which would further validate the study and provide additional support for pursuing equity.

Limitations

Limitations are research areas on which researchers have no influence (Simon, 2011; Wargo, 2015). An example includes the current sociopolitical context in which the research occurred. The limitations of the qualitative survey and semi-structured interview study design were that the data represented the experiences and opinions of the people responding and are not generalizable to larger populations. One possible limitation was that providing awareness of the study through social media, such as LinkedIn and Facebook, during the recruitment process may have influenced whether Georgia health department employees and legislators participated. Individuals who accessed the identified social media sites would have been exposed to the additional opportunity to participate. Another possible limitation was that study results were affected by the inherent personality differences in individuals who were eager to share their experiences versus others who were not. The opportunity to provide written responses to qualitative surveys or to participate in in-person interviews would not have attracted these people.

For the in-person interviews, the interview settings and time availability influenced meeting length and the amount of information provided. To ensure participants felt as comfortable as possible, I developed the interview protocol and participant consent forms to acknowledge the voluntary nature of the study and the discomforts that may arise from participating in a study related to the topic of racial and ethnic minorities. The measures taken to reduce the limitations were ensuring audio transcript confidentiality with the transcribing entity, reporting information in the aggregate, and ensuring data confidentiality through me, the sole researcher. The interviews took place in officials’ offices if the participants felt the setting was secure. Participants reviewed their online responses or transcripts for accuracy and had the opportunity to ensure their information was transcribed properly. The interviews lasted an average of 34 minutes per in-person interview for 9 of the 11 participants.

More time was necessary to obtain written online responses to the qualitative surveys. Participants choosing this option had an additional week added to the 2-week time frame to submit responses. In the interview protocol and participant consent forms, I also acknowledged the voluntary nature of the study. Likewise, survey respondents were assured of anonymity through aggregated reporting and data confidentiality through SurveyGizmo and me, the sole researcher. I kept a personal journal during the data collection and analysis process to assess my thoughts and recognition of partiality.

Study Significance

This phenomenological inquiry is significant because the findings reduce the knowledge gap regarding the lived experiences of Georgia state government health workers and legislators pursuing health equity policies for chronic diseases and behavioral risk factors. The findings and recommendations emerged from the data collected from participants. The findings may offer future policy solutions for “the causes of the causes” or root causes of racial and ethnic minority health disparities from a Georgia-specific state performance and policy perspective (Marmot, 2007, p. 1153).

Regarding positive social change, within the context of Habermas's communicative action theory, the voices of Georgia state government experts working to achieve health equity through policies favorable to health outcome improvement have the potential to expand the public health policy debate. Consequently, credible policies and practices can emerge for Georgia and the United States to implement to reduce disproportionate chronic disease and behavioral risk factors among racial and ethnic minorities, including racial and ethnic minorities in rural communities. Finally, in the midst of continuous and new governance efforts to change or dismantle the ACA since 2017, recommendations can inform health care coverage policy replacement provisions to support what the U.S. Congress proposes to pursue.

Summary

In Chapter 1, I documented the public health problem of costly and disproportionate chronic disease and behavioral risk factor burdens among racial and ethnic minority communities in Georgia. The challenges were substantiated in the literature, which also confirmed the need for the study results to contribute toward closing policy and practice solution knowledge gaps. Despite the limitations of conducting a phenomenological study among Georgia health department program employees and Georgia General Assembly legislators, this inquiry is significant because the participants' lived experiences offer health improvement recommendations and an understanding of the impact the racial and ethnic minority health disparity work has on Georgia public employees. In Chapter 2, I offer a detailed look at the literature and the theoretical foundation of the study.

Chapter 2: Literature Review

Introduction

Chapter 2 includes examples of the disproportionate health burdens. In this chapter, I discuss the literature search strategies, the theoretical foundation, and the literature review related to key concepts. The chapter ends with a summary and conclusions.

Since 1991, Georgia has had a minority health unit, and the unit evolved into the Office of Health Equity in 2010 (Georgia Department of Public Health, n.d.a; National Association of State Offices of Minority Health, n.d.). Within the evolution process, health equity was pursued through the Georgia Department of Community Health from the Office of Health Improvement and Minority Health Advisory Council (National Association of State Offices of Minority Health, n.d.). Consequently, researchers released the groundbreaking *Georgia Health Equity Initiative Health Disparities Report* in 2008, which included a clarion call to address the health disparities in Georgia's rural and racial and ethnic minority populations concerning chronic and behavioral risk factor related diseases. Nevertheless, health outcome inequities continued. The *Georgia Health Equity Initiative Health Disparities Report* in 2008 demonstrated similar persistent chronic disease and behavioral risk factor challenges for racial and ethnic minority communities that were found five to 10 years later. The purpose of this phenomenological inquiry was to explore how staff from the Georgia Department of Public Health chronic disease (including local health departments in Georgia counties) and Department of Community Health rural health programs addressed health disparity elimination policy efforts in their work. In addition, I sought to understand the experiences of Georgia health legislator decision makers in creating and passing state legislation to eliminate racial and ethnic minority health disparities.

Gaskin et al. (2012) established the relevance of the health disparity problem in the United States through comparisons of disproportionate adverse health outcome burdens among African Americans, Asians, Hispanics, and Whites by looking at variables, such as health status and health conditions, in relation to direct medical costs and lost productivity (p. 24). Their results indicated that disparities totaled “over $82 billion in year 2009 in health care spending and lost productivity” (Gaskin et al., 2012, p. 2). If unaddressed, Gaskin et al. projected costs could rise to “$126 billion in 2020 and $363.1 billion by 2050” (p. 14).

My review of the extant literature from the time frame of 2010–2015 on the effects of Georgia’s health disparities on healthcare spending and lost productivity showed limited results. An e-mail consultation with the director of the Center of Excellence on Health Disparities Research at Georgia State University confirmed this missing comparable information (M. P. Eriksen, personal communication, July 4, 2015). The Georgia Budget and Policy Institute affirmed Eriksen’s response for comparable studies as of 2018; however, though older, in 2008, years of potential life lost were factored into the Georgia Department of Community Health’s health disparity assessment (E. Strunz, personal communication, May 4, 2018). In 2019, I learned the Partnership to Fight Chronic Disease projected the average cost per year for chronic disease between

2016 and 2030 could be $64.6 billion in medical costs and $26.8 billion in lost employee productivity for Georgia (Partnership to Fight Chronic Disease, n.d.).

Additional considerations corroborating the importance of Gaskin et al.'s (2012) findings were that national demographics were changing to reflect population increases among racial and ethnic minority communities and multiple Latino ethnicities (Shrestha & Heisler, 2011). Therefore, with Georgia having one of the highest uninsured rates in the nation, a larger number of uninsured persons residing in rural areas, and a significant portion of communities of color reflected in the 267,000 Georgians without health coverage, there is a pressing need to have an effective policy to reduce costs and improve quality of life (Henry J. Kaiser Family Foundation, 2019b; Miller, 2018a, 2018b). Between 2013 and 2017, racial and ethnic minority populations as well as Whites experienced greater declines in uninsured rates in states with Medicaid expansion compared to states that do not expand (Henry J. Kaiser Family Foundation, 2019c). Overall, racial and ethnic minorities are more likely to have higher uninsured rates than their White counterparts in nonexpansion states compared to Medicaid expansion states (Henry J. Kaiser Family Foundation, 2019c).

By 2050, with the exception of persons who identify as solely Black or solely White, racial and ethnic minorities and persons of two or more races will see a population increase of between 220%–223% (Shrestha & Heisler, 2011). The racial and ethnic minority population has increased in Georgia by 6.7% between 2000 and 2010 (Center for American Progress, 2012). Georgia also had the fastest growing Hispanic population, which increased substantially between 2000 and 2015 (Flores, 2017). For Hispanic children in Georgia (i.e., persons younger than 18 years old), the population increased 131%, from 136,000 to 315,000 between 2000 and 2010 (Pew Research Center, 2011). Hence, without viable solutions for the health disparity, the consequences in financial costs, excessive and preventable deaths, and quality of life quality will be a continuous challenge over the long term for Georgia and the United States.

Disproportionate Health Burdens

As discussed in Chapter 1, the purpose of this section is to provide additional disproportionate health outcome examples among racial and ethnic minority populations in Georgia and nationally since the release of the initial action-oriented 2008 report. The information I provide offers a glimpse of the broader health challenges, which justifies my inquiry among Georgia state government leaders. Reflecting the excessive adult diabetes burden among Georgia’s racial and ethnic minority population compared to their non-Hispanic, White counterparts, racial and ethnic minority populations also have higher national incidence rates. For the White population, the rate was 5.9 per 1,000 population between 2015 and 2017; but, for Native American Indian/Alaska Natives the rate was 18.2, Blacks 9.7, Hispanics/Latinos 9.8, and persons of two or more races 6.0 (Healthy People 2020, 2017c). Diabetes is a costly disease for Georgia. Diabetes and prediabetes costs Georgia $9.9 billion per year in related health challenges, such as blindness, end-stage renal disease, and amputations (American Diabetes Association, n.d.). Health experts at the National Institutes of Health spent approximately $24.3 million in 2015 and health experts at the CDC spent approximately $12.9 million in 2016 on diabetes-related research and prevention and education programs in Georgia (American Diabetes Association, n.d.).

For Georgia, the 2017 adult electronic cigarette (e-cigarette) use prevalence among the American Indian/Alaska Native population was 10.4% versus 5.9% for their White counterparts and 4.4% for the state (CDC, n.d.a). Additionally, there are no Tobacco Retailer license penalties for violating youth access laws in Georgia (CDC, n.d. b). Costing Georgia $3 billion per year, leaders at the American Lung Association graded state policy makers unfavorable for not implementing effective commercial tobacco use policy strategies, such as raising taxes to reduce consumption or providing state funds to reverse the commercial tobacco use trend (Miller, 2019). While the Georgia Department of Public Health phone cessation counseling program was cited positively, American Lung Association leaders suggested the agency could benefit from tobacco-tax funding to serve Georgia residents more effectively (Miller, 2019). The funds could also contribute toward reducing commercial tobacco-related disease among all Georgians disproportionately addicted, including the Native American/Alaska Native community. The commercial cigarette smoking rate of this community (42.7%) in Georgia has been historically higher compared to all counterparts, the state, and United States (CDC, 2012). There has not been enough support in the Georgia General Assembly to increase tobacco taxes to return the investment into improving health outcomes. Local communities are either working toward passing or have passed various levels of secondhand smoke protection policies in Atlanta, Canton, Augusta, and Savanah, for example (American Nonsmokers Rights Foundation, 2019; Miller, 2019).

For Georgia Blacks in 2014, the colorectal cancer death rate was 19.9 per 100,000 population compared to their White counterparts at 15, the state of Georgia at 15.8, and nationally at 14.4 (Healthy People 2020, 2017a). To enhance screenings related to the guidelines, program evaluators for the Georgia colorectal cancer screening program recommended that future outreach efforts focus on persons age 50–75 years old who either were ready for the next exam or never had one (Woodruff, Hermstad, Honeycutt, Brown, & Kegler, 2017). Such actions may reverse disproportionate mortality trends.

As Georgia and national public health leaders wrestle with obesity reduction, disparities exist between racial and ethnic minority communities in comparison to the White population. For 2017, the Robert Wood Johnson Foundation reported that 37.1% of Georgia Blacks were obese compared to the state of Georgia at 31.6% and Georgia Whites at 29.5% (The State of Obesity, 2017). Nationally, several population groups struggle to reach the Healthy People 2020 target of 30.5%; however, there is also an obesity disparity between racial and ethnic minority groups and the White population (Healthy People 2020, 2017e). For 2013–2014, Whites had an obesity prevalence rate of 37.1% compared to Mexicans at 47.9%, Hispanics/Latinos at 44.9%, and Blacks at 48% (Healthy People 2020, 2017e).

Based on health leaders successfully educating Georgia legislators about the consequences of inaction on youth obesity, the Georgia Student Health and Physical Education Act of 2009 program addresses youth obesity through 15 evidence-based policy strategies, primarily in school settings (Powell et al., 2017; Vall, Kibbe, O’Connor, Greene, & Smith, 2017). Each racial and ethnic minority group and persons experiencing poverty could benefit from culturally appropriate attention to potentially prevent their obesity rates from remaining persistently higher should state rates decline by the end of the program in 2023. Furthermore, for a more comprehensive approach, Georgia racial and ethnic minorities and rural communities may benefit from being empowered to lead the implementation of model health equity interventions for obesity and physical inactivity, including policy changes within community neighborhood settings (CDC, 2013, 2010).

Regarding stroke deaths in 2015, nationally the rate was 37.6 per 100,000 population and for Georgia it was 45.3 (Healthy People 2020, 2017d). For Georgia Blacks, the rate was 53.4 per 100,000 population compared to 43.1 for their White counterparts (Healthy People 2020, 2017d). The Black population’s stroke death rate was higher than the national, the state, and the Asian and Hispanic/Latino groups’ rates (Healthy People 2020, 2017d). The award-winning Marcus Stroke and Neuroscience Center at Grady Health System is located in Georgia. Completing almost 3,000 procedures in 2017 (Marcus Stroke & Neuroscience Center, 2018), they are a major presence in the state; however, more needs to be done, including from a policy view, to support stroke prevention and education. Community-based policy change collaborations with other risk factor elimination programs to reduce nicotine and increase physical activity uptake may improve cardiovascular health outcomes.

More than 3 times more Hispanic/Latina females in Georgia are living with HIV compared to White, non-Hispanic females in Georgia, and the rate is 12.6 times greater for Black females compared to their White, non-Hispanic female counterparts (AIDSVu, 2017). Black gay men bore the greatest disproportionate burden of new HIV diagnoses, with 9,807 cases in 2017, compared to White gay men with 6,982 (CDC, 2019c). Furthermore, representing 18% of the national population, 26% of the HIV diagnoses were within the Hispanic/Latino population (CDC, 2019c). As of February 5, 2019, President Trump stated he will request congressional funds to “defeat AIDS in America” (Cable News Network, 2019, para. 79). HIV/AIDS advocates are concerned that supportive services (e.g., Medicaid and housing opportunities for persons with AIDS) to help persons living with HIV will be reduced or eliminated based on the 2020 fiscal year budget, undercutting efforts to properly defeat HIV/AIDS in the United States (Act Now End AIDS Coalition, 2019).

Literature Search Strategy

Disparity elimination and health equity are broad topics; therefore, my search for relevant literature on the topic included an inquiry-centered listing of keywords, including *chronic disease*, *health policy*, *parity*, *equity outcomes, experiences*, *perceptions*, *disparity elimination, state government, agency, legislature*, *lost productivity,* and *Georgia,* used in various combinations in multiple databases. For example, I used the terms *health*, *costs*, *Georgia*, *lost productivity,* and *legislature* in Business Source Complete and Political Science Complete. The terms *health*, *parity*, *equity*, *income*, *race, state*, and *agency* were used in the SocINDEX database. I also retrieved literature from Science Direct, Health & Medical Complete, Academic Search Complete, Political Science Complete, Cumulative Index of Nursing and Allied Health Literature, Sage Premier, PubMed Central, MEDLINE, ProQuest Central, Dissertations and Theses, and Google Scholar. Historically relevant articles filled the gap where literature was lacking after 2010.

My literature search also included an inquiry on the use of incentives for research participants. Examples of terms and accompanying databases for this search are *research design*, *qualitative research*, *monetary incentives*, *interviews*, and *incentives* in SocINDEX. I used the terms *research design*, *participants*, and *incentives* in searching ProQuest Central. A brief justification for including incentives in the data collection strategy for health department interviewees will appear in Chapter 3.

The literature search also included Habermas's theory and ways other health professionals used the principles to inform health-related work. The databases searched included Medline, PubMed, and Political Science Complete using Habermas's name and the terms *health promotion, communicative acts, critical theory, lifeworld, health care,* and *health insurance*. The search results further confirmed the theory of communicative acts was the proper lens through which to view my inquiry.

After receiving Walden University Institutional Review Board (IRB) approval, I reviewed bills and resolutions through Bill Track 50 and conducted website searches of various Georgia General Assembly committee members. If people disproportionately burdened by poor health outcomes could benefit from a bill, the information helped determine which legislators to recruit for the inquiry. Examples of searched terms were *health*, *Medicaid*, and *medical*, and the search also involved reading the bill's text.

Finally, toward the end of the literature review analysis, the CDC, in partnership with the Association of State and Territorial Health Officials, produced a pioneering health equity supplement with national leaders for the *Journal of Public Health Management and Practice* (Novick, 2016). My additional analyses incorporated connections between the newly released material and current literature assessments. The combination of the new and current literature further solidified the justification for my inquiry to learn more about health disparity elimination through officials working through Georgia state government.

Theoretical Foundation

The theory of communicative action as advocated by Habermas grounded the inquiry and suggested specific tenets for understanding the processes of overcoming social hegemony, which included building on the Marxist thought of expressing the wealthy community's subjugation of the working class (Corradetti, 2011). The first proposition derived from the influence of the defeated National Socialist movement. Seeking a direction away from Nazism toward a practical and egalitarian path to social existence, Habermas acknowledged, as affirmed by Joll (2015) and Bohman and Rehg (2014), that commerce and governance could unfavorably restrict trustworthy and unreserved citizen discussions in society.

Second, communicative action was essential for the populace to determine the advantages and disadvantages of social concerns, with the consequence being logical solutions grounded in fairness and public agreements for the larger society (Edgar, as cited in Joll, 2015, i.i. Habermas, para. 3). A third tenet affirmed engagement in public talks resulting in relief from social dominance (Corradetti, 2011). The assumption was that the theory of communicative action would relate to the inquiry based on including the voices of health legislator and state health department leaders into the broader health disparity elimination effort. The literature available on the conflicts associated with the pursuit of public health equity reflected the belief system challenges Habermas described (see Bohman, 2005), which confined racial and ethnic minority communities and persons experiencing poverty into disproportionate premature death and disease burdens. Despite U.S. democracy, *ideology* or *distorted communication* produced one group's dominion over another (see Bohman, 2005), which resulted in persistent poor health outcomes. Consequently, I used the communicative action theoretical lens to infuse into the broader health equity debate the lived experience of Georgia government health leaders working on health equity to reverse disparity trends among affected populations. Likewise, Habermas wished the public conversation would result in sound judgment on what was most favorable for all (Corradetti, 2011). Within the literature, there is confirmation that the logical conclusion on what was universally beneficial was the removal of preventable excessive human suffering and the associated financial costs to individuals and governments for health care.

The theory of communicative action involved contributing the voices of the public system's health department staff and legislators into the emancipation efforts of eliminating racial and ethnic minority health disparities. The method of using the phenomenological approach to engage state leaders, based on their lifeworld experience, in the dialogue on pursuing health equity relates to attempts to free racial and ethnic minority populations from the disproportionate burden of poor health outcomes.

Regarding the historical application of critical theory and the related communicative action theory tenets, Fay (1987) provided analysis under critical social science and suggested elements that affirmed the importance of scrutinizing social issues until they become the impetus for social change (pp. 27-29). Public phenomena under study were able to force social transformation through revelation, community mobilization, and eventually freedom from societal oppression. Fay (1987), aligning with Bohman (2005), confirmed my reason why the legislator and health department officials were appropriate participant groups to contribute to the public dialogue for racial and ethnic minority health improvement.

More recently, researchers have applied communicative action theory to health. First, Ward and Johnson (2013) noted that the ambiguity of the ACA during initial passage might result in citizens being insufficiently insured versus uninsured based on the lack of a clear health care need definition. Analyzing a way to elevate Pareto’s economic allocation view of one person’s benefit being at the expense of another, Ward and Johnson infused the Habermasian view of public debate as being a possible avenue for determining elementary health care need policies through the ACA; as a result, persons could have sufficient coverage for daily living within a challenging sociopolitical environment. With much of the conversation depending on the assets available for public distribution and the experiences of the people engaged in the dialogue, the Habermasian approach served as a way for ACA health policy provisions to emerge and support acceptable life-sustaining care (Ward & Johnson).

Second, Leanza et al. (2013) conducted an observational study with a coded analysis of conversations between interpreters, primary care physicians, and patients who experienced a range of problems including diabetes, hypertension, or sociopolitical challenges. All patients required interpreters. The study participants were female-dominated, with either all three or two of the three participants being a physician, patient, or interpreter for a majority of the sessions. Nevertheless, using Habermas's communicative action theory in conjunction with Mishler's voice of medicine and voice of the lifeworld, which is an expansion of Habermas's lifeworld tenet, Leanza et al. concluded that the medical and lifeworld views were equally important for sharing patient care responsibilities. Physicians should learn how to work with a variety of interpreters (i.e., professional and family-based); likewise, interpreters should know how to negotiate interactions to overcome controversies hindering optimal care; furthermore, patients should proactively contribute to their care (Leanza et al., 2013). Leanza et al.'s recommendations are in agreement with the empowerment all three stakeholders need to improve life quality among patients in health care facilities, which may reduce institutional dominance over patients.

Third, when looking at studies more closely aligned with a qualitative research approach, Fiorati and Saeki (2013) confirmed Habermas's view of institutions posing challenges with the ability to properly meet patients' needs. Researchers concluded that two mental health outpatient facilities in Brazil were not following the National Mental Health Policy or provisions of the Brazilian Psychiatric Reform that allowed for the use of the psychosocial care model for mental health care (Fiorati & Saeki, 2013). Fiorati and

Saeki noted additional agency assessments shifted the focus toward reinforcing the use of the psychosocial care model with support from all stakeholders, along with attention toward enhanced agency operations and funding transparency. Bevan (2013), within the context of action research, confirmed the importance of free and unobstructed group dialogue among a diverse group of mothers of young children as an optimal opportunity for participants to contribute to inquiries. All cases supported the Habermasian view of emphasizing the inclusion of the affected stakeholders and or considering their milieu for health improvement. Consequently, these examples from previous literature further confirm my use of Habermas's theory as an appropriate inquiry lens for health disparity elimination in Georgia. The elements of addressing health needs in the mist of limited resources, encouraging proactive participation from concerned parties, and publicly communicating lifeworld experiences relate to the reasons for the study.

The justification for using the theory of communicative action included, first, the 2004 release of a seminal document proposing solutions for racial and ethnic minority health disparities within state legislatures and public health agencies (McDonough et al., 2004). Despite the 1985 *Heckler Report on Black and Minority Health*, 20 years later, health equity still had not received the full government action needed to improve health outcomes among racial and ethnic minority populations (McDonough et al., 2004). For instance, legislator focus group participants concurred that challenges existed with securing acceptable legislative language to address racial and ethnic minority community needs directly, and the number of bills that came through state legislatures expressly stating the word "disparities" were small (McDonough et al., 2004, p. 5). The number of state bills introduced that addressed the health needs of Hispanics or American Indians/Alaskan Natives was also insignificant.

Second, in addition to literature on government leaders in various states grappling with how to eliminate health disparities, Rose (2015) and Thompson et al. (2014) confirmed the legislative political conflicts related to advancing the Medicaid expansion provision of the ACA of 2010, particularly among states with racial and ethnic minority populations experiencing high chronic disease rates and poverty (e.g., Arkansas, Georgia, and Tennessee). Third, internationally, Ottersen et al. (2014) identified governance disabilities that continually confined populations to poor health status (e.g., unequal power distributions).

Fourth, the key state policy ideas and health equity strategies in the literature included many minority health challenges and the efforts various health leaders were making to free the affected populations through multiple arenas. For example, the use of practice frameworks, local health department approaches, and recommendations from health care delivery were all commonly proposed solution themes for policies and practices, partnerships, and resource distribution and poverty elimination. Finally, the health equity supplement to the *Journal of Public Health Management and Practice* released in 2016 acknowledged the health disparity crisis in state governments and laid the foundation for state health department and legislator officials to pursue racial and ethnic minority health equity, along with health equity for the lesbian, gay, and bisexual community and persons affected by mental health challenges (Novick, 2016).

Public health and government leaders can view the institutional oppression that racial and ethnic minority populations must overcome to live in a healthier and less costly manner through the theory of communicative action. Five sociopolitical circumstances gave contextual understanding to the theory's relevance to the study: (a) the historical lack of holistic adequate public health solutions; (b) the persistent rejection of the federal health improvement response under the ACA; (c) the impact of the worldwide governance power struggle; (d) multidisciplinary health research, advocacy, and solution proposals to counter current poor health outcome trends; and (e) the federal effort to move states toward a policy practice view for greater positive health impact. Additionally, the inquiry contributed the lived experience voices of Georgia state government leaders to the public health policy dialogue on how best to improve health outcomes for racial and ethnic minority populations in Georgia.

Communicative action theory related to this study because the research contributed to the solutions through public discourse regarding persistent racial and ethnic minority health disparities in Georgia. Institutions in which state government health and legislator leaders served may have contributed to the inability to reduce or eliminate the disproportionate death and disease burdens. Consequently, the purpose of the inquiry through employees was to determine if their work experiences supported the theoretical tenets. Additionally, there was an intention to learn about what the employees believed public health and government policy leaders should have done to reverse persistent racial and ethnic minority health disparities in Georgia.

Communicative action theory is the lens through which I gained an understanding and learned about the Georgia state legislator leaders' experiences creating and passing policies to eliminate chronic disease and behavioral risk factor disparities among racial and ethnic minority communities. Regarding the first tenet of the theory, the focus of the research question was to determine descriptions of current actions to improve the health of the populations suffering disproportionately. It is not beneficial to the communities or government when individuals who are racial and ethnic minorities disproportionately exist in a state of premature death and poor health; thus, yielding extra personal hardships and economic costs. Regarding the second tenet, communicative action, the focus of the second research question was to learn from participants, based on their lived experience, what they believed needed to be done to improve health outcomes among Georgia's racial and ethnic minority populations (Edgar, as cited in Joll, 2015, i.i. Habermas, para. 3). The research questions may lead to ideas for public discussion after dissertation publication and data dissemination; consequently, the information can lead to publicly determined solutions for health disparities. Georgia-specific information will be available for the broader health disparity dialogue to shape new policies and practices for health outcome improvements, particularly in the midst of ongoing efforts to change or dismantle the ACA.

Consequently, the focus of the third theoretical tenet is on public talks resulting in the affected communities' release from social dominance. Freedom from confinement through disproportionate chronic disease and behavioral risk factors can be the result of multiple public health efforts operating toward health improvement for the affected communities (i.e., new policies and more effective policy-focused programs). Examples include dialogue through conferences, professional journals, and meetings emerging to move public health and cross-sector leaders' behaviors into appropriate solution directions. The infusion of the study results into the health equity debate through data dissemination and the publicly accessible dissertation may inform public health policy actions. Consequently, addressing racial and ethnic minority health disparities for chronic diseases and behavioral risk factors at the state level, when data-driven, may become the future public health norm, with effort intensity proportionate to need. This will be in contrast to pursuing separate unequal public health efforts for racial and ethnic minority communities, or focusing on the general public in hopes of positively affecting the populations disproportionately suffering from chronic diseases and behavioral risk factors.

Literature Review Related to Key Concepts

State Policies

With regard to studies on the key concepts of state policies for reducing chronic diseases and behavioral risk factors resulting in continued health outcome disparities, Young et al. (2015) conducted prime research on state legislature bill introduction and passage analysis from 2002 to 2011. A contrasting observation is the largest percentage of bills *introduced* centered on addressing states' capacity to eliminate disparities (e.g., creating an Office of Minority Health or a brain trust). However, the most common bills *passing* state legislatures reflected public acknowledgment of the health disparities problem. This circumstance further confirmed the importance of the inquiry to encourage placing equal emphasis on proactive problem-solving and recognition through policies and practices anchored in Georgia health leaders' experiences to remove racial and ethnic minority health disparities.

Using the results of Young et al. (2015), I conducted a focused literature search for studies on the challenges of inadequate health equity policies. This also included associated experiences of state legislators' or health department chronic disease practitioners' lived insights into achieving health equity through state policy passage. The criteria for choosing the eight states were the four states that introduced 30 or more health disparities bills (i.e., Arkansas, California, Florida, and New York), and the four remaining states that addressed up to 11 different health disparity subjects in their state legislatures (i.e., Illinois, Maryland, New Jersey, and New Mexico). Arkansas and Florida met both criteria. Including Georgia, the state of interest, led to a total of nine states.

Specifically for the nine states, there was a dearth of studies that reflected the qualitative or phenomenological analysis of state leaders' experiences working to address policies that had not reduced the chronic diseases and behavioral risk factors resulting in health outcome disparities. However, Thompson et al. (2014), without semi-structured interviews, provided the best instance of describing through an analytical essay the political challenges experienced while expanding Medicaid in Arkansas under ACA with an 1115 demonstration waiver. Maryland served as a noteworthy case study of actions to eliminate racial and ethnic minority health disparities using Health Enterprise Zones, passing the Disparities Reduction Act of 2012 (Hussein et al., 2014). The Georgia Partnership for Telehealth served as another case study of using innovative technological advances to improve access to specialty care for rural populations in poverty, inclusive of racial and ethnic minority communities (Brewer, Goble, & Guy, 2011).

Within the impacted communities' perspective, Maryland and Georgia resurfaced with qualitative studies. Baltimore, Maryland, is a city where African American women have the second highest breast cancer death rate in the state (Karcher, Fitzpatrick, Leonard, & Weber, 2014). African American women sharing a common lifeworld through educational outreach for breast cancer detection was influential and beneficial for enhancing screening (Karcher et al., 2014). In rural Georgia, Alexander et al. (2015) considered the beliefs among caretakers of obese children to be important for informing future obesity-reduction efforts.

Researchers have primarily approached the health disparities problem from a quantitative view; nevertheless, salient equity issues have supported the need for policy change or creation based on study results. For example, there was a call for attention to the unequal chronic disease burden in the South (i.e., rural north Florida), or the need for affordable health coverage and primary care among immigrant populations in California and Illinois (Barakat et al., 2017; Logan et al., 2013; Tshiswaka et al., 2014). A major challenge with the quantitative approach, as acknowledged by researchers, was self-report data threatening validity. When samples were small or contained outlier characteristics, there was no generalizability to the broader state citizens or the United States. Finally, as expected, under the ACA, Barakat et al. (2017) determined that health care payment burdens moved from hospitals and patients to government; however, the analysis only covered 1 year after Medicaid expansion took effect. The obvious challenge was the inability to capture the lived experience or opinions of leaders for corrective actions that may work toward health equity in the states.

In another undertaking, analytical essays and commentaries provided expert views on certain positions or explained a health equity policy implementation process experience in states inclusive of Georgia and Arkansas (Burki, 2015; Rose, 2015; Thompson et al., 2014). For expert analytical essays and commentaries, a shortcoming was that Burki (2015) did not specifically identify states with policies adverse to health equity. Examples include not providing reproduction education or birth control information, and preventing HIV/AIDS information in schools located in the Southern United States. Readers needed to seek these details elsewhere if interested. The Rose (2015) approach was to enhance the public's understanding of the political competition surrounding ACA in particular states. It gave a thorough analysis of various mini-case studies on state Medicaid expansion actions through the ACA.

With regard to qualitative study drawbacks, the information acquired was not representative of the general population and may not have reflected similar populations in other states. In contrast, for all three inquiry approaches for the nine states, a strong point was prioritizing addressing health equity through state health coverage and the ACA at the federal level. For example, in a cross-sectional study, Nguyen et al. (2015) emphasized the importance of the ACA closing the employer health coverage gap with results indicating that Koreans, mostly self- or small-business employed, were more likely to be uninsured regardless of job category. Nguyen et al. explored the context of influential social factors affecting Asians, such as educational achievement and years within the United States. Another benefit was that quantitative analyses through state population surveys highlighted state-specific health inequities yielding unique health policy change implications for New Jersey, California, and rural northern Florida (Logan et al., 2013; Nguyen et al., 2015; Pandey et al., 2014). Policy development considerations involved (a) viewing health access beyond health care availability, including English language proficiency and community beliefs influencing care-seeking actions; (b) disaggregating Asian ethnicity-specific data for adequate policy decisions through ACA for employer health coverage and understanding the effects of various social supports; and (c) prioritizing rural areas within states for chronic disease intervention and prevention efforts with emphasis on multi-disease or behavioral risk factor approaches. For instance, mental health and tobacco cessation could be incorporated within care for diabetes and cardiovascular disease.

For analytical commentaries and essays, the sense of urgency resonated with the need to address state-level health disparities and the importance of attending to ACA provisional policy implementation details in doing so (Allison, 2014; Burki, 2015). Consequently, a benefit of using the commentary approach was that the public message reiterated the same call for action as federal secretary-level public health authorities expressed in the framework section below. Thus, there were unifying health equity advocacy voices across government levels (Koh & Nowinski, 2010). Finally, for qualitative studies, the main strength was the display of specific examples of work to reverse the racial and ethnic minority disparities such as passing state legislation, Health Enterprise Zones strategies, and technological advances for geographic health disparities

(Allison, 2014; Brewer et al., 2011; Hussein et al., 2014). Even though policies in Arkansas or Maryland needed to be more impactful, there was evidence that both states, and the medical community in Georgia, were expending efforts to make improvements (Allison, 2014; Hussein et al., 2014).

There were four concepts regarding state policies for reducing chronic diseases and behavioral risk factor prevalence rates among racial and ethnic minority populations that resulted in persistent poor health outcomes. First, the human suffering toll from chronic diseases, especially among persons in poverty and in the South, warranted further exploration, particularly among leaders and state employees working to achieve health equity in the government sector (Alexander et al., 2015; Burki, 2015; Logan et al., 2013). Second, in addition to human suffering, literature confirmed excessive costs associated with racial and ethnic minority disparities and rural health disparities (Gaskin et al., 2012; Georgia Hospital Association, 2017). Third, with the federal level passage of the ACA, combined with the National Partnership for Action to End Health Disparities offering national guidance on racial and ethnic minority disparity elimination, the impact of the support for health equity should be examined within the context of states' receptivity and progress toward improving health outcomes. Finally, Spina (2013) confirmed that public administrators should proactively pursue racial fairness and support the work of legislator leaders for fair program implementation. As a result, there were multiple research-based factors substantiating the exploration of state policies for addressing racial and ethnic minority disparities, but this particular inquiry included a more in-depth focus on frontline employees and elected officials in pursuit of health equity.

Regarding the literature on state policies to address adverse racial and ethnic minority health outcomes, what is known within the public health arena is that the ACA played a major role in the research of and policy development for health equity. For example, in Arkansas, the struggles with racial and ethnic minority youth obesity justified the passage of the state law to improve health outcomes through ACA provisions (Allison, 2014; Thompson et al., 2014; Winthrop Rockefeller Institute, 2015). Additionally, New Jersey policy makers, inspired by the ACA, created Medicaid-accountable care organizations to improve care quality and reduce costs among vulnerable populations known to traditionally be high users of health care services (Cantor et al., 2014). Also for New Jersey, Pandey et al. (2014) investigated new (i.e., less than 5 years in the United States) immigrant health care access decisions and made an unusual discovery. Compared to U.S.-born natives, new immigrants' perceived desires to obtain health care were not consistent with their self-defined health status. The results had implications for health care access because regardless of being in need, the population might not seek care due to perceptions of not needing to do so.

Finally, among New Mexico residents, Sanchez and Sanchez-Youngman (2013) found various views on extending state health care coverage to noncitizens; however, the most salient was the more favorable support of providing coverage to noncitizen children at 52% versus their parents at 26% (p. 455). Health coverage for non-U.S. residents, or newly arrived nonnative residents, was contentious based on the political beliefs of the state population or governing body. Another factor was the social challenges that the communities in need experienced. The ACA did not extend coverage to non-U.S. residents; however, state funds could be used to cover persons as desired.

In general, with historical attempts to reverse the ACA at the federal level, future researchers should continue to look at the immigrant and U.S. resident racial and ethnic minority health outcome consequence to ensure there is no proposal of an imbalanced health coverage replacement or adjustment policy for the nation. In agreement with Pandey et al. (2014), states with significant immigrant populations that have not expanded Medicaid, such as Florida or Texas, should be investigated in the future to determine if new evidence confirms an expansion need. Such policy formation can be impactful for cost reductions and positive health outcomes. New Jersey, in contrast, has traditionally pursued coverage for all, “regardless of immigration status” (Pandey et al., 2014, p. 757). Consequently, health outcomes should be comparatively better in the future.

Outside the realm of the ACA, Alarcón, Cleghorn, Rodriguez, Hughes, and Oxtoby (2014) examined New York-bound refugees’ responses to the state policy encouraging access to primary care and determined primary visit influencers, namely “country of origin, county, resettlement agency, and provider” (p. 746) contributed significantly toward completing primary care exams. The study reinforced the commonly held notion that immigrating populations vary and require specific recognition of community circumstances for successful health policy to improve health access. The finding corroborated Nguyen et al.’s (2015) finding for the multiethnic Asian community.

In both instances however, the studies did not provide information about health outcomes as a result of health access or coverage; thus, this topic remains to be studied.

Regarding controversial successes, Arkansas has the history of a well-documented successful passage of a state health care law to curb obesity and disparate health outcomes. The law was secured within a state legislature that was majority Republican with a Democratic governor. Nevertheless, as Thompson et al. (2014) noted, despite enrolling tens of thousands of Arkansas residents in health coverage through a Republican-supported private-sector version of the ACA program, the politically charged law continued to garner resistance in the midst of the accomplishment.

The controversies within the nine state studies included, first, the expansion of health coverage to noncitizens in the United States. In New Mexico, most were not supportive; nevertheless, favorability for coverage was higher among Democrats than among Republicans or Independents, and was higher among persons with a greater degree of compassion toward the plight of the uninsured (Sanchez & Sanchez-Youngman, 2013). In contrast, within the Latino community, the Chicano identity fostered support for undocumented population health coverage. With 54% of New Mexico’s population being Hispanic and Native American Indian, for future studies, researchers suggested including the promotion of well-being, self-reliance, and the willingness to engage in social action among possible variables for determining study result influences on supportive views for health coverage (Sanchez & Sanchez-Youngman).

The second controversial element was policies that did not adequately address high chronic disease rates among racial and ethnic minority populations in Southern states. Regarding the study states of interest and the south, with the exception of Arkansas, Florida and Georgia were among the 14 states that had not expanded Medicaid to cover nonsenior adults in poverty (Henry J. Kaiser Family Foundation, 2019a, 2019b). Florida and Georgia account for approximately 445,000 and 267,000 of the 2.5 million adults not covered by health insurance, respectively (Henry J. Kaiser Family Foundation, 2019b). Burki (2015) stressed the urgency of disproportionately high HIV/AIDS rates in the deep South states not expanding Medicaid, and noted the policies were unfavorable for high-prevalence reversal (e.g., state policy makers can choose whether to support needle exchange programs). For northern Florida, Logan et al. (2013) confirmed the need to attend to rural populations in the southeastern United States with policies beneficial for chronic disease reduction. To confirm the concern regarding chronic disease among youth, Alexander et al. (2015) found that residents often cited personal actions as a main contributing factor for obesity. Researchers concluded that parents in rural Georgia needed to have their beliefs included in obesity elimination efforts.

A final controversial instance was that the state policy structure disproportionately prohibited health protections of racial and ethnic minority communities, which contributed to health disparities. For the tobacco behavioral risk factor, a challenge was the uncomprehensive Georgia smoking ban that allowed smoking in public places where children were not present or where separate ventilation existed, and outside (Chandora et al., 2015). The preemptive Florida state law disallowed local laws from being stronger than state laws. This prohibited local communities from passing stronger public secondhand smoke protections (Mowery et al., 2012). Of the three states in my study with local smoke-free preemptive laws (i.e., Florida, New Jersey, and Illinois), Florida was rated the most suppressive. With two policy challenges in the South (i.e., lack of Medicaid expansion and preventable secondhand tobacco smoke exposure), where the regional smoking prevalence is second highest in the United States, Blacks and Hispanics are at greater risk. They are more likely to work in service positions known for higher secondhand smoke exposure (American Cancer Society, 2014; Bureau of Labor Statistics, 2013; CDC, 2019b). However, researchers had not yet studied how to empower the impacted communities to shift inadequate laws in their favor.

For a balanced view, there were less politically charged policy successes in the literature for states. Wong et al. (2012) confirmed that through the Illinois Perinatal HIV Prevention Act of 2003, mothers and their babies were tested and knew their HIV status prior to hospital release. The policy mandated HIV testing, which increased normalization and contributed to reducing the spread of HIV. Wong et al. noted that the use of the rapid HIV test could be controversial because false-positives may cause unnecessary worries or a need for therapy until confirmed through additional tests (Wong et al.). Nevertheless, potential issues with laws and fairness did not outweigh the decision to secure HIV status for mothers and children.

Guydish et al. (2012) found the New York state nonsmoking policy for addiction treatment centers to be the most beneficial for cessation among persons in residential facilities. Despite tobacco use being legal, the policy reflects attempts to reduce the addiction of a comparatively socially acceptable product that is the number one preventable cause of death (CDC, 2019b). Researchers should look into how long residents stayed tobacco-free after leaving the residential facility. Also, Guydish et al. suggested looking at an “organizational change intervention” (p. e24) in connection with the state’s no-smoking policy to determine outcomes.

Through research questions I inquired about Georgia health department employees’ experiences with implementing policies to eliminate chronic disease and behavioral risk factor disparities among racial and ethnic minority populations. For Georgia legislators, I explored their experiences in creating and passing state legislation for eliminating racial and ethnic minority health disparities. The inquiry also included, based on their experiences, what Georgia legislators believe needed to do to improve health outcomes among racial and ethnic minority populations in Georgia. The two main studies most closely relating to the research questions were the description of Arkansas’ passage of the state law to expand Medicaid through the ACA for persons experiencing poverty, and the seminal literature providing recommendations for state government actions for racial and ethnic minority disparity elimination (McDonough et al., 2004; Thompson et al., 2014).

Within the 10-year time frame between the studies conducted by McDonough et al. (2004) and Thompson et al. (2014), the racial and ethnic minority disparity elimination movement had changed from informing state leaders about what to do (McDonough et al., 2004) to encouraging government leaders to accept federal financial support through the ACA. Later, directional guidance came through the National

Partnership for Action to End Health Disparities. McDonough et al. and Thompson et al. provided a glimpse of the political climate challenges related to legislative disparity elimination work warranting further inquiry from a phenomenological approach to give a voice to legislators' recommended solutions for health outcome improvement.

Whether there was beneficial feedback from state health practitioners for the development of a minority health disparity elimination framework (Rudolph et al., 2013) or a resource kit for local practitioners (Payne et al., 2015), there still was a lack of exploration into the lived experience of performing state health equity work and identifying possible state-specific solutions through the experiences. Finally, despite the nine identified states, with the exception of Arkansas, the lived experience was not available regardless of policy passage, program implementation, or policies successfully producing health improvement outcomes (Guydish et al., 2012; Hussein et al., 2014; Wong et al., 2012).

The qualitative phenomenological approach to my research was meaningful because it gave a voice to the practitioners working toward health equity in state government. With literature from the communities affected by disparities (Alexander et al., 2015; Tshiswaka et al., 2014) and advocacy-based analytical essays from federal and academic health experts (Koh & Nowinski, 2010; Rose, 2015), additional exploration into the professional lives of state health department and legislator employees provided new views to factor into the solution equation of rural and racial and ethnic minority disparity elimination work. Georgia health practitioners' and legislators' input into the governance process dialogue for health equity needed a more robust contribution;

consequently, the dissertation inquiry serves as a starting point. As national health care coverage continues to be a major policy issue, the study results may inform public health equity policy change.

Strategies to Achieve Health Equity

The focus of the literature inquiry was on the experiences of state legislators and state health department practitioners in their strategic pursuit of health equity. Based on observations through service in the state legislature, Massachusetts Representative John McDonough provided a report on state health equity policy through The Commonwealth Fund. McDonough et al.’s (2004) publication through The Commonwealth Fund’s panel of city, state, and national leaders working in health disparity elimination and health policy provided recommendations for infrastructure and capacity and for reducing specific diseases and behavioral risk factors that are overburdening racial and ethnic minority communities. He also sought Stone’s (2006) views on how to frame the need for such policies among state legislators to increase the chances for consideration and passage. Stone argued the distributive justice, need-based approach versus health care access through social status determination (e.g., race or income). McDonough et al.’s seminal contributions from The Commonwealth Fund’s expert panel gave a glimpse into state policy-making experiences and associated strategies legislators thought were necessary to make health equity legislation a priority. Ladenheim and Groman (2006) were the first to analyze the prevalence of racial and ethnic minority health care disparity elimination state legislation from 1975 to 2002. As noted earlier, Young et al. (2015) continued the analysis from 2002 to 2011; however, neither study provided insight into the legislators’ experiences or challenging efforts undertaken to have legislation considered or passed. For statewide practice efforts, Adams et al. (2016) described an effort to prevent obesity through a community change framework to address policy, systems, and environmental changes for obesity prevention among vulnerable populations. Stamatakis et al. (2014) conducted a qualitative study centered on state practitioner perspectives on local health department efforts to prevent obesity through policy change. The inquiry results did not capture the practitioners’ lived work experience of providing state-level support to local obesity-reduction endeavors.

In contrast, Hankivsky et al. (2014) offered an intersectionality-based policy analysis framework approach to health policy reviews from a social justice perspective that included the importance of the analysts looking at their own and others’ “everyday lived experiences” (p. 1). The approach was in alignment with my study. It confirmed the need to expand such inquiries for a greater understanding of the challenges among state health department practitioners and legislators in the health disparity elimination policy arena.

As the researcher, the literature inquiry afforded me the opportunity to review thoughts from health and policy experts attending health equity national meetings. Anderson (2012) focused on an expert gathering that assessed the advancements in addressing racial and ethnic minority disparities. Observations contained the challenges of state health practitioners not pursuing policy implementation accountability and the lack of sufficient understanding to address inequities; consequently, in terms of what health leaders still need to understand, there was an expressed need to illuminate contrasts between effective and ineffective health entities for health equity performance improvement. Additionally, practitioners needed evidence-based strategies to inform working across specialty realms for racial and ethnic minority chronic disease disparity elimination, as confirmed through the Health in All Policies approach (Anderson, 2012; Rudolph et al., 2013). The lived experience in addressing health equity was not evident in the meeting reports and was not the purpose of the meetings; nevertheless, informative recommendations from the gatherings were inherently present in such phenomena in order to offer advice for future actions. The national expert meetings further validated the inquiry choice of exploring legislators' and state health officials' work experiences pursuing health disparity reductions and related corrective actions that could be appropriate for Georgia.

The literature review also centered on specific state health department strategies to achieve health equity from a policy perspective and yielded three overarching focus areas: (a) various health equity frameworks to inform actions, (b) examples of local public health disparity elimination approaches, and (c) recommendations for pursuing equity in health care delivery. The information laid the foundation for the health department IQs.

Various Health Equity Frameworks

In the United States, guidance for disparity elimination to achieve health equity comes from the Department of Health and Human Services, Office of Minority Health. The framework is the National Partnership for Action to End Health Disparities Implementation Framework. Beadle and Graham (2011) provided a concept that offers guidance from the federal level for national partners to address disparities through five major tenets (p. S17). First, the model includes a *strategy* focused on the use of various experienced partners to develop critical materials for disparity elimination. Second, the effort considers the *scope* of the social factors that determine health outcomes (i.e., education or poverty) in partnership with various service delivery agencies. The third model operates within the *structure* of the Federal Interagency Health Equity Team to put in place effective policies and practices at the local, state, and national level. Fourth, the process offers expertise and guidance for using statistics for evaluations, program improvement, and public messaging. Fifth, *success* occurs when “goals, strategies, and actions” (Beadle & Graham, 2011, p. S17) can positively influence leaders, and society is compelled to confront the “social determinants of health” (Beadle & Graham, 2011, p. S17) through appropriate “policies, procedures, and practices of systems” (Beadle & Graham, 2011, p. S17) that contribute to poor health outcomes.

Additional federal-level guidance came from the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health. Within the National Partnership for Action to End Health Disparities Implementation Framework, the focus was on leadership. Koh and Nowinski (2010) emphasized leadership to achieve health equity and described effective skills and strategies for practitioners to be impactful that were inclusive of working with a wide range of partners and connecting “public health and medicine” (pp. S9–S10). Other areas involved translating the message by articulating the benefits of policy change, common beliefs, and building camaraderie in the midst of a multiplicity of persons. The World Health Organization’s international concern for equity resonated in the article by encouraging public health leaders to consider the distribution of “power, money, and resources” (Koh & Nowinski, 2010, p. S10). Finally, Koh and Nowinski emphasized the importance of having leadership combine “science, practice, and policy” (p. S10) within the context of the “social determinants of health” (p. S10) and provided evidence of national agencies pursuing health equity from their own areas of expertise. Examples included the National Institutes of Health engaging in the practice of community-based participatory research, the CDC’s Racial and Ethnic Approaches to Community Health interventions, and the Health Resources and Service Administration’s Health Disparities Collaborative that focused on health status improvement (Koh & Nowinski, 2010, pp. S10–S11).

Former Assistant Secretary Koh continued his personal example of national leadership by challenging U.S. public health practitioners and reiterating the need to focus on the societal influences on health based on successes in other countries. Multiple case studies confirmed public health successes from around the world and in the United States based on using various agency partnership approaches. Using several national and international case studies, Koh et al. (2010) confirmed the World Health Organization Commission on the Social Determinants of Health’s provisions that called for converting inquiry results into everyday life policy and program execution within the context of forging manifold partnerships for health disparity elimination. Examples of countries achieving population health improvements included England for increasing longevity and decreasing death rates from cancer and cardiovascular disease among intended populations. Ecuador removed premature deaths among mothers and children. In the

United States, Massachusetts was an example of government change through state laws that reduced the numbers of residents without health insurance coverage, which indirectly contributed toward health equity. Furthermore, members of the legislatively established Health Disparities Council were monitoring and advising the state on disparity elimination factors. In tobacco control, California and Massachusetts led the nation with policy change media campaigns aimed to reduce the social acceptance of product use among groups bearing disproportionate health burdens.

In Canada, Cohen et al. (2013) conducted a qualitative grounded theory inquiry to determine an agency-specific model for disparity elimination. Unlike the National Partnership for Action to End Health Disparities Implementation Framework from the U.S. Department of Health and Human Services, which was more partnership-centered, the Canadian approach was more specific to building organizational capacity to achieve health equity. The major elements emerging from interviews with key informants were (a) the importance of considering the combination of the agency’s belief systems, operational structures, and sociopolitical environment; (b) internal and external stressors on the agency; and (c) the extent of employee relationships among persons concerned about equitable health. Cohen et al. acknowledged that the work was not complete; however, the information was a foundation for other practitioners in agencies to make contributions to inform entity performance improvement for health equity.

Also from Canada, and in agreement with the social determinants of health framework, Raphael and Brassolotto (2015) sought to determine the extent to which Medical Officers of Health and health leaders consistently used the social determinants of health at the local health level in Ontario, Canada. Using a critical realist lens for focused interviews within nine Ontario public health units, Raphael and Brassolotto gave attention to the three tenets of the social philosophy. Critical realism, within the local health entities, existed through what is real (e.g., guidance, protocols, or division of labor), actual (e.g., the institutional employee partnerships; political resource distributions) and empirical (e.g., agency performance and projects) regarding the impact on the social determinants of health. Researchers concluded that much of the social determinants of health implementation effort were subjective and not uniform, with reliance on the leadership and Medical Officers of Health’s personal belief systems and the geopolitical dynamics of the local areas served.

Public health leaders created the Health in All Policies framework through a California task force that learned through key informant interviews and public input from the nation and globally (i.e., Australia, Canada, and Thailand) how to more comprehensively address health inequities, increasing health costs, and environmental challenges to population health improvement (Rudolph et al., 2013; Tucker, 2014). A guide for state and local governments resulted to help ensure local and state level health practitioners considered health consequences in nontraditional public service policies such as transportation, natural resource use, and the labor force. The main purpose was to ensure social policy, wherever possible, would not adversely affect population health outcomes, especially communities more frequently burdened by health disparities (i.e., racial and ethnic minorities and low-income populations). The framework reflects the foundational idea behind the social determinants of health.

Finally, Ottersen et al. (2014) approached health disparities through the influence of politics, advocating that the malfunctions of international governments contributed to worldwide disparities. Within the framework of challenges in worldwide administration, there were five factors needing attention. First, the general population under governance, the vulnerable, and subject matter authorities in health did not have their influence incorporated in final policy outcomes. Second, the officials who had the final say were not forthcoming or overstepped their boundaries in governance practices. Third, usual governance operations were often not responsive to population concerns; but, existed within the realm of political dominance that negatively impacted health. Fourth, there was little intra-country or international influence on the ability to affect policies outside the health care or public health field that also affected population health. In other words, worldwide, a consistent Health in All Polices approach was lacking (Rudolph et al., 2013). Finally, very few entities existed to preserve health globally. Ottersen et al. contended that the culmination of these circumstances resulted in the need for “global political solutions” (p. 630) for the “political determinants of health” (p. 630). Associated observations included correcting the imbalances of governmental influences to reverse global health disparities, and existing in a world with common understanding of mutual concern for the greater good of humanity and the earth. There was a need for external oversight of governing officials to ensure broad awareness of the activities undertaken. The framework was grounded in human rights, with the preservation of health being a common social act.

Rose (2015), through analytical commentary on the political challenges found in case studies for state Medicaid expansion, confirmed Ottersen et al.'s (2014) arguments for malfunctioning governance. For instance, among Southern, mainly Republican-majority states that had not passed the ACA (i.e., Alabama, Georgia, Louisiana, Mississippi, and South Carolina), most citizens favored the provision. Second, in the case where Republican Governor Haslam sought support from the Republican-led Tennessee legislature, political dominance, to the highest degree, prevented citizen health needs from being a priority through the ACA's passage.

Local Public Health Disparity Elimination Approaches

Raphael and Brassolotto's study (2015) also deserved consideration in the local health department area. In addition to the health unit leadership, and moral views determining the extent and form in which the social determinants of health were locally implemented in Ontario, Canada, there were two additional observations that would make health disparity elimination more feasible. First, researchers learned through their qualitative inquiry that Ontario needed to create an order with specificity and answerability to pursue the social determinants of health properly. Such measures would have provided direction to the local health units and addressed the lack of uniform program implementation. Also, corroborating McLeroy, Bibeau, Steckler, and Glanz's (1988) ecological theoretical framework for health promotion, researchers suggested further examination of the "micro-, meso-, and macro-level," or personal beliefs, local health units, and Ontario-based factors affecting efforts to address the social determinants of health at the province level (Raphael & Brassolotto, 2015, p. 13).

Stephens (2011) focused on urban public health environmental issues such as water quality, residential areas near busy roads, and the “distribution of parks” (p. 33) for exercise to confirm the importance of viewing public health policy through an equality and equity outlook. Stephens further suggested social coalitions and local government should partner to address the disparity in resource allocation and policy decision making. The recommendation aligns with Koh et al.’s (2010) advice to work through various partnerships to eliminate health disparities.

Spina (2013), through the lens of the legacy of segregation in the United States, cautioned public health administrators to not implement public service programs in a distant unattached manner, but to proactively pursue unity in efforts to serve “all citizens” (pp. 105-106). Administrators could form alliances with elected officials to ensure just policies and service delivery. The environmental health–racial disparity case studies offered recommendations that suggested admitting the problem, seeking input from the community members affected by the issues, encouraging public leaders to be introspective in assessing their own behavior, interacting with the appropriate constituents for solutions, and ensuring universities addressed equitable public service among students to shape the future minds of public administrators.

Pursuing Equity in Health Care Delivery

Regarding income inequality in Georgia, the poverty rate for Native Americans (28.8%), African Americans (22.5%), and Latinos (24.3%) is twice or greater than the rate for Whites, at 11. 9% (Center for American Progress, 2019). Researchers have linked poverty to poor health outcomes (Kennedy, 2013; Pruitt, Davidson, Gupta, Yan, &

Schootman, 2014). Saldaña-Ruiz et al. (2013) demonstrated how, over decades, the colorectal cancer death rates were reversed faster among the higher income community compared to the lower income community. In particular, in 1968, the higher income community's mortality rate ratio was higher than the lower income community's rate ratio at 4.24 versus 3.49, respectively (Saldaña-Ruiz et al., 2013). The American Cancer Society provided colorectal cancer guidelines in 1980, and the U.S. Multi-Society Task Force initially gave guidelines in 1997; by 2005, the rate ratio for the higher income community was 2.64 versus 3.23 for the lower income community (Saldaña-Ruiz et al., 2013). A conclusion drawn from the study was, within health care, there was a need to ensure equitable distribution of life-preserving resources or at least provide equal opportunities for adherence to guidelines among persons experiencing poverty.

Looking at rural Native American communities in the Northern High Plains, Belasco et al. (2014) concluded through analysis using the Health Care Access Index that counties with poor health care access also had "lower breast cancer screening rates, higher smoking and obesity prevalence, and higher cancer-related mortalities" (p. 461). Heath policy determinations should include factors that influence the ability to obtain care. Examples include the use of financial resources and proximity to or availability of medical providers.

Health Equity Strategy Common Themes

The most salient themes related to the strategies to achieve health equity were (a) policies and practices, (b) partnerships, and (c) resource distribution and addressing poverty. The first constantly maintained theme was the need to focus on changing or creating appropriate policies and practices (Adams et al., 2016; Beadle & Graham, 2011; Hankivsky et al., 2014; Ladenheim & Groman, 2006; McDonough et al., 2004; Ottersen et al., 2014; Raphael & Brassolotto, 2015; Rose, 2015; Rudolph et al., 2013; Saldaña-Ruiz et al., 2013; Young et al., 2015). Removing structural barriers impeding health equity within the context of the social determinants of health resonated consistently with me during the literature review; nevertheless, there was also an overall dearth of expansive information on descriptions of state practitioners' personal experiences to accomplish program and policy implementation through state government. A couple of slight variations to this observation included Payne et al. (2015) and Stamatakis et al. (2014) providing practice-based recommendations for local obesity prevention through work experiences; however, there were no insights on the essence of the experiences among state practitioners to achieve health equity through policies and practices. McDonough et al. (2004) provided the most noticeable information on addressing state-level health equity; likewise, for Hankivsky et al. (2014) concerning health equity policy, the information is applicable to either state legislative or health department entities. Finally, Ottersen et al. (2014) and the global power imbalance perspective seemed to both counter and support Rudolph et al.'s (2013) view of addressing the social determinants of health that sought to infuse health improvement in other public domains (e.g., education systems). Nevertheless, Ottersen et al. were primarily concerned with securing adequate administrative policies for worldwide health disparity elimination. Rose (2015) showed various government struggles in passing national health care policy that was beneficial for health disparity elimination in multiple states.

State health departments are unique compared to local health departments based on not having direct service responsibilities and the tendency to be more policy-focused. Furthermore, compared to their local counterparts, state government agencies have a greater likelihood of being affected by oscillating political climates as governorships change. Consequently, these circumstances warrant health equity strategy guidance within the context of volatile state government environments. Understanding personal experiences can contribute to practical recommendations for lessening the practitioner burden associated with achieving equity.

Second, partnerships were another key factor for disparity elimination. With guidance from the federal government through the National Partnership for Action to End Health Disparities Implementation Framework, Beadle and Graham (2011) laid the foundation for and described the type of partnerships that must exist, which includes various members from multiple backgrounds and “all sectors” (p. S17). For the complexity of health disparity elimination, the Health in All Policies framework stressed nontraditional partnerships between government health entities and social institutions that have influence on health status, such as the criminal justice and housing systems. Task force members determined that continuous appropriate social policies increased the chances of positively affecting health outcomes. For example, smoke-free housing policies in public housing units help reverse the prevalence of asthma attacks and poor lung health. Ottersen et al. (2014), through the global health disparity elimination view, confirmed the importance of government and nongovernment collective actions for improved international health. More importantly, the essence of their worldwide health disparity elimination approach argument centered on a multidisciplinary approach to positively affect all international policies in the pursuit of fair health outcomes.

Cohen et al. (2013) provided a framework specifically for organizations and represented a favorable model for state agencies to address health equity. Furthermore, the Canadian framework (i.e., Organizational Capacity for Public Health Equity Action) was similar to the National Partnership for Action to End Health Disparities Implementation Framework, with a reliance on partnerships, which was another common theme among all published studies reviewed. In contrast, the Beadle and Graham (2011) model is more fully developed and currently operating across the United States.

Finally, regarding resource distribution, poverty, and the impact on health outcomes, Spina (2013) confirmed that public administrators should focus on the public allocation of assets at the local level. The impact of the legacy of segregation on environmental health, where members of one community faced exposure to toxins because they were African Americans, mandated that administrators not be distant observers of circumstances. Stephens (2011) further affirmed that city-based government leaders should have the bravery to address adverse health outcome disparities regarding power decisions within local government. Citizen coalitions and local government should partner to address the disparity in resource distribution and policies, thus putting a fair view on local public health policies. Both confirmed the importance of local communities and the obvious unbalanced support distribution. States, working through multiple sectors with local communities through community action efforts, have the ability to influence policies, systems, and environments favorable for behavioral risk reduction (Adams et al., 2016). For state government policy, Stone (2006), through the distributive justice lens, historically provided an avenue for legislators to use in attempts to get health disparity elimination laws passed that were grounded in the disparate health needs of racial minority populations.

Ottersen et al. (2014) and Rose (2015) affirmed that governance powers were a resource that, when used in a debilitating manner, did not benefit vulnerable populations' health. Ironically, the power struggles associated with passing and sustaining the ACA contrasted with the suggestion from Stone (2006) to garner support for equity legislation through the distributive justice lens, which appealed to the needs of the underserved. However, more than 10 years later, McDonough et al. (2004) was still relevant as Rose demonstrated that the nation had not overcome the conflicts associated with racial and ethnic minority health disparity elimination within the context of governance political beliefs. Likewise, Raphael and Brassolotto (2015) confirmed the relevance of leadership worldviews as a determinant for the pursuit of the social determinants of health in Canadian public health.

Novick (2016), through a health equity supplement in the *Journal of Public Health Management and Practice*, captured various instances of state health department public health equity practice and policy change work, and provided critical interpretations from public health experts for reversing racial and ethnic minority health disparities. The information corroborated the historical and current literature analyses put forth in this dissertation prior to publication. The supplement also included suggestions on ways to move health equity achievement ahead through state and territorial governments. For example, the supplement authors' initial analysis began with support for the Health in All Policies approach for health improvement that set the tone for subsequent articles (Liburd, Ehlinger, Liao, & Lichtveld, 2016; Rudolph et al., 2013). The current public health stance for disparity elimination is mobilizing cross-specialty partnerships to ensure policy and program changes positively impact racial and ethnic minorities' health. Additional populations include the lesbian, gay, and bisexual community and persons affected by mental health and behavioral challenges, which were also cross-racial and multicultural.

The health equity supplement was a timely multidisciplinary document for normalizing racial and ethnic minority health disparity elimination through state government health intervention practices and policies. The supplement confirmed the approach from Rudolph et al. (2013) for addressing the societal factors influencing adverse health and the various partnership perspectives from the U.S. Department of Health and Human Services, Canada, and the international community (Beadle & Graham, 2011; Cohen et al., 2013; Ottersen et al., 2014). As the 2016 U.S. presidential election focused on income inequality and minority communities seeking relief from deadly gun violence, incarceration, and the need for immigration reform, the journal propelled public health leaders into a synergistic movement to elevate health equity in state governments. Evidence of unceasing disparities substantiated the call to action in the supplement. For instance, the literature included one health outcome study on gender differences in the primary causes of death among racial and ethnic minority persons and another acknowledged that 69% of the Healthy People 2010 target objectives with statistics remained a hurdle for racial and ethnic minority population health improvement (Chang, Moonesinghe, Athar, & Truman, 2016; Mendoza-Walters et al., 2016).

Penman-Aguilar et al. (2016) confirmed, through the fourth recommendation for assessing progress toward disparity elimination, the importance of analyzing various social positions (e.g., gender, ethnicity, English language proficiency, income) within the broader racial and ethnic minority communities. Considering the multifarious nature of populations gives public health practitioners the ability to tease out and work on hidden contributors to health disparities. Researchers such as Nguyen et al. (2015), who examined multiple Asian ethnicities for employer health care coverage, were able to determine that Korean immigrants were least likely and Filipinos were most likely to have health insurance. Furthermore, for New Mexico’s Latino community, Sanchez and Sanchez-Youngman (2013) confirmed that the originating country determined the chances of support for immigrant state health care coverage. Persons claiming Spain as a home country were more likely to deny support for noncitizen families receiving state health care coverage. In contrast, Hispanics with strong Chicano associations had greater favorability for such coverage. Suggesting a notable observation to understand population particulars, Mishra, Lupi, Carter, and Meeks (2016) recommended that state health leaders establish intergovernmental connections rather than concentrate on the American Indians and Alaska Natives as a community for interventions. Likewise, for the U.S.-affiliated Pacific Island territories, governance considerations are critical for health equity collaborations, which should be anchored in integrity.

To move states forward in effectively addressing racial and ethnic minority disparities, Dean, Roberts, Bouye, Green, and McDonald (2016) gave two key points for consideration that are relevant to state health leaders. First, decision makers should no longer view national health as separate from working toward health equity. A healthy nation is reflected in how well communities most in need receive care. Second, researchers confirmed health policy as the impetus for public health practice; consequently, leaders should be informed and dedicated to distributing limited assets according to the groups suffering the greatest health burdens. Dean et al.'s conclusions were supportive of Raphael and Brassolotto (2015). For the Ontario local health unit leaders, researchers determined that, within the context of local politics, the decision to focus on the social determinants of health also depended on personal views. As a result, the extent of devotion that Dean et al. expressed was rooted in the personal decision to pursue health equity. Consequently, decision makers release funds accordingly. The historical health equity challenges within state legislatures described through McDonough et al. (2004), state Medicaid expansion conflicts (Rose, 2015; Thompson et al., 2014), and international governance dysfunctions (Ottersen et al., 2014) confirmed a worldwide agreement on the need to exercise statistically driven program and policy implementation.

Finally, strategically placed in the supplement, the closing Ferrer (2016) commentary spoke of valuing the pursuit of the best health possible through public health "systems, policies, and practices" (p. S110). With an urgent plea to overcome racism in public health, Ferrer provided examples from the movement for racial equity as a way to secure health equity. The recommendations had three summarizing tenets. The message encouraged agency introspection to serve various cultures more appropriately, forming agency relations to expend funds among populations in highest need, and accepting opportunities for the “racial healing” (Ferrer, 2016, p. S111) required to disassemble population power dominance for health equity. From McDonough et al. (2004) to Novick (2016), at the local, state, and international levels, the empirical evidence called for a public health effort shift toward reducing the excessive disease burdens among racial and ethnic minority communities and persons experiencing poverty. Although several states could have been chosen, based on convenience, I examined Georgia.

Summary of Georgia’s State Policy Formulation Process

The purpose of this section is to give a brief overview of the Georgia state policy formulation process (Georgia General Assembly, n.d.). The policy formulation process starts with a legislator’s desire to either change an existing law or create one. Once drafted, the legislator files the bill with either the House or the Senate to receive an introduction and an initial reading, and then receives an assignment to a standing committee. The House will have a second reading of the bill among House members while in committee, but the second reading from the Senate will only come upon the committee’s approval of the bill.

After readings, the committee deliberates on the bill through the originator’s testimonials or public hearings if contentious. Possible actions from the committee review include recommending the bill or resolution to pass, recommending it not pass, recommending it pass with changes or amendments, or recommending holding the bill

(Georgia General Assembly, n.d.).

During the third phase, all bills receiving committee approvals are placed on the general calendar after receiving a second reading on the day prior to the third reading day. This allows the bills to be placed in sequence to receive active consideration prior to the Rules Committee's review. Eventually, the Rules Committee convenes to construct a rules calendar for the next day for bills still needing review. When the third reading occurs, the bill will go through assembly discourse, adjustments, and voting. Next, the main vote will occur, and if approved by either the House or the Senate, the bill moves on to the other chamber for a final vote (Georgia General Assembly, n.d.).

If the bill passes during the final vote, it returns to the original chamber. If rejected at this point, but the second branch persists, a conference committee can be created where both houses accept the final decision. The governor may sign the bill or not act and it becomes law. If the bill is vetoed, it can be overridden by two-thirds majority of each chamber (Georgia General Assembly, n.d.).

In addition to the bills and resolutions mentioned in Chapter 1, three other notable bills impact Georgia's racial and ethnic minority health disparity landscape. HB943 and HB990 (2013–2014a, b) place sole decision making or action for Medicaid expansion with the Georgia General Assembly (Georgia General Assembly, 2013–2014a, b; Williams, 2014). Georgia, unlike Ohio, will not permit the governor to act solely for Medicaid expansion under ACA. HB951 cites language acknowledging Georgia's economic successes and recognizing among several challenges, "insufficient health care access" in rural areas (Georgia General Assembly, 2017–2018e, section 1, 23). The newly created Center for Rural Prosperity and Innovation or Georgia’s Rural Center will continue to study the plight of rural locations “to identify policies and ideas” (Georgia General Assembly, 2017–2018e, section 1, 28) to financially augment the entire state. Georgia’s Rural Center could serve as an opportunity for *implementing* public health policy changes to improve rural and racial and ethnic minority health outcomes in partnership with other health entities serving the areas. Such collaborations are warranted based on the connection between healthy communities and economic viability.

Summary and Conclusions

The major themes in the literature included the urgent need to address racial and ethnic minority health disparities in the United States due to the large size of the population suffering and the high financial costs to individuals and governments. State health agencies and legislatures have engaged in belief system battles on how best and whether to directly address racial and ethnic minority health needs. Despite health leaders’ research-based recommendations and continued advocacy, chronic disease and behavioral risk factor disparities remain prevalent in Georgia, the United States, and internationally. The theory of communicative action was an appropriate research lens that allowed for the infusion of public health and legislator leaders’ views into the public debate on how best to eliminate the overburdened rural and racial and ethnic minority communities’ suffering in Georgia. In time, morally acceptable solutions shaped by public influence will surface.

The ACA was a major legislative health policy that raised expectations from public health and state government for addressing racial and ethnic minority health in the

United States, including persons of all races and ethnicities experiencing poverty. Health coverage, the extent of coverage, health outcome improvement, and health disparity elimination has received greater attention, which has forced the public debate to focus on marginalized populations in a more accountable manner. In qualitative analyses, the focus of most of the literature was on the views of health care providers and the populations affected by the disproportionate health burdens; consequently, there was still a need to know more about the state health department and legislator leaders' work experiences, particularly in the South. Additionally, there was a need to close the information gap about how employees address racial and ethnic minority health disparity policy implementation and their recommended solutions. The phenomenological analysis of state leaders' experiences addressing persistent chronic disease and behavioral risk factor prevalence rates among racial and ethnic populations in Georgia fills this gap. The knowledge will be extended because persons not commonly heard, yet whose voices are critical for health disparity elimination, will have their views brought to the forefront of the public health disparities debate. Within the literature, advocates provided analytical commentary of health equity challenges, and federal authorities presented national framework solutions for state and local governance to follow. Researchers in the health care arena described reasons for the disproportionate prevalence of chronic disease mortality, and provided health disparity elimination recommendations using information from the affected populations' responses. I addressed the knowledge gap by providing insight into the lived experience of 11 state government leaders to address disparities among racial and ethnic minorities. The phenomenological approach, as explained in

Chapter 3, produced information to inform public health actions for health disparity elimination policy.

Chapter 3: Research Method

Introduction

The purpose of my phenomenological inquiry was to explore the perceptions and lived experience of Georgia legislator policy makers and health department staff from chronic disease and behavioral risk factor programs to eliminate health disparities among minority racial and ethnic minority populations. In this study, I explored what members of both state leadership groups believed needed to be done to address health disparities and collected their recommendations for policy and practice solutions for the health inequities of racial and ethnic minority populations. This chapter includes the research design and rationale; role of the researcher; methodology; instrumentation; recruitment, participation, and data collection procedures; data analysis plan; trustworthiness; ethical procedures; and a summary of main points.

Research Design and Rationale

The following research questions guided this study:

Research Question 1: What is the Georgia Health and Human Services Committee legislators' lived experience in creating and passing state legislation to eliminate racial and ethnic minority health disparities?

Research Question 2: What is the Georgia Department of Public Health and Community Health employees' lived experience in implementing policies and policy programs designed to eliminate chronic disease and behavioral risk factor disparities among racial and ethnic minority populations?

Based on disproportionate health burdens borne by minority racial and ethnic populations in poverty, the focus of this study was to understand the experiences of Georgia health legislator decision makers creating and passing state legislation to eliminate racial and ethnic minority health disparities. The purpose was also to explore the perceptions of staff from the Georgia health department chronic disease and behavioral risk factor programs regarding their experiences implementing policies and policy programs to eliminate chronic disease and behavioral risk factor disparities among racial and ethnic minority populations. The results of this study can help inform Georgia and national policy and practice solutions for health inequities.

Phenomenological research traditionally focuses on *what* the research participants experienced and *how* they defined the experience (Creswell, 2013). More specifically, phenomenology focuses on the lived experience of the study participants (Creswell, 2013). Therefore, my rationale for using the phenomenological approach was to allow the state health department and legislator officials describe, in their own words, what it means to work on behalf of racial and ethnic minority communities from a health policy and practice view in Georgia. The practical understanding of their work can also provide policy and practice recommendations for reversing racial and ethnic minority health disparity trends in Georgia. Quantitative analysis does not provide an in-depth understanding of social phenomena through the participants' lived experiences, and the mixed methods approach was not optimal given the time and cost constraints.

Role of the Researcher

As the researcher, I developed the participant interview protocol from the research questions (see Appendices A, B, and C) and conducted the interviews with state government health department and state elected officials. I also transferred the IQs onto the online SurveyGizmo platform for state health and elected officials who preferred to give written responses (see Appendices B and C). The purpose of having two data collection options was to increase the likelihood of study participation.

One important task for the study was to bracket myself by acknowledging my successful and challenging personal experiences working in state government for 14 years as a tobacco program consultant and health disparities coordinator while not letting the historical knowledge interfere with capturing the reality expressed through study participants (see Creswell, 2013, pp. 78–79). I did not include in the participant pool any state employees with whom I was familiar. There were no anticipated power-based supervisory or instructor relationship challenges because I did not work within the Georgia state government system. As a 14-year federal employee working in an agency that funds state programs, I had no interactions with intended study pool program staff; consequently, there were no anticipated power relationship challenges. Likewise, there were no relationships with the elected officials interviewed.

I handled researcher bias management in three ways. All interviewed study participants confirmed their comments were properly transcribed before analysis, and I reviewed the transcripts along with the digital recordings as well as submitted them to the participants for review. Second, external health and social service professionals served as subject matter experts and reviewed the initial interview protocol instrument and research questions for possible bias. Finally, there were no plans to provide monetary incentives for elected officials, their aides, or study advisors to avoid the appearance of response influence or bias during survey instrument reviews. To avoid the appearance of response influence, elected officials did not receive compensation because their job is to serve and inform Georgia constituents. Gift cards in the amount of $10 or $20 were given to health department participants to express gratitude for their participation and for the time spent reviewing audio transcripts and completing online surveys.

Methodology

The purposeful sample strategy I used in this study included a preference for persons involved in health equity and or disparity elimination work on behalf of Georgia’s racial and ethnic minority communities, particularly for persons at or below the poverty level. Purposeful sampling centers on “information-rich” (Patton, 2002, p. 230) individuals and, in this study, were those who had proactively pursued the elimination of racial and ethnic minority health disparities in Georgia. My intent was to learn about efforts for eliminating racial and ethnic health disparities and any associated experiential connections to the key concepts identified in the literature; hence, it was most appropriate to interview Georgia state employees from the health department, and Georgia Health and Human Services Legislative Committees. Purposeful sampling allowed me to gather useful information on disparity elimination policy and practice work through the state government and contributed toward solutions beneficial for health equity.

Participant Selection Logic

The health department study population came from a pool of approximately 37 directors, managers, and consultants at the Georgia state health department level and 18 local public health districts. The sample included five health department employees. The programs of interest were Health Promotion, Health Equity, Cancer, Obesity/Nutrition, Diabetes, Heart Disease & Stroke, Rural Health, and Refugee Health. These programs focused on health disparity elimination and encouraged population behaviors favorable for disease reduction and prevention. These areas were also based on where racial and ethnic minority health disparities persisted in Georgia or the health disparity challenges were identified in the literature. I also included county health department officials in identified programs in Georgia receiving state or federal funds for chronic disease and behavioral risk factors for racial and ethnic minority disparity elimination.

During the 2017–2018 General Session, there was an initial pool of 53 Senate and House of Representative Health and Human Services Committee members who comprised the other half of the study sample. For legislators, I was particularly interested in the Health Care Delivery Senate Subcommittee members, to whom health care coverage access was a concern. In the interest of time, there was a need to pursue legislator aides who assisted representatives and senators serving Health and Human Services Committee members. When the recruitment process began showing evidence of elected officials from other committees also sponsoring legislation for health disparity elimination, the pool widened to the full Georgia General Assembly, which included 236 members. To attain a minimum legislator sample of six, I derived participants from various committees.

There were four study selection criteria. First, participants must have been a Georgia state representative or senator, and state health department employees must have been program consultants, managers, or directors. Second, interviewees must have had no less than 18 months of Georgia state government service experience for the state health department, where health disparity policies and practices were or could have been addressed. For the legislators, the participants must have had at least 18 months of service working, in any manner, toward the creation, introduction, or passage of health equity policies. Finally, county health department officials were included if there were not enough state-level employee program participants. Interviewees must have had at least 18 months of position experience working in the previously identified programs with state or federal funds for Georgia for health disparity elimination projects.

Health department online survey respondents completed the screener guide online to determine if they met the research criteria. I confirmed that legislators and legislator aides met the research criteria based on website reviews in which I confirmed their positions within the Health and Human Services and other committees as well as the types of bills or resolutions sponsored or cosponsored. The screening process occurred without difficulty.

After receiving IRB approval, I sent initial study recruitment notices explaining the study and selection criteria to prospective participants. Potential health department participants received their initial study recruitment notices through LinkedIn and

Facebook and recruitment efforts also took place through agency or professional organization inquiries and referrals. Potential legislator participants sent either a text or an e-mail notice of interest to me after viewing my legislator and legislator aide recruitment e-mail notice. If there were no responses from initial recruitment notices, I visited possible participants' offices and made phone calls to inquire about their participation, or I distributed additional recruitment notices through the mail for both participant groups. After confirming eligibility, discussions began to determine if participants wanted to use SurveyGizmo to provide written responses to the research questions or to choose a time and date for a face-to-face interview at a confidential meeting place of their choice.

There were 11 participants: five from the health departments and six Georgia state legislators. Rudestam and Newton (2015) noted that the phenomenological in-person data collection interview should take place with 10 or fewer persons for a 2-hour time frame. Dukes (as cited in Creswell, 2013) confirmed that three to 10 interviewees were sufficient. Guest, Bunce, and Johnson (2006) found that researchers can achieve saturation through seven to 12 qualitative interviews. The final participant number was determined when I reached information saturation with legislator and health department participants. Saturation occurred when themes for the research questions repeated among various participants and no more new information emerged from participant interviews and surveys. Recruitment was monitored and expanded within the pool to ensure there was not an imbalance of participants from any one program or committee.

Instrumentation

The primary data came from following a participant interview protocol (see Appendix A). The interview protocol provided me with guidance for conducting each audio-taped interview to obtain answers to the semistructured interview data collection instrument for the research questions (see Appendices B, C, and D) for state and county health department staff, elected state officials, and legislator aides. I also used the interview protocol for the online survey.

The semistructured interview and comparable online survey data collection instruments were sufficient to answer the research questions because the IQs were open-ended and the data collection instruments were created based on the concepts found in the literature review that confirmed the knowledge gap in understanding the experiences of health department staff and legislators in addressing racial and ethnic minority health disparities. As a result, participants were able to provide their experiences freely within the confines of the research question content. According to Creswell (2009), qualitative researchers should use open-ended questions and be comfortable with reforming the questions as the study dictates. Patton (2002) confirmed the relevancy of open-ended questions for the exchange to be interviewee centered to best capture interviewees' perspective of the study phenomenon.

The key concepts of state policies for racial and ethnic minority community health disparities and strategies to achieve health equity found in the literature review served as the basis for developing the data collection instruments to help understand participants' lived experience and perceptions. The initial interview instrument for the participants' questions underwent a preliminary review for content validity, and the results are available upon request. Two experts in the health policy research and health science fields provided feedback on the instrument. One sociologist working in public health provided general feedback.

I also conducted two mock interviews for a state health department participant and legislature participant, serving to test the expected length of the interviews and usefulness of the questions. Consequently, I revised the IQs to reduce wordiness to ensure participants could more clearly focus on their responses and ensure alignment with the literature review concepts. The expert in health policy research recommended narrowing the dissertation down to specific diseases and behavioral risk factors. The suggestion confirmed that it was not clear the inquiry was more about the lived experience and perceptions of the respondents while doing the health equity work within the state health departments and legislature rather than the specific policy challenges associated with the process or health disparity outcomes for particular diseases and risk factors. The mock interviews revealed the need to make a note to probe deeper for participants' feelings to develop a better understanding of the personal impact of pursuing health equity within their work environment. As a result, I revised the inquiry instrument to generate answers that were congruent with addressing the overarching research questions, which included a focus on the lived experience and perceptions of participants.

Recruitment, Participation, and Data Collection Procedures

Study recruitment notices appeared on Facebook and LinkedIn social media sites. Follow-up activities included phone calls, office visits, postal mail, and e-mail notices. I confirmed eligibility through the group-appropriate screener guides or website reviews. The selection of secure meeting places served to preserve confidentiality. I collected the interview data from five health department employees who addressed chronic diseases and behavioral risk factors in their work.

In total, I obtained interview data from six Georgia General Assembly legislators from various committees and five health department employees. I collected the data through individual face-to-face digital audio-recorded interviews and from online surveys conducted through SurveyGizmo. Data were obtained once from each participant, and each participant had the opportunity to confirm transcript accuracy and to make additional comments or changes to the transcripts and survey responses. For interviews, the participants reviewed and signed the consent form in person prior to the interview, and the participants received a final copy sent via certified mail. For the qualitative online surveys, respondents could review and print or save all responses after survey completion.

The digital audio-taped interviews averaged 34 minutes. The qualitative online survey could have been completed in approximately 1 hour. Recruitment, online surveys, and interviews continued for 6 months, from July 2018 to January 2019.

After the interviews, participants were thanked for their time and given the opportunity to provide additional information on all IQs. Prior to exiting interviews, participants received a reminder to review and return the transcripts with adjustments, or give comments through e-mail to ensure data accuracy. Qualitative online survey participants had time to review and edit their responses prior to submitting their final responses. There were no additional formal interviews. Participants received a handwritten thank-you note after completing participation and received no further communication.

Data Analysis Plan

The focus of the legislators' IQs was the experiences of creating and passing health equity policies, and the focus of the health department questions was the experiences of implementing health equity policies and policy programs. All questions were within the context of the key concepts found in the literature review. For example, there was a health department question about the health equity frameworks and practices guiding their policy or policy program work. The responses could have resembled a framework that included the Canadian grounded theory approach to building organizational capacity called Organizational Capacity for Public Health Action (Cohen et al., 2013). Considerations include political environments, belief systems, or employee relations. The response could also reflect a common framework describing the inclusion of health into non-health-service policies such as transportation or education known as Health in All Policies (Rudolph et al., 2013).

For the state legislature, there was a question about the participants' experience working on state health policy passage in the midst of the ACA or Georgia state health coverage for persons in poverty. A prominent theme from the literature was the importance of Medicaid expansion for states through the ACA and state health coverage for health outcome improvement and immigrant health coverage for cost containment. Interview responses corroborated policy passage challenges or successes associated with health coverage in Georgia for racial and ethnic minority populations in poverty. The plan for interview and online survey data analysis was to focus on the experiential research questions derived from the key concepts in the literature review to form primary or structural codes (Guest, MacQueen, & Namey, 2012; Hacker, 2015). For each group, I reviewed the transcripts for common themes to develop secondary codes (i.e., thematic codes) that matched the primary codes for each group, which came from the participants' words or were in vivo (Guest, MacQueen, & Namey; Hacker; Miles, Huberman, & Saldaña, 2014; Saldaña, 2016). I used applied thematic analysis to review transcript text to match structural and thematic codes to be placed in a codebook (see Appendices E and F) for the conceptual codes (Guest, MacQueen, & Namey; Saldaña). Coded data were stored in an Excel software spreadsheet to organize common phenomenological themes based on the key concepts guided by the research questions (Miles et al., 2014). This process made it easier to report on common themes and to quantify theme frequency among participants for Chapter 4. There were no discrepant responses, but the least common or single in vivo responses were paired with the most appropriate conceptual themes and explained in Chapter 4.

Issues of Trustworthiness

According to Cope (2014), trustworthiness refers to inquiry elements that should be present in qualitative studies, which results in the placement of trustworthiness on an equal level to quantitative research rigidity. Consequently, all participants received a request to review their interview transcripts and qualitative survey responses for accuracy and to edit responses for lucidity. A translation and transcription service called

TranscribeMe transcribed the digitally recorded interviews into Microsoft Word documents. I reviewed the transcripts while listening to the recordings, in addition to providing transcripts to the participants. For qualitative surveys, the data were easily available for placement into a Word document for analysis.

Common theme saturation for the research questions confirmed internal validity; data analysis showed theme frequency for all research questions. I maintained a personal reflexivity journal during data collection to document thoughts and activities of the data collection and analysis process, speculations, and personal views. Finally, I used triangulation between the existing research literature and interview data from both study groups to identify similarities and corroborations among multiple data sources. Likewise, participant response outliers were revealed for comparison with common themes.

The fact that all participants have relevant state or county experience supported external validity. The interview protocol asked for participants to respond to questions with details to ensure the responses analyzed would be highly descriptive and thus increasing the likelihood of transferability. Even though qualitative data are not generalizable to broader populations as is possible with data in quantitative studies, it is not uncommon for the lived experience and perceptions captured in one study to be similar in other related environments within a state or across the nation (Rudestam & Newton, 2015). To further verify dependability and confirmability, audit trails alert researchers to “potential biases and assumptions” (Rudestam & Newton, 2015, p. 134) and enhance the study’s credibility, despite the researcher’s personal experience with the topic. Such actions allow researchers to be transparent when bracketing themselves by disclosing personal exposure to the inquiry subject (Creswell, 2013).

Reflexive journaling assisted in recognizing personal bias during the data collection process. All data collection processes have a traceable history for external review. For intracoder reliability, I was the only person involved in collecting and analyzing data, and coding was an iterative process (see Levasseur, 2011). For example, the first transcript was coded for common themes matching the structural code derived from the research questions. Afterward, the second transcript was coded, and new thematic codes were also identified and pursued in the first transcript. This process of returning to previous data for additional analysis with new thematic codes continued for all data. Interviews for which there were no emerging codes were rechecked for matching thematic codes after all data had been coded. Each transcript was coded in vivo to capture the participants' experiential voices regarding connections with the research literature key concepts, which is common for phenomenological inquiries (Miles et al., 2014).

Ethical Procedures

To preserve participant confidentiality more effectively, the initial recruitment notices were placed on Facebook and LinkedIn social media sites. Interested candidates contacted me through their own cell phones or e-mail accounts and did not respond through the social media sites. The study received Walden IRB approval and Georgia IRB review. Both state health departments had the opportunity to review the study proposal. For the Georgia General Assembly participants, I did not seek any preliminary agreements for study participation. All intended legislators or aides were invited to participate through direct office e-mail, follow-up phone calls, and office visits upon IRB study approval.

All participants were treated with dignity and respect. Confidentiality was assured with me, the transcription service, and the online survey service through a mutual nondisclosure agreement and SurveyGizmo’s confidentiality agreement. There were no ethical concerns about recruitment materials because the recruitment advertisements for the health departments and elected officials reflected the study purpose and participant criteria, and expressly confirmed participation was confidential and voluntary.

A possible ethical concern that could have arisen from the small study sample and health equity topic was the need for extra assurance of participant confidentiality. No interview respondents’ identifying characteristics were tracked, and all participants’ transcripts and online survey responses were numerically tracked and assigned to either the legislator or the health department group. Health department employees who considered responding to the social media advertisement for study participation were told how to contact me while maintaining public anonymity. Health department program-specific identifiers were not linked to participants. No identifiers were linked to elected officials.

Additional participants were sought to replace interviewees and survey respondents who withdrew prior to the interview or survey or who did not complete the full interview or survey. Participants who skipped questions did not have data available for analysis on particular omitted questions. The impact of these circumstances, or similar situations, is acknowledged in the Results section.

Audio transcriptionists received number-coded recordings for transcribing audio files. Audio files were submitted through the TranscribeMe encrypted electronic data transmission portal, which is a standard security feature. SurveyGizmo also has an encrypted security feature for online data collection. The data are published in an aggregate manner to avoid linking specific participants to their responses. Interviewees and qualitative online survey respondents had the opportunity to review their interview transcripts and survey responses and to edit comments before the data were analyzed.

Participant transcripts, qualitative online survey responses, and analysis information are stored on a password-secured laptop and USB drives to which only I have access. The laptop is secured with Webroot Internet Security Plus and malware protection software. All confidential hard-copy study materials are secured in a locked fire-proof strong box. All study data with identifiers will remain securely held in the same strong box for 5 years under home security. Afterward, the data will be destroyed through a professional shredding service in my presence.

To maintain ethical research (e.g., confidentiality), face-to-face interviews took place in rooms participants believed were confidential. Online surveys were completed outside of the work environment. To avoid, conflicts of interest, there were no incentives for elected official participants and the two content-validity advisory members. Elected officials were not compensated because they were elected to serve and inform Georgia constituents. Any persons with whom I was personally familiar at the health departments were not interviewed and were confirmed through the screener guide.

Summary

Chapter 3 contains the data collection methods and a particular focus on justifying the qualitative research design based on seeking to understand state government leaders' experiences of creating, passing, and implementing racial and ethnic minority health equity policies within Georgia's state government. My role as the researcher included reviewing transcripts and online survey results within the context of reflexivity to ensure personal biases did not influence study outcomes. Furthermore, the chapter includes a discussion on conducting an ethical study using password-protected, fireproof security for data protection, and aggregate data analysis. Chapter 4 includes a detailed review of the data collection process and study results.

Chapter 4: Results

Introduction

Georgia's racial and ethnic minority communities have an on-going problem of disproportionately worse health outcomes, including higher chronic disease and behavioral risk factors, compared to their nonminority counterparts. The disparities were first comprehensively documented under former Georgia Health Commissioner, Dr. Rhonda Meadows, in a seminal report called the *Georgia Health Equity Initiative Health Disparities Report* (Georgia Department of Community Health, 2008). There are persistent barriers to overcome for improved health, and the problem is costly to individuals in terms of quality of life and financially, especially for persons who are uninsured. The uninsured rate among different racial and ethnic minority persons in Georgia ranges from 12% to 34%, while the state and national rate are 16% and 11%, respectively (University of Wisconsin Population Health Institute, 2018). Costing approximately $40 billion dollars per year, Georgia is also unfavorably impacted by high healthcare costs from chronic diseases, preventing optimal state financial operations (Georgia Department of Public Health, n.d.b).

Focusing on state leaders who are most able to address the problem, in this study, I wanted to know about the lived experience of legislators and health department officials to create, pass, and implement policies to eliminate health disparities among racial and ethnic minority communities. The purpose was to better understand what happens in their lifeworld or day-to-day activities to help marginalized persons become healthier. In an effort to understand how Georgia legislators and health officials do their work to address racial and ethnic minority disparities through health policies, I completed a literature review. For the legislators, the literature revealed examples of efforts to work on state policies to address human suffering from poor health, particularly in the South and rural areas. A major concern was disproportionate health burdens and healthcare costs (McDonough et al., 2004; Thompson et al., 2014). For health departments, the literature provided various health equity frameworks and approaches for health disparity elimination. These included public health policy and systems changes to impact how programs operate to serve citizens. The literature also provided insights on healthcare disparities and the need to focus on resource distribution (e.g., patient education) as well as multisector partnerships to improve health. I found a gap in the literature concerning the lived experiences of Georgia legislator and health officials working to improve health outcomes of Georgia racial and ethnic minority populations through health policies.

To fulfill the purpose of understanding Georgia officials' perspectives of pursuing and implementing health policies to improve health outcomes, I conducted this phenomenological study with the following two overarching research questions:

> Research Question 1: What is the Georgia Health and Human Services Committee legislators' lived experience in creating and passing state legislation to eliminate racial and ethnic minority health disparities?
>
> Research Question 2: What is the Georgia Department of Public Health and Department of Community Health employees' lived experience in implementing policies and policy programs designed to eliminate chronic disease and behavioral risk factor disparities among racial and ethnic minority populations?

I also asked officials to provide their recommendations for health outcome improvements. The results reflect an important first step towards reversing lengthy health disparity trends through barrier identification and proposed health equity policy solutions for Georgia.

In Chapter 4, I address the IQs and instrument. I also provide a brief overview of Georgia's political environment during the data collection process. The chapter also includes a discussion of data collection, the data analysis process, evidence of trustworthiness, results for both participant groups, and a summary.

No pilot study was conducted; however, I did conduct mock interviews for the legislature and health department IQs, which resulted in revisions for wordiness and alignment with the literature review concepts. For content validity, experts in the sociology, health policy research, and health science fields also provided feedback. Their input resulted in greater agreement between the study title, research purpose, and various research questions.

Setting and Demographics

Since the 1960s, the United States has not seen a more politically polarized time than now, starting with the emergence of the short-lived Occupy Wall Street movement in 2011 (Da Silva, 2018), which occurred after the Great Recession in 2007. During this time period, America underwent a conscience-raising experience about the socioeconomic inequalities prompting the Great Recession of 2007. Many financial institutions in the United States saw the consequences of risky housing market investments and financial practices in the interest of excess versus responsibility.

Consequently, even as markets stabilized through financial stimulus packages under President George W. Bush and President Obama (History, 2019), the enhanced socioeconomic competitiveness, within the ambience of Occupy Wall Street, became the new social norm and continues without a predictable end (Da Silva, 2019).

The United States, including Georgia, remains in the midst of political polarization, which often increases during election times. In May 2018, Georgia voters chose a Democratic Party candidate, former State Representative Stacey Abrams, who, had she been elected during the midterms, would have become the first black female governor in the United States (Martin & Burns, 2018). On July 24, 2018, Georgia Secretary of State Brian Kemp won a gubernatorial runoff election within the Republican Party (Blinder & Martin, 2018). On November 6, 2018 Secretary Kemp became Georgia's governor by a 1.4% margin over former Representative Abrams (Niesse, 2018). Health equity is a controversial topic partially because it is related to social areas of disagreement about race, ethnicity, and socioeconomic status within the context of how to distribute limited resources fairly. To preserve confidentiality due to the sociopolitical environment and small sample size, participants are identified as being from either health departments or legislature/Georgia General Assembly.

Data Collection

The Georgia Department of Public Health IRB reviewed the study, assigning IRB# 171001 on October 13, 2017 and deferred study oversight to Walden University who granted approval on January 11, 2018 (IRB Approval # 01-11-18-0428651). Data collection officially began in July 2018 and ended on January 27, 2019. There were 11 participants: six elected officials and five health department officials. Due to the need to preserve participants' confidentiality, more descriptive details are not available. For elected officials, three participants were from the intended Health and Human Services Committee and three were from outside the intended committee. I gathered data from participants from in-person interviews in private offices or through SurveyGizmo's online system. Data were collected one time. In-person interviews averaged 34 minutes per person and were recorded on two Olympus digital voice recorders. The audio recordings were converted to Microsoft Word text for analysis by TranscribeMe, a transcription company. Participants' online responses to research questions were also converted to Microsoft Word for analysis. All 11 participants' responses reflect their individual views and experiences and do not represent the views of Georgia government service entities. I used abbreviations (i.e., E1, E2, etc. or H1, H2, etc.) to distinguish and preserve the identities of elected officials and health department participants.

The recruitment process included notices posted to LinkedIn and Facebook as well as telephone, e-mail, post mail, and in-person communication to deliver study announcements. I also created a public service announcement for social media recruitment. Additional information about data collection and recruitment was previously covered in Chapter 3.

Data Analysis

I reviewed the audio recording with the transcripts twice and concurrently released the transcripts to the participants for accuracy. Persons completing the online survey could review their comments online prior to electronic submission. I also put notes in the margins of the transcribed Word document to show connections with other participants (intra- and intergroup; elected officials were coded first) and connections with literature concepts.

It is not uncommon to use more than one type of coding for analysis (Saldaña, 2016). Consequently, the research questions served as structural or primary codes deriving from key concepts in the literature review (see Hacker, 2015; Namey, 2017). For coding, I reviewed the transcripts of Participant 1 for Interview Question 1 (IQ1, structural code) to determine the theme for IQ1 for Participant 1 (i.e., IQ1, thematic code). I also documented related summary notes matching in vivo text for confirmation. Next, I reviewed the transcripts of Participant 2 for IQ1 (structural code) to determine for IQ1 the themes (thematic code) for Participant 2. If there were no matching themes to Participant 1, I created a new theme and returned back to Participant 1 to see if Participant 2's new theme could also be found in Participant 1's text. I moved on to Participants 3, 4, 5, and 6 to determine new themes and matching current themes for each IQ by going back over previously reviewed text from previous participants for all IQs. The least frequent themes, when relevant, were placed within the most appropriate conceptual codes and shown by parenthesis. I color-coded common themes in the Excel file for ease of review and transference into a chart for the final conceptual code analysis. Figure 1 shows the coding process. Throughout data collection I maintained a self-reflective diary to aid in objectivity during data collection and analysis. Reflexive journaling assisted in recognizing and minimizing personal bias.

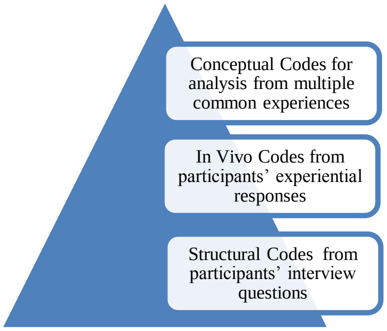

Figure 1. Evolving qualitative coding process.

Evidence of Trustworthiness

For credibility, I had all participants review their interview transcripts and qualitative survey responses for accuracy, and they were able to edit responses for lucidity prior to use for data analysis. I reviewed the transcripts concurrently while listening to the digital audio recordings twice to determine discrepancies and alignment between the recording and transcripts. I also used triangulation between the existing research literature and interview data from both study groups to identify similarities and corroborations among multiple data sources.

The study results may or may not be transferrable to other legislator and health department public service experiences, including persons working in nongovernment sectors. The challenges and successes participants reported through detailed descriptions can reflect similar experiences in other states and cities, perhaps even at the national level. Furthermore, the results specific to Georgia show the influence national healthcare policy efforts can have on states based on common themes such as the SDOH and the ACA.

Study dependability and confirmability were enhanced because I revealed my connection through a work history in commercial tobacco use prevention and HIV surveillance. I did not mention tobacco or HIV topics to participants during interviews; however, participants referenced these health areas during interview question responses. The research findings reflected the literature. Participants from programs for which I have a work history or work relationships were not included in the study. Aside from participant confidential information, all data collection processes have a traceable history for review.

The two overarching research questions related to the IQs for each participant group as shown below in Figure 2. The key concepts from the literature review served as the basis for the interview questions that are shown in the codebook for the elected official and health department participants (see Appendices E and F).

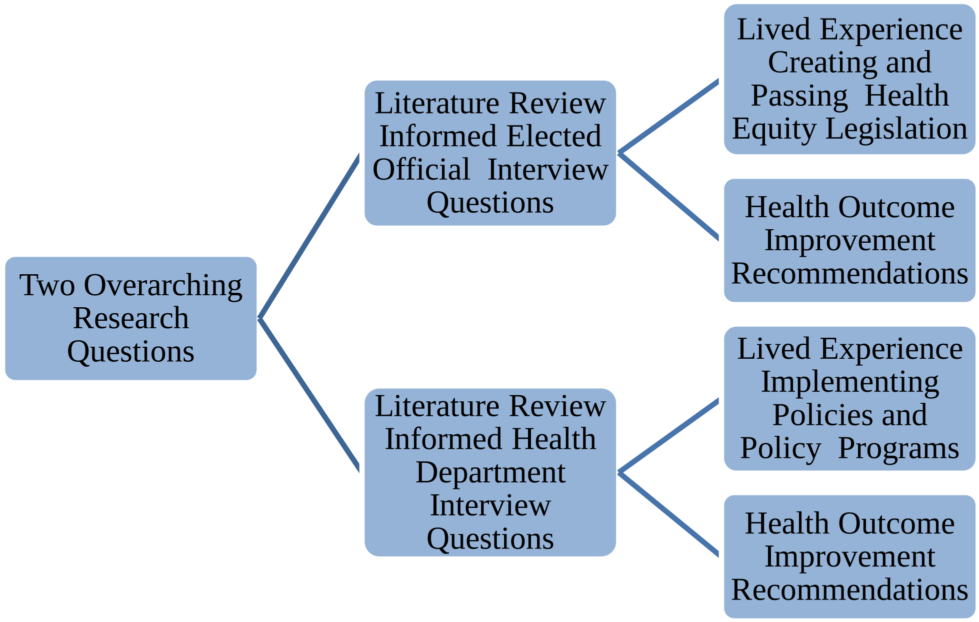

Figure 2. How the research questions relate to the literature review and interview questions.

Figures 3 and 4 show the key concepts from the literature review described in Chapter 2. The IQs related to the two overarching research questions that formed the structural codes for the data analysis starting point. The thematic codes came from the interview question responses of the participants using their own words or in vivo. The common themes from the IQs determined the final conceptual themes for the study reflecting the lived experience of each participant group.

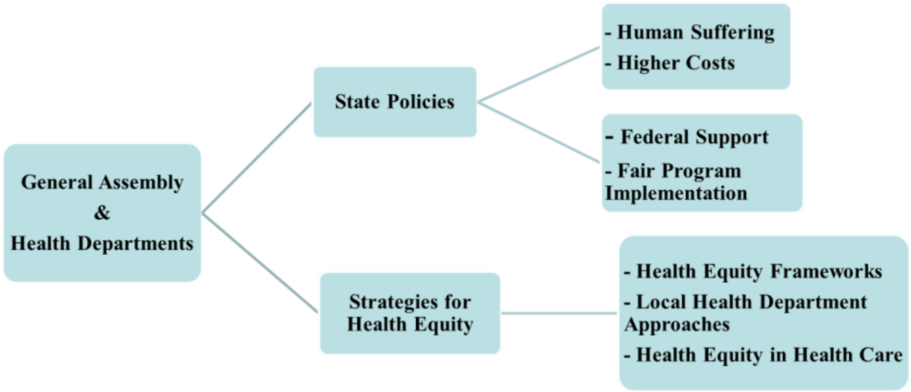

Figure 3. General key concepts from the literature.

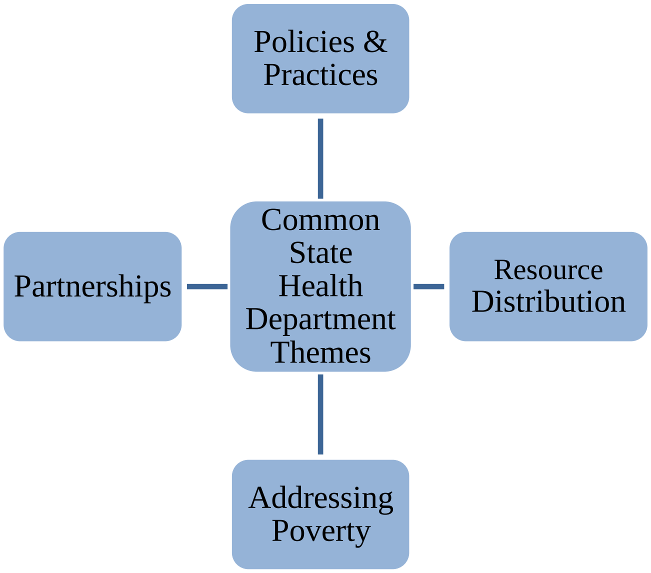

Figure 4. Key concepts from the literature for state health departments.

Elected Officials Data Analysis

Through the elected officials' research question, I sought to understand their perspectives working within the Georgia General Assembly to create and pass policies to positively improve Georgia residents' health outcomes. The officials also provided improvement recommendations based on their expertise. Consequently, the policies would also help reverse the health disparity trend for racial and ethnic minorities including racial and ethnic minorities living in rural locations. In general, I learned their experience confirmed the McDonough et al. (2004) and Thompson et al. (2014) explanations of a competitive political environment as described in Chapter 3. The themes below based on responses to the interview questions provide details of the lived experience to help outsiders grasp the inner workings of legislative actions and thought processes of the participants. Passing health policy laws is not a linear or smooth process, but a culmination of multiple attempts to get a measure approved among legislator leaders with multiple governance views. Despite the fierce discourse, participants who chose to contribute to my analysis believed their efforts to put forth adequate health legislation would eventually improve health for Georgians who are suffering the most from poor health.

Table 1 below shows 12 lived experience themes emerged from the elected officials' inquiry. The frequency level (Column 1) reflects the number of times the participants mentioned the common themes (Columns 2 and 3), and it ranges from most frequent to least frequent, or first to eighth place, respectively. The fourth column shows the most frequent IQs producing the common theme from participants.

Table 1

Hand Coding Results Showing Common Themes Related to Interview Questions for Georgia Elected Officials

Frequency	Common themes	Times referenced by participants	Questions most frequently receiving the theme response
1	Legislation adjustments (e.g., incomplete state policies or lack thereof)	17	1, 6, 8
2	General Assembly operates like a business	12	1, 2
3	Political nature of health (relates to human rights)	11	1, 3
4	Need to address the Social Determinants of Health (SDOH)	9	1, 7
4	Concern for individuals' inability to pay for healthcare or insurance (relates to human rights)	8	2, 3
5	Lack of access to healthcare	5	1
5	Prevention is the least expensive approach	5	2
6	Democrats strategize to pass legislation	4	1
7	Ensuring governance balances	3	4
7	Demographic and legislative representation realignment	3	1, 6, 9
7	Healthcare facility medical overcharges	3	2
8	Georgia's changing demographics (i.e., race and age)	2	2

Legislation Adjustments

There were no discrepant responses, but the least in vivo responses mentioned once or twice, when relevant, were placed in parentheses with the most appropriate themes previously established. For example, human rights was placed with the third most common theme, the *political nature of health,* because comments such as *we should not be political about health* or … [Medicaid expansion] *requires changing the underlying* *politics* also related to broader responses describing the political competition officials experienced to pass health equity legislation.

The legislation adjustments theme was by far the most common lived experience theme for Georgia legislator participants. This means once legislation is passed, subsequent amendments were needed in the following years to the original law to make it more effective. Or it could also mean a law should be in place to address a health need, but it is missing. The legislation adjustment theme is not surprising because the overarching research question focused on participants' perspectives creating and passing state legislation to eliminate racial and ethnic minority health disparities. Three IQs contributed the most comments to this theme, but all IQ responses except one, and all elected officials had some commentary elements about legislation adjustments.

IQ 8 received the most responses about legislation adjustments. Participants included E2, E3, E4, and E6. This question focused on recommendations for general actions to improve health outcomes among racial and ethnic minority populations in Georgia. Participant E2 said, "First thing is expand Medicaid." E3 agreed, as did E4 who also stated, "Expand Medicaid." "I mean, so many of our issues are because we haven't expanded Medicaid." However, participant E6 said, "… I don't want to say Marijuana Bill." "But the bill when it came to, we made sure we included health conditions such as Sickle Cell." "So I know they put [in the legislation] … diseases pertaining to African-Americans." Participant E6 emphasized, "and some words are just words that create [a] little friction, so we have to word them differently." E6 referred to the need to properly phrase healthcare legislation language so it could be acceptable to opposition party colleagues.

IQs 1 and 6 equally produced the second most responses related to legislation adjustments. IQ 1 focused on legislators' experiences working to create and pass legislation to eliminate excessive suffering caused by health disparities among persons in poverty in the rural South. IQ 6 was about recommendations for policy-specific actions to improve health outcomes among racial and ethnic minority populations in Georgia. Participants E1, E2, E3, and E6 contributed to both questions. For example, for IQ 1, participant E2 also discussed Medical Marijuana stating, "… there's a little disconnect in some of the legislation that we pass." The participant did not believe the legislation was comprehensive saying "[there is] a registry of diseases that people can use medical marijuana for, but what we don't have is we don't have any legislation that permits the cultivation or dispensing of the Medical Marijuana." There was a concern about costs as E2 stated,

> and so when you look at the cost factor of the THC oil, which is the marijuana oil, versus if we could get it here, versus having somebody… to move out of state or have to travel to get that, especially when we're looking at children who are suffering, right." Reading further, you will see E2, as a legislator, had a primary concern for prohibitive costs and healthcare access.

Also through IQ 1, E6 explained the unease in the General Assembly with adopting the Medicaid expansion provision of the ACA. The participant shared there was bipartisan supported legislation put forth; however, support for the bill declined after the

2016 election. The supportive legislators, E6 said, "… put it (i.e., bipartisan supported health coverage legislation) on the shelf because no one knew what healthcare was going to look like, and that's still a challenge today." The participant believed that much of the apprehension about Medicaid expansion at the state legislative level was about the potential lack of federal funds being available in the future versus state legislators being non-supportive of expanding Medicaid. From another view, E3 was concerned about preventing or reversing hospital closures in relation to IQ 1, addressing excessive suffering in the rural South. E3 said, "… we passed legislation that would allow folks to exempt 100% of any contributions given to one of these struggling hospitals, a charitable contribution ... it's not a viable funding mechanism to keep a hospital." Medicaid expansion was seen as a better option to financially support healthcare for persons experiencing poverty in Georgia, including preventing future hospital closures.

Through IQ 6, policy-specific actions to improve health outcomes, E1 focused on mental health stating, "I can't legislate a good parent …" "I believe we need to be dealing with mental health … in the mental health thing, we need to, for example, we need to fund it, okay?" E2 stated, "... increase funding, right." E2 also asked, "How can we work together ... be proactive as a state legislature to help our counties find out about these opportunities?" E2 further explained that passing House and Senate Resolutions to *strongly encourage* certain actions were not as beneficial as passing funded policy mandates. Participant E2 said,

> … what I've seen a lot in this past legislative session were resolutions to strongly encourage things, right. Strongly encourage to have posters up about potential

> human trafficking. Strongly encourage education about diet and obesity. I see those strongly encouraged kind of things. Part of the problem is that many of those are what we call unfunded mandates. There's no money behind it and the truth is a lot of these school systems, a lot of these counties, they don't have the extra money to do it.

E2 also believed that the state legislature should be more assertive about helping counties learn about federal funding opportunities. E3 said, "I think the first step is to expand Medicaid," as reiterated for IQ 8 above, which focused on recommendations for general actions to improve racial and ethnic minority health outcomes in Georgia.

Various responses about legislation adjustments showed that Georgia policy makers, in addition to expanding Medicaid, had other health legislation views, and the ACA was not considered a state health policy panacea. All elected official participants expressed the need to improve inadequate legislation, or put policies in place where needed; furthermore, all interview questions except the one for understanding the personal impact of the work, IQ 5, received a response showing strong support for improving healthcare governance policy.

Participants provided evidence of a lived experience for elected officials operating within a competitive governance environment to create and pass legislation to eliminate racial and ethnic minority health disparities. When asked about the future of health outcome improvement in Georgia for racial and ethnic minorities, IQ 7, E1 believed health outcomes would improve. E1 also stated, "We wouldn't have to come back here every year and fix the legislation we passed before if we did it right the first time."

Returning to IQ 1, E2 further confirmed, "… what ends up happening are all these unintended consequences …" E2 expressed the importance of ensuring state legislative policies resolve problems effectively. E2's approach with legislation was to ensure it did not adversely impact persons experiencing poverty or the proposed taxes were not regressive to avoid unintended financial burdens.

Legislation adjustments, as described by Georgia legislators, are likely the result of testing periods allowing the public and legislators to see how the new law operates and its usefulness after initial passage. It may also indicate the essence of power imbalances where legislation is written one way and passed with full support of the majority party; but, the minority party could not influence the measure for a different or more balanced version. Once a bill becomes law, the evidence for a change may become unavoidable, prompting amendments. Regardless of the reason for amendments, it can serve as a movement towards more beneficial policies for health improvement; though, the process is labor intensive.

General Assembly Operates Like a Business

The Georgia General Assembly operates in a manner that highly favors generating wealth. This was the second most common theme from elected official participants. IQs 1 and 2 focused on creating and passing health disparity elimination legislation to address racial and ethnic minorities' excessive suffering in the rural South and in the midst of high healthcare costs.

Five participants (E1, E3, E4, E5, and E6), made references to their lived experience legislating in a climate favoring state wealth building. For IQ 1, excessive suffering, participant E6 reflected the concern of possible federal support reversal for Medicaid expansion stating,

> It’s good legislation (referencing the above Georgia legislators’ former bipartisan supported state health coverage legislation), but it’s just hard to put yourself in a position to expand [Medicaid] and take, bring this money in and then the funding gets cut off because of different legislation from the federal level.

For another view, E5 stated, “They would rather spend the state’s resources to prop up businesses, to give large tax breaks to businesses, and the like.” E4 further confirmed E5’s sentiments, but with a focus on Georgia’s children saying, “… sick children can’t learn ... We can talk about jobs, we can talk about industry, but if they’re not educated, they can’t even apply for these jobs that you’re bringing.”

E1 stated there is evidence Georgia will be looking at “alternative ways to finance … healthcare” believing that if people are able, they should participate in a work requirement to receive Medicaid. With a view of avoiding potential state bankruptcy through Medicaid expansion, E1 stated,

> I think we’re going to end up… we’re going to be expanding Medicaid provisions. But Medicaid’s got its problems. I mean, we’ve got states that are bankrupt in this country, and some of them are the ones that have provided very liberal Medicaid provisions.
>
> … I am not a believer that the government should be running healthcare…. If you need significant treatment in some place like Great Britain, good luck with that. Look at the lines, and they got the biggest problems they’ve ever had with their

> national health system right now. So we’ve got to strike a balance, but it’s not a Republican, Democrat issue. It’s a human decency issue.

Within the context of legislating to relieve excessive health suffering, the priority of the Georgia legislature is to remain economically prosperous while determining how to best reduce costs associated with high chronic disease rates. Ensuring health coverage, whenever possible, is deemed most appropriate when recipients who are able to do so contribute, or there is a guarantee that public assistance will not adversely impact the state economy. More information about contributing something towards care, or no totally free care, is further expressed in a response to IQ 2 through E1 below.

For IQ 2, creating and passing state health disparity elimination policies to address excessive healthcare costs, E1 provided an example of why a work requirement was important, and stated, *able-bodied people* should contribute something to receive expanded Medicaid benefits. E1 also stated, “It’s the old saying about, you want to teach me how to fish or do you want to give me a fish?” Referencing the PeachCare for Kids health insurance program for Georgia’s children requires copays, E1 further pointed out “... people were putting something in the game.” The lived experience of pursuing legislation to address excessive racial and ethnic minority suffering from health burdens reflected a variety of views. From fears of possible financial abandonment by the federal government if Medicaid is expanded under the ACA, to ensuring state financial health remains intact; consequently, people should make financial contributions for government healthcare support. There was also an understanding for the human health concern; but, additional assistance with healthcare costs should not diminish state finances.

In contrast, the three other participants (E3, E4, and E5) responding to IQ 2 expressed the need to focus on prevention in order to address excessive health costs. E5 likened taking care of the human body with routine automobile maintenance to ensure proper operation over a longer period of time. Participant E5 also did not believe a hospital emergency room should be the place for primary care and stated, "... Emergency Room care is 4, 5, 6, 7, 8, 9 times as expensive as regular care." The participant discussed hospital emergency rooms providing legally required healthcare to undocumented immigrants arriving for care saying, "… those who are undocumented …. you can literally cross the border, come over here as an undocumented [*sic*], and injure yourself in the process, go to the hospital, and they must treat you." E4 stated,

> … preventive medicine is something that has proven over and over to save money in healthcare because it's cheaper to work on the side of prevention than it is to work on the side of treatment…. and statistics show that the earlier they're diagnosed and the earlier they're into treatment, the better their outcomes are."

E3 focused specifically on the impact of the aging southern population, including the United States' and Georgia's finances stating,

> … [The aging population's healthcare costs cause] enormous fiscal strain on our existing healthcare infrastructure… It's to incentivize folks to stay healthy. It's to incentivize family caregivers to keep their parents, their aging parents at home rather than institutionalizing them.

All participants agreed that healthcare costs were a priority; however, the state legislators' beliefs about approaches for bringing down healthcare costs differ widely. As stated in the literature review in Chapter 2, the lived experience of grappling with how to address costly healthcare needs of marginalized populations is consistent with the challenges national and international policy makers face; Georgia legislators are no different.

The Georgia General Assembly's business focus is significant and needs to be more clearly understood to determine how it can contribute towards health improvement because there will always be health costs for individuals and state government. Investing in prevention costs less. It is not beneficial for the government to spend more money while health outcomes remain persistently poor. While the desire to avoid state bankruptcy is understandable, the estimated 267,000 Georgians unable to obtain health coverage remains costly to individuals and the state (Henry J. Kaiser Family Foundation, 2019b). Proponents of traditional Medicaid expansion believe covering persons at or below 138% of the federal poverty level is critical to bring in the greatest amount of federal funding for Georgia. It is unclear how covering a lesser number of eligible persons within this provision financially benefits Georgia's government, as this type of plan is under review at the time of writing. Also, compared to the traditional provision, it will be important to see if Georgia's alternative approach to Medicaid expansion through waivers will be equally beneficial for all citizens most in need of coverage.

There continues to be opposition to the ACA for reasons related, but not limited to, health costs, healthcare provider shortages or lack of Medicaid acceptance, and Medicaid roll expansions (Moore, 2018). In contrast, despite the law needing improvements, Antonisse, Garfield, Rudowitz, and Artiga (2019) reviewed 202 studies to summarize the effects of Medicaid expansion on participating states. The states under study with Medicaid expansion through the 1115 waiver received similar health coverage increases compared to traditional Medicaid expansion states. However, as cautioned by the researchers, waivers and provider capacity should be monitored to not impose additional access hardships (Antonisse et al.) There was also evidence of providers being able to cover increased patient loads. Georgia policy makers would benefit from giving close attention to the waiver and provider capacity areas.

There are notable reports of reductions in uncompensated care for clinics and hospitals (Antonisse et al., 2019). Also increases in access to medications, and improvement in constant chronic disease care (Antonisse et al.). Studies showed Medicaid expansion has been beneficial in helping citizens overcome medical debt (Antonisse et al.). There are also confirmations of health coverage gains and beneficial effects for racial and ethnic minority and rural populations in Medicaid expansion states, while fewer studies showed results that were mixed or no effect in particular areas (Antonisse et al.). Additionally, states expanding Medicaid showed particular vulnerable groups (e.g., persons living with HIV, cancer patients, low-income workers, or persons living with cardiovascular disease) benefiting from health coverage gains compared to nonexpanding states (Antonisse et al.). Individual state studies showed connections between Medicaid expansion and employment continuity, volunteerism, and employment among adults with disabilities. It remains unclear, given the economic challenges associated with poor health outcomes, what the future healthcare landscape will look like for Georgia in the midst of persistent racial and ethnic minority and rural health disparities.

Finally, from a human rights view, emergency rooms are required to treat persons arriving in need of care. The participant's comment about expensive emergency room care for undocumented immigrants arriving in the United States is a question likely to be a topic for discourse among Democrats in the campaign the 2020 election (Diep, 2019) and debated beyond this time frame addressed by my research. California has become the first state to give Medicaid coverage to undocumented aliens age 25 and younger who meet financial requirements, so it is too soon to accurately determine the additional financial consequence in California or other states that adopt similar legislation. (Associated Press, 2019). The ability to offer Medicaid coverage depends on each state's policy; however, national coverage through the ACA is not permitted. For Georgia, the discussion seems premature given the current healthcare landscape; nevertheless, the participant is aware of the cost factor. Policy makers may want to look at the overall health status of the undocumented population to consider benefits to the overall insurance risk pool.

Political Nature of Health

Politics is the ability to control or effect governance decisions, often characterized by competitive views as persons individually or collectively vie for dominant positions to lead or establish policy (Merriam-Webster, 2019). The political nature of health was a theme less difficult to determine because participants expressly stated this experience for IQ responses. In all other instances, based on multiple perspectives from IQs, I considered what the most appropriate theme was to ensure I captured all similar in vivo themes.

Question 1 focused on participants' lived experience of creating and passing legislation to eliminate excessive human suffering caused by health disparities among persons in poverty in the rural South. Four participants gave the most comments (E3, E4, E5, and E6). E3 stated, "Unfortunately, healthcare has become a very partisan issue in the state of Georgia and has been." E4 referenced the history saying, "… I'm sure you're aware that the Democrats lost power in 2004…. when the tables turned, a lot of the healthcare issues didn't seem to be on the high priority list of the Republican Party." E4 further expressed frustration with the ability to pass healthcare legislation by stating,

> We lost the governor's office in '02, and then the House in '04, and … it went down from there… and so being a member of the minority party for the last 10 years was all but frustrating because, for me, health has never been political… I think one of the major frustrations was when the Republican Party moved to raise the threshold for children that would qualify for PeachCare.

PeachCare for Kids is Georgia's CHIP or Children's Health Insurance Program. It is for children whose families earn too much money for Medicaid; but, cannot afford private coverage. E5 expressed a similar sentiment of the competitive nature of health and said,

> … the best way to say it, a very conservative way of dealing with health issues in the state, and as a result of that we kind of, or I should say… most health policy to deal with disparities are viewed as social in nature, social programs.

Finally, E6 corroborated E5 by saying, “I found that my colleagues feel there’s a need to address healthcare in general for everyone. But for political reasons, they’re reluctant to move forward on the legislation.” Ahead, IQ 3 responses show similar participant views.

Responses to IQ 3 allowed three participants to further share their experience of working on health policy passage in the midst of the ACA or the current status of health coverage for Georgians experiencing poverty. Again, the most common perspectives were about the political environment. E2 stated, “So it’s been difficult, sometimes frustrating because as a Democrat, we're in the minority party, right.” E2 further described feelings saying,

> We need people from the other side of the aisle to come in and join us… they give us the ideas like, well, this is a federal issue, we don't have to do anything on the state level …. Or they’re like, well, it’s going to cost us millions and millions of dollars …. I mean, it’s also an issue of where you put your money is going to tell me where your priority is.

E3 believed competitiveness was a necessary part of the process for legislating and stated,

> ... politics plays an enormous role in terms of what gets passed or not. There are party politics, Republicans versus Democrats, but there are also personal politics at play… both can be impediments to passing good policy and good legislation, which is one of the most frustrating aspects of the work. But at the same time, to a certain degree, it is a necessary element because the legislator process

> undoubtedly permits an enormous amount of scrutiny at any one piece of legislation.

Echoing the sentiments of E2 regarding finances versus health, E5 gave an analogy comparing Medicaid expansion to expanding auto plant jobs in Georgia. The participant said,

> The reality is, a study that I've saw [*sic*] recently, for instance, we gave, I don't know, millions of dollars to [Company name withheld] which created X amount of jobs for the [Company name withheld].
>
> But expanding Medicaid in Georgia would create the economic impact of like 10 [Company name withheld]. But, as I said, you're viewed one way politically if you are for expanding Medicaid and Affordable Care Act, and you're viewed a different way that you oppose it. One of these days we're going to get beyond that to where our primary focus should be what is good policy, not necessarily what is good politics, Yeah."

IQs 1 and 3 provided the most responses for the experience of working within the political environment of the Georgia General Assembly. Five out of 6 participants discussed the political nature of health. They linked it to their attempts to create and pass legislation to eliminate excessive health suffering in the rural South and health insurance coverage.

The political nature of health theme was also the first of two for which I applied the supporting human rights theme. Four out of six participants made comments to various interview questions about health care being a basic need. Additionally, based on political pressures described, I understood their experience of pursuing adequate health legislation as existing in the midst of an imperative mandate to come to an agreement for Georgians' optimal health, a basic human need for the state to thrive.

The Need to Address the Social Determinants of Health

IQs 1 and 7 focused on creating and passing policies to eliminate excessive suffering in the rural South and participants' positions on future health outcome improvements for racial and ethnic minority populations, respectively. The questions drew the most comments on the need to address the SDOH. It is the fourth most common theme through the perspectives of E2, E3, E4, and E6. The elected officials helped me understand their awareness of how social elements influence their constituents' health. For example, for working to address excessive suffering in the South, IQ 1, E3 said, "So, it's not just having access to healthcare, I think there is undoubtedly a cultural aspect factor to it that has to be addressed in some capacity as well." E4 further confirmed, "… in the ethnic communities, we have to also deal with the other determinants of health. There are social norms that play a big, big part in whether people even seek healthcare." As the elected officials work on legislation to make healthcare more fully available, they are aware of possibly not being able to legislatively mitigate all social determinants impacting health; nevertheless, social factors must be addressed for better health outcomes.

For elected officials' positions on the future of health outcome improvement, IQ 7, E2 suggested state policy makers should consider the impact of race on health. The participant believed there was still much work to do to reverse racial unease stating, "So if you look at poverty and race, if you look at race and gender, you might find different stats coming out of who is actually impacted because of those factors in combination of that." E3, taking a more philosophical approach said,

> ... if there are significant disparities in one's health based on race, based on ethnicity, that is we've fallen short of providing or creating an equal opportunity to live that life of liberty, to be free, to pursue your American dream, if you are shackled by your poor health.

E3 concurred with E2 for the need to move ahead to improve future racial and ethnic minority health outcomes; however, health improvement does not occur in isolation. Socially constructed barriers must also be overcome for health to improve for racial and ethnic minority populations. Addressing the SDOH is a way to improve health; thus, a start towards reducing disproportionate poor health outcomes among racial and ethnic minorities and minorities in poverty in Georgia.

As a research framework, a plethora of scholarly literature focuses on various interrelationships between race, ethnicity, gender, socioeconomic status and their impact on health outcome inequalities (Larson, George, Morgan, & Poteat, 2016). E6 gave a response interconnected to the views of E3 and E2, saying for future health improvement, "... some of it has to do with income …. well, in terms of income related to that [future health improvement], I don't see much would change." Referring to family income, the participant also said, "That [income] has a big impact … because they don't have access to [healthcare]." In sum, without access to healthcare, which is often hindered in society due to race, ethnicity, gender, and low income, future health improvement will be taxing for racial and ethnic minority populations in Georgia unless there is a purposeful effort to remove these barriers.

If Georgia legislators are collectively willing, they are in a good position to directly and indirectly address social determinants influencing health such as mental health, education, transportation, for example. Within the social determinants are racial and ethnic minority and rural health disparities rooted in poverty. With appropriate legislation, these surrounding social aspects can be turned in a direction supportive of health; consequently, creating opportunities for residents to be healthier and more capable of contributing to Georgia financially, along with improved quality of life.

Concern for Individuals’ Inability to Pay for Healthcare or Insurance

IQs 2 and 3 gave the most responses for the theme of concern for individuals’ inability to pay for healthcare or insurance. It tied for fourth common theme with the SDOH theme mentioned above. Furthermore, concern for the inability to pay for health coverage is the second area where I applied the human rights theme based on participants’ responses. Question 2 focuses on the elected officials’ lived experience working to create and pass health disparity elimination legislation to address excessive health costs. Not surprising, four participants, (E1, E2, E3, and E6), made comments about individuals’ inability to pay for health coverage in response to this question.

Participant E1 confirmed engaging in policy making in a manner not to over tax persons experiencing poverty. The participant said, “… [I] did some property tax relief in there…. excluded food from an increase in the sales tax because it’s a regressive tax. It would hit the poor." E2 discussed being aware of how people are creatively funding health insurance by stating,

> And one thing that I've been seeing lately is an increase in like GoFundMe campaigns for people who are sick or people who need help. They don't have insurance, and now that they're sick, they can't get insurance because the premiums are super high …. and they're asking their friends [for funds to cover health costs].

E3 described a relative's personally impactful experience with health costs stating, "But it was $15,000 every single time she went to chemotherapy, and she had chemo two times a month over 3 years." Even though persons are employed, E6 was aware that healthcare costs were too high for some working people and said, "The healthcare costs is [*sic*] just-- it just seems to rise every year…. and it's making it much hard for working class people to afford it." Persons who are either able-bodied workers or affected by a debilitating condition in Georgia still struggle to pay for health costs.

Article 25.1 of the Universal Declaration of Human Rights confirms the human right to healthcare for the welfare of self and family, and the protection of such if a person is unable to provide for it on his or her own (United Nations, 1948). Furthermore, the Sustainable Development Goals (SDG) 1 and 3 are applicable to participants E3's and E6's comments. The goals focus on ending poverty and ensuring all people regardless of age are healthy and well, respectively (United Nations, 2019). Approved by the United Nations General Assembly in 2017, particularly to address persistent poverty, the SDG are a more current version of optimal aspirations for human life, since the 1948 Universal Declaration of Human Rights articles.

Three participants, (E1, E4, and E6), also mentioned concern for the ability to pay in response to IQ 3. The interview question is about elected officials' work on state health policy passage in the midst of the ACA or the current status of Georgia state health coverage for persons experiencing poverty. E1 stated, "… I think we should be covering preexisting conditions." The perspective connects to human rights because costly genetic or chronic health conditions are beyond the person's control; thus, the federal government provided a state partnership safety net to address this circumstance through the ACA. E4 stated, "... it still was a situation where even people that were gainfully employed could not afford the insurance in the marketplace." Even though there is a Georgia marketplace to purchase health coverage, due to the system not being connected to the ACA Medicaid expansion provision, Georgia's marketplace insurance remained inaccessible to many residents. E6 reiterated concern for constituents' finances saying, "… one of the issues they have financially is that a lot of them are in debt because of healthcare costs…. Because they go to the emergency room …" E6 stated further, "… those who are in the gap, who make too much for the ACA program, they're also the ones who are suffering the most." In Georgia, 267,000 people are in the gap because they are unable to access the marketplace and have no Medicaid expansion access (Henry J. Kaiser Family Foundation, 2019b).

The elected officials' perspectives on their constituents' inability to cover healthcare costs relate to attempts to preserve human rights, just like the work they do to get through the political nature of health to legislate, as previously mentioned. The participants’ legislator lived experience exists within a highly competitive condition through the Georgia General Assembly. The fifth theme below will give a broader understanding of the officials’ lived experience legislating in the milieu of their constituents’ lack of access to healthcare, which is primarily related to costs.

Lack of Access to Healthcare

From the lack of access to healthcare theme to the final or 12th theme, there is a noticeable decrease in the number of times participants referenced a theme. This reflected my point of saturation for understanding the lived experience of the elected official participants creating and passing state legislation to eliminate racial and ethnic minority health disparities. Nevertheless, themes mentioned less frequently do not indicate irrelevance to the study phenomena. The additional themes provide more contextual understanding of what is important to the elected official participants and other views of their work to address health equity for marginalized populations in Georgia.

There were two themes that tied for the fifth most common. The first of the two is the lack of access to healthcare. This theme also connects to the previous ones stated above such as concern for the inability to pay for health insurance and legislation challenges. However, this theme was created as a stand-alone because it reflected participants’ specific references to healthcare access that was not totally related to affordability for citizens. The inability to pay for insurance can impact access, yet the primary discussion focus for this theme was not about persons’ ability to pay for healthcare.

Two participants answering IQ 1 gave the most comments for the lack of access to healthcare theme. Question 1 focused on participants' experience creating and passing legislation to eliminate excessive human suffering caused by health disparities among persons in poverty in the rural South. Participant E1 stated,

> Well, I think if you look at Georgia, we've obviously had issues from a standpoint of access in the state… and so what we've tried to do in some instances-- we've broadened the scope, for example, whereby someone can now order an MRI that couldn't do that before, simply because there's not a doctor available, okay? .... or a physician's assistant now got broader scope of practice of things they can do…. That's one area I think that we've dealt with.

The rural areas experience greater challenges addressing residents' health needs due to physician and specialist shortages. Broadening providers' ability to offer more services are beneficial for increasing healthcare access. This is an appropriate policy for potentially improving health outcomes.

From a Medicaid expansion view, E3 stated, "But when we're talking about disparities in health, I look at it from multiple ways. I think the most direct way is simply access to healthcare." E3 expressed being in favor of the traditional approach to expanding Medicaid because studies have shown for the long term, the federal provision is "more cost effective and efficient," the official said. However, E3 also stated,

> I consider myself to be an incremental pragmatist and so for me, regardless of how it's done, so long as we take that first step of covering and insuring our state's population, I'd be supportive of it, given the political realities.

E3 will compromise to move in the direction toward healthcare access, which is common among politicians who are successful in passing bipartisan legislation. This is also a part of the lived experience as noted in the sixth theme ahead called Democrats strategize to pass legislation. Compromising is a strategy that is often needed among both parties to pass optimal legislation for citizens.

Prevention is the Least Expensive Approach

Tying with the lack of access to healthcare theme for fifth most common theme is prevention is the least expensive approach to health improvement. Three participants (E3, E4, and E5) gave the most comments and they all came from IQ 2. The question was about the elected officials' experiences working to create and pass health disparity elimination legislation to address excessive health costs. E3 spoke of the aging baby boomers and the need for the United States, Georgia, and specifically the South to focus on prevention because "[They] will place enormous fiscal strain on our existing healthcare infrastructure…. It's to incentivize folks to stay healthy." E4 was also in favor of prevention and stated,

> The preventive medicine is something that has proven over and over to save money in healthcare because it's cheaper to work on the side of prevention than it is to work on the side of treatment… and statistics show that the earlier they're diagnosed, and the earlier they're into treatment, the better their outcomes are.

The participant described working on important technological advances to serve Georgians such as Telehealth Medicine and also stated, "… simply because not just disparities, but access issues as well …" Health disparities are often linked to a lack of access to healthcare, which impacts the ability to prevent diseases. Elected officials are conscious of how important prevention is to the state's budget for healthcare cost reductions. This could be seen as a wise business decision for Georgia. More of this awareness is shared through participant E5 who used car maintenance as an analogy for prevention and stated,

> When I first got my automobile, my father used to say… if you do the little things up front, the oil changes and the tune-ups, it's going to save you a whole lot money down the road, and your vehicle is going to last so much longer… and so it is with the human vehicle. I mean, if we do the little things and do the preventative things that we ought to do, it will keep a lot of us out of the emergency room where the healthcare is so much more expensive.

In relation to legislating to prevent excessive health costs, 3 of the 6 elected official participants focused on prevention, among other areas of concern.

Democrats Strategize to Pass Legislation

IQ1 provided the two main comments from participants E4 and E5 for the sixth most common theme, Democrats strategize to pass legislation. Question 1 was about elected officials' experience creating and passing legislation to eliminate the excessive human suffering caused by health disparities among persons in poverty in the rural South. Participant E4 described efforts to cross the aisle as E2 stated above when discussing the political nature of health. E4 commented …"So what we did a lot of times is that we [Democrats] partner with a Republican ... usually, those were healthcare professionals that understood and would cosponsor with us to get the legislation passed." Reflecting the national level of competition between Democrats and Republicans for the survival or removal of the ACA, the state of Georgia elected officials engage in a similar contest to create and pass legislation to eliminate racial and ethnic minority health disparities. The ACA and Medicaid expansion in Georgia will need to exist interdependently for all marginalized populations to benefit over the long term, thus reduce health costs.

Understanding the philosophy behind the work, E5 said,

> I don’t think its [economic approach] our greatest argument from my point of view, but from those who are presently in leadership, I think it is the most impactful to them in that what will it do to the economics of running Georgia? ... and that means more to them than perhaps me saying that there’s a moral and social component to this.

The strategy connects back to attempts to effectively deal with how business operations are prioritized for legislation, the second theme mentioned above. Having a strategy is important for success when operating in a highly competitive or political environment to obtain legislation, particularly for health equity.

Ensuring Governance Balances

Ensuring governance balances between the state and local, and state and federal governments is the first of three themes forming a three-way tie for seventh place. Federalism ensures that local and state governments maintain autonomy while coexisting with the national government. IQ 4 asked about the elected officials’ experience working with state health department program administrators to ensure policies included the needs of populations most impacted, or to ensure policies did not have an unintended adverse impact on racial and ethnic minorities.

To answer IQ 4, two participants (E2 and E4) made reference to the governance challenges of the separation of powers between the state and local governments in Georgia for health information and public health funding. E2 stated,

> So there is a split in the state legislature of those who say, we should tell counties what to do, and then there are others who say it should be local control depending on the issue.
>
> In my district, we try to work together, right, the state legislative delegates and then those on the county level like the mayor and the commissioner, but there's only so much we can do, and we don't necessarily want to step on each other's toes, right. We want to have a good working relationship, but we can encourage, and we can try to get increased funds for them and to help them …"

The participant was speaking of the importance of what state elected officials can do to keep libraries open for residents to access health information which, in some cases, may save lives.

E4 elaborated on a funding example and said,

> We saw a lot of changes in even how our local health departments were funded… central office of the health department has so much … influence over the local health departments until that changed the way local health departments were able to serve the communities that they know the best ....we saw… the usage of our

> [local] health department go down mainly because some of those services that were otherwise offered free were no longer free and were cut way back or off. A lot of the federal funding that was matched or supplemented by state funding, a lot of the state funding once it was reduced or eliminated.... the federal government considered just to continue to fund their part of it, and then the state was backing up and giving a little less and less.

There is always a balancing act between various government levels and entities within the same governance level. In this case, it is the state government leaders' decision to determine the level of support for optimal governance autonomy. E4's observation provides a foundation to more thoroughly understand the health department officials' lived experience, which is forthcoming in this section, titled Health Department Employees Data Analysis.

Demographic and Legislative Representation Realignment

The second theme of the three-way tie for seventh place was derived from three separate interview questions. IQ 1 focused on participants' experience creating and passing legislation to eliminate excessive suffering caused by health disparities among persons in poverty in the rural South. Elected officials were aware the future may be different demographically as racial and ethnic minority populations become the majority population in the United States. Therefore, health improvement may become a greater priority for constituents and consequently, the candidates for Georgia's state legislative elections.

For IQ 1, participant E3 mentioned the changing demographics in Georgia and said, “So Georgia is very much becoming a more purple state.” The change has implications for health legislation in the Georgia General Assembly. Future legislative bills may be more reflective of the health needs of the changing demographic population.

The purpose of IQ 6 was to learn about elected officials’ policy-specific actions to improve health outcomes among racial and ethnic minority populations in Georgia. E5 believed constituents had the responsibility of putting officials in the legislature who would work on their behalf. Regarding citizens, the participant said,

> [They should] seek out policy makers that will look after the best interests of what they feel is important...but we have states that have far less resources than we do that do a better job of making certain that their citizens are healthy. And that’s only because the citizens in those states are demanding that they get that kind of attention. And Georgia is not there yet.

The participant was uncertain of why constituents would put policy makers in office who did not match their interests. Nevertheless, the official noted the constituents should learn about the issues and weigh their public policy expectations in comparison to what the candidates offer for being elected to the Georgia General Assembly. As stated previously in Chapter 2, the racial and ethnic minority population has increased in Georgia by 6.7% between 2000 and 2010 (Center for American Progress, 2012). Georgia also had the fastest growing Hispanic population, which increased substantially between 2000 and 2015 (Flores, 2017). As Georgia’s demographics change, the legislator representation may eventually align more with the population served and their public health needs.

Finally, IQ 9 focused on elected officials' additional information about their health equity legislative work experiences or recommendations for health equity improvement in Georgia. E5 reiterated the constituents' responsibilities again and stated,

> ...there had been times when I'd go to meetings thinking the vote was going to go one way, and then maybe some neighborhood would come out and say, Look, we don't want this because of A, B, C, and D, and that vote would change on the spot. And it's no different from the state government, county government, or federal government. If enough people said, this is something that we don't want, it would change, and that just means that people need to be more informed. If healthcare's important to your community, then you've got to let the policy makers know that this is something that's so very important to you, and it will be done.

Speaking from experience, E5 gave an example of how citizens can adjust policy makers' decisions to match their preferences. According to Participant E5, this is a level of civic engagement yet to be fully realized in Georgia. It is particularly important in states like Georgia where they must seek approval from the General Assembly for a voice through ballot initiatives. For health measures, the ability to share views on policy decisions at the time of inception is an alternative approach favorable for citizens.

Healthcare Facility Medical Overcharges

The third theme of the three-way tie for seventh place is medical overcharges. Not surprising, the only interview question producing two participant responses (E2 and E5) for this theme is IQ 2. The question focused on the elected officials' experience working to create and pass health disparity elimination legislation to address excessive health costs. Participant E2 stated, "I mean, a constituent of mine showed me a bill, it was over $600 for a Band-Aid." E5 was also familiar with excessive charges in medical facilities saying, "The aspirins in the emergency room are 5 or 6 times as much as you can get." Regardless of constituents' health insurance coverage status, charges for medicine, along with other medical facility related costs can be extraordinarily high. The elected official participants were keenly aware of the costs that could cause some citizens to go bankrupt if uninsured. As a result, at the root of financial challenges, is how to contain excessive or unnecessary charges from health facilities treating patients. Handling this area of healthcare will complement Georgia's ability to improve health outcomes and preserve the state's budget.

Georgia's Changing Demographics

The eighth theme from the Georgia elected official participants came from IQ 2 through two participants (E1 and E3). I decided to keep this theme separate from the demographic and legislative representation realignment common theme mentioned above. The demographic change responses for this question were discussed outside of the context of incongruent legislative representation.

IQ 2 was about the elected officials' lived experience working to create and pass health disparity elimination legislation to address excessive health costs. Participant E1 shared,

> I live in a county that at the public school system, [a certain percent] of the kids are Caucasian ... [A certain percent] are African American … I believe [a certain percent] are Hispanic, okay? So what was the minority is quickly becoming the majority from an ethnic standpoint.” Participant E1 explained that the school system was primarily African American, with the second largest minority student group being Hispanic. Participant E1 assured that Democrats and Republicans on the health committee, “… seem to sit down and work together to try to do something, to basically do the best job we can for everybody.”

Participant E1 further stated the work to set up a study committee to address dyslexia in the school system to improve reading proficiency would help, “… a good portion of the minority population.”

Above participant E3 mentioned the aging baby boomers for the theme focused on prevention being less expensive. Additionally, E3 stated, “Georgia and the United States as a whole, but particularly the South, we’re facing an enormous, unprecedented demographic shift, which is an aging of the baby boomers.” Participants touched on two population groups, racial and ethnic minorities and senior adults who will need further attention as they become a greater share of Georgia’s population. Georgia legislators must take into account the state’s future population landscape and the associated challenge with rising medical payments.

Personal Impact of the Work, Question 5 Responses

Finally, the responses for IQ 5, the personal impact of the time spent pursuing health equity, were positive overall. Two participants felt that being a Georgia state legislator was rewarding (E1 and E5). Three elected officials were determined or resolved (E2, E3, and E6) to achieve their legislative goals; however, one person was frustrated (E4). Two participants gave comments connected to two interview themes for question 5.

Participant E5 stated,

> … creating a public policy is something that keeps me going, and enthused, and that we are able to enact policies and enact resolutions to people's problems…very oftentimes, I have people who'll sit right where you are that's having a particular problem with the health department, some health agency. And to be able to cut through the bureaucracy, go to the commissioner and get those issues resolved is always something that, it's rewarding.

The comments reflect the political nature of health, Theme 3. Complications are not only within the Georgia General Assembly; but, also exist in the work elected officials must do to solve administrative challenges outside of the legislation system. Participant E5 is not deterred by the complications of legislator work; but, motivated by the internal and external political pressure that comes with being an elected official.

Regarding the SDOH theme, E1 expanded on his passion for youth education and stated,

> Well, I think it's awareness, first of all. I live in a world that-- I never had anybody with dyslexia in my family that I was aware of… same thing with autism. I was very heavily involved in what we did for autism, where we now pay for services for these kids, where we never did before for a number of years. I

> mean, these are real conditions… A big thing in the minority community-- again, most of my stuff is education. But [we] passed the original … bill to give kids options besides college.

E1 stated further,

> …and to me, at the end of the day, yes, health issues, very, very real. But the key to success for everybody, everybody - Black, White, you name it - is education. If you don't have the education; every kid in this state deserves the opportunity to get a good education.

Education reduces the risk for poverty; therefore, improves a person's chances for better health outcomes. It is why, as reflected in the health department data analysis below, one strategy for health disparity elimination is to focus on children, including infants. One health department official was interested in stimulating their brains as soon as possible for early development.

The goal of the program is to give traditionally marginalized children an opportunity to have a successful education experience. Consequently, the health official believes this will put Georgia children on a path to a better quality of life, which will further reduce or eliminate health disparities for future generations. Next, I provide the interview results for five Health Department participants who provided four lived experience themes.

Health Department Employees Data Analysis

Through the Health Department officials' research question, I sought to understand their perspectives working within chronic disease and behavioral risk factor programs to implement policies and health policy programs to improve Georgia residents' health. The officials also provided recommendations for health improvement actions for state health agencies or particular programs within agencies. Because health department participants' positions were not as uniform as the elected officials', responses tended to vary more widely by comparison. However, I learned health department participants are highly aware of the SDOH and how important this focus is for eliminating racial and ethnic or rural health disparities in Georgia. In this sense participants' views reflected recommendations in the literature as discussed by Rudolph et al. (2013) or the study outcomes of Raphael and Brassolotto (2015). This means focusing upstream to prevent adverse health outcomes through policy change in non-health arenas such as education, or implementing a social determinants of heath policy was not always consistent among leaders, but reflected various beliefs within health agencies, respectively.

Table 2 below shows four themes emerged from the health departments' inquiry. Two themes tied for most common theme among health department participants: the SDOH and second, funding needs and external opportunities. The SDOH are social, physical, and economic areas that impact health outcomes such as, but not limited to, education, job skills, or transportation. Improvements in the SDOH may increase the chances for racial and ethnic minority and rural populations to have positive health outcomes, reduced premature death, and lower disease burdens compared to their counterparts.

Table 2

Hand Coding Results Showing Common Themes Related to Interview Questions for Georgia Health Departments

Frequency	Common themes	Times referenced by participants	Questions most frequently receiving the theme response
1	SDOH or Health Equity	13	1, 6, 8
1	Funding needs and external opportunities	13	2, 4, 5, 6
2	State/local health policy practices, lack thereof, and improvement recommendations	12	2, 5
3	National policy practices affecting Georgia, lack thereof, and improvement recommendations	6	6

Social Determinants of Health

Regarding the SDOH, four participants (H1, H2, H3, and H4) provided comments mainly through IQs 1, 6, and 8. Participants shared three conditions operating within the Georgia state or county health departments. Some officials worked in environments where the SDOH are addressed. Others worked in programs where they saw no current impact on the SDOH or health equity; or, the programs have current efforts focused only on future generations (e.g., infants or children) traditionally from communities affected by excessive health burdens. The justification for focusing on future generations was the greater return on investment for health outcomes. Finally, some persons are in work environments where the work is shifting towards addressing the SDOH.

IQ 1 asked what health equity or health disparity elimination frameworks/practices guide their policy or policy program work. Four participants (H1, H2, H3, and H4) contributed the most information to the SDOH theme through this question. Participant H1 said, “Now, we’re working with workforce development ... get the moms jobs, get them housing, we do parenting classes, we do Dress for Success, how to put a good resume together, so it’s transformational.” The purpose is to support the individuals’ ability to become gainfully employed, thus reducing the chances of living in poverty, which adversely impacts health outcomes.

Participant H2 spoke of borrowing from an infectious disease model and stated,

> There are particular programs though that I think we really need to be using as models because they seem to be working well in addressing those issues [health equity]. The one that I’m most impressed with is our Ryan White Program for HIV and AIDS individuals… and the thing that is unique about that program - that I wish we had in every program…We also cover what are referred to as *wraparound services*.

Participant H2 described wraparound services as social support for persons living with HIV/AIDS such as, but not limited to, nutrition, transportation, and housing. To address the SDOH, these services should also be a part of other health programs to address health disparities, according to Participant H2. Furthermore, Participant H2 stated the number one challenge was persons experiencing poverty and said,

> They have great difficulty getting a productive job. So they have difficulty even getting proper food. They may end up eating things that are less expensive but not nutritious which may lead to chronic disease with diabetes, with hypertension, with obesity.

Additionally, H2 believes the focus on infants' brain development would positively impact children's lives in a way that would decrease their chances for living in poverty, resulting in healthier adult lifestyles. Participant H2 said, "So if there is anything that I think Public Health can do most effectively, but not immediately, to address equity issues and disparity issues, it's going to be our focus on language nutrition." Dr. Jack Shonkoff specializes in early childhood development research and is the director of the Center on the Developing Child at Harvard University. His research is the basis for the health department's focus on child brain development for health disparity elimination.

Participant H2 explained that *language nutrition* or talking with newborns for up to the first two years of life with encouraging words or expressions of love would allow children to have a greater capacity to learn. Consequently, Participant H2 stated,

> ... I believe [language nutrition] is going to cause markedly-improved outcomes and - in the process of doing that- is going to address equity and disparity too, and that's our priority on dealing with early brain development. We have about six programs that focus on this. But the number one is a program that we call Talk with Me, Baby … And those babies have about an 85% greater chance of graduating from high school and getting a productive job.

The purpose, as stated above, is to positively impact the early development stages of children's lives, hoping that as adults, they will be productive and Georgia will have lower rates of chronic disease or poor health in the future. The babies exposed to the intervention should be in the 85% success category.

While the social determinants of education and job skills are the focus of the approach, controlling for other factors influencing a child's life such as exposure to buffers against the adverse impact of racism, the parents' skills and resources, and various other social environments the program cannot control may also influence the children's future health outcomes. Optimally, the project should exist within a comprehensive strategy with multiple approaches to achieve health equity within Georgia.

Participant H3 said one of the successes around health disparity elimination frameworks and practices is,

> Some government agencies are beginning to see the importance of addressing public health from a health equity lens. As a result, it is becoming a requirement for programs to address equity, even if it's not a priority for the state.

Participant H3 did not see a specific established policy or policy frameworks informing programs, but recognized change is starting to move towards addressing health equity. Sometimes there are multiple local level policy changes before there is a similar policy placement at the state level.

H4 agreed with H3's view and said,

> So we're kind of in a time of just shifting a little bit of the way we kind of approach public health and based on Public Health 3.0…Looking at policy and system change and environmental changes, right?

Participant H4 further stated,

> … a lot of times, there are problems that are even higher up on the problem list that are leading to a lot of these changes, and a lot of that is a social determinants of health… and we're in the early stages, but we have a health disparity, and infant and maternal mortality here ... and they're in African American women ... and this is what we're seeing...

H4 assured the SDOH would now be the focus and said, "… you have to go upstream and cut it off at the source …. this is our new philosophy here which is to -- this is how we try to look at things, so." Participant H4 spoke of infant mortality being an area to address the SDOH, but also mentioned vaping, and secondhand smoke exposure, along with the opioid addiction as being health department concerns.

IQ 6 focused on the participants' position about the future of health outcome improvements among racial and ethnic minority populations in Georgia or their county. Participant H2 said,

> I see opportunities for significant improvement. I think that if we are diligent in Public Health in documenting the value of dealing with social determinants through providing wraparound services, if we can show the metrics, and if we can then make a business case, that's the one thing that most of our policy makers will listen to, is a business case.

As was done for IQ 1, the participant reaffirmed the belief in the approach of the Health Resources and Services Administration's provision of support services for persons living with HIV/AIDS. Participant H2 says the same services should be provided to help persons affected by other chronic diseases.

Indicating a need for deeper exploration into health disparities, participant H3 said, “If we want to improve the health of Georgia, we must address why health outcomes are poorer for racial and ethnic minority populations and put effective interventions in place to fix the problem.” Contrasting and supporting H3’s view, H4 said,

> … I think it’s going to be a bright future. We already know that this county, in particular [undisclosed county], will become majority-minority soon ... if you have more African Americans and more African Americans women [*sic*] that will be having babies, we will still face our infant and maternal mortality, right?... Not only does this baby have an increased risk of death, but so does mommy... what's in place to be able to take care of some of that? And I don't know. I don't know what that is, but I know it’s not working. We know that, right?

Expanding the thought, participant H4 also said, “… and so I think it will get better when we start identifying and then doing what we need to do to take care of it, so.” Participant H4 displayed a dichotomous view, believing the future would be positive; however, acknowledging the challenge of finding solutions to health disparities among racial and ethnic minorities, particularly African American women and infants.

IQ 8 asked participants to give additional information about their health equity work or health improvement recommendations. Participant H1 stated,

> We have very in-depth conversations about social determinants of how often all those things that drive people to not be well that don't have anything to do with doctors’ offices. [Describing some of the SDOH], transportation, and jobs, and

> education, and all those kinds of things. So I think our group gets it. But as an overall state, and the nation, we need to have more education on the backend of things.

Confirming participant H1’s understanding, H4 said,

> So, when we look at social determinants of health, you have to move upstream, right? So we cannot just keep looking at taking care of things on the front-end. We got to move it up a little bit, but that'd [*sic*] take some strategy and prevention and convincing people that that’s the right thing to do.

Both participants (H1 and H4) believed the SDOH is the right way to address health disparities, yet recognized that more persons need to be converted into believing the same.

Funding Needs and External Opportunities

Tying with the SDOH for the most common theme is funding needs and external opportunities. IQs 2, 4, 5, and 6 gave the most lived experience responses for this theme. All participants contributed to this theme except Participant 5. IQ 2 asked how state health departments either supported local health departments or health care delivery agencies. If participants were from the county, the question asked how their health department is supported by the state health departments for disparity elimination policy work.

For IQ 2, participant H1 stated,

> ... the state has their own set of priorities and what they deem, they fund. And that’s fine. My frustration sometimes with the state is that, in their efforts to be

> equitable, in terms of financial distribution …Well, you can't split everything into 18ths because the burden is different. And sometimes you need to think about who has the greatest problem. And so they support us... I'd say helpful, but not optimal.

For federal funds, Participant H2 said, "… we at the state, basically, are a pass-through agent. Our local public health cannot get what's called Ryan White Part B Funding." For state funds, H2 further confirmed participant H1's comment about supporting all 18 health districts. This was true of support allocated for the Talk with Me, Baby program discussed earlier. However, funding distribution amounts were not explored in detail during the interviews.

Participant H3 said,

> We provide local health departments with some funding and other resources …The resources includes conferences and webinars, as well as guidance such as the National Prevention Strategies, Healthy People 2020, and the National Stakeholder Strategy to Achieve Health Equity [*sic*].

Also, Participant H3 elaborated further on the lived experience of disparity elimination policy work by saying more help is needed in "getting buy-in from the local health director or boards of health and having enough funding to support the work." IQ 2 brought forth views on funding strategy and health equity leadership participation levels that will need further inquiry for resolutions; however, the lived experience offers an opportunity to see where to begin efforts towards health improvement in Georgia. Participants described a need to focus on getting the limited funding into areas of greatest need, and obtaining support from local leadership for health improvement in the areas of greatest need of health equity interventions.

For IQ 4 participants described working within the budget allocated for chronic disease and behavioral risk factor health disparity elimination. Participant H1 stated, “We don't have a lot of behavioral risk [funding]. I don't know that we have any, honestly, that are specifically earmarked for that. We sort of incorporate it into other funding. But it’s gap. It’s a gap.” Participant H2 also confirmed the lack of sufficient funding for chronic disease saying,

> I think that our budget for chronic disease has been very inadequate … we’ve got such horrendous rates of chronic diseases in Georgia ... But I’m conflicted because, on the one hand, I want to help those people that already have those conditions, but the greatest return on investment would be when we learn how to prevent those conditions. And that’s why I want to focus, as much as I can, on early brain development, and if I possibly can, on that environment around the baby. Because that’s where we're going to reduce -- and prevention - the return on investment would be so much greater if we can prevent those things, rather than have to treat those things. They’re so costly to treat.

Participant H2 noted “… it’s really hard to get allocations of funding for prevention, very hard to convince the federal government or the state government to give us money for prevention.” Consequently, Participant H2 remains focused on infant brain development to positively impact health improvement among future generations in Georgia.

Participant H3 also confirmed funding scarcity stating, “The budget does not always allow for us to complete the work that needs to be done. Funding restrictions often prevent great work from happening.” Participant H4, corroborating the three previous participants said,

> There is no budget …. we set our priorities and so looking at these issues, health equity and health disparities is one of our priorities. So if we do have some extra money… when there's a little extra opening, we try to put everybody in the same line going the same way… but there’s never enough money, but we continue to apply for grants and try to supplement and do the best we can…

There is agreement between all four participants that Georgia needs more chronic disease and behavioral risk factor funds to reduce disproportionate burdens among populations most in need. H3 made an important point in comments to this question stating that if officials were “properly trained” to do the work through an equity lens, the funding that is available could be more influential in disparity elimination. Even though health equity resources are made available, there appears to be an additional need for uniform leadership with a health equity view to give direction to program implementation. This approach may help to make the best use of the funds for health disparity elimination if and when they become available, regardless of the amount.

For IQ 5 participants told me what policy-specific actions need to be taken to improve health outcomes among racial and ethnic minority populations in Georgia or their county. Participant H1, reiterating the concern for expending the resources in areas of greatest need said, “… I think that funding needs to be data-driven and more thoughtful. When you see pockets of pathology, your funding needs to address that." Describing the health department's preparedness to focus interventions where most needed, Participant H1 also said, "... we have zip code-specific, census-tracked specific data. So we know almost by the house where the problems are …. it has to be targeted, and somebody's got to collect the data, make sure that we're on point, the outcomes."

Focused on community engagement, Participant H1 believed,

> It's hard to get the community to participate in things sometimes. We start off all hyped about things and then we lose momentum. So you've got to have resources. And we can't keep expecting people to be community leaders without compensating them for this. I mean, there's got to be some draw for them. It's a lot. It's a lot of time and commitment if it's done correctly.

Participant H2 was interested in Georgia receiving national support for prevention, expressly stating, "…so that there was more funding." Participant H3 said, "An Office of Health Equity needs to be reestablished, through legislation, and fully funded with state dollars." An entity responsible for health equity in Georgia, if adequately staffed and funded, could possibly address the budget allocation challenges, as described by participants, with greater accountability. H3 also recommended an alliance of various representatives from the community to inform the work of staff, which should include, at minimum, an epidemiologist and program manager. An evaluator is also important to ensure there are improvements based on program implementation, as H1 suggested earlier.

Finally, for IQ 6 participants gave their positions about the future of health outcome improvements among racial and ethnic minority populations in Georgia or their county. Participant H1 believed, "… I think it'll be fine because at this point, after this much time here that I have developed a relationship with the people who make the funding happen." Explaining further H1 said, "… I think I personally have developed enough goodwill that we'll do as much as we can based on all of the other priorities, but at least we have their [the funders'] ear." Participant H4 stated, "… I have seen the federal reports that look like some funding is coming down the line and research is coming, and that's what we need." Participant H4 remains hopeful also stating, "… it looks like we're making some positive forward progress, and so I think it will get better when we've start [*sic*] identifying and then doing what we need to do to take care of it, so." There are thoughts of positive future outcomes from two different views. One Health Official will rely on current funding relationships to support the work and the other official anticipates future outside funding opportunities and research to reverse health disparity trends. It is likely that all three of the actions will need to happen (i.e., funding relationship support, federal funding, and research), in addition to greater state support, to successfully improve health outcomes in Georgia.

State/Local Health Policy Practices, Lack Thereof, and Improvement Recommendations

IQs 2 and 5 provided the most responses for the theme of current Georgia policy practices, lack thereof, and recommendations for racial and ethnic minority health improvement. Participants H2, H3, and H5 accounted for the majority of responses for both questions. IQ 2 asked participants how state health departments either supported local health departments or health care delivery agencies. If participants were from the county, the question asked how their health department is supported by the state health departments for disparity elimination policy work.

For IQ 2, participant H2 stated previously the funds are released to all 18 health districts, giving specific reference to Health Resources and Services Administration's federal funds. For state funds or Grant-In-Aid, the Talk with Me, Baby program are examples of that type of support. Participant H2 further elaborated on how local health districts are funded by saying,

> So when we send money, we have a special formula that's based on poverty, basically, and population. Because we're very concerned about trying to reach the population that might not otherwise be reached by healthcare, people in rural Georgia. So the greater the population in an area and the greater the poverty share in that area, the more money we send and that money is to support everything. We don't turn anybody away. If they have the ability to pay, we take the money to support the program, but if they don't have the money, we still treat them.

Participant H2 further explained how funding is dispersed by saying, "So the way we influence at the local level is through resources .…We receive it, but we then funnel it out. But we dispatch it based on where the greatest needs are."

As stated above, Participant H3 gave evidence of providing support to staff for health equity beyond funds stating, "… other resources such as the National Prevention Strategies, Healthy People 2020, and the National Stakeholder Strategy to Achieve

Health Equity, as well as host conferences and webinars that focus on health equity to help guide their work." Participant H3 further confirmed a success in offering support by stating, "There are a couple of local health directors who fully support addressing health equity and their efforts are reflected in the programs implemented by their staff." Participant H5 agreed with Participant H3, but stated, "Other than distributing training opportunities (e.g., conferences, seminars) to employees, I'm not sure of additional supports that may be provided." The state/local health policy practices theme is related to the funding needs and external opportunities theme mentioned above. The study participants covered a variety of positions; consequently, the views reflect the same variety making it less likely that the five participants will identify similar challenges and successes. All may agree state funding is scarce; however, there is disagreement on how the available funding is distributed. Furthermore, health officials who are not involved in the funding distribution aspect of support, only have access to, and can share the lived experience of receiving non-financial resources, such as training.

For IQ 5 participants were asked what policy-specific actions need to be taken to improve health outcomes among racial and ethnic minority populations in Georgia or their county. Participant H2 stated,

> You also hear people say that 'we need policies that will expand access to healthcare.' I agree with that. I'm concerned about it though, because one of the things that you will hear a lot of people advocate, and many states have done this, is to advocate for Medicaid expansion, and I'm really concerned. In Georgia, if you look at what's happened … for uninsured children in Georgia which, I think,

> it went up by 21,000 more uninsured children in 2017 than in the previous year. And much of this is related to … a baby may have been born here but the parents may be illegal [immigrants]. And they’re afraid to take the baby in for treatment, even though the baby is a U.S. citizen. They’re afraid to take the baby in because they may get deported.

Offering further insight on Medicaid in Georgia, Participant H2 also said,

> And, right now, every time a physician accepts a Medicaid patient, they lose money…. So we need policy changes such that academic medicine is encouraged more to work in the practice community, not to stay isolated in their academic institutions. And part of it is related to the federal share versus the state share. Medicaid is a combination of the two. And the reimbursement rate in Georgia and the southern states, in general, is poor and we are a prosperous state.

As stated earlier, Georgia has not expanded Medicaid under ACA. As a result, the state does not benefit from reimbursement levels seen by states that have expanded. However, Participant H2 pointed out that Georgia’s Medicaid reimbursement rate is low regardless of not expanding Medicaid under the ACA.

Additionally, participant H2’s Medicaid expansion and immigration comments bring attention to how other non-health national policies or a lack thereof may be adversely affecting health. Elected Official E2 also expressed similar concerns with deportation when asked about additional recommendations for health equity improvement, IQ 9 for elected officials. The official said,

> So we’ve been having a lot of discussions on immigration and immigration status. And what we've seen, there's a lot of fear in that community. And even Hispanics who are legally here or citizens, they were born here, are still reluctant sometimes to go to the hospital or to seek help because they're afraid that they're going to be arrested or deported …. So… high cholesterol, diabetes, these things are prevalent … as well as an increase in cancer for women, okay. So we see those things, we know they're happening, but it's hard to get people to go for screenings. One, because of money, or two, because of their status, or just three, the fear that regardless of their status, they're going to have to go through something that nobody else had to go through, okay.

Participants H3 and H5, for IQ 5, offered recommendations related to community engagement and program operations. Participant H3 said, “Addressing health equity must be included in all program strategic plans, and all programs should have a diverse group of stakeholders (i.e. coalition or advisory board) that help guide and provide input on the work.” Participant H5 suggested the state should, “Implement mandatory training for employees to promote awareness and understanding of health equity and health disparities and their roles within the services we provide....ensure health equity is included in the current policies and procedures implemented in daily operations.” Participants recommended internal and external health department policy adjustments to improve health outcomes among marginalized communities. If implemented, along with adequate healthcare coverage and Medicaid reimbursements, Georgia policy makers appear to feel that policy changes will be helpful for cost reductions and health outcome improvements. The recommendations should be evaluated.

National Policy Practices Affecting Georgia, Lack Thereof, and Improvement Recommendations

For this theme, Participant H2 provided most of the information while the other participants offered local and state comments and recommendations. Participant H2, with H4 contributed to the national policies theme through IQ 6. Question 6 focused on participants' positions on the future of health outcome improvements among racial and ethnic minority populations in Georgia and their county.

Participant H2 stated,

> If I were going to get paid according to the quality of care and the quality of outcomes that I got from my patients, my ordering would be different and the cost of our healthcare would be much less, I think …. So, there is a major movement to begin Pay-for-Performance, and I think this is going to sweep the country over the next 5 years …. And I predict that will also be a major deterrent to health inequities and disparities.

At the federal level, the Centers for Medicare and Medicaid Services offer this type of value-based care model for the nation.

As previously mentioned, participant H4 acknowledged federal support is forthcoming by stating,

> … I have seen the federal reports that looks [*sic*] like some funding is coming down the line and research is coming, and that's what we need. We really need to

> be able to take a look at [health disparities] - - because it’s been going on too long, but it looks like we're making some positive forward progress...

Along with Participant H2, H4 believed that national movements and initiatives can positively impact health disparity elimination work within Georgia. The ACA exists for the same purposes participants are suggesting, to improve health outcomes among people who cannot afford health coverage, but do not qualify for Medicaid.

Participant H2 offered comments to IQs 1, 2, 5, and 7 noteworthy for improving Georgia health outcomes with support or examples from the national level. For instance, Participant H2 previously mentioned the use of *wraparound services* (i.e., nutrition support, transportation, mental health, and housing). HRSA’s Ryan White program gives this type of support to persons living with HIV/AIDS. Racial and ethnic minority and rural communities affected by other chronic diseases and behavioral risk factors could also benefit from the same type of wraparound services to assist with health improvement.

Second, Participant H2 expressed the importance of having a stable Preventive Health and Health Services Block Grant saying,

> I would love to see policies developed at the national level that recognize the importance of prevention so that there was more funding. We have a Preventive Health Block Grant, but it’s fairly small, and every year it’s in jeopardy of being wiped out.

The Preventive Health and Health Services Block Grant is a flexible funding opportunity for states, American Indian Tribes, and U.S. Affiliated Pacific Islands to address their own health priorities and achieve public health goals (CDC, 2019d). Recipients are free to use funds to form partnerships to cover public health needs as warranted.

The third national policy participant H2 would like to see is related to everyone receiving care regardless of ability to pay. Participant H2 said,

> I would like to see an overall health policy such that caretakers of patients, whether it be the doctor. Whether a nurse practitioner. Whether it be a PA [Physician's Assistant]. Whether it be a respiratory therapist. Whether it be a physical therapist - - I would like to see a nationwide policy such that no patient could be turned away. We had that in the emergency department for an emergency condition under EMTALA ... Emergency Medical Treatment and Labor Act.

The recommendation is similar to what the ACA allows state policy makers to do for health insurance coverage - provide affordable healthcare insurance for persons who are not eligible for Medicaid; but, cannot afford private health insurance. The purpose is to have no one uninsured. Approximately 267,000 Georgians meet the health coverage gap and are uninsured (Henry J. Kaiser Family Foundation, 2019b).

Personal Impact of the Work, Question 3 Responses

Finally, as with the Georgia elected officials, responses for IQ 3, the personal impact of the time spent pursuing health equity at the state or county level, were positive. One person described the work as rewarding (H1), and another said the work gives a sense of accomplishment (H5). Two participants identified themselves as having an intrinsic concern for vulnerable populations or health equity (H3 and H4); the responses aligned with the SDOH theme. For example Participant H3 said, “I am passionate about addressing health equity…. I try to incorporate health equity into the programs…but it is hard to do that when it is not a priority for everyone else.” Participant H4 said,

> So it’s very eye-opening and enlightening, and I’ve always had a kind of a heart for vulnerable populations…it’s nice to be in the position I’m in now because as the strategist, we can have a little bit more impact versus being the person that was trying to save people’s lives every day by treating their diabetes and their hypertension .… to be in this position … it is my job to take a look at how are we going to change this system versus just the day-to-day [disease treatment] right?

The two responses give examples of lived experience in work places where one participant sees no impact on the SDOH or health equity, and another official reflects on the experience of anticipating shifting towards addressing the SDOH as a health strategist. A proposed state Health Equity Office, as suggested by H3 previously, could be responsible for providing consistent foundational guidance to bring all health districts further along in this area regardless of where they currently exist.

One response for this question (H2) was removed. Instead of expressly asking about the *personal* impact of the work, I asked the participant to discuss the impact of the work. Based on the response, the question was interpreted differently, and could not be included for analysis.

Summary

During interviews to determine the lived experience of creating and implementing health equity policies, two shared themes emerged between the elected officials and the health departments. First, was the relationship between the elected officials’ legislation adjustments theme (Theme 1) and health departments’ funding needs and external opportunities theme (Theme 1). The health departments’ second most common theme, state/local health policy practices, was also connected to the elected officials’ lived experience because practices are more effectively implemented with adequate funding.

The elected officials and health department officials both expressed concerns with the lack of funds or most appropriate funding strategies for policies or practices to address racial and ethnic minority and rural health disparities in Georgia. For elected officials, interest areas included the passage of Medicaid expansion through the ACA to cover healthcare costs, or funding approaches to keep hospitals operating, for example. For the health departments’ interest area, officials stated the lack of funding for chronic diseases programs. When funding is available and because chronic disease is costly, the action is to focus on early childhood development with hopes of positively influencing future generations’ health outcomes, versus persons who are currently impacted. Participants also believe the funding available is not used optimally or due to scarcity, there must be a reliance on outside funding sources to address health equity.

Second, in terms of being expressly stated or implied, the SDOH theme ranked fourth for the elected officials and first for the health departments. Regardless of rankings, both groups are mindful of the direction they say policy makers and health leaders need to be moving. Elected officials are keenly aware of the impact of the changing demographics of Georgia regarding race, ethnicity, and age, as well as the impact of poverty and the lack of education on health outcomes. Likewise, health officials expressed awareness of additional actions needed to address health equity, and also recognized new approaches must focus upstream to address policies for structural causes of health inequities, along with disease treatment.

The results show more congruence in responses for the elected officials compared to Health Department participants. For example, there was a strong perception that the state needed to improve policy passage to support better health outcomes in Georgia as shown by the most common theme of legislative adjustments, particularly Medicaid expansion. For the Health Department officials, there was a broader variation of experiences regarding work on policies and policy programs to address the social determinants of health or health equity. The Georgia elected official participant group was more homogeneous than the Georgia Health Department group which could account for more uniform responses from elected officials.

Chapter 5 will give interpretations of the findings. This includes participants' lived experience as they relate to literature concepts, the theoretical lens application, and the impact of the findings on public health equity policy. I will close with study limitations, recommendations, social change implications, and a conclusion.

Chapter 5: Interpretations, Recommendations, and Conclusions

Introduction

Georgia’s racial and ethnic minority populations, including racial and ethnic minorities in rural locations have persistent poor health outcomes (Alexander et al., 2015; Henry J. Kaiser Family Foundation, 2017b). The purpose of this phenomenological study was to explore the lived experience of legislators and health department program public administrators while creating, passing, and implementing policies to reduce chronic disease and behavioral risk factor disparities in the racial and ethnic minority population in Georgia. I also sought recommendations for health improvement from both study groups.

Overall, the key findings of the study show 12 themes from six legislators and four themes from five health department officials. There were two shared themes between both groups. First, both the legislator and health department participants expressed a desire to have more funding and alternative funding strategies to align with policies and practices to adequately address racial and ethnic minority and rural health disparities in Georgia. Second, while the SDOH theme ranked fourth for the elected officials and first for the health department employees, both groups were aware of the need to address the SDOH (e.g., education, employment, poverty, mental health, etc.) due to their adverse impact on health outcomes among racial and ethnic minority and rural populations.

Interpretation of the Findings

Elected Official Results and the Literature

The study findings confirmed the literature in multiple ways, and in this section, I provide six examples. First, for legislators, Ottersen et al. (2014) called for human rights to prevail in policy making through a return to the 1948 Universal Declaration of Human Rights as guidance for improving health conditions in the world due to positive health outcome hindrances from the “political determinants of health” (p. 636). Two of the themes emerging from the elected officials, the political nature of health and concern for individuals’ inability to pay for healthcare or insurance, also revealed thoughts of human rights as elected officials discussed politically affiliated competition with adopting the ACA or their constituents’ financial struggles to pay for health insurance. Elected official participants believed healthcare should not be denied; however, they acknowledged constraints with acquiring mutually agreed upon healthcare legislation for constituents in Georgia.

Second, the sixth most common elected official theme was Democrats strategize to pass legislation in the Georgia General Assembly. The participants who were legislators described (a) ensuring to not use words that would increase the likelihood of losing support for intended legislation, (b) partnering with the opposing party’s representatives in the medical profession to sponsor legislation, and (c) framing healthcare from a business perspective. Previous research also showed that state legislators sought to determine how to frame health inequity to ensure proper state legislation is passed to address racial and ethnic minority health disparities (McDonough et al., 2004). Participants in my study confirmed similar efforts in Georgia for creating and passing laws to address racial and ethnic minority health disparities.

Third, there was a dichotomous belief for the ensure governance balance theme. One legislator believed there was disagreement among Georgia elected officials regarding how much influence to exert over county commissioners to address local public needs. In contrast, another legislator described a rewarding experience working with a health department commissioner to resolve problems. Spina (2013) encouraged elected officials and health administrators to coalesce in working towards solutions to constituents' health challenges. Both perspectives offer evidence that partnerships between elected and civil service leaders vary, yet participants realize Georgia leaders from different governance arenas need to work interdependently towards improving health outcomes.

Fourth, one elected official participant stated a common legislator practice is to pass resolutions strongly encouraging certain actions to improve health. However, this approach is not as impactful as passing funded laws to support health improvement action. Likewise, Young et al. (2015), in analyzing the prevalence of racial and ethnic minority focused state legislation, discovered that the state legislator bills most likely to pass were intended to inform versus provide significant resources to implement the measure. In contrast, occasionally resolutions can pass to create study committees to inquire about a health concern. It is beneficial for study committee outcomes to lead to effective legislator solutions to avoid unfunded mandates, as the official explained.

For the fifth area, regarding Medicaid expansion, one elected official who preferred the traditional model through the ACA provision, recognized the constraints of the legislators' political environment. To move forward, the legislator described being rationally open to supporting the Arkansas model, which uses a Republican-supported private-sector version of the ACA program as described by Thompson et al. (2014). This strategy for legislating also aligns with the theme of the Georgia General Assembly's tendency to prioritize business for state operations.

There are on-going discussions about *how* Medicaid should be expanded in Georgia. At the time of writing Chapter 5, Governor Kemp, with the advice of contractor subject matter experts, created an 1115 waiver plan for a Section 1332 innovation waiver plan to expand Medicaid in Georgia (Georgia General Assembly, 2019-2020k). The approach is to receive the full 90% federal reimbursement rate under a 100% poverty level versus the 138% required under the ACA law; therefore, a reduced number of people will receive health insurance coverage under Georgia's plan. Georgia's SB 106 law requires the plan to be submitted to the federal government for review no later than June 30, 2020 (Hart & Bluestein, 2019).

The U.S. Centers for Medicare and Medicaid Services rejected Utah's Medicaid expansion plan, which is similar to Georgia's 1115 waiver plan (Hart, 2019). While some pundits (i.e., Hart, 2019) believe Georgia's plan will receive similar rejection, proponents of fully expanding health insurance coverage at 138% of the poverty level through the ACA believe Utah's decision further justifies the need for Governor Kemp to seek full, traditional Medicaid expansion. A Georgia health policy analyst suggested the approach will avoid having more people without coverage at a higher cost to the state (Hart, 2019). The Kemp Administration does not favor the 138% of the poverty level expansion requirement to get the full 90% federal Medicaid reimbursement (Hart, 2019). There has been no formal update on Georgia's Medicaid expansion plan since Utah's decision at the time of writing.

For the sixth theme, also related to Medicaid expansion, elected official Participant E5 suggested in addition to lowering costs for routine care, there must be consideration of the high costs of medical treatment for undocumented persons' healthcare through emergency rooms. One health department official noted the concern for deportation in the Latino community and its impact on U.S. children in Georgia not being able to receive medical care due to parental deportation fears. E2 confirmed a general unease regarding deportation among Latino adult residents who are U.S. citizens, which was leading to their decreased desire to seek care.

For Georgia, Medicaid expansion specifically for undocumented persons is not the predominant discussion. However, research by Sanchez and Sanchez-Youngman (2013) about state healthcare coverage for undocumented persons in the majority-minority state of New Mexico showed mixed results among adult respondents depending on political party affiliation. For example, Democrats were more supportive compared to Republicans or Independents (Sanchez & Sanchez-Youngman). Furthermore, those who identified with being Chicano supported healthcare coverage for undocumented children and their parents (Sanchez & Sanchez-Youngman). In spite of the lack of majority support for this type of policy overall, participants favored state healthcare coverage for undocumented children compared to undocumented adults. In Georgia, based on legislators’ comments, the concern is with keeping healthcare costs down regardless of who is seeking care and ensuring health insurance coverage among Georgia residents.

Health Department Results and the Literature

A first way health department participants connected to the literature is for the SDOH. This theme tied for most prevalent along with the funding needs and external opportunities theme mentioned later in this chapter. The SDOH are social, physical, or economic areas impacting health outcomes, such as, but not limited to, education, transportation, or geographic area (Rudolph et al., 2018). Participants described their agency as either presently addressing the SDOH; shifting towards addressing the SDOH; or the work would impact future generations, but not persons disproportionately burdened with chronic disease presently.

Several authors in the literature confirmed focusing on the SDOH as a path forward for eliminating health disparities. For example, through the National Partnership for Action to End Health Disparities Implementation Framework, Beadle and Graham (2011) recommend addressing the SDOH through appropriate “policies, procedures, and practices of systems” (p. S17). Additionally, Koh and Nowinski (2010) emphasized the importance of public health leadership within the context of addressing the SDOH through practices and policies that were science based. Penman-Aguilar et al. (2016) advocated breaking down the broader societal circumstances affecting health, such as income or gender, to more closely focus on their impact on health outcomes.

The Health in All Policies framework, as put forth by Rudolph et al. (2013), may seem to reverse the traditional SDOH view due to the phrase *health in all policies*. The emphasis is on health rather than the social or environmental aspects of health; nevertheless, the final outcome is likely the same: to bring public health and external agencies from areas such as, but not limited to, education, labor, transportation, and housing together to improve health outcomes Rudolph et al. (2013). The SDOH approach to improving health outcomes is also corroborated internationally through the World Health Organization and in Canada, according to research by Raphael and Brassolotto (2015).

The second relationship to the literature was the funding needs theme, a form of alternative resource acquisition when funds are insufficient. The need for internal adequate funding or any funding for a particular program causes leaders to seek external money to address the health demands of Georgia residents. Young et al. (2015) confirmed that state legislative bills most likely to pass were intended to inform the public rather than require significant resources or action. State legislators have the authority to release state funds to support health policies and policy programs for implementation by state and local health departments (Harker 2019a). These decisions can positively impact health outcomes and should be externally evaluated to determine effectiveness.

Confirming racial and ethnic minority health disparities to be a world-wide challenge, Koh and Nowinski (2010) referenced the World Health Organization's international concern for equity and encouraged public health leaders to consider the distribution of power, money, and resources. Georgia health department officials acknowledged training resources are released to staff for eliminating health disparities (e.g., training information and external conference opportunities). However, Participant H1 recommended improvements in the area of funding alignment to match citizens' health needs, where disease burdens are the greatest. In contrast, H2 stated funding was distributed according to areas of greatest need. Along with H1, Participants H2, H3, and H4 also expressed the need to have a greater distribution of funds for their health work.

A third area for literature connection was partnerships. Relationships between public health leaders in various agencies to share resources to achieve public health goals were a common theme for public health department actions. Health Department participants, based on their lived experiences, expressed a need to build external partnerships outside of their own agency to acquire funding for health department operations or to assist with policy-based intervention guidance. Other than money, to fill the resource void, Participant H3's experience led to the recommendation of recruiting members for coalitions or advisory groups to inform health disparity elimination efforts. Stephens (2011) and Spina (2013) confirmed the importance of government partnerships to address constituents' health needs. Furthermore, Young et al. (2015), through legislation research, determined the extent to which health equity laws were created for governance. The researchers confirmed that state legislator bills promoting various sector partnerships for racial and ethnic minority health outcome improvements were not prevalent compared to creating state infrastructure (e.g., agencies or work groups), appropriations, or focusing on a specific disease. Therefore, Participant H3's recommendation aligned with Young et al.’s (2015) findings to ensure the communities most affected by poor health outcomes contribute to the solutions in an advisory role to health department leadership.

The theoretical framework, Habermas’s communicative action theory, was the appropriate inquiry lens based on advocacy for the importance of using public dialogue for determining optimal actions to overcome social oppression. Answering the research questions gave the legislator and health department participants an opportunity to share their lifeworld or lived experience working towards health equity. Their work is based on serving racial and ethnic minority Georgians, including minorities in rural locations, who are disproportionately burdened with chronic and behavior risk factor related diseases. Publishing the inquiry results and their health improvement recommendations contributes to the greater societal health equity dialogue. Their information offers ways to improve health outcomes among marginalized populations in Georgia, the United States, and worldwide.

Publishing the elected officials’ and health officials’ perspectives and lifeworld experience pursuing and implementing health equity policies could produce synergy. This occurs when both participant groups have a greater impact on reducing racial and ethnic minority and rural health disparities together than they would separately. For example, the elected officials expressed the greatest agreement in the three most common themes of legislation adjustments (i.e., state policies are insufficient or lack thereof), the Georgia General Assembly prioritizes operating like a business, and the political nature of health. If policy makers can make improvements in these three areas, the changes may possibly impact health department participants' three highest ranking themes. These are addressing the SDOH, funding needs, and health policy practices (i.e., lack thereof or improvement recommendations for pursuing health equity). As a result, social oppression, as described in the literature on the disproportionate chronic disease and behavioral risk factor rates, may decline or cease. Health outcomes may start to improve among racial and ethnic minority and rural racial and ethnic minority populations in Georgia. Health improvements can be realized through action on participants' recommendations to health officials and legislators, and continued public discussions about reducing disproportionate health burdens. As discussed below in the Implications for Positive Social Change section below, if additional financial support provided through the Georgia General Assembly's 2019-2020 budget is sustained and advanced according to future needs, along with full Medicaid expansion as intended by the ACA, Georgia has a good chance of improving health outcomes and reducing uncontrolled costs due to excessive disease.

Limitations of the Study

A study limitation is the sociopolitical context in which the research occurred. The on-going public debate over how to provide health coverage to 267,000 Georgians within the coverage gap continued to receive news coverage during and after the interviews completed. This could have placed limits on participants' responses or eligible persons' decision to participate in the study. Another limitation was the use of social media, LinkedIn and Facebook, for recruitment. The approach may have deterred or encouraged participants; thus, influenced study outcomes. Some individuals, depending on their personality, were willing to share their experiences and others with similar experiences were not. The study results are not generalizable; however, similar views, recommendations, and observations from the lived experience can also transfer to other health service agencies throughout the United States and internationally.

After the interviews, I realized a limitation to trustworthiness was being an African American female researcher conducting in-person interviews. This may have influenced or deterred participation. While the focus of the study was on African Americans, Hispanics/Latinos, Asian Americans, Native Hawaiians/other Pacific Islanders, and American Indians/Alaska Natives, my race and gender could have influenced responses to interview questions. If participants viewed my publicly accessible social media information, it could have also influenced or deterred participation and or interview responses.

Further Research Recommendations

Based on study limitations, I recommend replicating the inquiry with a researcher of a different race and or gender to determine if similar results are produced in another southern state with high chronic disease and behavioral risk factor disparities among racial and ethnic minorities. A second recommendation is to use the 15 themes (SDOH is counted once) from this study to conduct an anonymous quantitative study to learn from state legislators and health officials about the factors influencing the ability to create, pass, and implement health equity policies in Georgia or various southern states in the nation. Both approaches could broaden the understanding of how to more effectively reduce health disparities through policy, and the role the themes may play in health equity policy. Logistic regression to determine associations between the themes and the actions of creating, passing, and implementing health policies can inform future health equity policy work.

A strength of the study is legislator and health department officials were able to educate the public about their lived experience and recommendations for reversing poor health outcomes among racial and ethnic minorities and racial and ethnic minorities living in and rural locations. Within the lens of Habermas's theory of communicative action, the future may show movement towards improved health outcomes based on new and more efficient policies and policy programs for eliminating health disparities. To determine if trends are becoming more favorable, future research should continue to monitor the prevalence and premature death rates from chronic diseases and behavioral risk factors disproportionately affecting racial and ethnic minorities and racial and ethnic minority populations in rural Georgia.

The literature shows a public health concern for disproportionate human suffering from chronic diseases, particularly in the South and rural areas, and the associated high costs of healthcare for citizens and state governments. There is evidence of federal support and guidance for addressing racial and ethnic minority and rural health disparities through the ACA and the National Partnership for Action to End Health Disparities Implementation Framework (Beadle & Graham, 2011), for example. As described by McDonough et al. (2004) and Spina (2013), there is also information to help policy makers engage in more equitable governance to eliminate health disparities.

Study results confirm the literature findings regarding Georgia residents needing to benefit from state health equity policies. The goal is to more efficiently address health care costs and reduce disproportionate suffering due to persistent chronic diseases and associated behavioral risk factors. Elected official and health department participant groups understand the need to address the SDOH; however, health department participants described various levels of pursuing health equity in this manner. Some officials worked in environments where the SDOH are addressed. Others worked in programs where they saw no current impact on the SDOH or health equity; or, the programs have current efforts focused only on future generations (e.g., infants or children) traditionally from communities affected by excessive health burdens. Finally, some persons are in work environments where the work is shifting towards addressing the SDOH.

Regarding the literature, my recommendation is to conduct comparative research to determine the future health status of racial and ethnic minority and rural racial and ethnic minority populations being served by health department programs addressing the SDOH through the three different circumstances described above. Once Georgia policy makers decide on a strategy for expanding Medicaid (see Conclusions section below), further research should determine if the 267,000 people who have no healthcare coverage through the private sector or Medicaid have adequate health insurance coverage. Researchers should also assess the affected populations' health status before and after coverage. Additionally, future research should look at the Georgia state fiscal year 2020 legislation measures passed to determine if there have been improvements in health and other outcomes among racial and ethnic minority and rural racial and ethnic minority populations in such areas, but not limited to mental health in school systems, HIV/AIDS, or education.

Implications for Positive Social Change

To give a fair representation of the inquiry, my social change implications include a brief informational summary about policy actions by the Georgia General Assembly since participant interviews concluded and during the writing of dissertation Chapters 4 and 5. Social change rarely occurs in isolation, but within the context of multiple influencers causing movement in particular directions. Consequently, Habermas's theory of communicative action may be preliminarily confirmed based on continuous national and statewide conversations about health insurance coverage, which may have led to policy actions in Georgia for the 2019-2020 Session.

During the Georgia General Assembly 2019-2020 session, newly approved measures show a shift towards pursuing health improvement. The Senate Health Care Delivery Subcommittee added "access" to their committee name to become known as Healthcare Delivery & Access. This is a notable move toward efforts to improve access to healthcare in association with the new health policy direction to consider Medicaid expansion, along with advanced related laws enacted during the 2019-2020 Session. Likewise, through SB 207 the Georgia Board of Physicians' Workforce was renamed the Georgia Board of Health Care Workforce and allows for broader healthcare provider representation (Georgia General Assembly, 2019-2020a). An entity's name change can signal a shift in strategic thinking or a new approach for remaining true to the mission.

Within the context of the study results and Georgia's recent policy actions, there is potential for positive social change at the organizational and social policy level in the state.

The SDOH was identified by both participant groups as necessary for pursuing health equity. Health and elected officials suggested mental health needs to be adequately addressed and funded. The Department of Behavioral Health and Developmental Disabilities received $78.8 million more for state fiscal year 2020 than in 2019 (Harker, 2019b). This includes $8.4 million going to the Georgia Apex Program for expanding mental health services through providers in community schools (Harker, 2019b). Furthermore, the newly funded Georgia Behavioral Health Reform and Innovation Commission (HB 514) will allow for a complete assessment of current mental health systems and workforce capacity for future improvement recommendations (Georgia General Assembly, 2019-2020b).

Education is also a social determinant of health positively associated with health status. Persons with higher education have better health overall. Legislator and health officials stressed the importance of education to reduce the risk of poverty; thus, reducing the chances for poor health. Regarding the SDG for human rights, Goal 4 stresses the importance of "inclusive and equitable quality education and [promoting] lifelong learning opportunities for all" as a way to reduce poverty and live an optimal life (United Nations, 2019, p. 6).

The fiscal year 2020 state budget under HB 31 funded teacher salary increases (Georgia General Assembly, 2019-2020c; Kanso, 2019). Literature results are varied for the relationship between teacher pay and student achievement, but there is evidence that investment in teachers through competitive pay, when considering other factors, can positively impact student performance (Dolton & Marcenaro-Gutierrez, 2011; Tran, 2017). Due to local school governance decisions, all teachers and professional staff in Georgia may not uniformly receive a direct $2,775.00 pay raise. Nevertheless, schools will benefit in various ways from the increase, Georgia educators' professional associations are supportive, and it is one of the highest teacher pay increases in Georgia (Downey, 2019; Salzer, 2019).

At the heart of Medicaid expansion, legislator and health officials suggested the need for adequate health providers, particularly in rural regions for greater healthcare access. HB 287 was passed to give income tax credits to licensed physicians, physician assistants, and registered nurses with advanced training who are not compensated for teaching and training students (Harker, 2019a). Support for the healthcare workforce can also be seen through passage of SB 16 for the Interstate Medical Licensure Compact Act to give physicians and other healthcare providers the ability to obtain multistate licenses expeditiously with associated oversight for professional integrity in the patients' interest (Harker, 2019a).

Health technology is used to improve Georgia rural communities' access to specialty care (Brewer, Goble, & Guy, 2011). Enhancements through SB 115 allows physicians outside of Georgia to use Telehealth technology (i.e., electronic or telecommunication) for Georgia's patients, and SB 118 changes the name from Georgia Telemedicine Act to Georgia Telehealth Act (Georgia General Assembly, 2019-2020d,e).

More important, the act achieves pay fairness for telehealth practices comparable to “in-person service” (Harker, 2019a, para.12). The practice is a significant opportunity to expand the pool of providers for Georgia residents in need of medical providers where distance is a barrier to care.

Regarding chronic diseases, there were legislator victories and areas for additional work. For example, as referenced in Chapter 3, President Trump declared the desire to defeat AIDS (Cable News Network, 2019). Georgia is in a stronger position to participate in the “Ending the HIV Epidemic” movement with the passage of HB 217 (Georgia General Assembly, 2019-2020f; HIV.gov, 2019). The law permits evidence-based Syringe Services Program access for persons struggling with intravenous drug addiction, thus reducing the spread of HIV through this transmission mode. Also, for the elected official theme, legislation adjustments, HB 324 provides a favorable change to the previous Tetrahydrocannabinol (THC) oil law. In Georgia it is now legal to produce, manufacture, and supply medical THC oil to persons living with state-specified chronic diseases who appear on the Low THC Oil Registry (Georgia General Assembly, 2019-2020g). The registration card required to purchase the medication in Georgia costs $25.00. Costs for the Low THC Oil are unknown at the time of completing the dissertation; it will be beneficial for patients and citizens of the state of Georgia if prices are not cost prohibitive.

Finally, there are several other funded provisions in Georgia’s state fiscal year 2020 budget under HB 31, too numerous to mention, but supportive of healthcare workforce enhancements and health improvements. Funded areas include rural broadband service, primary care and Obstetrics/Gynecology residencies, maternal mortality, medical schools, rural loan repayment support, and health provider tuition elimination for 6 years of service in underserved areas, for example (Georgia General Assembly, 2019-2020c; Harker, 2019a; Salger, 2019). These laws and others, sometimes co-sponsored in a bipartisan manner (e.g., HB 514, HB 217, or HB 324), demonstrate how Georgia policy makers can begin to eliminate persistent health disparities affecting racial and ethnic minority and rural racial and ethnic minority communities and improve health for all Georgians. But the investment commitment must be sustained, comprehensive, and adjusted according to future citizen needs.

Looking ahead, I recommend ensuring Georgia residents benefit from attention to community-level and SDOH policies, whether passed at the state or local level. Much of the health policy work can be supported through sustained state-federal financial investments in relationships between the state and local health departments along with public-private partnerships. The purpose is to focus more on investing in the prevention of chronic diseases and behavioral risk factors which will help reduce individual and state costs.

As health department official H1 recommended, adults and youth can be trained as financially compensated community leaders. Racial and ethnic minority community members can be taught how to engage in evidence-based health policy interventions to make their neighborhoods healthier. Doing so will allow them to partner with elected officials to better understand governance to make it more responsive to residents’ needs. Neighborhood policy efforts may include, but are not limited to, decreasing access to unhealthy food and drinks (i.e., food swamps), decreasing the amount of food deserts, increasing availability of affordable vegetables and fruits in diets, and increasing access to neighborhood walking and hiking trails to support obesity reduction. Such actions will complement the Georgia Student Health and Physical Education Act of 2009 program, the Atlanta Strong4Life Initiative, and similar projects to reverse childhood obesity trends (Issa, 2019; Powell et al., 2017; Vall et al., 2017).

A city-wide example of health policy change is policy makers in Atlanta and Chamblee passing clean air ordinances as of July 2019 (Braverman, 2019; Yamanouchi, 2019). Secondhand smoke prevention policies reduce lung cancer risks among business patrons and persons in lower-wage service jobs, who tend to be predominantly racial and ethnic minorities (Bureau of Labor Statistics, 2013). Also, eliminating youth and adult access to illegal *loosie*s or single cigarettes along with tobacco tax increases on cigars, cigarettes, and e-cigarettes can be beneficial. It is optimal to have a portion of the tax funding to support community-based cessation and on-going social norm changing efforts to help eliminate disproportionate tobacco-related health burdens. I would also recommend determining the feasibility and effectiveness of using tobacco product tax funding to suppress the emergence of underground markets and social sources access (e.g., family members or friends of legal age who acquire tobacco products and provide them to minors). Consequently, cancer, heart disease and stroke, diabetes, and various other adverse health outcomes may improve, with quality of life and financial cost reductions for individuals and Georgia state budgets. The prevention work requires a comprehensive approach for synergy and impact.

My final recommendation to Georgia elected officials is to consider the work the New Zealand government has done to create the world's first *wellbeing budget* (Leal, 2019). Borrowing and objectively evaluating implemented elements from New Zealand's new governance approach may help sustain Georgia's path towards enhancing racial and ethnic minority and rural racial and ethnic minority population health to positively impact individual and state financial health. The expanded financial measures to address mental health and education through HB 31 are similar to the approach New Zealand is taking to improve their population's wellbeing. With a focus on the SDOH for their cost assessments, the report's executive summary states, "So any wise government will target wellbeing, on prudential as well as moral grounds. It will do this on the basis of robust evidence, paying special attention to those who are really struggling in their lives" (All Party Parliamentary Group, 2019, p. 4). Government policy makers further confirm the link between health, productivity, and dependency reduction; thus financial well-being.

Conclusion

As stated in Chapter 3 for the 2017-2018 Georgia legislative session, and for the 2019-2020 session, elected officials committed to full Medicaid expansion covering persons at 138% poverty level for the 90% federal reimbursement continue to offer legislation for the health coverage of the 267,000 Georgians who fall through the coverage gap. These persons are unable to afford private insurance and do not qualify for Medicaid (Henry J. Kaiser Family Foundation, 2019b). Georgia elected officials have introduced SB 3 for government healthcare premium assistance with co-pays from the insured person, and HB 37, and SB 36 to expand Medicaid through the ACA (Georgia General Assembly, 2019-2020h, i, j). The elected officials sponsoring the legislation, along with other like-minded officials, argue traditional Medicaid expansion, without the 1115 waiver to cover less persons living in poverty, under the ACA will cover more persons with less state costs. There is progress in the fact that the discussions have advanced to *how* to increase health coverage compared to the point officials were at the beginning of my inquiry. However, the *details of how*, and possibly *if* the expansion will occur still remains unknown.

By sharing their lived experience in Chapter 4, Georgia health and legislator officials gave health policy program operation and legislative policy research results and recommendations for health improvement. They helped me understand their resilience, courage, challenges, and future expectations for better health among racial and ethnic minority Georgians. Health department officials operate in various ways to implement health and health policy programs and will benefit from consistent leadership and constituency-informed guidance to address the SDOH among racial and ethnic minority Georgians most in need of health improvement. Some of the Georgia General Assembly advanced policy changes are reflected in the health and related laws passed during the Georgia General Assembly 2019-2020 legislative session.

To reduce costs, Georgia policy makers may see benefits in sustaining and improving the financial gains provided through the 2019-2020 legislative session as population health circumstances require in the future. The laws reflect Georgia policy makers’ beginning steps to address the SDOH such as mental health, healthcare access, and education. However, with Medicaid expansion and the SDOH being prominent topics in the health equity literature and on the minds of my study participants, it appears that Georgia, along with the South, and the United States, are wrestling towards progress to improve health outcomes; therefore, still working to *form a more perfect union*.

Frederick Douglass told us,

> …if there is no struggle, there is no progress. Those who profess to favor freedom, and yet depreciate agitation, are men who want crops without plowing up the ground … This struggle may be a moral one, or it may be a physical one, … but it must be a struggle… (BlackPast, 2019, para. 6-7)

For Georgia, I believe the struggle will lead to the right decision where *all* who are eligible will receive the health coverage needed. The health coverage gaps will cease for improved health and economic outcomes. The legislative leadership, as they have evolved since the beginning of my research, will inevitably continue on their path forward, where no one is left behind in the acquisition of health outcome improvement for Georgia residents.

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Appendix A: Participant Interview Protocol

Introduction **[Audio recording starts here after consent form is signed] [The online qualitative survey starts here after the consent form is "accepted" (radio button) so the participant can proceed; the participant number is not recorded.]**
Thank you for participating in the *Understanding Georgia Government Health Leaders' Lived Experience Creating and Implementing Health Equity Policies* study. The study involves exploring Georgia state health employees' activities and experiences implementing health equity policies and policy programs to eliminate excessive chronic diseases and behavioral risk factor rates among racial and ethnic populations and seeks recommendations on how to improve health outcomes. As a state health department government employee [or county health department government employee; Georgia state elected official; Georgia state legislator aide], your participation will assist in understanding the experiences in addressing racial and ethnic minority health disparity elimination to inform future policies and practices beneficial for health equity.

You have signed the consent form.

Interview Questions
The next 14 questions are open-ended [12 questions if legislature participants]. Most of these questions are follow-ups to the original questions rather than 14 different questions [12 if legislature participants]. I will ask you a question and then give you time to respond at your own pace. Take as much time as you need and please be as detailed as possible with all responses. There may be times when I will ask probing questions to get deeper responses or for clarification. I will not ask questions to lead you to specific types of answers or views.

Again, you have the right to withdraw at any time without penalty.
Are you ready to proceed? [Yes – move on] [No – give more time; address questions, etc.; if participant is still not ready to proceed with the interview and withdraws, thank him or her for being willing to participate and seek another person who meets the

interview criteria. If participant withdraws anytime during the study, no information will be included for this participant.]

[Begin the interview research questions here]

Interview Completion Follow-Up

If you have further input for any of the questions you were just asked, please give it now, or contact the researcher, Tracy M. Clopton, through the information given below, if you are taking the qualitative online survey. [Await response]

Thank you very much for your time. Next, your recorded interview will be transcribed, and you will be given a copy to review and edit as you desire. Once you have done that, please send it back to me as soon as possible. This way, I will be telling your story as you want it to be told. [For qualitative online surveys, immediately prior to submitting the survey, responses to all questions will be provided for review and edits, and again up to 24 hours after submission.]

I cannot tell you now when the study will be available, but I will keep your name and locating information to provide a summary of the study if you wish; do you want a study summary? [Yes/No]

For any new information, questions, or comments, please contact Tracy M. Clopton, XXXXXXX Dr. Christopher Jones, Chair, XXXXXXX. If you want to talk privately about your rights as a participant, you can call the Research Participant Advocate (XXXXXXXX from within the United States or XXXXXXXX from outside the United States), or use the following e-mail address: XXXXXXXX. Thank you again for your participation, have a great day/evening; good bye…

Appendix B: State and County Health Department Interview Questions

[Used for qualitative online surveys and in-person interviews]
What are Georgia Department of Public Health/Community Health or County Health Department employees' experiences with implementing policies and policy programs designed to eliminate chronic disease and behavioral risk factor disparities among racial and ethnic populations?

There will be two different sets of questions. The first set is about the experience in implementing health policies and policy-related programs and the second set is about your recommendations for health outcome improvement actions.

1. Within the Georgia Department of Public Health/Community Health or County Health Department, what health equity or health disparity elimination frameworks/practices guide your policy or policy program work? [if necessary, clarify by asking how the work is approached]
    - A. What are the challenges?
    - B. What are the successes?
2. How do you support local health departments <u>or</u> health care delivery agencies in your health disparity elimination policy work? [If county participants, ask how they are supported by the state health department for disparity elimination policy work.]
    - A. What are the challenges?
    - B. What are the successes?

3. What has been the personal impact of the time you have spent pursuing health equity at the state or county level? [For the need to understand deeper impact, how does doing the work make him/her feel?]

4. Describe working within the budget allocated for chronic disease and behavioral risk factor health disparity elimination.

A. What are the challenges?

B. What are the successes?

Based on their experiences, what actions do they believe need to be taken to improve health outcomes among racial and ethnic minority populations in Georgia?

The next set of questions is about recommendations for health outcome improvement actions:

5. Based on your work experiences, what policy-specific actions do you believe need to be taken to improve health outcomes among racial and ethnic minority populations in Georgia or your county?

6. What is your position about the future of health outcome improvements among racial and ethnic minority populations in Georgia or your county?

7. What other actions in general, including policy-related program practices, do you believe need to be implemented to improve health outcomes among racial and ethnic populations in Georgia or your county?

8. What else would you like to add [about your health equity work experiences or recommendations for health equity improvement in Georgia or your county]?

Appendix C: Georgia Elected Officials' Interview Questions

[Used for qualitative online surveys and in-person interviews]

What are Georgia Health & Human Services Committee legislators' experiences with creating and passing state legislation to eliminate racial and ethnic minority health disparities?

There will be two different sets of questions. The first set is about the experience in creating and passing health equity legislation and the second set is about your recommendations for health outcome improvement actions:

1. Within the Health & Human Services Committee/Senate Healthcare Delivery Subcommittee, describe your experiences creating and passing legislation to eliminate the excessive human suffering caused by health disparities among persons in poverty in the rural South? [May need to clarify racial and ethnic minority populations specifically.]

   A. What are the challenges?
   B. What are the successes?

2. What are your experiences working to create and pass health disparity elimination legislation to address excessive health costs? [Be prepared to probe for specifics such as lost productivity, state costs, individual/personal costs]

   A. What are the challenges?
   B. What are the successes?

3. What has been your experience working on state health policy passage in the midst of the Affordable Care Act of 2010 (ACA) or the current status of Georgia state health coverage for persons in poverty?

A. What are the challenges?

B. What are the successes?

4. What has been your experience working with state health department program administrators to ensure policies are including the needs of the populations most impacted or to ensure that policies do not have an unintended adverse impact on racial and ethnic minority populations? [May need to clarify I am speaking of administrators from chronic disease/behavioral risk factor programs addressing racial and ethnic minority population's health disparities.]

5. What has been the personal impact of the time you have spent pursuing health equity? [For the need to understand deeper impact, how does it make him/her feel?]

Based on their experiences, what actions do they believe need to be taken to improve health outcomes among racial and ethnic minority populations in Georgia?

The next set of questions is about recommendations for health outcome improvement actions:

6. Based on your committee work experiences, what policy-specific actions do you believe need to be taken to improve health outcomes among racial and ethnic minority populations in Georgia?

7. What is your position about the future of health outcome improvements among racial and ethnic minority populations in Georgia?

8. What other actions in general, including within the Health and Human Services Committee or Senate Health Care Delivery Subcommittee, do you believe need to be taken to improve health outcomes among racial and ethnic populations in Georgia?

9. What else would you like to add (about your health equity legislative work experiences or recommendations for health equity improvement in Georgia)?

Appendix D: Georgia Elected Officials Legislator Aides' Interview Questions

[Used for qualitative online surveys and in-person interviews]

What are Georgia Health & Human Services Committee legislator aides' experiences working with a Georgia State legislator to create and pass state legislation to eliminate racial and ethnic minority health disparities?

There will be two different sets of questions. The first set is about the work experience with your legislator in creating and passing health equity legislation and the second set is about your recommendations for health outcome improvement actions:

1. Within the Health & Human Services Committee/Senate Healthcare Delivery Subcommittee, describe your experiences working with your legislator creating and passing legislation to eliminate the excessive human suffering caused by health disparities among persons in poverty in the rural South? [May need to clarify racial and ethnic populations specifically.]

    A. What are the challenges?
    B. What are the successes?

2. What are your experiences working with your legislator to create and pass health disparity elimination legislation to address excessive health costs? [Be prepared to probe for specifics such as lost productivity, state costs, individual/personal costs.]

    A. What are the challenges?
    B. What are the successes?

3. What has been your experience working with your legislator on state health policy passage in the midst of the ACA 2010 or the current status of Georgia state health coverage for persons in poverty?
    A. What are the challenges?
    B. What are the successes?

4. Working with your legislator, what has been your experience working with state health department program administrators to ensure policies include the needs of the populations most impacted or to ensure that policies do not have an unintended adverse impact on racial and ethnic populations? [May need to clarify administrators from chronic disease/behavioral risk factor programs addressing racial and ethnic disparities.]

5. What has been the personal impact of the time you have spent working with your legislator to pursue health equity [for the need to understand deeper impact, how does it make him/her feel]?

Based on their experiences, what actions do they believe need to be taken to improve health outcomes among racial and ethnic minority populations in Georgia?

The next set of questions is about recommendations for health outcome improvement actions:

6. Based on your legislator aide work experiences, what policy-specific actions do you believe need to be taken to improve health outcomes among racial and ethnic minority populations in Georgia?

7. What is your position about the future of health outcome improvements among racial and ethnic minority populations in Georgia?

8. What other actions in general, including within the Health and Human Services Committee or Senate Health Care Delivery Subcommittee, do you believe need to be taken to improve health outcomes among racial and ethnic minority populations in Georgia?

9. What else would you like to add (about your health equity legislative work experience as a legislator aide or recommendations for health equity improvement in Georgia)?

Appendix E: Codebook (Elected Officials)

Literature review key concepts for state policies and strategies to achieve health equity.

Key:
L= Legislator or legislator aide H= State or county health department
All = L and H

Structural codes (Literature review key concepts)	Thematic codes (most common responses)	Interview question(s)
Work on legislation for excessive suffering in the South	Political nature of health; General Assembly operates like a business	L1
Work on legislation for excessive health costs	General Assembly operates like business; Concern for inability to pay	L2
State health policy within ACA (2010) or Georgia health insurance coverage	Political nature of health; Concern for inability to pay	L3
Policies for the people most in need or no unintended adversities from the policy	Legislation adjustments; General Assembly operates like business; Ensuring governance balances	L4
Personal impact of work	SDOH; Democrats strategize to pass legislation	L All, L5
Policy actions for health outcome improvement	Legislation adjustments	L All, L6
Position on future health outcome improvement	SDOH	L All, L7
Other actions to improve health outcomes	Legislation adjustments	L All, L8
Additional information	Political nature of health	L All, L9

Appendix F: Codebook (Health Departments)

Literature review key concepts for state policies and strategies to achieve health equity.

Key:
L= Legislator or legislator aide H= State or county health department
All = L and H

Structural codes (Literature review key concepts)	Thematic codes (most common responses)	Interview question(s)
Frameworks and practices guiding policy and policy programs	SDOH	H1
Support local health department or healthcare delivery	Funding needs and external opportunities; State/local health policy practices, lack thereof, and improvement recommendations	H2
Personal impact of work	SDOH	H All, H3
Working within budget allocations	Funding needs and external opportunities	H4
Policy actions for health outcome improvement	Funding needs and external opportunities; State/local health policy practices, lack thereof, and improvement recommendations	H All, H5
Position on future health outcome improvement	SDOH	H All, H6
Other actions to improve health outcomes	State/local health policy practices, lack thereof, and improvement recommendations	H All, H7
Additional information	SDOH	H All, H8