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The Challenges and Strategies of Affordable Care Act Navigators and In-Person Assisters with Enrolling Uninsured, Violently Injured Young Black Men into Healthcare Insurance Coverage

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Abstract

Low-income young Black men experience a disproportionate burden of violent injury in the United States. These men face significant disparities in healthcare insurance coverage and access to care. The Affordable Care Act (ACA) created a new healthcare workforce, Navigators and In-Person Assisters (IPAs), to support low-income minority populations with insurance enrollment. Using a longitudinal qualitative case study approach with Navigators and IPAs at the two busiest urban trauma centers in Maryland, this study identifies the culturally and structurally responsive enrollment strategies used by three Navigators/IPAs as they enrolled violently injured young Black men in healthcare insurance coverage. These approaches included gaining their trust and building rapport and engaging female caregivers during enrollment. Navigators and IPAs faced significant barriers, including identity verification, health literacy, privacy and confidentiality, and technological issues. These findings offer novel insight into the vital work performed by Navigators and IPAs, as they attempt to decrease health disparities for young Black male survivors of violence. Despite high rates of victimization due to violent firearm injury, little is known about how this population gains access to healthcare insurance. Although the generalizability of this research may be limited due to the small sample size of participants, the qualitative case study approach offers critical exploratory data suggesting the importance of trauma-informed care in insurance enrollment by Navigators and IPAs. They also emphasize the need to further address structural issues, which affect insurance enrollment and thus undermine the well-being of young Black men who have survived violent injury.

Keywords

uninsured, violent injury, Affordable Care Act, Black men

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Background

Young Black men experience a disproportionate burden of violent injury in the United States and are at a particularly high risk for emergency department (ED) visits for violent victimization (Centers for Disease Control and Prevention, 2020; Monuteaux et al., 2017; Pathak, 2018; Sheats et al., 2018). While Black emerging adults (ages 18–29) account for 2.4% of the U.S. population, they experience 26% of violent injury and account for 25% of homicide victims in this age category (Centers for Disease Control and Prevention, 2020). The racial disparities in firearm related injury and homicide continue well past early-adulthood, as Black men remain at a higher risk than any other group until the age of 49 (Wintemute, 2015). This population is more likely to be victims of violent crime and have higher rates of serious non-fatal violent injury than any other racial group (Centers for Disease Control and Prevention, 2020; Rich, 2009). Individuals who are violently injured are at increased risk

for repeat victimization; the average rate of trauma recidivism in the United States is approximately 35%, with rates reaching as high as 65% in some locations (Cooper et al., 2000, 2006; Richardson et al., 2016). Of the young Black men who survive a gunshot wound, nearly half are re-hospitalized for a similar injury within 5 years and 20% are killed (Rich, 2009).

In addition to acute physical injuries, survivors of violence experience long-term adverse physical and psychological outcomes that require longitudinal care, such as disability and posttraumatic stress disorder (PTSD) (Vella et al., 2019). However, providing outpatient treatment and continued care is often difficult, as violently injured young Black men are disproportionately uninsured, have low health literacy levels, and are estranged from the traditional medical care system (Harris et al., 2012; Jacoby et al., 2020; Liebschutz et al., 2010; Nutbeam, 2008; St. Vil et al., 2018). These men are more likely to be unaware of healthcare services due to the complexity of navigating the traditional healthcare system, lack of trust in medical professionals, and diminished access to services. Similarly, low literacy levels, lack of access to broadband internet, and limited English proficiency limit their ability to independently enroll in healthcare insurance coverage (Brooks and Kendall, 2012). This population experiences significant social and structural barriers to accessing healthcare, including racial discrimination, unsafe transportation, and high financial costs (Cheatham et al., 2008; Richardson et al., 2020; St. Vil et al., 2018). Rich et al. (2020) noted that stigma, difficulty expressing concerns, and a preference for self-reliance reduce the likelihood of this population receiving services. Additionally, Richardson et al. (2020) found that symptoms associated with PTSD also factor into healthcare utilization, as survivors may experience barriers to healthcare usage due to feelings of hypervigilance, avoidance of external reminders, and increased irritability.

Uninsured low-income young Black male survivors of violent injury treated in trauma centers across the United States are frequently discharged without enrollment in healthcare insurance coverage and access to continued care, a process colloquially termed in clinical settings as "treat and street" (Harris et al., 2012; Singer et al., 2019). The lack of access to health insurance coverage among victims of violent injury often creates a cascade of escalating hospital costs and prohibits them from receiving continued care (Purtle et al., 2015; Spitzer et al., 2017). Barriers to accessing healthcare for survivors of violent injury impacts their overall physical, social, and mental health statuses, prevention of disability, detection and treatment of health conditions, quality of life, and preventable death (Department of Health and Human Services, 2020).

Elevated levels of insurance instability are a contributing factor to the significant disparities in healthcare delivery and inequalities in health outcomes among Black men (Bond and Herman, 2016; Mitchell and Perry, 2020). Disproportionate burdens of morbidity and mortality may be even more pronounced among violently injured populations who have histories of incarceration. A recent study of a large sample of violently injured Black men in Baltimore reported that almost 90% had been incarcerated for 6 months or longer (Richardson et al., 2016). Maryland, the state where this study was conducted, incarcerates the highest percentage of people who are Black in the United States (more than twice the national average) (Justice Policy Institute, 2019). These inequalities will ultimately impact enrollment into health insurance coverage, continued access to care, health disparities, and overall health and well-being of young Black men.

The Expansion of the Affordable Care Act

The Affordable Care Act (ACA) has generated sweeping changes in the financing, organization, and accessibility of health and social services. The expansion of Medicaid and the establishment of state health insurance exchanges through the ACA have significantly increased insurance access in the United States with an estimated 30 million Americans gaining coverage, particularly among people of color (Andrews et al., 2013; Buchmueller et al., 2016). The ACA emphasizes improvements to the accessibility and delivery of healthcare services, particularly for low-income, uninsured, and vulnerable populations (Islam et al., 2015). The expansion of Medicaid has significant implications for subpopulations of Black Americans, as uninsured Black people compose 76% of excess trauma center deaths from assaults (Harris et al., 2012; Liebschutz et al., 2010). Additionally, it remains necessary to consider differences in access to insurance by age. The recent

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Dependent Coverage Mandate of the ACA now allows parents to cover their children until age 26 regardless of their marriage, residential, and employment statuses to reduce un-insurance as young people transition into adulthood. This mandate has improved coverage among individuals ages 19 to 25 years (Antwi et al., 2015); however, it is limited to private health plans which are disproportionately held by people with higher income (Sohn, 2017).

Despite increased enrollment of people of color under the ACA, significant disparities in healthcare insurance coverage still exist. As of 2018, Blacks, Hispanics, American Indians, Alaskan Natives, and Native Hawaiians and Other Pacific Islanders remained more likely to be uninsured compared to Whites. Throughout the period from 2010 to 2018, Blacks remained 1.5 times more likely to be uninsured than Whites—approximately 14% of nonelderly adult Blacks between the ages of 19–64 were uninsured in 2018. However, no research has examined the percentage of young Black men who have been shot who were uninsured at the time of their injury. This gap is particularly notable as research has indicated that the rate of being uninsured increases to around 20% between 18 and 24 and reaches its peak in early adulthood between ages 25 and 35 (Sohn, 2017). Low-income young Black men in this age group are largely unprepared to navigate the exchanges established by the ACA, thereby precluding a substantive increase in coverage (Barcellos et al., 2014; Natale-Pereira et al., 2011). High rates of being uninsured are particularly pertinent to the well-being of young Black males between the ages of 26–35, as they are ineligible for health insurance through their parents and continue to be disproportionately overrepresented among nonfatal violent firearm injuries (Centers for Disease Control and Prevention, 2020). Additionally, data from Massachusetts before and after its health insurance coverage reform, found that younger men, racial minorities and those experiencing penetrating injuries all had lower rates of insurance both before *and* after insurance reform. This stresses the importance of understanding the role and potential for using the tools of the ACA to improve insurance rates in violently injured Black men (Santry et al., 2014)

Existing Research on ACA Navigators

To increase the likelihood of enrolling socially marginalized individuals into healthcare coverage, the ACA mandates that every Health Insurance Marketplace establish a Navigator Program (Vargas, 2016). Navigators are individuals trained to assist consumers and employers with finding qualified healthcare plans through the marketplace (Centers for Medicare & Medicaid Services, 2015). In-Person Assisters (IPAs) perform similar duties as Navigators but are only authorized to enroll or renew clients into Medicaid. Like other community health workers (CHWs), Navigators and IPAs employ a health literacy model that emphasizes personal forms of communication and community-based educational outreach to assist clients in enrolling in healthcare (Natale-Pereira et al., 2011; Nutbeam, 2000; Vargas, 2016). Studies demonstrate that Navigators within these programs have had some success in improving health coverage for the uninsured poor by implementing strategies that build trust and legitimacy (Sommers et al., 2015; Tummers and Rocco, 2015; Vargas, 2016). A study of ACA rollout in Kentucky, Arkansas and Texas, for example, found that application assistance from Navigators was the strongest predictor of enrollment (Sommers et al., 2015). An ethnographic study of health Navigators in Chicago demonstrated multiple strategies used by these CHWs, including the building of ethnic solidarity and disassociating themselves from public bureaucrats, in order to build trust among low-income minority populations with high levels of distrust toward the government and medical profession (Vargas, 2016).

These studies provide limited but valuable insight on the challenges experienced and strategies used by CHWs to enroll vulnerable populations into healthcare insurance coverage. However, no previous study has explored how hospital-based CHWs identify and intervene upon social and patient-level factors to facilitate access to healthcare insurance coverage and health resources for violently injured low-income young Black males (Powell et al., 2016). This study begins to fill this substantial gap, as it examines the culturally and structurally responsive strategies employed by Navigators and IPAs in enrolling this population in healthcare insurance coverage.

Methods and Data

Research Design and Procedures

This study was funded by the Robert Wood Johnson Foundation New Connections Program for Early and Mid-Career Scholars. It was reviewed and approved by the University of Maryland Institutional Review Board (Approval #670816-7). The study setting, explained in further detail subsequently, included two trauma centers in Maryland serving predominantly urban populations affected by high rates of violent injury. The inclusion criteria for the study were individuals working in these trauma centers who (1) hold the role of Navigator or IPA at the start of the study and (2) serve as a primary CHW enrolling violently injured young Black men into healthcare coverage. The three participants in the sample were the only certified Navigators/IPAs assigned to the research sites. Due to the small sample size ($n = 3$), a

case study approach was used to explore how CHWs perceive and interpret information, understand their own actions, solve problems, and interact with others. This methodological approach has been previously utilized to study phenomena in their specific context and allows for initial theory development and evaluation of interventions (Baxter and Jack, 2008; Schensul et al., 1999). Notably this methodology is contextually specific and can be used to explore how an intervention or phenomenon takes form in a given cultural milieu rather than to form generalizable findings, as may be the goal in larger qualitative or quantitative studies. The qualitative study approach, however, can be hypothesis generating and guide future research questions.

Data Collection

After obtaining written informed consent, semistructured qualitative interviews and participant observations were used to explore the challenges encountered and best practices employed by Navigators and IPAs as they enrolled violently injured patients into health insurance programs at two trauma centers in Maryland. At each site, the Principal Investigator (PI) conducted two in-depth qualitative interviews at the beginning and conclusion of the study with each participant. These interviews were 60–90 min in length and provided the opportunity to collect detailed contextual data about the Navigators and IPA (i.e., educational background, years working in the health sector, perceptions and expectations of their role as a Navigator or IPA). Additionally, the PI conducted brief semistructured interviews (15–30 min) with each participant after they had completed their work every week. This repeated interviewing process was used to gather data on the number of patients they interacted with, number of enrollments, challenges, best practices used in their work, and changes in barriers (if any) to enrolling patients.

Interviews and participant observations were conducted with the certified ACA Navigators assigned to County General Hospital Trauma Center (CG) ($n = 2$) from January to July 2015. They were also conducted with an IPA assigned to United Medical (UM) ($n = 1$) from June to December 2015. The sample was limited by the fact that there were only two ACA Navigators working at CG and one IPA working at UM to include in the study. All interviews were recorded and transcribed verbatim. In conjunction with fieldnotes, these transcripts served as the primary data source.

Settings and Participants

Pseudonyms are used in order to protect the anonymity of the Navigators/IPA and research sites. CG is a Level II trauma center; it is the second busiest in the state of Maryland. Located less than five miles from the border of the District of Columbia, CG receives a large volume of patients from both the District and Prince George's County, Maryland. In 2015, of the patients who were treated for violent injury at CG and had a residence in D.C., 90% were men and 98% were Black. Patients treated at CG with a residence in Prince George's County had similar demographic profiles, as 89% were men and 81% were Black. UM is a Level I trauma center which is located in a large metropolitan area in Maryland; while a larger volume of trauma patients are seen at UM than CG each year, demographic information for that center is not available. It is known however, that the significant majority of gunshot victims are Black males. According to the National Violent Deaths Reporting System (NVDRS), for the state of Maryland in 2017, the crude rate of violent mortality for Black individuals is about 51 per 100,000 relative to a crude rate of violent mortality for White individuals of about 45 per 100,000. In the United States, for the 36 states with available data in 2017, Black individuals had a crude violent mortality rate of about 30 per 100,000 compared to about 20 per 100,000 for White individuals (Centers for Disease Control and Prevention, 2020).

Corey Jones was the first Navigator observed at CG. He is an African American male in his late 20s. When the PI initiated the case study, Mr. Jones revealed that it was his first time serving as a CHW in any capacity. The PI conducted interviews and observations with Mr. Jones for 1 month before he was terminated by CG for unknown reasons. Mr. Jones was replaced by Teresa Williams, who is an African American woman in her early 50s. She was designated as the Lead Navigator for the County's Department of Social Services (DSS) and had extensive experience and expertise enrolling county residents into health insurance coverage, including Medicaid and qualified healthcare plans. She was trained by the DSS to assist patients with identifying a primary care physician. The IPA at UM, Rhonda Rhodes, is an African American woman in her early 50s, with 20 years of experience enrolling patients into Medicaid. The PI was specifically assigned by the UM Department of Patient Services to work with Ms. Rhodes because she had extensive experience as an IPA in her department and was the only IPA assigned to the UM trauma center.

Analysis

The research team utilized a grounded theory approach (Glaser and Strauss, 1967). This analytical strategy was chosen as there is no previous literature on the experiences of Navigators and IPAs in enrolling violently injured young Black men into healthcare coverage. Interviews were coded separately by two researchers, using open, axial, and selective coding strategies (Glaser

and Strauss, 1967). This iterative process generated possible themes, patterns of experiences between interviewees, and possible relationships between codes (Charmaz, 2014). Formal definitions and representative examples of codes were determined collaboratively throughout the analysis process, these data were included in the codebook. Upon completion of this analytical procedure, a final coding process was utilized to ensure uniform assignment of codes to the transcripts.

Results

Beyond their delineated duties to enroll uninsured populations into healthcare insurance coverage, our findings suggest that ACA Navigators and IPAs play a critical important role in providing structurally competent, trauma-informed care for violently injured young Black men. The research team inductively developed seven areas of focus which best describe the practices used by Navigators/IPAs and barriers they experienced in enrolling violently injured young Black men into health insurance coverage. These include: (1) Gaining Trust and Building Rapport; (2) Caregivers: The Role of Women in the Enrollment Process; (3) Identity Verification; (4) ACA Health Literacy; (5) Hospital Integration: Accessing Violently Injured Patients; (6) Privacy and Confidentiality; (7) Technological Issues.

Navigator and IPA Strategies to Bolster Enrollment

Gaining Trust and Building Rapport. Consistent with the literature, Navigators and the IPA were challenged with working with patients who distrusted state institutions, specifically the criminal justice system and law enforcement. In order to address this barrier, they noted a commitment to first building trust and rapport with violently injured young Black men prior to helping enroll them into healthcare coverage. CG Navigator, Mr. Jones described the challenge of gaining trust with patients who assumed that he was cooperating with law enforcement:

> *I had a 16-year-old GSW. The first day I went in and talked to him as soon as I walked in and I said, my name is Corey Jones, I'm doing the ACA through the State of Maryland. When I said, 'state' it was a no-go. He didn't want to talk about anything. I couldn't even get him to give me his name. So the second day. . .I said, well I'm not here to deal with anything in regards to your [investigation by law enforcement] or anything like that, but I am here to ensure that you have health insurance. Once I did that he opened up just a little bit. And I could tell the second day he was a little bit different, he was in a different mood than he was the day before.*

Enrollment was further complicated by law enforcement activity within the hospital. Several patients were in custody while hospitalized for their injuries, causing a police presence in the hospital that made it more difficult for Navigators and the IPA to effectively enroll patients into healthcare insurance coverage. Mr. Jones explained:

> *I had another gunshot wound [GSW] patient, he's on 24-hour watch so there's always going to be 2 to 3 police officers in his room at a time. The first day that I went to speak with him, whenever I mentioned who I was and I mention anything in regards to 'the state' instantly that was the end of the conversation.*

The importance of building a trusting relationship with survivors was imperative to successful enrollment, as the UM IPA was often the first nonclinical staff member in the trauma center to engage violently injured patients at bedside. Ms. Rhodes noted how distrust posed as a significant challenge to enrollment:

> *You have patients that don't trust. They don't trust period. Sometimes they curse me out. But I have to show empathy for their injury. If I come into a room and you tell me you don't want to talk to me right now, I have to respect that. I have to keep coming back until I gain [their] trust because I have something to offer [them] so [they] can not only get [their] hospital bill paid but getting insurance may also lead to [them] getting counseling.*

Ms. Rhodes routinely referred patients to UM's hospital-based violence intervention program (HVIP) for psychosocial services. She clarified that supporting patients by informing them of available, no-cost psychosocial services helped her gain their trust and build rapport. Although this was not part of her job responsibilities, the IPA felt compelled to connect patients with additional hospital-based violence intervention services. This level of caring beyond the limits of their role in enrolling patients in health insurance allowed the IPA to foster deeper connections with the violently injured young men she engaged. Indeed, this caring is reflected in how the IPA often felt constrained by her formal duties of insurance enrollment and expressed that her role should be expanded to work with the HVIP as well:

> *I think I would be a good Navigator for the HVIP, I really do. But I'm only allowed to say but so much. I tell [violently injured patients], make sure before you are discharged you talk to somebody because we all go through something. It may not be me you want to talk to but these people that work for the HVIP, they can get you on the right track. Be it social services, medical services or whatever. I am not going to say that the HVIP will give you a mountain of gold, but at least they can start you on the right track. They can sort of turn it*

around for you. I try to make [patients] aware that violence intervention services are there.

The IPA at UM assumed multiple roles—including informal social worker and advocate. These roles allowed Ms. Rhodes to encourage violently injured young men to complete their education and seek continued physical and psychological services. She instilled hope that young men could use their injury as a turning point to alter their high-risk behaviors and lifestyles while acknowledging the significant structural barriers they faced. Although Ms. Rhodes had no formal training in trauma informed care, she intuitively practiced its principles—establishing a culture of empathy, safety, trustworthiness, transparency, and empowerment with patients. She stated:

I had one case, a [gunshot wound], where the patient told me: "my mom abandoned me when I was nine years old, and I was raised by my uncle. I was abused in that situation." I told the patient I'm sorry your uncle did that to you. But if I can get you some [insurance] maybe you can go get the counseling you need so maybe you can put this behind you.

The Navigators and IPA highlighted their use of trauma-informed care as a necessary feature of their work when working with violently injured young Black males. These survivors often suffer from traumatic stress due to their injury and history of trauma across the life-course. According to the Navigators and IPA, acknowledging the lived experiences of these young men better and establishing a culture of empathy, trust and transparency bolstered their ability to enroll patients in insurance coverage and connect them to the healthcare system.

Caregivers: The Role of Women in the Enrollment Process. The Navigators and IPA reported the importance of developing rapport with female caregivers, including mothers, sisters, wives and girlfriends, as this enhanced their ability to gain the trust of violently injured young Black men. The Navigators and IPA perceived these caregivers as more engaged and well informed on the healthcare system compared to survivors, thus making their participation in the enrollment process vital. Consistent with the literature, participants noted that their race, age and gender helped them develop racial and gender solidarity with caregivers. Ms. Rhodes described why identifying and engaging female caregivers is a successful strategy for enrolling young Black men into healthcare insurance coverage:

If you want to get the guy enrolled, it's usually the women that kind of take the initiative. The woman that is there in the room either the mother or girlfriend has a better grasp of walking him through [enrollment] she understands because most [mothers or girlfriends] are already receiving services. When I enter the room, I always look for mama and I'll ask where or who is the mother? I ask, is she mom, and I will pull her out and say I need to speak with you privately please. Sisters usually play a vital role too. For some reason young men listen to their sisters.

The UM IPA made additional efforts to speak with caregivers about the UM-HVIP. Ms. Rhodes worked closely with the mother of a 19-year-old Black male who had been shot six times—the survivor had also been previously hospitalized three times at UM for violent injuries. Ms. Rhodes described her conversations with the young man's mother regarding his participation in the HVIP:

His mother is beside herself. Her concern is that she doesn't want [her son] coming into this [HVIP] where the person that perhaps assaulted him will also be in this program. I told her I had no guarantee on that one. I said why don't you just give it a chance? She said she didn't know. I was hoping today we could visit her and try to get her to get this boy enrolled in the HVIP because if not, he's not going to make it to twenty.

At UM, the IPA consistently attempted to connect patients to the HVIP despite no formalized referral relationship between the IPA and the HVIP. In this capacity, she addressed the case-by-case concerns of patients and their families to facilitate needed psychosocial and medical aftercare for survivors. The UM-IPA acknowledged the need for additional trauma care for the caregivers themselves due to the burden of repeat violence:

It hurts me because you know eventually, he (violently injured patient) will be back. The next time he might not be as lucky. But I can't pull him out of Baltimore. I can't tell a parent what to do with her child. I think the mom needs counseling as well but who am I to say I am only the IPA.

Significant Barriers to Successful Enrollment

Identity Verification. Verifying a patient's identity was the most significant challenge to insurance enrollment for the Navigators and IPA. While a patient's identity could be verified using a driver's license, social security card, and/or birth certificate, many survivors did not have these forms of identification at the time of treatment. If the patient or caregiver was unable to provide the necessary documents, Navigators or IPA used the Health Exchange portal to confirm the patient's identity through the use of a credit reporting company (i.e., Experian) or IRS tax records—a process known as remote identity proofing (RIDP). Ms. Williams, a CG Navigator, explained the difficulties that arise from using RIDP for patients without a history of credit or legal employment:

A lot of times we get identity issues when people reside in another state. . .we typically see identity issues with young people because they don't have a lot of credit established so I can't get the system to locate them, or you may see it with someone who doesn't file taxes or has never filed taxes so we can't identify them. Our system cannot identify them. It's not so much that the credit companies are involved in getting them insurance this is what our system uses to identify people because sometimes you might have a social security number that's off. Or they may have moved, living in different states, so we're trying to verify their identity. If an application doesn't go through the system it will tell you to call Experian. So we have to do additional work to get them into the system. As the Lead Navigator I have access to the workers portal, a backup system, so if I run into issues or sometimes can't get their health insurance application through the health exchange portal I have access to enroll these folks through the workers portal.

The UM IPA approximated that up to 60% of the violently injured patients were unidentifiable through this method:

INT: In our last conversation you said that anywhere between three to six out of ten violently injured patients encounter this identity issue?

IPA: Yes, unable to identify. And the system won't let you get but so far and it will tell you go to Experian, that's the credit site, and when you go there it says unable to identify. So when I get that, I try to get mom, dad, or grandma to get the patient's birth certificate, Social Security card, ID or have the patient transported to 201 West Baltimore Street, which is the state's health exchange. Wherever the family is, we transport them down there.

In situations when the IPA experienced challenges with identity issues, the patient's application would be forwarded to the hospital's attorney. For Ms. Rhodes, this raised questions why the hospital attorney was not assigned to work directly with her. She felt that this partnership would have streamlined the enrollment process. Identity verification challenges were exacerbated for patients who experienced lengthy periods of incarceration. Ms. Rhodes described how a caregiver could not complete the identification process for her recently released husband, despite possessing his identification documents:

[His wife] has their marriage license, she has his birth certificate, she has his Social Security card, and she has his prison ID. . .[however he remains unidentifiable] because he never worked and he doesn't have any credit. . .you can't apply for credit when you're incarcerated, right?

Identification documents that were deemed acceptable varied by hospital, as Ms. Williams, a Navigator at CG experienced no challenges when enrolling patients with histories of incarceration. She explained that she was able to successfully enroll formerly incarcerated patients using prison release papers:

I actually went into the room for a traumatic injury and the other roommate overheard us talking about who I was and why I was there and he said well I don't have health insurance. I said okay, I will get you signed up and we started talking and he said well I just got out of prison and he was explaining to me that he tried before to get enrolled but the health exchange was telling him he couldn't enroll because he had just gotten released. I said no that's not right, all we would need would be your release papers. So I processed his Medicaid application right there and he got Medicaid.

ACA Health Literacy. The two institutions reflected varying degrees of awareness about the ACA and its implications. The IPA at UM reported that violently injured young Black men were relatively well informed regarding the ACA, despite previous research suggesting that many Americans were unprepared for the legislation. Ms. Rhodes explained that many young Black men in Baltimore had a fundamental understanding of Medicaid expansion based on their childhood experiences as Medicaid beneficiaries:

Most had Medicaid as a child so they understand it. . .Most of them understand that [the IPA] is going to help me. She's going to help me get my bill paid. She's going to help me get services. And I tell them I got other things too. We sit and talk. I tell them I know you're angry, I know you're hurting but let me get you started on the right road.

In contrast, Navigators at CG had varied perceptions of health literacy among patients. Mr. Jones was pessimistic about the health literacy of young Black male patients. He described that many patients were misinformed about "Obamacare," often expecting free insurance:

The patients I talk to don't know too much about it (ACA) at all. I have to explain to them what the Affordable Care Act is. That it is a mandate that was passed down by the federal government that enables you to have access to healthcare and it does not guarantee that it will be free because a lot of them think it's free. I tell them we have to look at your household income and things like that so there are different components to it. For the most part it, it's challenging at times. . .. at times it becomes very challenging. A lot of people don't fully understand what it is, you know that little information they get about it maybe from a neighbor who doesn't know a lot about what's going on or they heard an advertisement for it on the radio. We all know that advertisement is only 30 or 60 seconds. A lot of people coming in, they ask for Obamacare, which is not health

insurance but they refer to it as Obamacare. The first thing that they say is Obamacare oh I get free insurance.

Similarly, Ms. Williams highlighted several misconceptions about the ACA such as limited knowledge of all available services, the cost of services, and the deadline for enrollment. She attributed some of the misinformation to the media's reporting of the ACA. As a Navigator, Ms. Williams was able to clarify these misconceptions and communicate the full range of services available through Maryland Medicaid such as medical, dental, and vision insurance:

Many of them (young Black men) are not familiar with the Affordable Care Act. If you say Obamacare, they kind of understand that but they are not educated about what services are available. Most young people think it's just medical, especially if you're on Medicaid but its medical, dental and vision. Then they get a little bit excited because then they say "I have all of those services?" Or they think that they have to pay for it. A lot of the information that was out there initially from the media was false information as far as people thinking there was a deadline for those that were on Medicaid. There's never a deadline it's a year-round service opposed to people that actually have to pay for their plan.

Hospital Integration: Accessing Violently Injured Patients. At both hospitals, Navigators and the IPA noted poor integration of insurance enrollment into hospital treatment and discharge procedures. At CG, Navigators were assigned to enroll "walk ins" through the hospital's emergency room. Although victims of violent injury represented a significant percentage of the hospital's trauma center population (20%), the vast majority of violently injured patients were treated in the hospital's trauma center, rather than as a "walk-in" to the emergency department. At CG, this population was more likely to be uninsured (92%) and was frequently discharged without enrollment. Despite the high percentage of uninsured violently injured population, when the investigators initiated the study, Navigators were not provided access to the trauma center. Mr. Jones emphasized his frustration with the hospital administration for prohibiting access to violently injured patients in the trauma center:

I don't have a clear understanding of where I'm supposed to be or where I'm allowed to go throughout the hospital or where I'm permitted to be. I know initially when I was given access it was only supposed to be in the fast track area in the [emergency department]. I ended up having to speak with my point person . . . [to work in] the trauma center to access the violently injured patients.

Ms. Williams encountered challenges with hospital administrators and staff being uninformed and unaware of her role and function as an ACA Navigator. Their lack of knowledge impacted her access to specific patient populations, she explained:

A lot of people (hospital staff) were asking me, "What do you do or who are you?" I still get that. I have to explain it a lot. Even with the people that I work directly with in the hospital's registration office, a lot of them are unaware of what a Navigator does.

Despite these issues, Ms. Williams was granted permission to access the trauma center within a month of her start date. She noted that the Chief Medical Officer of CG intervened when he became aware that Navigators could not access uninsured violently injured patients. As medical and administrative staff familiarized themselves with her role as a Navigator, they often referred patients that needed insurance coverage. Ms. Williams explained that the nurses and clerks on the trauma floor have enabled her to see more uninsured patients by suggesting that she cover both the intensive care unit (ICU) and the trauma center. She said:

The nurses and the secretaries at the trauma desk have been very responsive. They even made suggestions to me because initially I started on the 8th floor (trauma center floor) then the nurses on the 8th floor told me make sure you go down to the 7th floor which is ICU (intensive care unit). I'm going to both floors now. The trauma nurse called me to let know that I should go on the 7th floor too because there are a lot of uninsured patients on that floor too.

In addition to patient access, the management of the hospital's trauma registry was a significant barrier for Navigators at CG and the IPA at UM. Ms. Williams reported difficulty retrieving the trauma registry face sheet, a form which summarized vital patient information such as their name, gender, birth date, mechanism of injury, room and bed number, and insurance coverage status. There was a 24-hr lag between the generation of these face sheets by the trauma registry and the Navigators access to the form. This lag prevented the ability to quickly identify uninsured patients and often resulted in discharge with no Navigator or IPA contact. The UM-IPA described this challenge:

I went to the patient's room identified on the face sheet but when I got to his room he was already discharged, because I don't have any information on him, and we can't solicit it, I'm just hoping that him being knowledgeable, he'll just go to the local health and human services or call and get enrolled.

The Navigators and IPA identified that violently injured patients often walked out of the hospital without official

discharge by a physician. Because the Navigators and the IPA were unable to follow-up with patients who walked out, many violently injured patients were likely to remain uninsured. This has significant implications for the health status of survivors of violent injury. Here Ms. Williams emphasized her challenges:

> *The patient had a tube in his chest and he basically walked out of the hospital. The nurses tried to stop him but he said he didn't want any help. Once I made my rounds, he called back and said he was coming back in to the hospital because he said the tube was hurting him. The trauma clerk actually gave me his information. . .but by the time I got upstairs to the trauma center he was gone again because he was discharged early.*

The Navigators and IPA identified the weekend staffing schedule as a barrier to enrollment. Although both hospitals experienced the highest volume of violently injured patients admitted on the weekends, Navigators and IPAs were not assigned to work during these times, creating critical gaps in coverage for enrolling patients. At CG, violently injured patients who were treated and discharged over the weekend were not enrolled into health insurance coverage and did not receive any follow up. At UM, weekends were peak times for treating violently injured patients; during this time a staff member was assigned to enroll patients on the weekends. However, the IPA was not confident that this staff member successfully engaged these patients.

> *Someone handles discharges (on weekends) but how many people do you think you're going to catch? We're talking about Friday night to Monday morning. Someone else handles those but let's say out of 50 how many do you actually get to process out of that 50? Not many. When I return on Monday few patients have been processed.*

Privacy and Confidentiality. CG Navigators expressed challenges with protecting the privacy and confidentiality of patients, most notably having to try and avoid discussing protected health information in a public setting. The Navigators reported making additional efforts to maintain compliance with HIPAA regulations, citing the need for private rooms in the trauma center to enroll patients into health insurance coverage, Navigators voiced serious concerns that the hospital did not provide adequate private space to ensure confidentiality and privacy of patient health information. CG Navigators were instructed to use their laptops to gather patient information at bedside which required patients to divulge personal information, such as their social security number, in the presence of another patient assigned to the room. If the patient felt uncomfortable discussing their personal information at bedside, the alternative was to enroll the patient at the Navigator's cubicle which was located in an open office space adjacent to the emergency room. A CG Navigator describes the challenges with ensuring patient confidentiality and privacy:

> *If they (patients) want to do the application, then we have to go through the whole thing about finding space. A lot of times, patients don't really want to talk because they know that we're sitting out here in the waiting area, I'm on one side - you're on the other side, and I might have people that are sitting behind me that can hear my whole conversation; and the patients may not necessarily want anybody to know that they haven't worked in five years, you know. Or whatever their reason may be. But that's what I'm running up against. But the few times that I was actually able to speak with them in private, they were a little bit more forthcoming with certain pieces of information.*

However, this procedural and structural barrier varied by institution. The UM IPA did not identify any challenges with privacy and confidentiality because she collected pertinent enrollment information via phone and had a private office. Once she established rapport with the patient at bedside, she would return to her office and call the patient's room to collect confidential enrollment information via phone.

Technological Issues. The Navigators and IPA experienced numerous technology-related problems that affected their ability to enroll patients. At CG, Navigators routinely experienced issues with Wi-Fi connectivity which affected their ability to connect to the state's Health Exchange portal. Notably, this included the Health Exchange portal which frequently crashed during peak hours. When this occurred, Navigators had to stop enrollment or enroll patients using paper forms. There were significant delays with Navigators receiving the face sheets electronically, ultimately decreasing their ability to identify uninsured patients in real time. Similar issues occurred at UM, as the IPA was not given a laptop or tablet; therefore, she had to collect preliminary information at bedside using paper forms, returned to her office several floors up, and enter the information on her desktop. She then gathered the remaining pertinent information by calling the patient's room. This was an inefficient and time-consuming process. Here the IPA elaborates on her tech challenges:

> *A laptop would help. If I had a laptop or an I-Pad, I could process an application on the trauma floor in 20 minutes, boom, and go on to the next person.*

Navigators and the IPA emphasized that better access to appropriate technology would increase their ability to

enroll survivors, as it would not require multiple stages of data collection. While some of the issues were related to the state-run health exchange, they noted that the hospital could have better supported their work by providing the necessary equipment.

Discussion

The study suggests that Navigators and IPAs perform important duties beyond enrolling low-income violently injured young Black men into health insurance coverage despite considerable structural challenges. Navigators and IPAs are important patient advocates, service providers, and sources of structural competency for improving health service access and quality.

Structural competency describes the ability of practitioners to understand and navigate the unique social and economic barriers faced by patients (Metzl and Hansen, 2014). Navigators demonstrated structural competency in their engagement with violently injured Black men—recognizing insurance enrollment and meaningful healthcare access is shaped by numerous factors including disproportionate traumatic stress in this population, distrust of medical and legal institutions related to histories of exploitation, and significant economic barriers.

To successfully enroll violently injured young Black men into health insurance, the Navigators in our study, acknowledged and understood these unique challenges—specifically issues of traumatic stress. As described by the Navigators and IPA, trauma, for marginalized young Black men, often extends beyond the proximal violent injury to lived experiences across the life course, chronic exposure to violence, and negative experiences with the healthcare and criminal justice systems. By acknowledging the lived experiences of survivors of violence, Navigators and IPAs are engaged in structurally competent, trauma-informed care. Although referring patients to the HVIP is not a required responsibility for Navigators and IPAs, the findings indicate that these CHWs encourage patients to seek additional services through hospital-based violence intervention programs. At CG and UM, CHWs performed these duties even with significant institutional barriers and no formal training in trauma-informed care.

Another meaningful example of the structural competence of the Navigators and IPA relates to their social awareness of the impact of law enforcement presence in the hospital. The Navigators and IPA clearly understood how this presence affected patients' trust and willingness to participate in insurance enrollment. These hospital-based CHWs also found effective, structurally competent ways to gain the trust of their patients, such as directly addressing that they were not associated with law enforcement and avoiding the use of charged language ("the state") which connoted a relationship with the police. Finally, Navigators showed structural competency in challenges with verifying a patient's identity. They articulate how the identity verification requirements led to the systematic exclusion of vulnerable patients that needed healthcare insurance coverage and sought to use creative ways to overcome the requirements for formal identification documents including the use of prison documents or RIDP when necessary.

The Navigators and IPA identified several additional multilevel barriers that limited enrollment of low-income violently injured young Black men into health coverage. Navigators described disorganization and dysfunction in the culture of the hospital regarding their role and function. Poor hospital integration of Navigators (e.g., placement in out-patient units and emergency rooms, lack of access to patient data, lack of privacy, technology concerns) limited their ability to enroll patients.

Despite the recent rollout of the ACA, these CHWs noted varying degrees of patient health literacy on the ACA. According to the CHWs, most young men and their caregivers were familiar with health coverage options due to their previous enrollment in Medicaid. CHWs did an excellent job informing patients that Medicaid services were expanded to include dental and vision and that there were no enrollment deadlines. However, one CHW did encounter some healthcare literacy challenges with patients who were misinformed about the ACA. This finding emphasizes the importance of CHWs receiving necessary training on how to best educate violently injured young Black men about the ACA, including a recognition of local variations in healthcare literacy.

The hospital-based CHWs raised several concerns regarding the privacy and confidentiality of enrolling patients in a public space, including discussing protected patient health information and avoiding HIPAA violations. In order to ensure privacy, confidentiality, and trust, CHWs must be provided access to private rooms where they can enroll patients into health insurance coverage. Studies have noted that remote identity proofing (RIDP) impacts access to health insurance (Shaw and Gonzales, 2016). Barriers to enrollment such as verifying a patient's identity through Experian and tax records should be eliminated and the documents consumers can use to verify their identity should be expanded (Shaw and Gonzales, 2016). Additionally, classifying subpopulations of hard-to-reach patients as "unidentifiable" further marginalizes this population, effectively reinforcing distrust of the healthcare system and reproducing invisibility among low-income young Black men.

Hospitals have an important role in providing survivors of violent injury with health insurance and psychosocial services which may improve health outcomes among violently injured Black men. Hospital-based

CHWs must be trained to address the unique enrollment needs of highly marginalized individuals. This will require culturally, structurally, and developmentally appropriate training for enrolling young adults and hard-to-reach populations that have been estranged from the traditional healthcare system. Changes to hospital procedures may better integrate health coverage enrollment and referrals to health promotion resources, including HVIPs. The findings suggest that a formalized referral system for connecting violently injured patients to HVIPs could improve access to continued care. Thus, future studies should explore the ways Navigators, IPAs, and HVIPs can work collaboratively with violently injured populations. Hospital staff involved in treating violently injured populations, including Navigators and IPAs, should be trained and certified in trauma informed care, and techniques like motivational interviewing, to better meet the needs of these populations.

Hospitals have an opportunity to draw upon the knowledge and experience of Navigators and IPAs to better facilitate access to continued care, reduce healthcare costs, and improve the health outcomes of low-income violently injured young Black men. Future research must include larger sample sizes to assess the challenges and best strategies of the CHWs as they work with this population and longitudinal studies which asses the health outcomes of patients recently enrolled. One innovative approach could compare the utilization of health services and health outcomes among violently injured patients enrolled into healthcare insurance coverage by CHWs to patients who were not. The findings presented illuminate several challenges for CHWs, however, we have only begun to understand the impact of CHWs who work with violently injured populations. Ultimately, no violently injured patient should be discharged from the hospital without being enrolled into healthcare insurance coverage. Because victims of violent injury are disproportionately uninsured, this is a golden window of opportunity to do so.

Strengths and Limitations

The strength of the study was our ability to capture the nuanced experiences and narratives of the Navigators and IPA who were tasked with enrolling a hard to reach population of low-income uninsured violently injured young Black men into health insurance coverage. This population is estranged from the normative healthcare system and has expressed stigma of service usage and distrust of practitioners. To our knowledge, despite the disproportionate number of violently injured young Black men in the United States, many of whom are often uninsured, we know little qualitatively about how CHWs enroll this population into healthcare insurance coverage. Navigators and IPAs provide an invaluable narrative in understanding this process. Our study is the only qualitative inquiry of which we are aware that specifically explores the role of these CHWs as they enrolled violently injured populations into healthcare insurance coverage (specifically the expansion of Medicaid) prior to discharge from the hospital. These narratives provide an intimate look into the interactions of CHWs and socially vulnerable patients in ways that have not been captured by previous research on the ACA. These data have the potential to inform how Navigators and IPAs should engage this vulnerable population in the enrollment process and how these vital workers can collaboratively engage with HVIP staff and victims of violent injury.

A limitation of the study is the small sample size of case studies ($N = 3$). As a case study approach was used, the generalizability of the study's findings to a broader population are limited. However, we believe that despite the small sample taken from two trauma centers, the data provide depth that is novel, rich, and descriptive. Future research studies should include larger sample sizes of Navigators and IPAs assigned to trauma centers across the United States who are tasked with enrolling this population. Comparative studies could examine continued access to care and long-term health outcomes among violently injured populations, particularly by firearms, in states where Medicaid has been expanded compared to populations in states where Medicaid has not expanded. This is particularly pertinent, as the states in the Southern region of the United States that have not adopted Medicaid expansion experience the highest rates of gun ownership, gun violence, and have the largest low-income Black populations (Geier et al., 2017). The lack of Medicaid expansion may have negative implications for continued access to care and long-term health outcomes for young Black male survivors of nonfatal violent firearm injury. Future studies should further examine the disparities in healthcare coverage and access to healthcare among this population.

Recommendations

1. **Employing ACA Navigators and IPA with shared experiences of racialization can contribute to structurally competent enrollment strategies:** In our in-depth interviews the ACA Navigators and IPA, who all shared a racial background with the young, violently injured Black men, understood the various social barriers impacting their ability to enroll. This included, for example, a nuanced awareness of distrust of law enforcement, which led the Navigators and IPA to clarify that they did not have a relationship with the police when engaging with young Black men.

2. **Targeted training for ACA Navigators and IPAs for the subpopulation of violently injured Black men may improve enrollment:** Our qualitative data indicate that the subpopulation of violently injured Black men require special considerations. For example the word "state" was linked to policing and invoked distrust in this population. Additionally, engaging the sisters, mothers or other important women in these young men's lives seems to improve willingness to enroll. Training Navigators and IPAs in appropriate language and relational techniques, such as incorporating female caregivers, can help build rapport with violently injured young Black men. Such training may serve to be critical in enrolling this population in health insurance.
3. **Including ACA Navigators and IPAs in hospital level administrative decisions:** The Navigators and IPAs clearly voiced physical constraints and structural barriers that affected their ability to enroll violently injured Black men into healthcare insurance coverage. These barriers included lack of private space to converse with and enroll patients, the general lack of understanding of the role of Navigators and IPAs in the hospital and unnecessary constraints in accessing trauma patients. Including the Navigators and IPAs in administrative structures may contribute to policies to address these issues.

Conclusion

Although this paper focused on improving healthcare insurance coverage and access to services for young Black men who survive violent injury, the findings suggests that much of the violence occurring in the lives of these young men is structural in nature. Our success or failure as a society lies in our ability to address preventable harm—healthcare insurance coverage for all is the first step. We cannot continue to simply "treat and street" young Black men who survive violent injury, as this practice contributes to and sustains the harm experienced by this population. Our findings suggest the importance of including the perspectives of those who are responsible for assisting this population in gaining access to insurance, as these hospital-based CHWs highlight the importance of treating survivors with empathy, and cultivating a healthcare context defined by safety, trustworthiness, and transparency. In doing so, Navigators and IPAs play a vital role in empowering young Black men to achieve their personal goals for health and well-being.

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References

Andrews, C. M., Darnell, J. S., McBride, T. D., & Gehlert, S. (2013). Social work and implementation of the affordable care act. *Health & Social Work*, *38*(2), 67–71. https://doi.org/10.1093/hsw/hlt002

Antwi, Y. A., Moriya, A. S., & Simon, K. I. (2015). Access to health insurance and the use of inpatient medical care: Evidence from the Affordable Care Act young adult mandate. *Journal of Health Economics*, *39*, 171–187.

Barcellos, S. H., Wupperman, A. C., Carman, K. G., Bauhoff, S., McFadden, D. L., Kapteyn, A., Winter, J. K., & Goldman, D. (2014). Preparedness of Americans for the Affordable Care Act. *Proceedings of the National Academy of Sciences*, *111*(15), 5947–5502.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report*, *13*(4), 544–559.

Bond, M. J., & Herman, A. A. (2016). Lagging life expectancy for black men: A public health imperative. *American Journal of Public Health*, *106*(7), 1167–1169.

Brooks, T., & Kendall, J. (2012, September). *Designing navigator programs to meet the needs of consumers: Duties and competencies*. Georgetown University Health Policy Institute: Center for Children and Families.

Buchmueller, T. C., Levinson, Z. M., Levy, H. G., & Wolfe, B. L. (2016). Effect of the Affordable Care Act on racial and ethnic disparities in health insurance coverage. *American Journal of Public Health*, *106*(8), 1416–1421.

Centers for Disease Control and Prevention. (2020). Web-based Injury Statistics Query And Reporting System (WISQARS). Injury Mortality Reports. Accessed 2020. https://www.cdc.gov/injury/wisqars/index.html

Centers for Medicare & Medicaid Services. (2015). *In-person assistance in the health insurance marketplaces*. Retrieved April 18, 2020, from https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance

Charmaz, K. (2014). *Constructing grounded theory*. Sage Publications.

Cheatham, C. T., Barksdale, D. J., & Rodgers, S. G. (2008). Barriers to health care and health-seeking behaviors faced by Black men. *Journal of the American Academy of Nurse Practitioners*, *20*(11), 555–562.

Cooper, C., Eslinger, D., Nash, D., Al Zawahri, J., & Stolley, P. (2000). Repeat victims of violence: Report of a large concurrent case-control study. *Archives of Surgery*, *135*(7), 837–843. https://doi.org/10.1001/archsurg.135.7.837

Cooper, C., Eslinger, D. M., & Stolley, P. D. (2006). Hospital-based violence intervention programs work. *Journal of Trauma and Acute Care Surgery*, *61*(3), 534–540.

Department of Health and Human Services. (2020). *Healthy people 2020: Injury and violence prevention*. Retrieved January 8, 2020, from https://www.healthypeople.gov/2020/topics-objectives/topic/injury-and-violence-prevention.

Geier, K., Kern, J. K., & Geier, M. R. (2017). A longitudinal ecological study of household firearm ownership and firearm-related deaths in the United States from 1999 through 2014: A specific focus on gender, race, and geographic variables. *Preventive Medicine Reports*, *6*, 329–335.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Aldine Transaction.

Harris, A. R., Fisher, G. A., & Thomas, S. H. (2012). Homicide as a medical outcome: Racial disparity in deaths from assault in US level I and II trauma centers. *Journal of Trauma and Acute Care Surgery*, *72*(3), 773–782.

Islam, N., Nadkarni, S. K., Zahn, D., Skillman, M., Kwon, S. C., & Trinh-Shevrin, C. (2015). Integrating community health workers within Patient Protection and Affordable Care Act implementation. *Journal of Public Health Management and Practice: JPHMP*, *21*(1), 42.

Jacoby, S. F., Rich, J. A., Webster, J. L., & Richmond, T. S. (2020). Sharing things with people that I don't even know': Help-seeking for psychological symptoms in injured black men in Philadelphia. *Ethnicity & Health*, *25*(6), 777–795. https://doi.org/10.1080/13557858.2018.1455811

Justice Policy Institute. (2019). *Policy brief: Rethinking approaches to over incarceration of Black Young Adults in Maryland*. http://www.justicepolicy.org/uploads/justicepolicy/documents/Rethinking_Approaches_to_Over_Incarceration_MD.pdf

Liebschutz, J., Schwartz, S., Hoyte, J., Conoscenti, L., Christian, A. B., Muhammad, L., Harper, D., & James, T. (2010). A chasm between injury and care: Experiences of black male victims of violence. *Journal of Trauma - Injury, Infection and Critical Care*, *69*(6), 1372–1378. https://doi.org/10.1097/TA.0b013e3181e74fcf

Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine (1982)*, *103*, 126–133. https://doi.org/10.1016/j.socscimed.2013.06.032

Mitchell, J. A., & Perry, R. (2020). Disparities in patient-centered communication for Black and Latino men in the US: Cross-sectional results from the 2010 health and retirement study. *PloS One*, *15*(9), e0238356.

Monuteaux, M. C., Fleegler, E. W., & Lee, L. K. (2017). A cross-sectional study of emergency care utilization and associated costs of violent-related (assault) injuries in the United States. *Journal of Trauma and Acute Care Surgery*, *83*(2), 310–315. https://doi.org/10.1097/TA.0000000000001525

Natale-Pereira, A., Enard, K. R., Nevarez, L., & Jones, L. A. (2011). The role of patient navigators in eliminating health disparities. *Cancer*, *117*(S15), 3541–3550.

Nutbeam, D. (2000). Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International*, *15*(3), 259–267.

Nutbeam, D. (2008). The evolving concept of health literacy. *Social Science & Medicine (1982)*, *67*(12), 2072–2078. https://doi.org/10.1016/j.socscimed.2008.09.050.

Pathak, E. B. (2018). Mortality among black men in the USA. *Journal of Racial and Ethnic Health Disparities*, *5*(1), 50–61. https://doi.org/10.1007/s40615-017-0341-5

Powell, R. E., Doty, A., Casten, R. J., Rovner, B. W., & Rising, K. L. (2016). A qualitative analysis of interprofessional healthcare team members' perceptions of patient barriers to healthcare engagement. *BMC Health Services Research*, *16*(1), 493.

Purtle, J., Rich, L. J., Bloom, S. L., Rich, J. A., & Corbin, T. J. (2015). Cost-benefit analysis simulation of a hospital-based violence intervention program. *American Journal of Preventive Medicine*, *48*(2), 162–169. https://doi.org/10.1016/j.amepre.2014.08.030

Rich, J. (2009). *Wrong place, wrong time – Trauma and violence in the lives of young black men*. Johns Hopkins University Press. https://doi.org/10.7748/ns2010.03.24.30.30.b1037

Rich, J. A., Corbin, T. J., Jacoby, S. F., Webster, J. L., & Richmond, T. S. (2020). Pathways to help-seeking among black male trauma survivors: A fuzzy set qualitative comparative analysis. *Journal of Traumatic Stress*, *33*(4), 528–540. https://doi.org/10.1002/jts.22517

Richardson, J. B., St. Vil, C., Sharpe, T., Wagner, M., & Cooper, C. (2016). Risk factors for recurrent violent injury among black men. *Journal of Surgical Research*, *204*(1), 261–266. https://doi.org/10.1016/j.jss.2016.04.027

Richardson, J. B., Wical, W., Kottage, N., Galloway, N., & Bullock, C. (2020). Staying out of the way: Perceptions of digital non-emergency medical transportation services, barriers, and access to care among young black male survivors of firearm violence. *Journal of Primary Prevention*. https://doi.org/10.1007/s10935-020-00611-2

Santry, H. P., Collins, C. E., Wiseman, J. T., Psoinos, C. M., Flahive, J. M., & Kiefe, C. I. (2014). Rates of insurance for injured patients before and after health care reform in Massachusetts: A possible case of double jeopardy. *American Journal of Public Health*, *104*(6), 1066–1072. https://doi.org/10.2105/AJPH.2013.30171

Schensul, S. L., Schensul, J. J., & LeCompte, M. D. (1999). *Essential ethnographic methods: Observations, interviews, and questionnaires* (Vol. 2). Rowman Altamira.

Shaw, T., & Gonzales, S. (2016). *Remote identity proofing: Impacts on access to health insurance*. Center on Budget and Policy Priorities. https://www.cbpp.org/sites/default/files/atoms/files/1-7-16health.pdf

Sheats, K. J., Irving, S. M., Mercy, J. A., Simon, T. R., Crosby, A. E., Ford, D. C., Merrick, M. T., Annor, F. B., & Morgan, R. E. (2018). Violence-related disparities experienced by black youth and young adults: opportunities for prevention. *American Journal of Preventive Medicine*, *55*(4), 462–469. https://doi.org/10.1016/j.amepre.2018.05.017

Singer, A. J., Thode, H. C., & Pines, J. M. (2019). US emergency department visits and hospital discharges among

uninsured patients before and after implementation of the affordable care act. *JAMA Network Open*, *2*(4), e192662.

Sohn, H. (2017). Racial and ethnic disparities in health insurance coverage: Dynamics of gaining and losing coverage over the life-course. *Population Research and Policy Review*, *36*(2), 181–201.

Sommers, B. D., Maylone, B., Nguyen, K. H., Blendon, R. J., & Epstein, A. M. (2015). The impact of state policies on ACA applications and enrollment among low-income adults in Arkansas, Kentucky, and Texas. *Health Affairs*, *34*(6), 1010–1018.

Spitzer, S. A., Staudenmayer, K. L., Tennakoon, L., Spain, D. A., & Weiser, T. G. (2017). Costs and financial burden of initial hospitalizations for firearm injuries in the United States, 2006–2014. *American Journal of Public Health*, *107*(5), 770–774.

St. Vil, C., Richardson, J., & Cooper, C. (2018). Methodological considerations for research with black male victims of violent injury in an urban trauma unit. *Violence and Victims*, *33*(2), 383–396. https://doi.org/10.1891/0886-6708.VV-D-17-00065

Tummers, L., & Rocco, P. (2015). Serving clients when the server crashes: How frontline workers cope with E-government challenges. *Public Administration Review*, *75*(6), 817–827.

Vargas, R. (2016). How health navigators legitimize the Affordable Care Act to the uninsured poor. *Social Science & Medicine*, *165*, 263–270.

Vella, M. A., Warshauer, A., Tortorello, G., Fernandez-Moure, J., Giacolone, J., Chen, B., Cabulong, A., Chreiman, K., Sims, C., Schwab, C. W., Reilly, P. M., Lane-Fall, M., & Seamon, M. J. (2019). Long-term functional, psychological, emotional, and social outcomes in survivors of firearm injuries. *JAMA Surgery*. https://doi.org/10.1001/JAMASURG.2019.4533

Wintemute, G. J. (2015). The epidemiology of firearm violence in the twenty-first century united states. *Annual Review of Public Health*, *36*(1), 5–19. https://doi.org/10.1146/annurev-publhealth-031914-122535