Regis University
ePublications at Regis University

All Regis University Theses

Spring 2013

Perceived Barriers to Accessing Healthcare As Experienced By the Participants of Project Homeless Connect 2012

Morgan Potter
Regis University

Follow this and additional works at: https://epublications.regis.edu/theses

Recommended Citation
Potter, Morgan, "Perceived Barriers to Accessing Healthcare As Experienced By the Participants of Project Homeless Connect 2012" (2013). *All Regis University Theses*. 599.
https://epublications.regis.edu/theses/599

This Thesis - Open Access is brought to you for free and open access by ePublications at Regis University. It has been accepted for inclusion in All Regis University Theses by an authorized administrator of ePublications at Regis University. For more information, please contact epublications@regis.edu.

Regis University
Regis College
Honors Theses

Disclaimer

Use of the materials available in the Regis University Thesis Collection ("Collection") is limited and restricted to those users who agree to comply with the following terms of use. Regis University reserves the right to deny access to the Collection to any person who violates these terms of use or who seeks to or does alter, avoid or supersede the functional conditions, restrictions and limitations of the Collection.

The site may be used only for lawful purposes. The user is solely responsible for knowing and adhering to any and all applicable laws, rules, and regulations relating or pertaining to use of the Collection.

All content in this Collection is owned by and subject to the exclusive control of Regis University and the authors of the materials. It is available only for research purposes and may not be used in violation of copyright laws or for unlawful purposes. The materials may not be downloaded in whole or in part without permission of the copyright holder or as otherwise authorized in the "fair use" standards of the U.S. copyright laws and regulations.

PERCEIVED BARRIERS TO ACCESSING HEALTHCARE AS EXPERIENCED BY THE PARTICIPANTS OF PROJECT HOMELESS CONNECT 2012

A thesis submitted to
Regis College
The Honors Program
in partial fulfillment of the requirements
for Graduation with Honors

by

Morgan Potter

May 2013

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES	iv
LIST OF APPENDICES	v
ACKNOWLEDGEMENTS	vi
I. INTRODUCTION	1
II. LITERATURE REVIEW	3
III. METHODS	11
IV. DATA ANALYSIS	14
V. IMPLICATIONS	19
BIBLIOGRAPHY	22

LIST OF TABLES AND FIGURES

TABLE I: Descriptive Statistics 16

FIGURE I: Gender Breakdown 21

FIGURE II: Race/Ethnicity Breakdown 22

FIGURE III: Rates of Substance Abuse 23

LIST OF APPENDICES

Appendix A: Project Homeless Connect Survey: Barriers to Health Care 36

Appendix B: PROJECT HOMELESS CONNECT MEDICAL SCREENING QUESTIONAIRE 38

Appendix C: Written information about the survey/study 41

Appendix D: Crosstabulations, Frequency Tables and Figures 42

ACKNOWLEDGEMENTS

First and foremost, I have to thank my advisor, Dr. Eve Passerini, who has helped me every step of the way. She witnessed the birth of this study, helped me design it, advised me on how to get it passed by the Regis Institutional Review Board, and connected me with Drs. Coast and Finn of the nursing program, with whom I actually did the study. She supported me through the many ups and downs of college in general, as well as the thesis writing process. I would also like to thank Dr. Howe for being infinitely patient as my thesis reader.

I would be remiss not to mention Drs. Coast and Finn, with whom I worked to get this study passed by the IRB, done, and possibly published. I must, of course, also thank Dr. Bowie for being the foundation of my Regis experience, as he was the first person I ever met at Regis and positively influenced my decisions to attend Regis and to join the Honors Program, and always reminded me of the importance of stories and of "strapping myself to the fuselage."

I also thank my fiancé and the Regis Queer Student Alliance. Matt, without you I likely would have given up when things got as rough as they did, and I thank you for being there for me the entire way, no matter how grouchy I got when stressed. QSA members and advisors, you helped me come into myself in so many ways, and provided endless bouts of inspiration for both my work and for life in general.

INTRODUCTION

The purpose of this project is to research the unique health problems that the general homeless population has and the barriers they face in accessing healthcare, especially those homeless persons who have multiple illnesses, are mentally ill, or are veterans. Some previous studies show that homeless persons face barriers to accessing healthcare, including high cost of healthcare, lack of transportation, and feeling discriminated against. During some research I was doing for a class, I came across the fact that homeless persons with multiple illnesses are at higher risk of being homeless longer than those with only one illness, that mentally ill homeless persons face higher rates of physical illness and staying homeless longer, and that homeless veterans had higher rates of mental illness and substance abuse than homeless non-veterans. This led me to be curious about the homeless population in Denver, and I learned that while many people hold the idea that there are not very many homeless people in the United States, there are in fact thousands.

This project has been in the works for a couple of years, now. However, the inspiration behind it began far longer ago. I have been heavily involved in the healthcare system, both as a patient and provider, for most of my life. I was always well aware of how privileged I was, but I always had a hard time imagining not having access to the healthcare that I so desperately needed. As I moved around quite a lot growing up, I saw many homeless people on the streets, but I had always assumed it was different in the

United States. However, when I moved to Denver to come to college, I saw countless homeless people on the streets, and I wondered how their health was suffering due to their homeless status. Gradually, my interests transitioned into what barriers people faced in accessing healthcare, what subgroups of the homeless population were more likely to face barriers, and what could be done to remove those barriers.

LITERATURE REVIEW

Philip Lynch suggests that there are four different types of causes of homelessness: structural causes, like poverty and unemployment, cultural causes, like lack of culturally-appropriate housing options, policy causes, like taxation and the amount of money spent on public housing options and education, and interrelated individual causes, like substance abuse, domestic violence and ill health (2005). However, the main purpose of my study is to research the unique health problems that the general homeless population has and the barriers they face in accessing healthcare, especially those homeless persons who have multiple illnesses, are mentally ill, or are veterans.

One of the largest consequences of the homeless population's lack of access to care is their mortality rate. Homeless persons suffer from an increased risk of all mortality (Hwang et al). The overall mortality rate of homeless people is two times higher than the general population (Savage et al., 2006) and the age-adjusted mortality rate is three to six times higher than their housed peers (Muñoz et al., 2006). For adults that use the family shelter system, the leading causes of death are heart disease and cancer (Kerker et al., 2011), and there is a higher evidence of cancer risk factors in homeless people (Muñoz et al., 2006).

The only way that I foresee a change in this mortality rate is if we increase homeless people's access to healthcare. In order to understand the scope of healthcare problems in homeless populations, one must first look at how many people have healthcare problems, what specific problems they face at a higher rate than the general population (including dental problems, contagious illnesses, and other health problems), and what groups are considered at a higher-risk for both homelessness and being ill while homeless.

Illness and homelessness seem to go hand in hand, partially because many people who are homeless were ill before they became homeless (Schanzer, Dominguez, Shrout & Caton, 2007), and being homeless only made their health worsen. The research group led by Christine Savage (2006) suggested that 33% to 55% of the homeless population have some kind of physical illness. This was supported by Schanzer, Dominguez, Shrout & Caton's 2007 research that discovered that 40% of the participants of their study had a chronic health issue, and 60% who were studied for 18 months or more had at least one health issue. Also, 46% of the participants of Baggett, O'Connell, Singer & Rigotti's study in 2010 had two or more medical conditions. These are outrageously high percentages for a population to have. Many people would suspect that this is due to the homeless population being largely over 35 years old, and attribute these illnesses to aging. Although this is sometimes the case, younger homeless people have also seen similar effects on their body prematurely (Daiski, 2007). This concentration of health problems indicates that they may be environment-driven.

There are some health problems that are more common than others. Many homeless people have difficulty obtaining dental care (Daiski, 2007) and large dental

problems are found in nearly 2/3 of homeless people. In the study performed by Baggett et al. more than 30% of respondents had a past-year dental problem, and tooth loss, dental decay and disease are common in homeless populations (John & Law, 1990; Lynch, 2005). Even common problems like vision impairments are found in higher concentrations in homeless populations. 26% have difficulty seeing and almost 40% have functional vision impairments (Baggett et al., 2010).

There are also many chronic illnesses of which high concentrations are found in homeless populations. These include seizure disorders, diabetes, and cardiovascular diseases like hypertension, cardiac disease and other circulatory disorders (Daiski, 2007; Hwang et al., 2010; John & Law, 1990; Muñoz, Crespo & Pérez-Santos, 2006; Schanzer, Dominguez, Shrout & Caton, 2007). Other common disorders include musculoskeletal problems, foot problems, malnutrition, difficulty with movement and arthritis (Daiski, 2007; Hwang et al., 2010; John & Law, 1990; Lynch, 2005; Muñoz et al., 2006). Perhaps the most common type of chronic non-contagious illness that homeless populations suffer from is respiratory diseases, such as asthma, chronic obstructive pulmonary disease, breathing problems, and emphysema (Daiski, 2007; Hwang et al, 2010; John & Law, 1990; Muñoz et al., 2006; Schanzer et al., 2007) Drug abuse, alcohol abuse, mental illness and PTSD are also quite common (Hwang et al. 2010; Lynch, 2005; Schanzer et al. 2007), and we will go into more detail on those later.

Contagious illnesses are also quite common among homeless populations. Some commonly found contagious illnesses are pneumonia, tuberculosis, and dermatological infections (Daiski, 2007; John & Law 1990; Lynch, 2005; Muñoz et al., 2006; Schanzer et al., 2007). Other health issues found in homeless populations are sexual health

problems such as STDs and blood borne viruses such as HIV (John & Law, 1990; Lynch, 2005; Muñoz et al., 2006; Schanzer et al., 2007). The sheer number of diseases that are easily treated that run rampant in homeless populations is astounding. However, it makes more sense than one would think because many homeless persons were in ill health before becoming homeless, and so new conditions may have been caused by and preexisting conditions may have been aggravated by being homeless (Daiski, 2007; John & Law 1990).

There are some health problems which are found in all populations, but seem to be at an abnormally high concentration in homeless populations. One of the most commonly found health problems in homeless populations is mental illness. More than 50% of homeless people have a history of mental illness, with almost all of that being depressive symptoms (Arangua, Andersen & Gelberg, 2006; Baggett et al., 2010). 48% of the respondents in Baggett et al.'s study (2010) had a history of treatment for mental illness, and almost 25% of the homeless population has a history of hospitalization for psychiatric treatment (Arangua et al., 2006). While being homeless aggravates many mental disorders, at least one in five members of the homeless population suffered from mental health problems before becoming homeless (Woollcott, 2008). Due to the deinstitutionalization movement that began in the 1960s, hundreds of thousands of mentally ill patients were released with little community support, which led to many of them living on the streets (Hill, 1991). Some studies have shown that between 15 and 30% of the homeless population suffer from a major affective disorder, and that around 60% of the homeless population suffer from substance abuse (Toro & Bellavia, 1997). 4

Many homeless people suffer from drug and alcohol dependency (Baggett et al., 2010). More than 70% of homeless youth living in Los Angeles suffer from drug or alcohol dependency (Van Leeuwen et al., 2006). In the same study, it was discovered that of homeless youth in Denver in a nine-month period, 69% used alcohol, 75% used marijuana, 18% used methamphetamine, 19% used cocaine, 12% used heroin, 30% used hallucinogens, 25% used ecstasy, 13% used ketamine, and 13% shared needles. Substance abuse is even more prevalent among those homeless persons with mental disorders, with up to 65% suffering from substance abuse, which creates a need for specialized treatment to help them overcome their health issues (Marshall, 1998).

Another group needing specialized care are those suffering from multiple illnesses. Individuals suffering from multiple illnesses at once are more likely to be an older, unemployed male, and are at higher risk for many health issues (Segal, Gomory & Silverman, 1998). They typically remain homeless longer than those with only one health problem, and typically need more specialized, integrated help to overcome their barriers (Quimby, 1995). In a study performed by Gormory, Segal, and Silverman in 1998, they found that homeless adults with a dual diagnosis of a psychological illness and substance abuse suffered from anemia, chronic cough, headaches, heart problems, bone and muscle aches, dental problems, and back pain at a greater frequency than the general homeless population. These are only a few of the health problems facing this especially vulnerable group.

Another especially vulnerable subgroup of the homeless is veterans. According to the U.S. Department of Housing and Urban Development 2012 Point-In-Time Estimates of Homelessness, “62,619 veterans were homeless on a single night in 2012.” Veterans

are at a higher risk of homelessness than the general population, especially those who served following the Vietnam War in the all-volunteer force (Tsai, Mares & Rosenheck, 2012). Veterans are older than the general homeless population, are more likely male and are more likely to be high school graduates than the general population (Tsai, Mares & Rosenheck, 2012). However, they are also at higher risk for mental illness and substance abuse than the general homeless population (Tsai, Mares & Rosenheck, 2012). In a 2007 study, Tracy Dietz found that being a veteran increased the risk of a lifetime substance abuse disorder by a factor of 1.46 as compared to a homeless non-veteran. PTSD, a common side effect of being a veteran, is also quite common in homeless populations (Lynch, 2005). Being homeless, PTSD can be both caused and aggravated by the sufferer's environment. This is due to the fact that there are such high rates of victimization in homeless populations, as well as lack of access to proper treatment.

For many homeless people, lack of access to proper treatment leads to the use of Emergency Rooms for non-urgent needs. Perhaps one of the reasons for the use of E.R.s for non-urgent needs is the lack of health insurance among homeless people. It is estimated that between 54% and 60% of homeless people do not have health insurance (Baggett et al., 2010; Schanzer et al., 2007). With lack of insurance and use of Emergency Rooms, it makes sense that many people have unmet healthcare needs. Between 41% and 73% of homeless people have experienced an unmet healthcare need, or a need to go see a doctor when they did not (Baggett et al., 2010; Hwang et al., 2010). The highest rate of disparities between healthcare that was needed and healthcare received occurred with homeless women with children, and those with worse physical and mental health had increased odds of an unmet healthcare need (Hwang et al., 2010).

The unique barriers that the homeless population faces are some of the most influential factors that prevent homeless populations from accessing the healthcare that they need. Some common barriers that homeless people face in accessing the healthcare they need are lack of health insurance and the feeling of being disrespected because of their lack of insurance, lack of affordable health care, and overcrowded clinics with long wait times (Arangua et al., 2006; Baggett et al., 2010; Hudson et al., 2008; Hwang et al., 2010; Lynch, 2005; Nickasch & Marnocha, 2009). Other barriers that I find much more intriguing, are the feeling of discrimination against people with "problematic" behaviors, even if those behaviors are signs of another issue, the inability or refusal of healthcare providers to treat people suffering from both substance abuse and mental illness, and little availability of treatment for those who were ready to deal with substance abuse (Daiski, 2007; Lynch, 2005). Among the barriers to homeless people's access to the healthcare they need are lack of transportation, lack of privacy and confidentiality which negatively impacts their self-worth, and competing priorities, such as finding food and shelter rather than seeking medical treatment (Arangua et al., 2006; Daiski, 2007; Hwang et al., 2010; John & Law, 1990; Nickasch & Marnocha, 2009; Savage et al., 2006).

Many homeless people are reluctant to seek healthcare due to negative past experiences (Lynch, 2005). Two examples of well-founded worries that homeless people have about seeking healthcare are that healthcare providers are unwilling or may not be able to empathize with them due to their homeless status, and that the provider was not taking them seriously or ignoring them (Hudson et al., 2008; Wen, Hudak & Hwang, 2007). They also report feeling unwelcome due to their homeless status, felt that they were stigmatized due to their homeless status, and that they were stereotyped due to the

assumption that homeless people are "freeloaders," all of which discouraged them from seeking healthcare (Arangua et al., 2006; Hwang et al., 2010; John & Law, 1990; Nickasch & Marnocha, 2009; Wen et al., 2007). Overall, homeless people report feeling disempowered, with feelings that the healthcare providers saw them as less of a person due to their homeless status (Wen et al., 2007). This kind of disrespectful treatment has been found to be one of the main causes of homeless people seeking healthcare reluctantly and only for serious illness (Daiski, 2007).

There have been many studies done about the barriers to accessing healthcare among various homeless subgroups. However, I am interested specifically in the barriers that the homeless population faces in the city of Denver, especially in regards to homeless veterans, the mentally ill, and those with multiple health issues. I will research the most prevalent illnesses in the Denver homeless population, common threads that influence their illnesses and ability to access care, and what they see as the most common barriers to accessing adequate healthcare.

METHODS

Project Description

This is a descriptive study using a survey design. Our surveys investigated two concepts: perceived barriers to accessing healthcare, and a general description of health status and problems for this population. Two survey tools were used: (A) "Project Homeless Connect Survey: Barriers to Health Care" and (B) PROJECT HOMELESS CONNECT MEDICAL SCREENING QUESTIONAIRE (see appendices A and B). This data was obtained at Project Homeless Connect 2012, an event in Denver which helps to connect homeless persons to the healthcare they need. A table was set up at the event, which they were led to and asked if they wanted to participate in our study. The study was approved by the Regis University Institutional Review Board (IRB), and permission was obtained from the study site. Data was collected in September 2012.

Sample

To participate in the study, individuals had to be participants of Project Homeless Connect 2012, be at least 18 years old, and speak English or have a translator. They also needed to be willing to answer questions regarding their employment, military service history, and experiences of healthcare. 84 participants were interviewed after they were deemed to have met the criteria and gave their consent.

Data Collection

The “PROJECT HOMELESS CONNECT MEDICAL SCREENING QUESTIONAIRE” was one which all Project Homeless Connect participants filled out regardless of whether or not they participated in this study that included demographic questions, questions about which, if any, physical and mental illnesses they suffered from, as well as drug, alcohol and tobacco usage. The participants were then asked if they wanted to opt into taking “Project Homeless Connect Survey: Barriers to Health Care,” which had more in-depth questions, including questions about the barriers they felt that they faced in accessing adequate healthcare, if they had ever served in the military, their gender, race, how many hours per week they worked, and if they had ever felt uncomfortable or unable to receive physical or mental healthcare.

Consent

Participants were invited to complete the health data survey, 'PROJECT HOMELESS CONNECT MEDICAL SCREENING QUESTIONAIRE as standard intake for each individual when they entered the health care area as part of the current standard of care, allowing them to identify their needs for the day. Participants were then invited to complete the "Project Homeless Connect Survey: Barriers to Health Care" survey as they left the health care area after all care and exit processes had occurred. In this way, participants did not feel compelled to answer the survey in order to receive care since full health evaluation had already been made and care had already been rendered. The Participants indicated consent by completing the survey, which was anonymous with no

personal identifiers. Information was given to each participant in writing or if unable to read, read to them, about the study, their participation, and their information was studied in aggregate only; all information is confidential and anonymous (see appendix C).

DATA ANALYSIS

First, univariate analysis was used to determine the basic demographic breakdown of the participants in our study in order to compare to the national and local statistics. Then, univariate analysis was used to find the number of participants who had served in the military, who had any type of mental illness, who had multiple health issues, and who felt as though there were barriers that prevented them from accessing adequate healthcare. Those four variables were then crosstabulated to discover the frequency of overlaps between all possible two-variable combinations of those variables. Correlations were discovered, investigated, and determined to be either statistically significant or insignificant. Bivariate correlations showed that there was a positive correlation between military service and barriers to accessing healthcare, as well as between mental illness and barriers to accessing healthcare, and having multiple illnesses and barriers to accessing healthcare.

Univariate Analysis of Descriptive Statistics

57 participants (67.9%) in our study were men, with the other 27 (32.1%) identifying as women. The age groups ranged from the 18-24 year old group to the 65+ group, with all groups having at least one member, and the 45-49 and 50-54 year old age groups having the most members with 16 and 15, respectively. 16% of our participants

had served in the military, 39%reported having some type of mental health problem, 63% had multiple health issues, and 88.1% felt that there were barriers preventing them from accessing adequate healthcare. The average age group was group 6, so age 45-49, and the racial breakdown was 40.5% White/Caucasian, 21.4% Black/African-American, 17.9% Hispanic/Latino, 6% Native American, and 14.2% Biracial/Other. All descriptive statistics can be seen in Table 1. 34.5% of respondents reported using only alcohol regularly, and 12% reported using only drugs regularly, with very little overlap, so 64.71% of our total population reported substance abuse.

74 respondents (88.1%) reported that they felt as though there were barriers that prevented them from accessing adequate healthcare. Of the barriers participants reported, lack of health insurance was by far the most common, with 48 participants (57.1%) marking that as part of the problem. 42 participants (50%) said that healthcare costing too much was a barrier that prevented them from accessing healthcare, and 32 (38.1%) said that not having transportation was a barrier for them. Other barriers reported included long wait times, not being taken seriously (due to their lack of education), not getting adequate care and not being understood were barriers for them, with 22.6 to 35.7% of participants marking those options. Some other barriers reported were not knowing how to talk to providers, having previous negative experiences, feeling a lack of empathy from providers, being discriminated against, lack of privacy, or other priorities (such as seeking food or shelter) taking precedence, with 20.2 to 11.9% of participants marking those answers.

Table I: Descriptive statistics

	Participants (n=84)
Gender	
Man	57 (67.9%)
Woman	27 (32.1%)
Genderqueer/Genderfluid/Other	0
Race/Ethnicity	
White/Caucasian	34 (40.5%)
Black/African-American	18 (21.4%)
Hispanic/Latino	15 (17.9%)
Native American	5 (6.0%)
Asian/Pacific Islander	0
Middle-Eastern	0
Biracial	8 (9.5%)
Other	3 (3.6%)
No Information	1 (1.2%)
Age	
18-24	2 (2.4%)
25-29	5 (6.0%)
30-34	9 (10.7%)
35-39	6 (7.1%)
40-44	10 (11.9%)
45-49	16 (19.0%)
50-54	15 (17.9%)
55-59	12 (14.3%)
60-64	6 (7.1%)
65+	2 (2.4%)
No Information	1 (1.2%)
Mental Illness	
Yes	32 (38.1%)
No	52 (61.9%)
History of Military Service	
Yes	13 (15.5%)
No	70 (83.3%)
No Information	1 (1.2%)
Alcohol Use	
Yes	29 (34.5%)
No	55 (65.5%)
Drug Use	
Yes	10 (11.9%)

No	74 (88.1%)
Experienced Barriers to Healthcare	
Yes	74 (88.1%)
No	9 (10.7%)
No Information	1 (1.2%)
Experienced Specific Barriers to Healthcare	
No Health Insurance	48 (57.1%)
Healthcare Costs Too Much	42 (50.0%)
Long Wait Times	30 (35.7%)
Transportation	32 (38.1%)
Lack of Privacy	10 (11.9%)
Other Priorities taking Precedence	10 (11.9%)
Previous Negative Experiences	16 (19.0%)
Lack of Empathy from Providers	15 (17.9%)
Not Being Taken Seriously	24 (28.6%)
Being Discriminated Against	11 (13.1%)
Not Getting Adequate Care	23 (27.4%)
Not Being Understood	19 (22.6%)
Don't Know How to Talk to Providers	17 (20.2%)
Healthy; Don't Need Healthcare	11 (13.1%)
Other	6 (7.1%)

Crosstabulations

Crosstabulations were useful to determine how many of our participants were positive for more than one of the variables we were focusing on. 8 people said they suffered from multiple health issues and had previously served in the military, 27 said that they suffered from multiple issues and also had mental health problems, and 5 said that they had mental health problems and had previously served in the military.

Even more important were our crosstabulations with barriers to accessing healthcare. Out of 13 participants who had served in the military, 10 felt that there were barriers to them accessing adequate healthcare, which is 76.92% correlation. Out of 53 participants with multiple health issues, 50 felt that there were barriers that prevented them from accessing adequate healthcare, which is a 94.34% correlation. Out of 32

participants with mental health problems, 28 felt that there were barriers that prevented them from accessing adequate healthcare, which is an 87.5% correlation.

38.46% reported abusing drugs or alcohol, as compared to 64.71% of non-veterans..

Limitations of Study

Limitations of this study include the exclusion of non-English speakers (unless they provided their own translator) and homeless children. Since the study was done at Project Homeless Connect, members of the homeless community in Denver that could not attend were not able to take the survey.

IMPLICATIONS

Our Data as Compared to National and Local Data, and the Social Implications

This study strongly implies that while members of the overall homeless population have individualized needs that are not being met, specific subgroups have even more unmet needs.

Homeless veterans face approximately the same rates of mental illness as homeless non-veterans and have a higher rate of comorbidity. Prior research has indicated that veterans are at a higher risk of homelessness than the general population, as well as being at a higher risk for mental illness and substance abuse. Our data showed that the veterans we surveyed had higher rates of drug use, and approximately equal rates of alcohol usage, as non-veteran homeless persons. Also, participants who had served in the military, had mental illness, or had multiple health issues had much higher percentages of reporting barriers to accessing healthcare than the rest of the participants of our study.

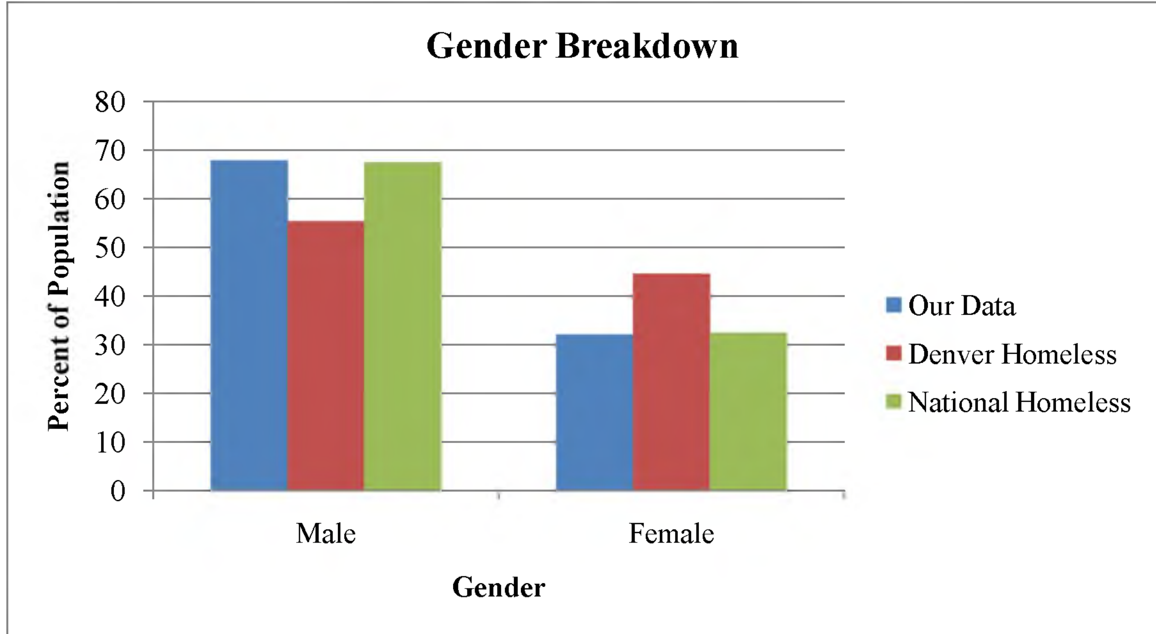
This implies that veterans are not being cared for after they leave the service, or at least not to the extent that they need. Americans have this idea that we treat veterans better than the general population, but they are obviously not getting the extra care that they need if they have higher rates of drug use and comorbidity than the general homeless population, and are at high risk of becoming homeless, and suffering from mental illness.

They need specialized care that can help to keep them from becoming homeless, as well as assistance to help them access healthcare that could assist them in overcoming health problems, mental illness, and substance abuse, all of which will simply be exacerbated by homelessness. Perhaps increasing the ease with which they can access their GI benefits would help prevent them from becoming homeless (since GI benefits often include payments, housing and medical benefits).

When comparing the demographic makeup of our population, it became clear that our respondents, in some cases, were atypical of both Denver and national trends in homelessness.

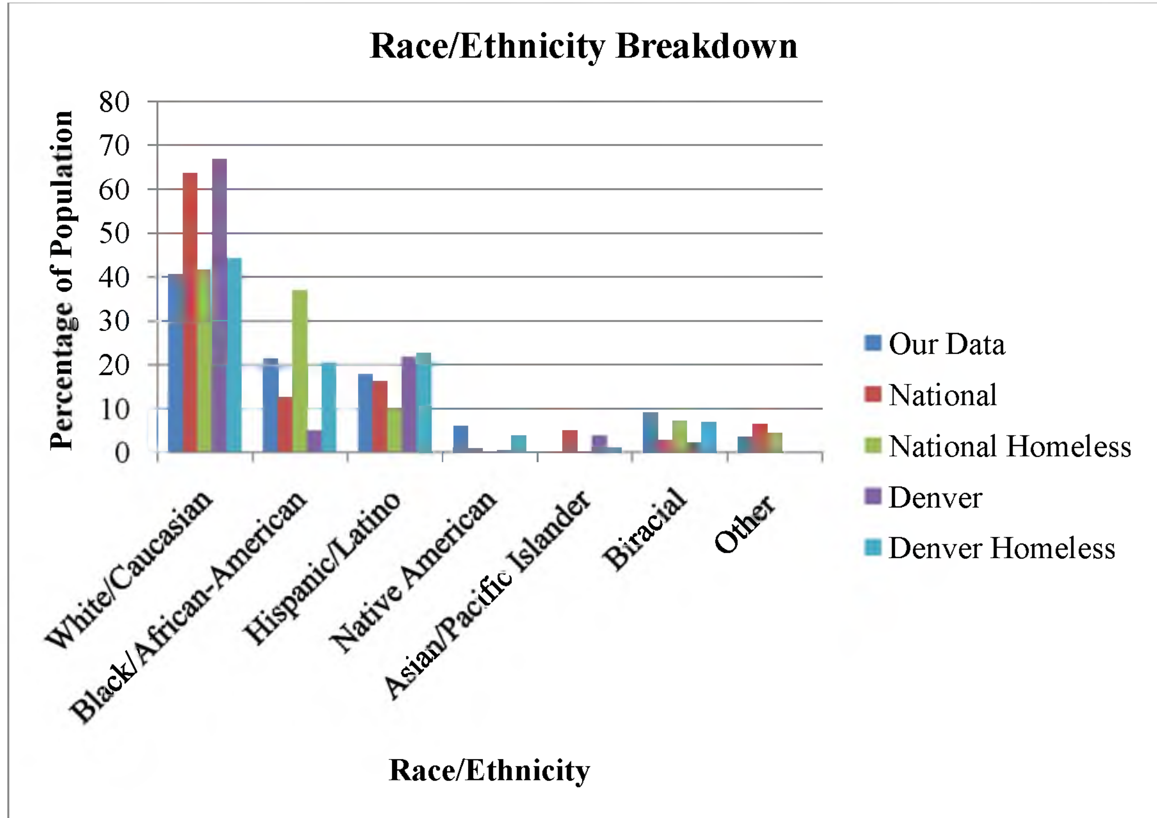
Figure I shows our gender breakdown as compared to the Denver homeless gender breakdown and national homeless gender breakdown. Where 67.9% of our respondents were male, and 32.1% were female, the Denver homeless population is 55.4% male and 44.4% female, and the national homeless population is 67.5% male and 32.5% female (Metro Denver Homeless Initiative, 2012; National Coalition for the Homeless, 2009). This is further complicated by the fact that the national population is 49.2% male and 50.8% female, and the population of Denver is estimated to be between 48.5 to 50% male, and 51.5 to 50% female (Howden & Meyer, 2011; United States Department of the Interior). This implies that our data was slightly skewed as the gender breakdown that we ended up with is vastly different from the Denver homeless and general populations. However, our data is almost exactly that of the national homeless gender breakdown, so our data may simply be more in line with national averages than with local averages.

Figure I.



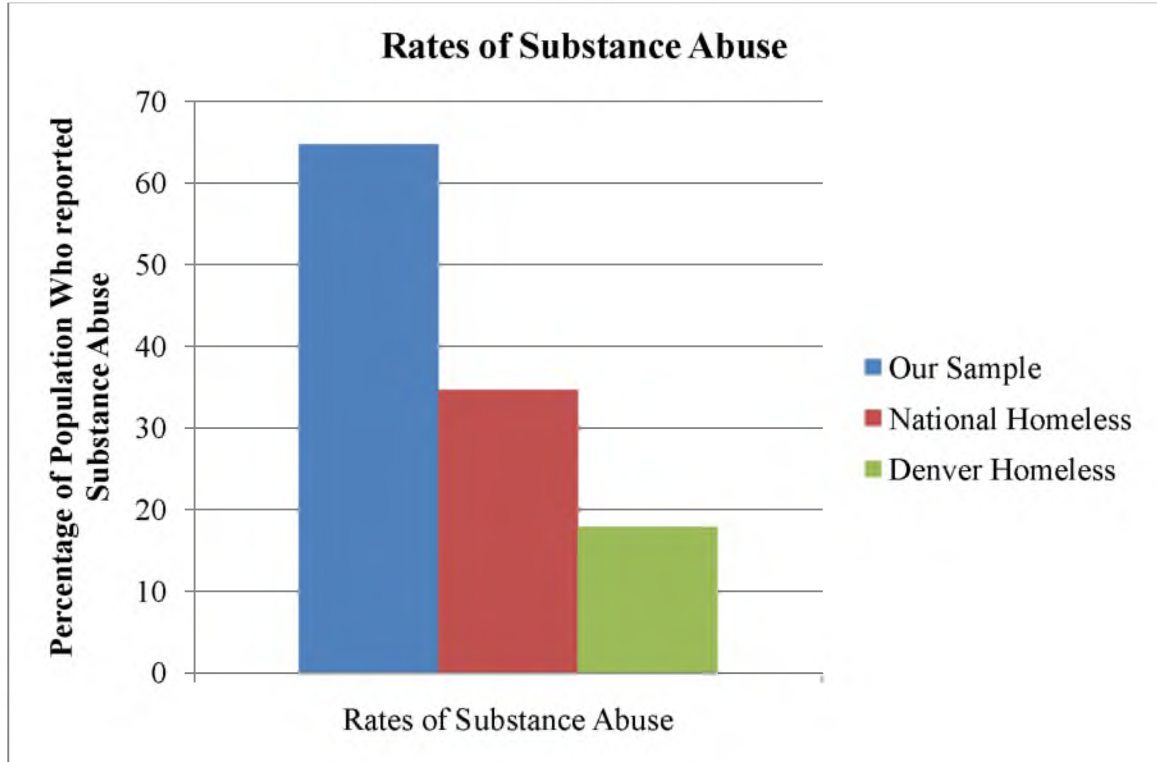
On the other hand, the racial breakdown of our participants aligned in some ways with national homeless demographics, and in others with Denver homeless demographics (Figure II). Overall, our data had vastly different racial breakdowns from national averages for both homeless and non-homeless populations, as well as from the Denver homeless population.

Figure II.



Our data collected about alcohol indicated that 34.5% of our population used alcohol, which is incredibly close to the national homeless rate of substance abuse, at 34.7% (U.S. Department of Health and Human Services, 2011), but our drug use rates, at 11.9%, are much lower than the average rate for substance abuse among the Denver homeless, which is at 17.9% (Metro Denver Homeless Initiative, 2012). Overall, our data collected about substance abuse indicated that 64.71% of our population used alcohol or drugs, which is much higher than the national homeless rate of substance abuse, at 34.7%,and more than three times as high as the average rate for substance abuse among the Denver homeless, which is at 17.9% (Figure III).

Figure III.



Similarly, our age data didn't align very well with the Denver homeless age, with 84.1% of the Denver homeless population being between 25 and 64, and 94.2% of our population being within the same age range but with our data having the same rate of participants being age 65 or older as Denver's homeless population, at 2.4% (Metro Denver Homeless Initiative, 2012). Nationally, around 10% of homeless adults are veterans, and 26.2% have mental illness, but 15.5% and 38.1% of our participants were veterans and had mental illness, respectively. (U.S. Department of Health and Human Services, 2011; Kessler et al., 2005)

These differences indicate that the population we served were perhaps more vulnerable than the national homeless population and general homeless population of Denver. The people we served were most likely the individuals who the system failed to

support adequately, and thus were not only unable to utilize to resources available to them, but their illness, mental and physical, were likely exacerbated.

The individual barriers faced by the homeless population also indicate that perhaps the American healthcare system is failing some of its citizens. Many of the reasons cited by participants of our study as to why they can't get adequate healthcare indicate a failure in the lines of communication between doctors and patients, with not being understood and not knowing how to talk to providers are two such examples. Other perceived barriers, such as feeling a lack of empathy from providers, feeling discriminated against, and previous negative experiences, indicate that homeless persons are feeling as though they are being treated differently because of their homeless status and that perhaps healthcare providers need

When more than 57% of participants say that lack of health insurance keeps them from getting the healthcare they need, and 50% say that healthcare's high prices keep them from getting adequate healthcare, I believe that it indicates that the healthcare system has its priorities twisted. Fortunately, the Patient Protection and Affordable Care Act may help quite a lot. Under the new act, people under age 65 with incomes under $15,000 a year can receive Medicaid. While it would still be difficult for those without an address to apply for the coverage, it will soon be far easier to receive it rather than being rejected. If the point of the healthcare system is to provide care rather than make a profit, then lacking health insurance should not prevent people from accessing care. Similarly, many of the other reasons participants listed for not being able to access healthcare indicate a system that is failing them, such as not being taken seriously, being discriminated against, long wait times, not being understood, and feeling a lack of

empathy from healthcare providers. The point of healthcare is to care for all people, especially those who are most vulnerable, and to help them become healthy again, but when the most vulnerable populations cannot reach the healthcare system, it means that the system is failing those groups.

Implications for Future Research and Policies

This study was one of many studies that attempt to find out if the healthcare system is failing the homeless, and if so, how. There are numerous studies regarding the healthcare needs of the homeless population, including the needs of vulnerable subgroups like youth, drug users, veterans, the mentally ill, and people with multiple illnesses. In my opinion, we do not need any more research to show how difficult it is for homeless persons to access adequate healthcare. The main problems are that there are simply not enough resources currently being distributed to homeless populations and that current resources are too difficult to access.

The barriers we researched indicate that there are three main changes that need to be made in order to decrease the barriers faced by homeless populations. The first category of barriers is that which can be remedied (and may be remedied) by the Patient Protection and Affordable Care Act (PPACA). These barriers included “lack of health insurance” and “healthcare costing too much,” which 57.1% and 50% of our population marked as preventing them from accessing adequate healthcare. Eventually, the PPACA will hopefully assist all of these people by making healthcare less expensive and offering more coverage to these people.

The second category of barriers is those which can be fixed by increasing the ease with which people can apply for Medicaid and Medicare, and by opening more low-cost clinics at which they can receive healthcare. These barriers include "lack of transportation," "long wait times at clinics," "not getting adequate care," "lack of privacy," and "having other priorities." Between 11.9% and 38.1% of our population marked these as barriers that prevented them from getting healthcare. We could increase accessibility by having the offices for Medicaid and Medicare open at different times, to begin with. Currently, their offices are only open from 8:00 am to 4:30 pm, or they can be mailed, emailed, or faxed to them, but none of these options are really feasible for homeless people. Those hours are hours in which they could be getting food or trying to make money. Also, once the applications have been filled out (which is no easy task, as the language used on the forms is often at a very high reading level), they have to bring in the application with their identification, social security number, proof of any assets they have, proof of status in the US (Such as passport or birth certificate), and proof of expenses. They also need an address, which is something that most homeless people do not have, and many people also get rejected after applying. In short, this very difficult and arduous process may not even be possible for homeless people, and they may also be discouraged from applying since they know how difficult it is to get approved. Similarly, there are not currently enough low-cost health clinics for homeless people, which leads to long wait times, a lack of privacy (because they providers are rushed), and difficulty even getting there, since many homeless people struggle with transportation.

The final type of barriers that participants in our study faced were those that could be fixed by increasing communication between healthcare providers and patients. These

perceived barriers include patients feeling like they're "not being understood," "not being taken seriously," or "being discriminated against," and also that patients feel like they "don't know how to talk to providers," they had "previous negative experiences," and they felt a "lack of empathy from providers." Between 13.1% and 22.6% of our participants marked these as barriers that prevented them from accessing adequate healthcare. The first step to increasing communication between homeless persons and healthcare providers is to educate the providers on how to interact with homeless persons. The fact that some patients feel discriminated against, feel a lack of empathy, and feel like they're not being taken seriously indicates that perhaps some healthcare providers are still holding stereotypes in mind when they treat homeless patients, and that affects the care that those patients receive. By educating doctors about the truth and dispelling stereotypes about homeless people, we may be able to lower the rates of discrimination and help raise the level of empathy that homeless patients receive. Also, since some participants indicated that they feel like they aren't being understood when they try to talk to providers and don't know how to talk to providers means that perhaps we need to help providers listen better, rather than just assuming they know what is going on and the best course of action automatically.

I also think that there are structural issues which prevent homeless people from accessing the resources available to them, such as lack of affordable housing. Since many cities, Denver included, are currently experiencing gentrification, many affordable housing areas are being replaced with higher cost housing, and since no affordable places are being built in the same area, people are ending up unable to pay their rent or mortgages, and lose their housing. When people end up without shelter, they may be

forced to decide between getting a place to sleep for the night or taking the time to go fill out forms for Medicaid that may be fruitless anyways.

All of these barriers and problems facing homeless persons ought to concern the general population. However, I think it is important to consider why we allow these problems to exist. I believe that we do not feel concern for people who are lower-class and/or homeless. We focus on helping the middle-class rise to the upper-class (even though that rarely happens) and on keeping them from falling to the lower-class. However, once somebody is lower-class we forget about them, they are already a lost cause in American eyes. This all stems from our belief of everybody pulling themselves up by their bootstraps. We believe strongly in individualism and that if anybody fails to succeed, it is simply because they're not working hard enough. This is shown in how we treat homeless people: as though they are lazy, or worthless, or not as deserving as help as other people. However, many people still claim to love others and to be generous. In my opinion, we cannot continue simply helping those groups which we consider to be more deserving than others. We need to help everybody overcome the structural causes that keep them oppressed and unable to be healthy, and that includes those people who are already lower-class and homeless.

By increasing accessibility of resources and reducing the structural causes of homelessness, we may be able to help the homeless population increases their access to healthcare, and thus, decrease both the rate of illness within homeless populations, but also the severity of illness within homeless populations. In fact, if these changes are implemented properly, we may in fact lower the rate of homelessness, since becoming ill or not being able to pay their mortgage due to high healthcare costs will no longer force

them to become homeless. Overall, by implementing the right policy changes and education, we may lower the rates of homelessness, and the mortality rate within homeless populations, which, as human beings, is what we ought to aim for.

Bibliography

Arangua, L., Andersen, R., & Gelberg, L. (2006). The health circumstances of homeless women in the United States. *International Journal of Mental Health*, *34*(2), 62-92.

Baggett, T. P., O'Connell, J. J., Singer, D. E., & Rigotti, N. A. (2010). The unmet health care needs of homeless adults: A national study. *American Journal of Public Heath*, *100*(7), 1326-1333. doi: 10.2105/AJPH.2009.180109

Cohler, L., Maran, M., Miller, D., Nathan, J., & Perris, B. (1987, March 23). The new faces of poverty; the U.S. economy is healthy, but more Americans are poor than at any time since the 1960s. Scholastic Update, 119, 6+

Daiski, I. (2007). Perspectives of homeless people on their health and health needs priorities. *Journal of Advanced Nursing*, *58*(3), 273-281.

Dietz, T. L. (2007). Predictors of Reported Current and Lifetime Substance Abuse Problems Among a National Sample of U.S. Homeless. Substance Use & Misuse, 42(11), 1745-1766. doi:10.1080/10826080701212360

Fonseca, M. L., Kizer, K. W., & Long, L. M. (1997, Fall). The veterans healthcare system: preparing for the twenty-first century. Hospital & Health Services Administration, 42(3), 283+.

Hill, R. P. (1991, June). Health care and the homeless: a marketing-oriented approach. Journal of Health Care Marketing, 11(2), 14+

Howden, L., & Meyer, J. U.S. Department of Commerce, Economics and Statistics Administration: U.S. Census Bureau. (2011). *Age and sex composition: 2010*. Retrieved from website: http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf

Hudson, A. L., Nyamathi, A., & Sweat, J. (2008). Homeless youths' interpersonal perspectives of health care providers. *Issues in Mental Health Nursing*, (29), 1277- 1289. doi: 10.1080/01612840802498235

Humes, K., Jones, N., & Ramirez, R. U.S. Department of Commerce, Economics and Statistics Administration: U.S. Census Bureau. (2011).*Overview of race and hispanic origin: 2010*. Retrieved from website: http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf

Hwang, S. W., Ueng, J. J. M., Chiu, S., Kiss, A., Tolomiczenko, G., Cowan, L., Levinson, W., & Redelmeier, D. A. (2010). Universal health insurance and health care access for homeless persons. *American Journal of Public Heath,100*(8), 1454-1461. doi: 10.2105/AJPH.2009.182022

John, W., & Law, K. (1990). Addressing the health needs of the homeless. *The Journal Of Practical Nursing,40*(3), 134-139.

Kerker, B. D., Bainbridge, J., Kennedy, J., Bennani, Y., Agerton, T., Marder, D., Forgione, L., Faciano, A., & Thorpe, L.E., (2011). A population-based assessment of the health of homeless families in New York City, 2011-2003. *American Journal of Public Heath*, *101*(3), 546-553. doi: 10.2105/AJPH.2010.193102

Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 2005 Jun;62(6):617-27.

Lynch, P. (2005). Homelessness, poverty and discrimination: Improving public health by realising human rights. *Deakin Law Review*, *10*(1), 233-259.

Marshall, J. (1998). Dual diagnosis: co-morbidity of sever metal illness and substance misuse. Journal Of Forensic Psychiatry, 9(1), 9.

Metro Denver Homeless Initiative. (2012). Homelessness in the Denver metropolitan area: 2012 homeless point-in-time study. Retrieved from http://mdhi.org/wp-content/uploads/2012/05/2012-Point-in-Time-Report.pdf

Muñoz, M., Crespo, M., & Pérez-Santos, E. (2006). Homelessness effects on men's and women's health. *International Journal of Mental Health*, *34*(2), 47-61.

National Coalition for the Homeless. (2009, July). *Who is homeless?*. Retrieved from http://www.nationalhomeless.org/factsheets/who.html

Nickasch, B., & Marnocha, S. K. (2009). Healthcare experiences of the homeless. *Journal of American Academy of Nurse Practicioners*, *21*(1), 39-46. doi: 10.1111/j.1745-7599.2008.00371

Quimby, E. (1995, Summer). Homeless clients' perspectives on recovery in the Washington, DC, dual diagnosis project. Contemporary Drug Problems, 22(2), 265-289.

Savage, C. L., Lindsell, C. J., Gillespie, G. L., Dempsey, A., Lee, R. J., & Corbin, A. (2006). Health care needs of homeless adults at a nurse-managed clinic. *Journal of Community Health Nursing*, *23*(4), 225-234. doi: 10.1111/j.1365-2524.2007.00758.

Schanzer, B., Dominguez, B., Shrout, P. E., & Caton, C. L. M. (2007). Homelessness, health status, and health care use. *American Journal of Public Heath*, *97*(3), 464-469. doi: 10.2105/AJPH.2005.076190

Segal, S. P., Gomory, T., & Silverman, C. J. (1998). Health status of homeless and marginally housed users of mental health self-help agencies. Health & Social Work, 23(1), 45-52.

Toro, P. A., & Bellavia, C. W. (1997). Evaluating an intervention for homeless persons: Results of a field experiment. Journal Of Consulting & Clinical Psychology, 65(3), 476.

Tsai, J., Mares, A. S., & Rosenheck, R. A. (2012). Do Homeless Veterans Have the Same Needs and Outcomes as Non-Veterans?. Military Medicine, 177(1), 27-31.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2011). *Current statistics on the prevalence and characteristics of people experiencing homelessness in the united states*. Retrieved from website: http://homeless.samhsa.gov/ResourceFiles/hrc_factsheet.pdf

U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2012). The 2012 Point-in-time estimates of homelessness.

Retrieved from website:
https://onecpd.info/resources/documents/2012AHAR_PITestimates.pdf

United States Department of the Interior, (n.d.). *National atlas of the United States*. Retrieved from website: http://nationalatlas.gov/mapmaker?AppCmd=CUSTOM&LayerList=mtof00&visCats=CAT-people.CAT-population

Van Leeuwen, J. M., Boyle, S., Salomonsen-Sautel, S., Baker, D. N., Garcia, J. T., Hoffman, A., & Hopfer, C. J. (2006). Lesbian, gay and bisexual homeless youth: An eight-city public health perspective. *Child Welfare*, *85*(2), 151-170.

Wen, C. K., Hudak, P. L., & Hwang, S. W. (2007). Homeless people's perceptions of welcomeness and unwelcomeness in healthcare encounters. *Journal of General Internal Medicine*, *22*(7), 1011-1017. doi: 10.1007/s11606-007-0183-7

Woollcott, M. (2008). Access to primary care services for homeless mentally ill people. Nursing Standard, 22(35), 40-44.

Appendix A

Project Homeless Connect Survey: Barriers to Health Care

Race/ethnicity:
- Caucasian or White (not Hispanic or Latino)
- African-American or Black
- Hispanic, Latino or of Spanish Origin
- Native American or Alaskan Native
- Asian
- Pacific Islander
- Arab
- Biracial or Mixed-race
- Other: ______________________

Gender:
- Male
- Female
- Genderqueer/Genderfluid
- Other: ______________________

Are you employed?
- Yes
- No

If so, how many hours do you work per week?
- 0-9
- 10-19
- 20-29
- 30-39
- 40+

Have you ever served in the military?
- Yes
- No

Have you ever felt uncomfortable or unable to go to a health care provider (nurse practitioner, doctor, nurse, hospital, clinic)?
- Yes
- No

Have you ever felt uncomfortable or unable to go to a mental health care provider (counselor, nurse, nurse practitioner, doctor, hospital, clinic)?
- Yes
- No

What do you see as the reasons keeping you from getting the medical or mental health care you need? Check as many as apply, if any.

- Don't have health insurance
- Costs too much
- Long wait times
- Not able to get there
- No privacy
- Other things were more important to you (please list what___________________________).
- Previous bad experiences
- Health care providers unable/unwilling to empathize
- Health care providers not taking you seriously
- Feeling discriminated against
- Not getting the care you need
- Not being understood
- Don't know how to talk to them
- You are healthy – don't need to go
- Other things not included in this list (please list below)

Appendix B:

PROJECT HOMELESS CONNECT MEDICAL SCREENING QUESTIONAIRE
REGIS UNIVERSITY

Please complete at Medical Screening Station			Date:
First Name:	Age:	Gender: Male Female	
Preferred Language		Do you have children to be seen? YES	
NO			
Reason you want to be seen today:			

Question
Answer: Check all that apply

Do you have any of the following health concerns?

- Diabetes
- Heart disease
- High blood pressure
- Stroke
- Asthma
- Dental/Teeth
- Neurologic condition
- Surgery
- GYN conditions
- COPD or other lung conditions
- Blood clots
- Vision/eyes
- Infections
- Wounds
- Stomach problems (constipation or diarrhea)
- Cancer
- Liver or kidney

For your children: do you have any concerns about their walking, talking or eating?

- Yes : walking talking eating going to the bathroom other
- No

Medications: Which medications are you supposed to be taking? Which do you take?

- Blood pressure
- Pain medicine
- Heart Disease
- Thyroid medicine
- Insulin
- Antibiotics
- Others:

Do you smoke/use tobacco: cigarettes, cigars, pipes, chewable tobacco?

- Yes details: number/day ___ how many years?____
- No, ex smoker details: years or months non smoking
- No, never smoked

Do you use street drugs?

- Which ones?
- How often?
- How much?

Do you drink alcohol?

- No, never
- Yes details: How often?
- How much?
- How long have you been drinking?

Nutrition questions

- Lost or gained more than 10 lbs in last 6 months?
- Number of meals/day ______

Do you have any muscle or joint pain?

- Low back
- Neck
- Shoulder/hand
- Hip/knee/ankle/foot
- Assistive device? Cane crutches wheelchair

Mental health: Would you like to see a counselor?
Yes No

Have you been told you have a mental health problem?

- Which one?

Have you taken medication for this problem?
Yes No

- Stress
- Anxiety
- Depression
- Other, specify:

Current Medication:

Do you need medication? Yes No
Relationships: Do you feel safe in your current relationships? Yes No
Health / Vital Signs Screenings: Height/Weight BMI BP Glucose Heart rate TEMP RR SaO2 Recommended Stations: (circle desired stations) Nurse Practitioner/physical exam skin/wound nurse Physical Therapy Vision Counselor Dental Health Education Child Developmental Screening Vital Signs (Health) Screening

Appendix C:

Written information about the survey/study:

Hello, you are being asked to complete a survey and a health information record. The information you give us will help us understand how to improve the health section of Project Homeless Connect and also general health care for you and other people who are homeless. You may choose not to complete the survey, or to stop at any time, and your care here will not be affected. The health information record helps us give you the care you need today. All information that you give on the surveys is confidential, and we will not keep any personal identifying information for these surveys. The study investigators are MaryJo Coast and Cris Finn, and they, as well as the person asking you to complete the survey are available today if you have questions. Just ask any of the health care area workers. Thank you.

Appendix D:

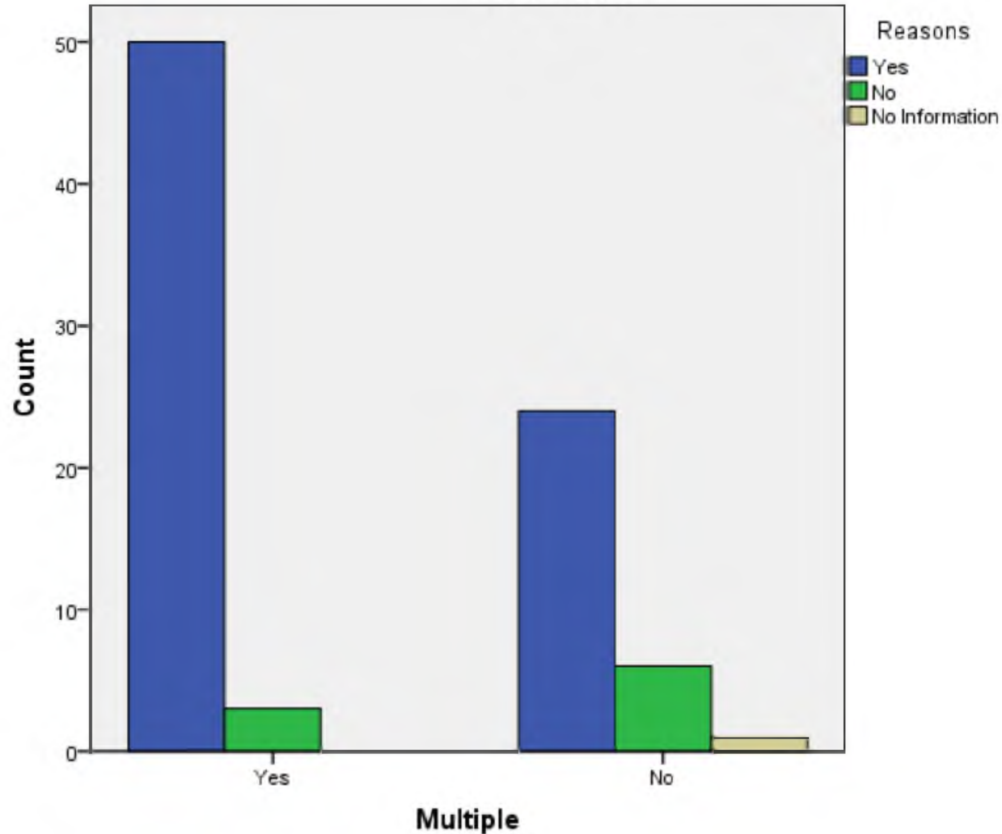
Crosstabulations, Frequency Tables and Figures

Crosstabs

Multiple * Reasons Crosstabulation

Count

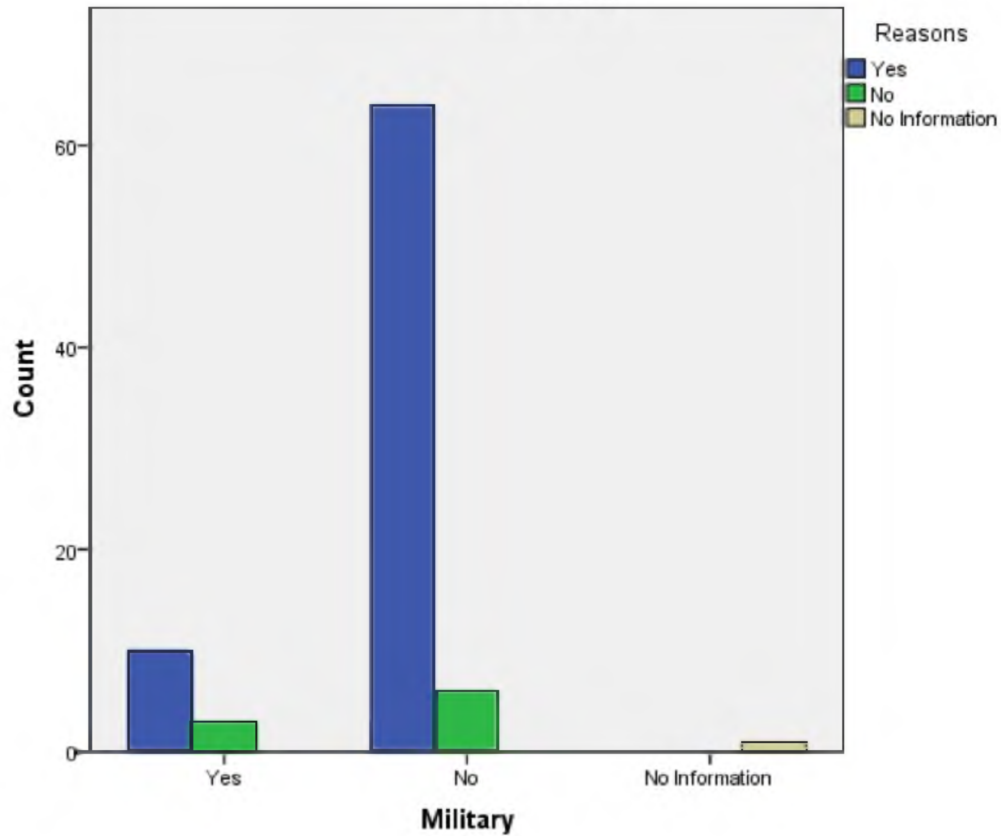
		Reasons			Total
		Yes	No	No Information	
Multiple	Yes	50	3	0	53
	No	24	6	1	31
Total		74	9	1	84



Military * Reasons Crosstabulation

Count

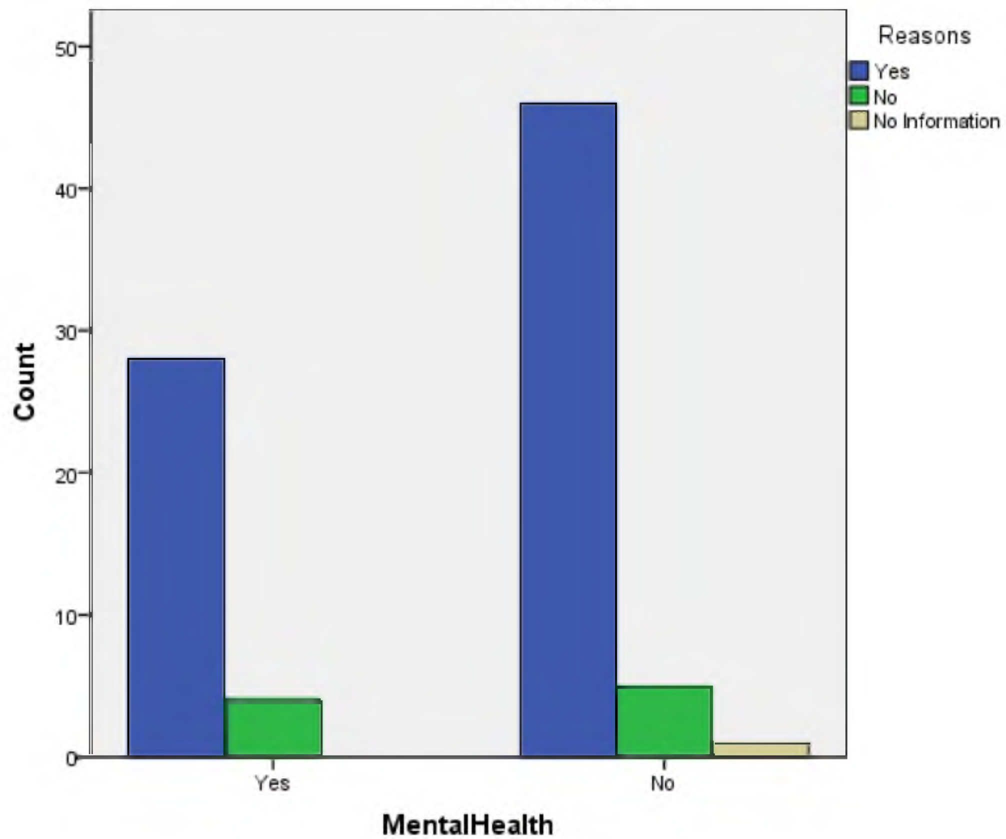
		Reasons			Total
		Yes	No	No Information	
Military	Yes	10	3	0	13
	No	64	6	0	70
	No Information	0	0	1	1
Total		74	9	1	84



MentalHealth * Reasons Crosstabulation

Count

		Reasons			Total
		Yes	No	No Information	
MentalHealth	Yes	28	4	0	32
	No	46	5	1	52
Total		74	9	1	84

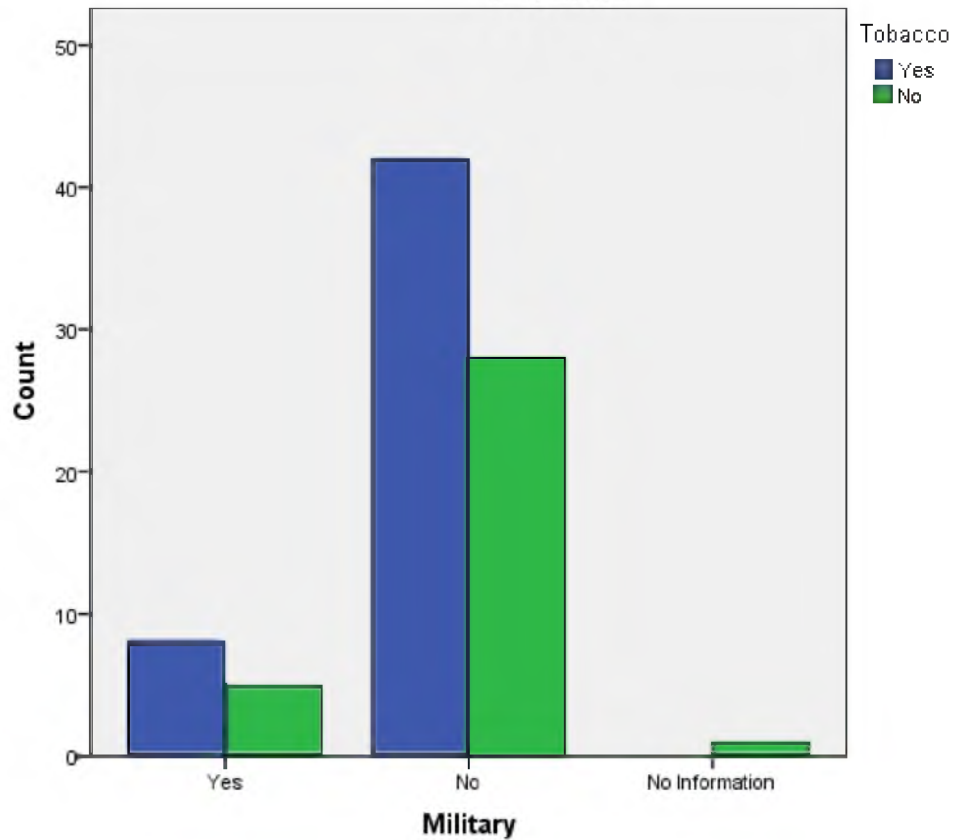


Crosstabs

Military * Tobacco Crosstabulation

Count

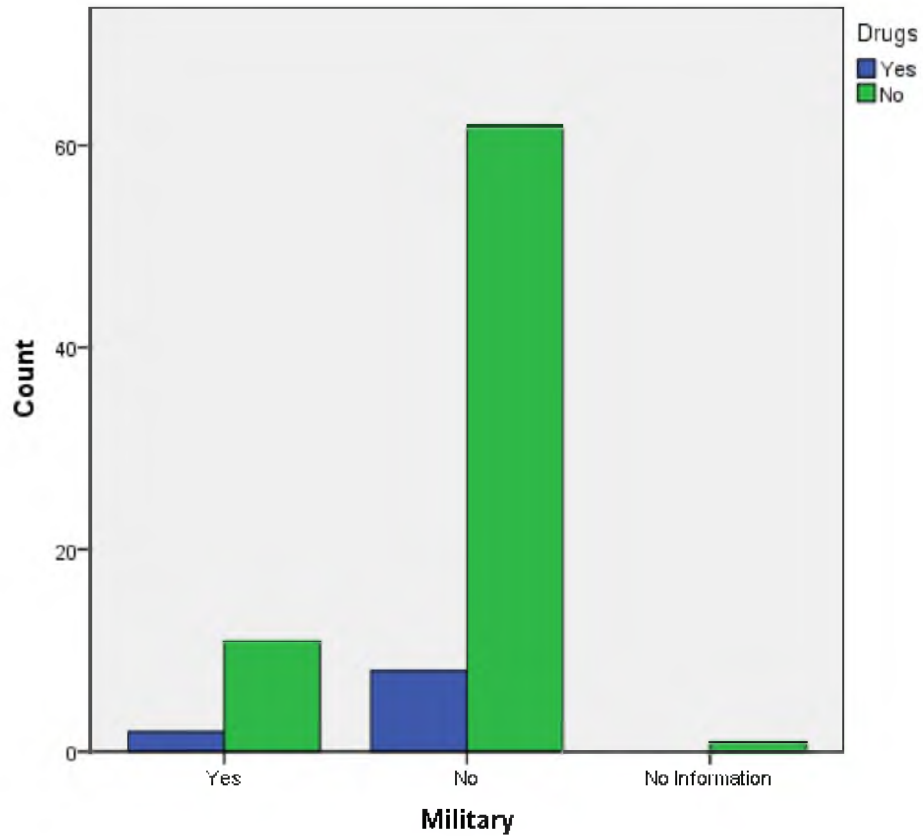
		Tobacco		Total
		Yes	No	
Military	Yes	8	5	13
	No	42	28	70
	No Information	0	1	1
Total		50	34	84



Military * Drugs Crosstabulation

Count

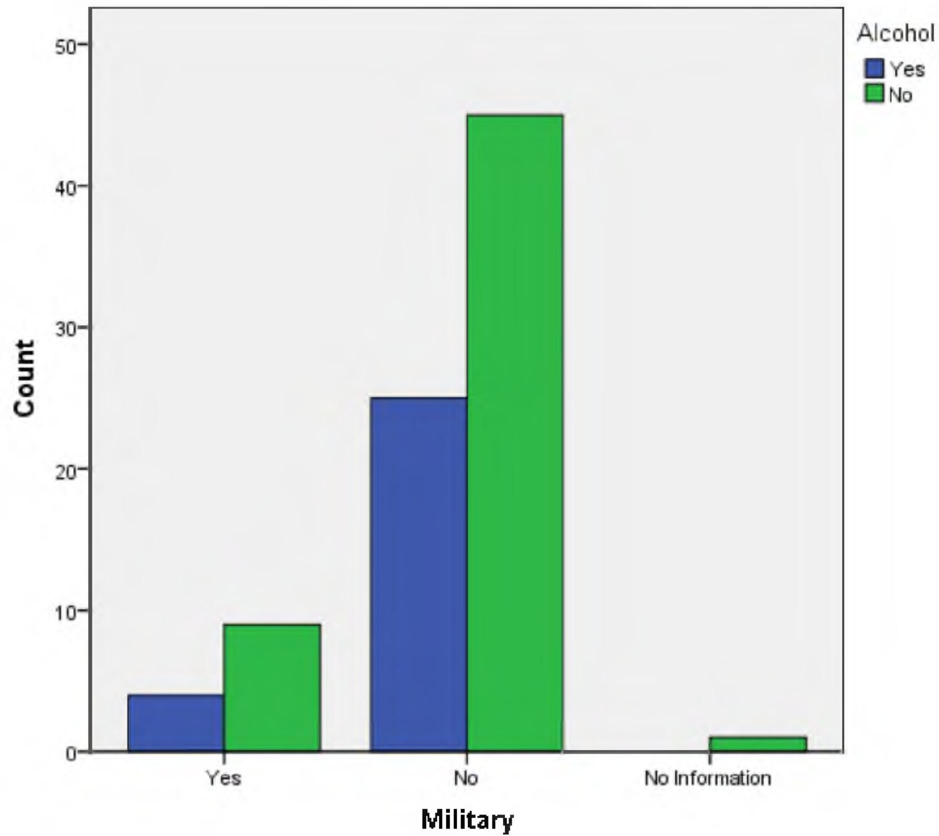
		Drugs		Total
		Yes	No	
Military	Yes	2	11	13
	No	8	62	70
	No Information	0	1	1
Total		10	74	84



Military * Alcohol Crosstabulation

Count

		Alcohol		Total
		Yes	No	
Military	Yes	4	9	13
	No	25	45	70
	No Information	0	1	1
Total		29	55	84



Frequencies

Frequency Table

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18-24	2	2.4	2.4	2.4
	25-29	5	6.0	6.0	8.3
	30-34	9	10.7	10.7	19.0
	35-39	6	7.1	7.1	26.2
	40-44	10	11.9	11.9	38.1
	45-49	16	19.0	19.0	57.1
	50-54	15	17.9	17.9	75.0
	55-59	12	14.3	14.3	89.3
	60-64	6	7.1	7.1	96.4
	65+	2	2.4	2.4	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	57	67.9	67.9	67.9
	Female	27	32.1	32.1	100.0
	Total	84	100.0	100.0	

Language

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	English	82	97.6	97.6	97.6
	Spanish	2	2.4	2.4	100.0
	Total	84	100.0	100.0	

Diabetes

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	14	16.7	16.7	16.7
	No	70	83.3	83.3	100.0
	Total	84	100.0	100.0	

HeartDisease

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	5	6.0	6.0	6.0
	No	79	94.0	94.0	100.0
	Total	84	100.0	100.0	

HighBloodPressure

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	22	26.2	26.2	26.2
	No	62	73.8	73.8	100.0
	Total	84	100.0	100.0	

Stroke

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	6	7.1	7.1	7.1
	No	78	92.9	92.9	100.0
	Total	84	100.0	100.0	

Asthma

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	15	17.9	17.9	17.9
	No	69	82.1	82.1	100.0
	Total	84	100.0	100.0	

Dental

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	34	40.5	40.5	40.5
	No	50	59.5	59.5	100.0
	Total	84	100.0	100.0	

Neurologic

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	17	20.2	20.2	20.2
	No	67	79.8	79.8	100.0
	Total	84	100.0	100.0	

Surgery

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	19	22.6	22.6	22.6
	No	65	77.4	77.4	100.0
	Total	84	100.0	100.0	

GYN

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	4	4.8	4.8	4.8
	No	80	95.2	95.2	100.0
	Total	84	100.0	100.0	

Lungs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	5	6.0	6.0	6.0
	No	79	94.0	94.0	100.0
	Total	84	100.0	100.0	

BloodClots

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	2	2.4	2.4	2.4
	No	82	97.6	97.6	100.0
	Total	84	100.0	100.0	

Eyes

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	46	54.8	54.8	54.8
	No	38	45.2	45.2	100.0
	Total	84	100.0	100.0	

Infections

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	2	2.4	2.4	2.4
	No	82	97.6	97.6	100.0
	Total	84	100.0	100.0	

Wounds

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	5	6.0	6.0	6.0
	No	79	94.0	94.0	100.0
	Total	84	100.0	100.0	

Stomach

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	13	15.5	15.5	15.5
	No	71	84.5	84.5	100.0
	Total	84	100.0	100.0	

Cancer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	2	2.4	2.4	2.4
	No	82	97.6	97.6	100.0
	Total	84	100.0	100.0	

LiverKidney

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	13	15.5	15.5	15.5
	No	71	84.5	84.5	100.0
	Total	84	100.0	100.0	

Meds

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	48	57.1	57.1	57.1
	No	36	42.9	42.9	100.0
	Total	84	100.0	100.0	

BloodPressure

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	16	19.0	19.0	19.0
	No	68	81.0	81.0	100.0
	Total	84	100.0	100.0	

HeartDiseaseMeds

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	2	2.4	2.4	2.4
	No	82	97.6	97.6	100.0
	Total	84	100.0	100.0	

Insulin

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	4	4.8	4.8	4.8
	No	80	95.2	95.2	100.0
	Total	84	100.0	100.0	

Multiple

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	53	63.1	63.1	63.1
	No	31	36.9	36.9	100.0
	Total	84	100.0	100.0	

Tobacco

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	50	59.5	59.5	59.5
	No	34	40.5	40.5	100.0
	Total	84	100.0	100.0	

Drugs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	10	11.9	11.9	11.9
	No	74	88.1	88.1	100.0
	Total	84	100.0	100.0	

Alcohol

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	29	34.5	34.5	34.5
	No	55	65.5	65.5	100.0
	Total	84	100.0	100.0	

MentalHealth

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	32	38.1	38.1	38.1
	No	52	61.9	61.9	100.0
	Total	84	100.0	100.0	

RaceEthnicity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	White	34	40.5	40.5	40.5
	Black	18	21.4	21.4	61.9
	Latino	15	17.9	17.9	79.8
	Native American	5	6.0	6.0	85.7
	Biracial or Mixed	8	9.5	9.5	95.2
	Other	3	3.6	3.6	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

Employed

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Applicable	69	82.1	82.1	82.1
	0-9	4	4.8	4.8	86.9
	10-19	4	4.8	4.8	91.7
	20-29	3	3.6	3.6	95.2
	30-39	2	2.4	2.4	97.6
	40+	1	1.2	1.2	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

Military

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	13	15.5	15.5	15.5
	No	70	83.3	83.3	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

Reasons

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	74	88.1	88.1	88.1
	No	9	10.7	10.7	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

NoInsurance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	48	57.1	57.1	57.1
	No	35	41.7	41.7	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

CostTooMuch

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	42	50.0	50.0	50.0
	No	41	48.8	48.8	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

LongWait

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	30	35.7	35.7	35.7
	No	52	61.9	61.9	97.6
	11.00	1	1.2	1.2	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

GettingThere

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	32	38.1	38.1	38.1
	No	51	60.7	60.7	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

Privacy

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	10	11.9	11.9	11.9
	No	73	86.9	86.9	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

OtherPriorities

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	10	11.9	11.9	11.9
	No	73	86.9	86.9	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

BadExperiences

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	16	19.0	19.0	19.0
	No	67	79.8	79.8	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

Empathy

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	15	17.9	17.9	17.9
	No	67	79.8	79.8	97.6
	11.00	1	1.2	1.2	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

NotTakingSeriously

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	24	28.6	28.6	28.6
	No	59	70.2	70.2	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

Discrimination

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	11	13.1	13.1	13.1
	No	72	85.7	85.7	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

NotGettingCare

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	23	27.4	27.4	27.4
	No	60	71.4	71.4	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

NotUnderstood

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	19	22.6	22.6	22.6
	No	64	76.2	76.2	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

CantTalk

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	17	20.2	20.2	20.2
	No	66	78.6	78.6	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

Healthy

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	11	13.1	13.1	13.1
	No	72	85.7	85.7	98.8
	No Information	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		78	92.9	92.9	92.9
	doctor won't prescribe medicine they want	1	1.2	1.2	94.0
	doesn't have ID	1	1.2	1.2	95.2
	Gets care except dental	1	1.2	1.2	96.4
	needs help locating office and scheduling appointments	1	1.2	1.2	97.6
	Unable to get a doctor, feels the system is working against him	1	1.2	1.2	98.8
	Willing to accept more risks to longterm health for daily needs	1	1.2	1.2	100.0

Other

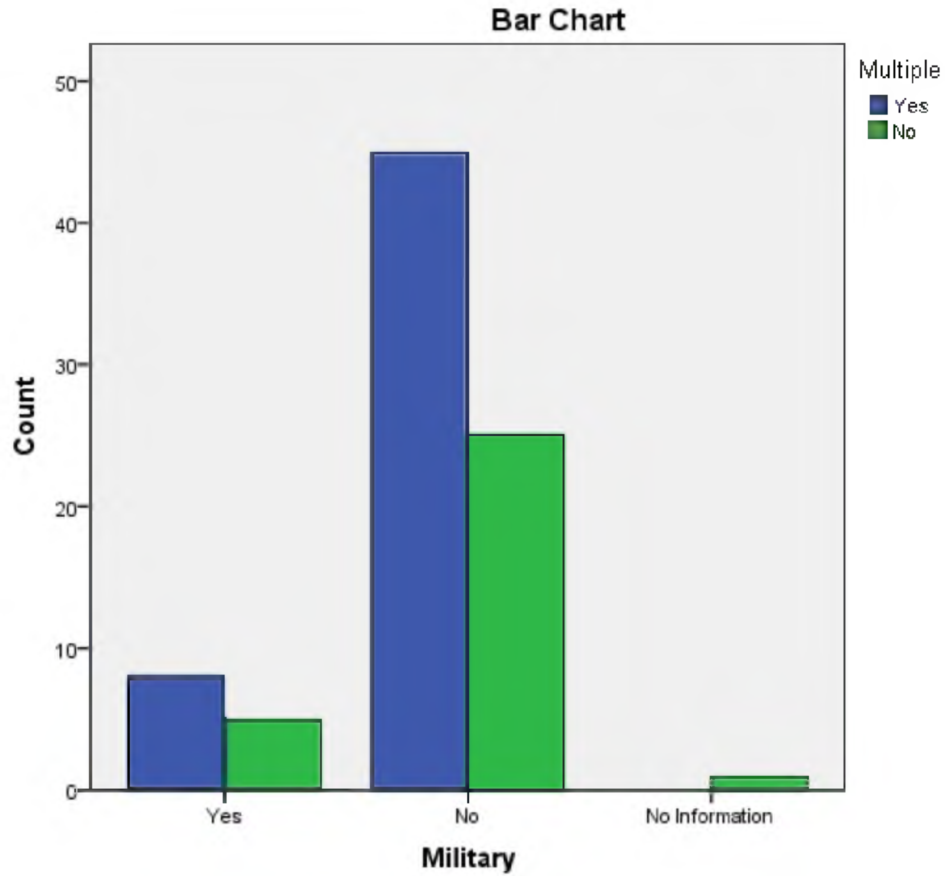
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		78	92.9	92.9	92.9
	doctor won't prescribe medicine they want	1	1.2	1.2	94.0
	doesn't have ID	1	1.2	1.2	95.2
	Gets care except dental	1	1.2	1.2	96.4
	needs help locating office and scheduling appointments	1	1.2	1.2	97.6
	Unable to get a doctor, feels the system is working against him	1	1.2	1.2	98.8
	Willing to accept more risks to longterm health for daily needs	1	1.2	1.2	100.0
	Total	84	100.0	100.0	

Crosstabs

Military * Multiple Crosstabulation

Count

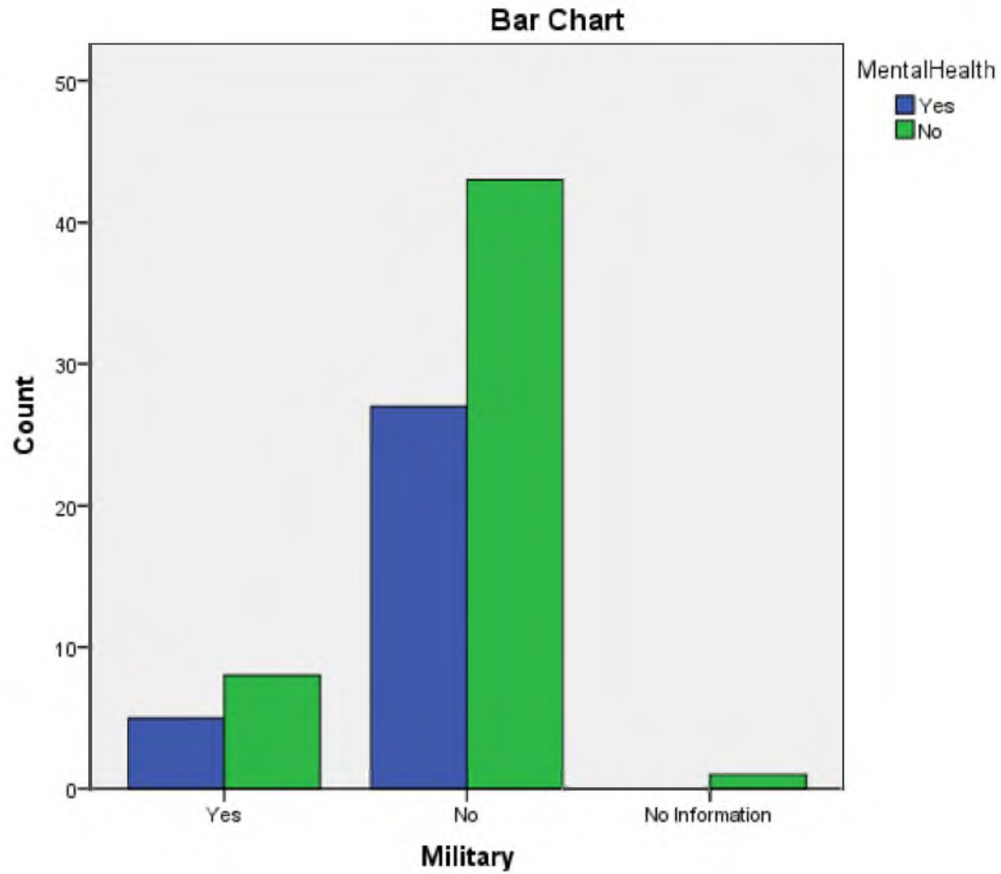
		Multiple		Total
		Yes	No	
Military	Yes	8	5	13
	No	45	25	70
	No Information	0	1	1
Total		53	31	84



Military * MentalHealth Crosstabulation

Count

		MentalHealth		Total
		Yes	No	
Military	Yes	5	8	13
	No	27	43	70
	No Information	0	1	1
Total		32	52	84

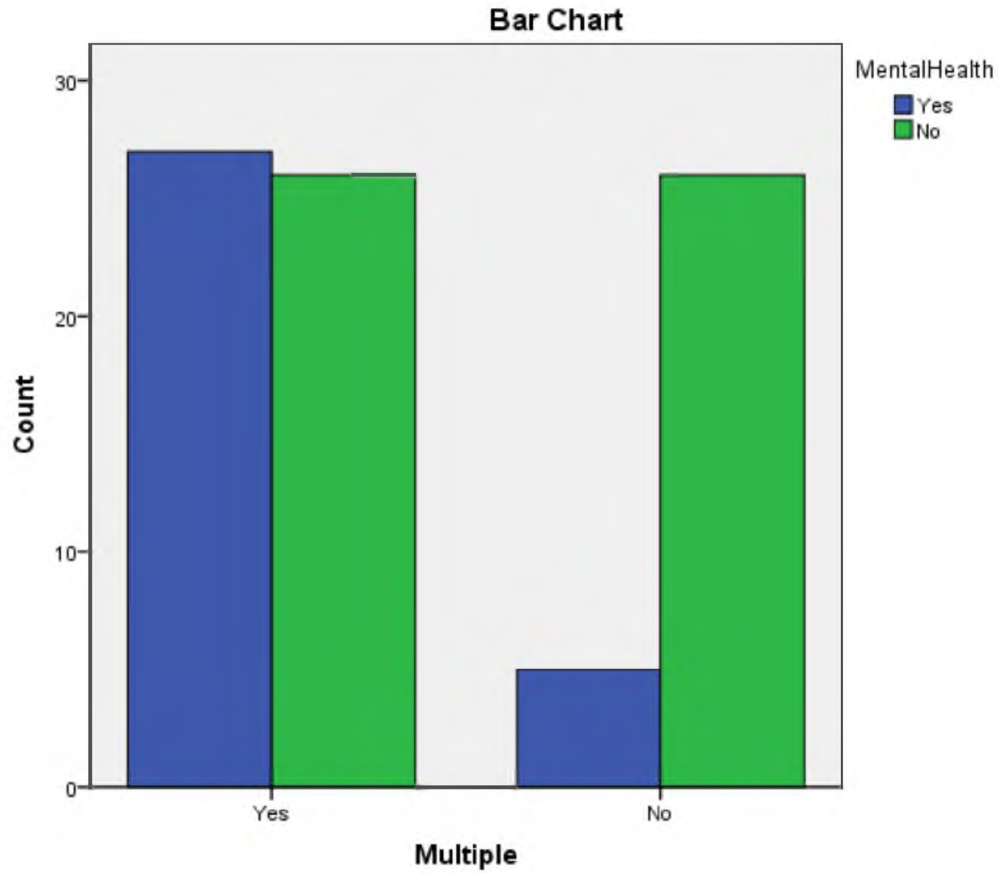


Crosstabs

Multiple * MentalHealth Crosstabulation

Count

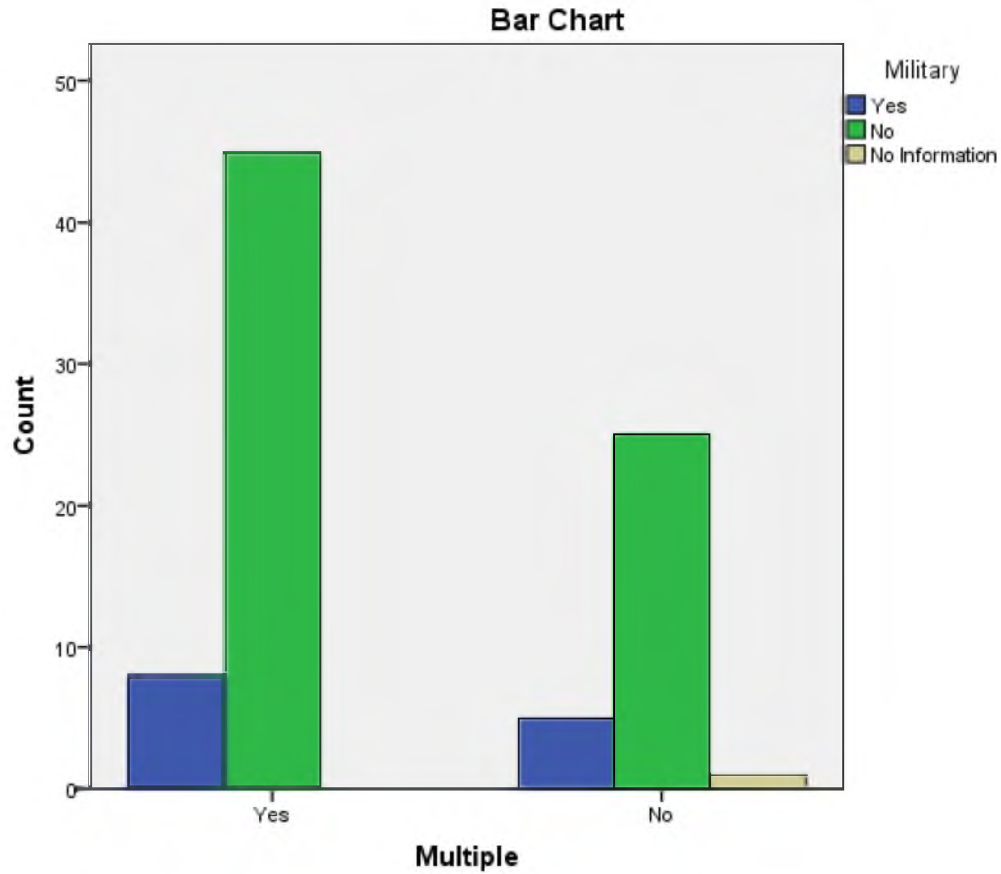
		MentalHealth		Total
		Yes	No	
Multiple	Yes	27	26	53
	No	5	26	31
Total		32	52	84



Multiple * Military Crosstabulation

Count

		Military			Total
		Yes	No	No Information	
Multiple	Yes	8	45	0	53
	No	5	25	1	31
Total		13	70	1	84

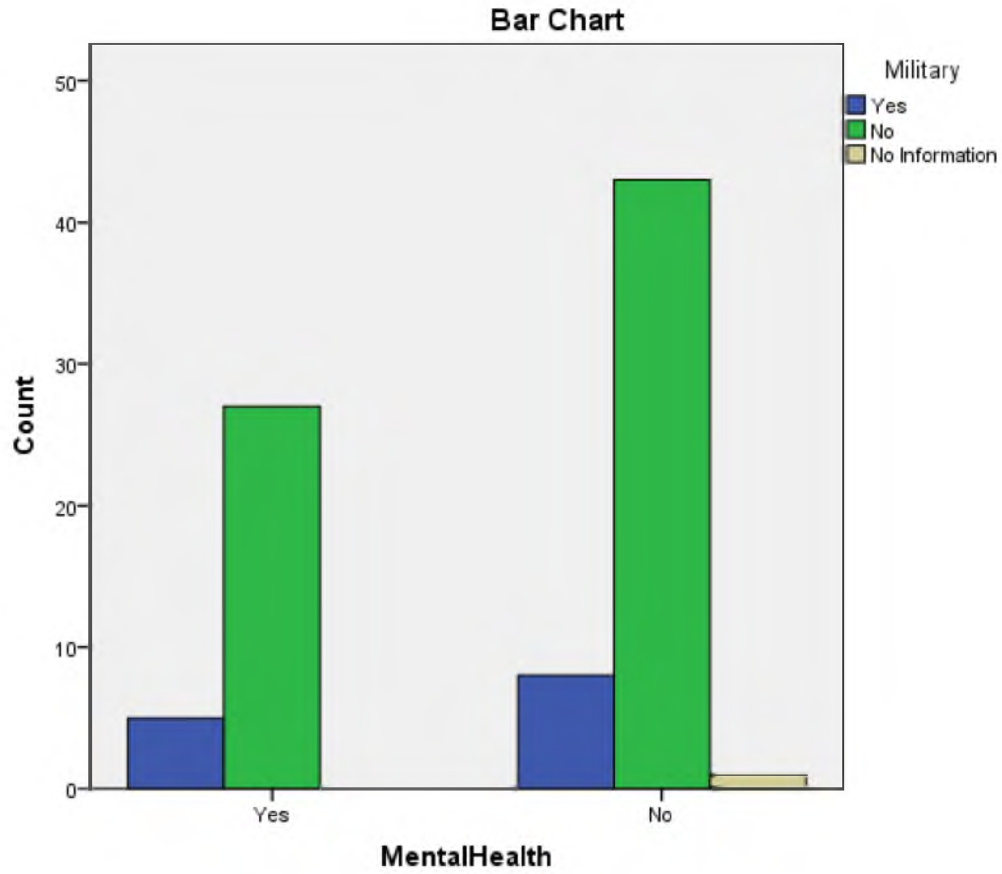


Crosstabs

MentalHealth * Military Crosstabulation

Count

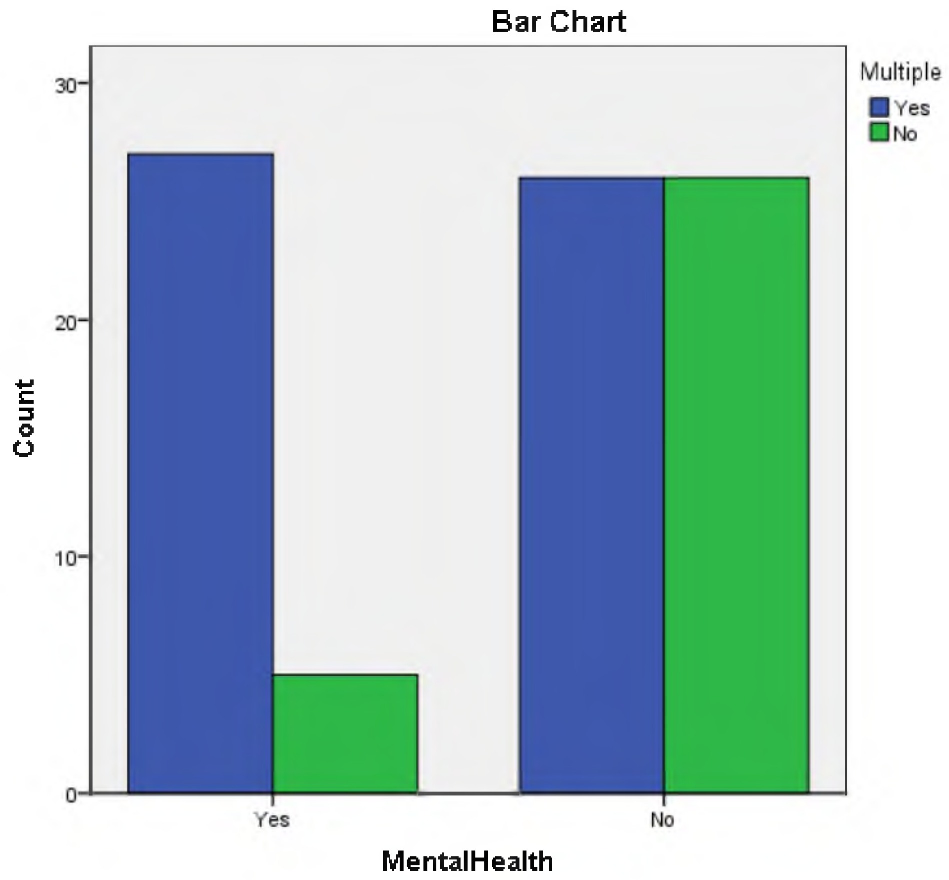
		Military			Total
		Yes	No	No Information	
MentalHealth	Yes	5	27	0	32
	No	8	43	1	52
Total		13	70	1	84

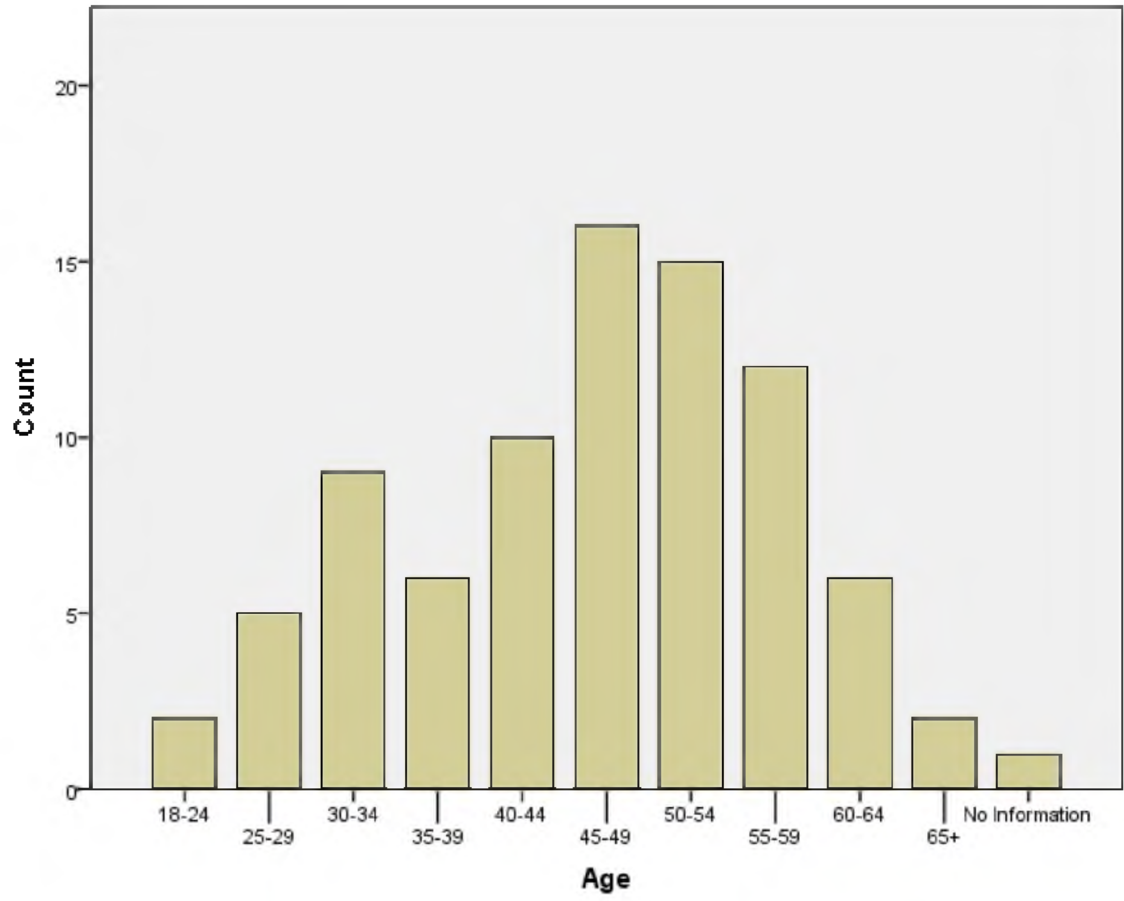


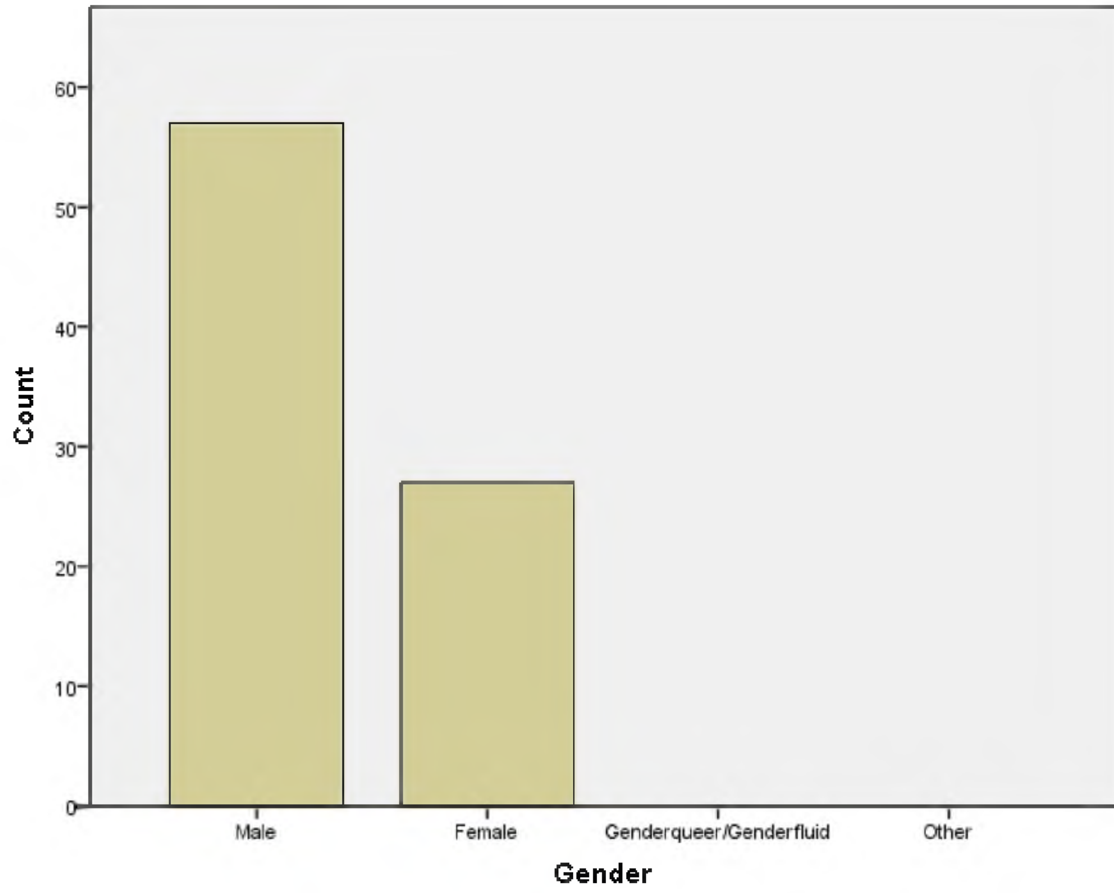
MentalHealth * Multiple Crosstabulation

Count

		Multiple		Total
		Yes	No	
MentalHealth	Yes	27	5	32
	No	26	26	52
Total		53	31	84


Bar Chart
Multiple
Yes
No
30
20
10
0
Count
Yes
No
MentalHealth


20
15
10
5
0
Count
18-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65+
No Information
Age


60
50
40
30
20
10
0
Count
Male
Female
Genderqueer/Genderfluid
Other
Gender