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Exploring ways to improve healthcare access for the homeless population in Merced County

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ABSTRACT

Homelessness is a societal dilemma that affects people in the United States and around the globe. Homelessness relates to poor health conditions that affect the living conditions of individuals (Institute for Urban Initiatives, 2018). Chronic and acute illnesses are rampant in this group, most of these illnesses are treatable but accessing healthcare poses a challenge for this vulnerable population. Homeless persons are often unable to access healthcare due to fear and denial of ill health, difficulty in communicating health needs, and low self-esteem (Lamb & Joels, 2014).

In the study, questionnaires were administered to 25 homeless individuals through random sampling. From the study, homelessness is still a big problem in Merced County with a substantial impact and distresses on a considerable number of individuals. Healthcare systems should find ways to help homeless individuals improve access to better medical services, acquire insurance coverage, and live hygienically by observing every aspect of healthy living. Although the healthcare system has tried to meet the individual's needs, satisfactory levels are low.

A long-term solution like housing facilities for the homeless population is the best way to tackle this threat. Permanent housing will remove the individuals from the streets which will, in turn, avoid their health vulnerabilities. It is worth noting that harsh environmental conditions like cold and psychological fear encourages the homeless individuals to use drugs that make them numb to the reality.

Keywords: Homeless, healthcare, vulnerable

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Exploring ways to improve healthcare access for the homeless population in Merced County

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CHAPTER 1: INTRODUCTION

1.1: Background

Homelessness is a major social problem with substantial implications for physical and mental health. Homelessness is the inability to possess permanent accommodation for a period. It is the description of people that sleep in cars, parks, train stations, behind dumpsters, and camping grounds (Lambs & Joels, 2014). Homelessness is a challenge in California and the United States at large. There are several government initiatives to reduce numbers of individuals considered homeless but with little success. In 2016, over 118,000 individuals were homeless in California alone, which constitutes 22% of the nation's homeless population (California Department of Housing and Community Development). In Merced County, there is a 13.3% rise observed for homeless individuals from 2017 to January 2018. About 514 adults and children are homeless or displaced (Institute of Urban initiative, 2018). Accessing healthcare poses a challenge for the homeless population that struggles daily with basic human needs like food, clothing, and a comfortable area to sleep. Homelessness is a precursor to chronic and acute illness like hypertension, Diabetes Mellitus, hypothermia, anemia, alcoholism, substance abuse, tuberculosis, and pediculosis (Lambs & Joels, 2014). Most of these illnesses are treatable but accessing healthcare poses a challenge

1.2: Problem Statement

In a single night in January 2018, approximately 552,830 individuals were homeless in the United States, and 24% of those individuals reside in California (USDHUD, 2018).

In comparison to other states, California has the highest rate of individuals experiencing homelessness (approximately 50 or more people experiencing homelessness per 10,000 individuals) 129,972 individuals are considered homeless, and 89,543 are unsheltered (USDHUD, 2018). Life expectancy of homeless individuals is significantly lower compared to the national average of those that are considered non-homeless. As earlier stated, Merced County has experienced a 13.3% increase in homeless cases between 2017 and 2018. Homeless individuals lack access to healthcare due to other challenges they face daily like lack of food, clothing, and a comfortable dry area to sleep.

According to a study by Fryling et al. (2015), homeless individuals have a higher disease burden and an average life expectancy of about 41-47 years compared to a national average of 78 years among those with stable accommodations. Exploring a way to bridge healthcare gap among the homeless population in Merced County will not only improve access to healthcare but will reduce healthcare cost, reduce emergency department recidivism, improve quality of lives, and also reduce premature deaths.

1.3: Project Purpose

Homelessness is a precursor to poor physical and mental health. Chronic and acute illnesses like hypertension, Diabetes Mellitus, hypothermia, anemia, alcoholism, substance abuse, tuberculosis, and pediculosis are rampant among this group. Most of these illnesses are treatable but accessing healthcare poses a challenge for this vulnerable population. As such, this project will explore the problems faced by the homeless community in Merced and recommend ways to improve their health conditions.

1.4 Objectives

- To study and understand the healthcare challenges faced by the homeless population in Merced County.
- To explore ideas, and to gain insight on how to bridge the healthcare gap among this vulnerable population in Merced County.
- To foster a healthcare environment that encourages mutual respect, trust, active listening and open communication which might help in alleviating their fear of the healthcare system.

1.5: Research Questions

1. Do homeless individuals have difficulty accessing healthcare services compared to non-homeless Individuals?
2. What measures are possible to improve access for the homeless population in Merced County?

1.6: Hypothesis

The homeless in Merced face many barriers to access to healthcare services.

CHAPTER 2: LITERATURE REVIEW

2.1 Review of Evidence

A thorough literature search was done to find literature supporting this proposed project. The literature review included keywords like homelessness, vulnerable, healthcare, the Affordable Care Act, substance abuse, and primary care.

Significant studies have been done to explore ways to improve healthcare for the homeless population, and understanding the consequences of homelessness to health. Fryling et al. (2015) led a study to identify barriers to healthcare among the homeless individuals and their knowledge of the Medicaid expansion (the Affordable Care Act-ACA). The study also accessed communication methods that could improve enrollment among the homeless. A cross-sectional quantitative survey conducted in an urban county emergency department (the study was a blinded for peer review study of 650 participants (441 were male with a median age of 46), took between the hours of 9 am and 5 pm Monday through Friday for ten weeks. A 30-question survey served to assess barriers, ACA knowledge, and health insurance status. Descriptive statistics were used to analyze the results; the result indicated that homeless individuals that are not certain they qualify for ACA are the most common (70%), no knowledge of ACA was 26%, and 30% have challenges with enrollment. The study concluded that homeless individuals have little knowledge, and poor understanding of the Affordable Care Act compared to their non-homeless counterparts. The study stated that educating homeless population about suitable health insurance will improve their chances of having a stable general practitioner instead of using the Emergency Department for such services. The study omitted Non-English speakers. The findings cannot be generalized since it involved

limited research for only one urban Emergency Department. The sample size is appropriate for a survey of this nature; over 650 participants participated. There were signed consents, and authors are educationally qualified to conduct this study.

Stringfellow et al. (2016) did a study with the aim of establishing the need for primary care that is tailored to serve homeless individuals because of the complexity in their medical care as they are predisposed to mental health challenges and substance use disorders. A sample size of 601 participants presented for quantitative survey research, mostly male (about 85%), the average age of 53 and over one-half acknowledged as black and non-Hispanic. The study occurred at four Veterans (VA) federally funded primary care organizations in Alabama, Pennsylvania, California, and Massachusetts. A one-time standardized survey applied to participants between January 2011 and March 2012. Descriptive statistics were used to identify the socio-demographic and health characteristics of the participants. Bivariates test of association and risk grouping was expressed using the t-test, ANOVAS (Analysis of Variation) and Pearson's Chi-square, and a multivariable binomial logistic regression model helped in referencing analysis. Ninety-five percent of participants admitted to lifetime use of alcohol, and 90% agreed to lifetime use of illicit drugs. One half used juice and one third used illegal drug recently. Eighty-four percent admitted to lifetime use of cannabis, and 19% admitted to using it lately. Seventy-six percent agreed to a lifetime of cocaine use, and 16% of recent use, only 7% admitted to the current use of opioid. These findings highlight the need for tailored, individualized primary care services which could assess past and ongoing substance abuse among the homeless, and to sensitize care to include rehabilitation. There is no concrete difference in addiction severity between homeless veterans and non-

veterans. ASSIST include only two questions regarding substance use disorder, and it emphasizes more on assessing alcoholic misuse and not so much on illicit drug misuse (Moore,2004). The study occurred in four veteran primary care facilities in four states; this could limit its generalization.

O'Toole et al. (2016) conducted a quantitative observational study of 33 Veterans Health Administrative (VHA) facilities from October 2013 through March 2014. The primary purpose of the study was to analyze if incorporating social elements like transportation in primary care can improve homeless individual's overall health outcome. About 3,454 homeless Veterans' clinic sites were part of the study. Besides, they enrolled at H-PACT (Homeless Patient Aligned Care Team) program for the study duration. The results were analyzed using the z-test statistical values. The result illustrates that 17 clinical sites were considered high performance, nine sites were mid-performing, and seven sites were considered low performance. The findings established that incorporating social elements like transportation, on-site shower, laundry, food assistance, food pantry, and hygiene kits into clinical care setting are beneficial to homeless veterans that are considered high risk. The study only included veterans accessing veteran's health facilities. The study took place throughout four years with many clinical sites observed; 3,454 participants surveyed.

Crystal et al. (2015) piloted a survey based quantitative research from July 2008 through June 2010, about 366 individuals (mostly male, 33% were white, 56% were African American, and 2% were American Indian/Alaskan native, and less than 1% Asian/Pacific Islanders) were randomly sampled two or more times to compare their primary care experiences. The participants were patients at three clinical sites: Veteran

clinic, homeless tailored Veteran clinic, and non-Veteran clinic. The Primary Care Quality-Homeless (PCQ-H) questionnaire, and Sofaer and Firminger's patient perception model served in guiding the study. The general regression model, model variable, ratio test, and multiple regressions were used to note positive healthcare experiences among the participants. The results showed that clinical sites with tailored care received more favorable scores ($F=2.80$, $p=0.03$), with the professed level of choice ($F=23.29$, $p>0.0001$), and housing status ($F=2.91$, $p=0.03$), proves very important. The study lasted for about two years, and in person assessment generated significant response rate.

Lin et al. (2015) conducted a cross-sectional quantitative study to examine reasons associated with recurrent hospitalizations and emergency department (ED) visits among homeless individuals who are Medicaid recipients. About 6,494 Massachusetts Medicaid members (71% were male, and an average age of 45.5 years), participated in the study in a healthcare facility for the homeless, that lasted for one year. For statistical analysis purpose, ratio, multivariate and the negative binomial regression were used to establish factors attributed to the observed frequent hospitalization and ED utilization among the homeless individuals. The result suggested that homeless individuals who have a mental illness and those addicted to substance use disorder (SUD) indicated the most significant number of frequent hospitalization and ED utilization (66% of the sample). Participants with schizophrenia or SUD alone and physical conditions were the least common. The study confirmed that homeless individuals with a mental illness history as well as those with substance use disorder have a higher probability of utilizing the Emergency and unnecessary hospitalization. However, this cross-sectional study used only one-year data and therefore it is not sensible to generalize the findings.

Quensell, et al. (2017) piloted an exploratory qualitative study to observe a weak outlook of the impact of housing in preventing hospitalization. Ninety participants (71% were working age [18-64 years], 33% were female, 19% were white, 13% were other Asians, and 12% were Filipino) were recruited from The Queen's Medical Center (QMC) in Hawai'i from June 2013 to December 2014 for Diabetes Mellitus or Congestive heart failure-related hospitalization. A 45-minute face to face interview including a questionnaire and a semi-structured interview with close and open-ended questions administered. A qualitative analysis was used to identify patterns of preventable hospitalization. The result established that not having a stable accommodation is the main reason for participant re-hospitalization. The result also confirmed that difficulties in the management of complex chronic care, provider associated stigma and finally stress coupled with mental issues constituted to participants ED recidivism. Survey participants gave their consent, and an experienced nurse researcher helped in securing sensitive information of the participants. Non-English speakers were not included in the study.

Chong, Yamaki, Harwood, D'Assalenaux, Rosenberg, Aruoma and Bishayee (2014) led survey-based quantitative research to assess health conditions and medication use among the homeless population in Long Beach, California. The study occurred at the American University of Health Sciences in Long Beach California with about 95 participants (74% were male, and the age range of 20-72, and mean age of 48). The survey was carried out during a two day "brown bag" event during December 2011 and February 2012. The questionnaires administered to participants were designed to collect data like age, sex, family history, medication and health conditions. For statistical analysis, continuous variables were used to compare student's t-test, and dichotomous

data were analyzed using x2 with Yates correction or Fisher test where applicable. The result suggested that adherence to medication regime was a challenge for this population, with more than 30% of the participants not following medication regime, psychiatric disorders were prevalent in about 32%, and cardiovascular diseases in about 46% of the participants. Participants confirmed that they felt ashamed and embarrassed when expressing their healthcare needs to clinicians. The authors also suggested that programs should be designed to improve healthcare access and availability for this vulnerable population.

2.2: Theoretical framework

A theory is as an organized and interrelated set of notions relating to reality; it can also predict and explain phenomena that can be used to express testable propositions (Bem & De Jong, 1997). Referring to a dissertation project that focuses on "Exploring ways to improve healthcare access for homeless individuals in Merced County," a transtheoretical model of behavior change is practical and appropriate. The transtheoretical model of behavior change is a concept that was developed to intervene and promote personal health behavior changes. The integrative framework or assumption of this model is designed to access individual willingness to change encourages own changes (contrary to positive), and how to maintain positive changes. This model also helps healthcare providers to evaluate patients who are presenting with at-risk behavior, and patient's readiness for change; which might facilitate a lasting positive behavior change (Velasquez et al., 2005).

2.2.1: Concepts of the theory

The transtheoretical model of behavior change has core concepts to assess, formulate and predict behaviors changes; these core concepts are stages of evolution, the process of change, self-efficacy, and decisional balance (Werch et al., 2009).

Stages of change: The stages of change also known as stages of readiness comprises of five steps: pre-contemplation, contemplation, preparation, action, and maintenance (Prochaska et al., 2008). These stages may not happen in an undeviating manner but may be intertwined; phase three may coincide with stage four or stage two with step four. The scenes of change happen on an individual basis which makes this model ideal for the homeless individual who is ready or seeking to promote healthy lifestyles and prevent diseases. Defining the stages of change model about changing homeless individuals' behaviors towards finding healthcare on time for improving health, avoiding reckless behaviors and preventing diseases:

1. Precontemplation (Not ready stage): The homeless individual is unconscious of the need to prevent problem behaviors, and to seek healthcare services in promoting good health or in preventing diseases (Butts & Rich, 2011).
2. Contemplation (getting ready stage): The homeless individual is aware or thinking about changing present health situation or condition; but, not putting any effort in facilitating changes (Butt & Rich, 2011)
3. Preparation (ready stage): A homeless individual is planning to avoid problem behaviors, and to seek healthcare services on time. At this stage, the individual is prepared for the change to occur in the future by taking better care of self (Butt & Rich, 2011).

4. Action (achievement stage): The homeless individual is adopting new habits; like applying for health insurance, making doctor's appointment, and seeking healthcare services for promoting better health (Butts & Rich, 2011).

5. Maintenance (upkeep stage): Following through with avoiding problem behaviors, sticking to all medication regimes, showing up at doctor's appointments, and not participating in behaviors that could jeopardize good health (Butts & Rich, 2011).

The process of change: This idea expresses how an individual could change his or her negative behavior to a positive one; this process describes the shift from one state to another (Clark, 2013). The method of change is not an instant phenomenon; instead, it is a gradual process that comes from within. Acknowledging the need for a change marks the beginning of positivity. At this juncture, an individual that wants the switch initiates the idea of change cognitively and makes conscious decision to activate and achieve the change. For example: A homeless person can start a change process by merely acknowledging that there is a problem that needs change; problems like not seeking healthcare services on time, downplaying ill health, substance abuse, and alcoholism; then, making conscious decision not to engage in such behaviors, and shifting towards choosing positive health behaviors. Many factors are present in change process; these ten factors correlate the process of change: consciousness raising, dramatic relief, environmental reevaluation, self-reevaluation, social liberation, stimulus control, counter conditioning, reinforcement management, self-liberation, and helping relationships (Prochaska et al., 2008).

Self-efficacy: Bandura developed the perception of self-efficacy; it defines one's ability to activate motivations on how to resist bad behaviors, and to cease from

temptations to continue with that behavior (Velasquez et al., 2005). Self-ability is very important to the success of behavior change as an individual move towards behavior change, seen the positive result or being convinced that the difference is possible motivates the individual to do better (Butts & Rich, 2011). Self-efficacy uses four techniques to influence behavior change: performance enactment, vicarious learning, verbal persuasion, and emotional arousal (Trunnell & White, 2005). Verbal persuasion is a technique that has been proven to help in increasing self-efficacy, especially if the message is from a famous person (person of significance to the individual) who has faith in the individual in being successful by completing and maintaining the change (Trunnell & White, 2005).

Decisional balance: Decisional balance is a concept that was modified by Janis and Mann in their work in 1977; the idea is vital in measuring the strengths and weaknesses of a certain behavior (Velasquez et al., 2005). The advantage and disadvantages of a wrong act prompt about a behavior change. The pros and cons of behavior changes as individuals go through the stages of evolution. In the early stage of change (pre-contemplation stage), individual support for the disadvantage of behavior is higher compared to individuals in the action and maintenance stages (upkeep stage) who tend to prefer the pros of a response (Prochaska et al., 2008). The crossover from disadvantage to advantage is experienced in the middle of stages of change which happens around the contemplation and preparation stages (Prochaska et al., 2008)

2.2.2: The Relationship between the Concepts of TTM

The core concepts of the transtheoretical model of behavior change. Stages of change (five stages of intellectual and behavior change); process of evolution (describing

how the shift from adverse reaction to affirmative action happens); self-efficacy (ability to activate motivation to resist dangerous behaviors and to avoid temptations to continue with that behavior), and balance in decisions (analyzes the pros and cons of a behavior change) are self-motivated factors that are correlated or intertwined to facilitate a lasting behavior change. The process of making a positive behavior change must first be initiated from within by an individual who is willing or seeking the change. An individual must be ready and willing to embrace change for the change to be lasting. The transtheoretical model of evolution has been used extensively by researchers and studies that encourage health promotion and disease prevention (Clark, 2013). The model also helps healthcare providers to assess how ready an individual is.

2.2.3: The Transtheoretical Model of change in Published Literature

The transtheoretical model of evolution has undergone extensive research, tested, critiqued and published in much literature. Published literature that inspires behavior changes like smoking cessation, improving hand washing, motivating exercising, adhering to medication regime, developing substance abuse treatment programs, and reducing obesity have benefited extensively from this theory (Velasquez et al., 2005). The integrative assumption of this model makes it an excellent choice for scholars to design ways to access individual willingness to change, to encourages personal changes (contrary to positive), to facilitate skills that will help in upholding those positive changes, and also to help healthcare providers to access patients who are presenting with at-risk behaviors (Velasquez et al., 2005). One of the standards for evaluating a theory is its testability nature (Prochaska et al., 2008). For an argument to be tested, understanding the theory's assumptions is strongly suggested. The transtheoretical model of change has

been tested and critiqued by others who are for or against parts of the theory propositions (Prochaska et al., 2008).

2.2.4: Applicability of the theory to the proposed population of interest

The correlation between the concepts of TTM is very applicable to a homeless individual who is looking to adopt better ways to promote better health. A homeless individual with challenges with substance abuse and reckless health behaviors will benefit from the transtheoretical model of behavior change; by cognitively admitting the existence of a problem that requires an intervention. The stages of evolution are the process when a homeless individual considers change by avoiding bad behavior, seeking ways to maintain the right practice, and preventing relapse. The method of change helps the homeless person to shift from a state of substance abuse and engaging in reckless acts to being aware of interventions to help change this behavior. Self-efficacy will encourage the individual to keep working on avoiding irresponsible practices, and believing in oneself to complete change and prevent relapse. Self-efficacy tends to increase when progress in behavior change is noticed (Cheung et al., 2007). The core concepts of TTM are intertwined and do not follow a linear pattern; but it has been proven in published literature to help in behavior changes (Prochaska et al., 2008).

2.2.5: The relevance of TTM to the proposed project

The uniqueness of TTM in contrast to other theories is evident in its application to behavior changes. Changing negative behavior to a positive one is a complex phenomenon that requires a sophisticated approach like TTM. TTM is widely applied to human health challenges that need interventions like smoking cessation, enhancing hand washing, motivating exercising, adhering to medication regime, and developing

substance abuse treatment programs (Velasquez et al., 2005). Improving access to healthcare for a homeless individual in Merced County requires homeless individuals to want the change. TTM assesses one's readiness for change because without making a conscious decision for a change, evolution cannot be lasting. The transtheoretical model of change also helps healthcare providers to assess patients who are presenting with at-risk behaviors (Velasquez et al., 2005). In conclusion, the importance of assessing, encouraging, and verbal persuasion in behavior change is difficult to underestimate among this group.

CHAPTER 3: METHODS AND MATERIALS

3.1: Ethical Issues

The project author completed an online course from the National Institute of Health (INH) on "Protecting Human Persons Research," and approval obtained from Internal Review Board (IRB) of California State University, Fresno School of Nursing before this research study transpired.

3.2: Participants

About 25 homeless individuals were sampled at Sound Life International Ministries in Merced CA (the church allows individual with no stable accommodation to be a part of their congregation). Men and women between the ages of 21-75 of all ethnicities and backgrounds that are experiencing homelessness for more than three months uninterruptedly were sampled for this project. Inclusion criteria: Adults between the ages of 21-75, homeless for more than three months. Exclusion criteria: Intoxicated or under the influence of a substance(s), minors, and individuals with severe mental illness, or cognitively impaired. Only individuals who are capable of providing informed consent were included in the study. Persons under the influence of illicit drugs, alcohol, and the mentally impaired were not allowed to participate in the study.

3.3: Sampling Procedure

Upon reading and signing the written consent form, the participants completed a standardized 15 item closed and open-ended questionnaire. A cross-sectional quantitative research method was explored to answer the research question**:** The questionnaire was completed in about 45 minutes on a convenient day and time. To

eliminate bias, repeated testing was strongly discouraged throughout the study, and enforced by completing the questionnaire on the same day and time. All study volunteers underwent training before the commencement of the study. Participants' identity will not be revealed in any publication resulting from this study. Participating in this study is voluntary. Participants possess the right to refuse to participate or may withdraw their consent at any time during this study. Participants may ask questions and answers will be provided about this research. No particular procedure like radioisotopes, IND, or any electrical equipment is necessary for this study.

3.4: Potential benefits and risks

This research is designed to gain knowledge and insight about barriers that individual with no stable accommodation in Merced County face when accessing healthcare, and exploring ways to bridge the healthcare gap among this group. Participants may or may not benefit personally from being in this research study, but their experiences will add to the literature, and help in improving healthcare access for the vulnerable individuals in Merced County. Homelessness is a complicated situation that requires a complex solution, and tackling the healthcare gap among this group should be explored and lasting solution formulated.

There is a minimal risk that some questions may cause sadness or grief; some of the questions will ask about housing and health conditions. Psychotherapy services in the form of counseling and stress management were available to participants who might benefit from it. There are no social, physical, economic, and legal or violations of normal expectations associated with this study. Individuals participating in the study were reassured of the utmost confidentiality.

CHAPTER 4: FINDINGS

4.1: Findings overview

From the research, it became evident that homeless people in Merced county face substantial challenges in accessing healthcare services compared to the non-homeless individuals. The study that surveyed 25 homeless people in Merced addressed the following objectives

- To explore and understand the healthcare challenges faced by the homeless in Merced County.
- To explore ways and to gain insight on how to bridge the healthcare gap among this vulnerable population in Merced County.
- To foster a healthcare environment that encourages mutual respect, trust, active listening and open communication which might help in alleviating their fear of the healthcare system.

4.2: Health seeking behaviors of the Merced homeless population

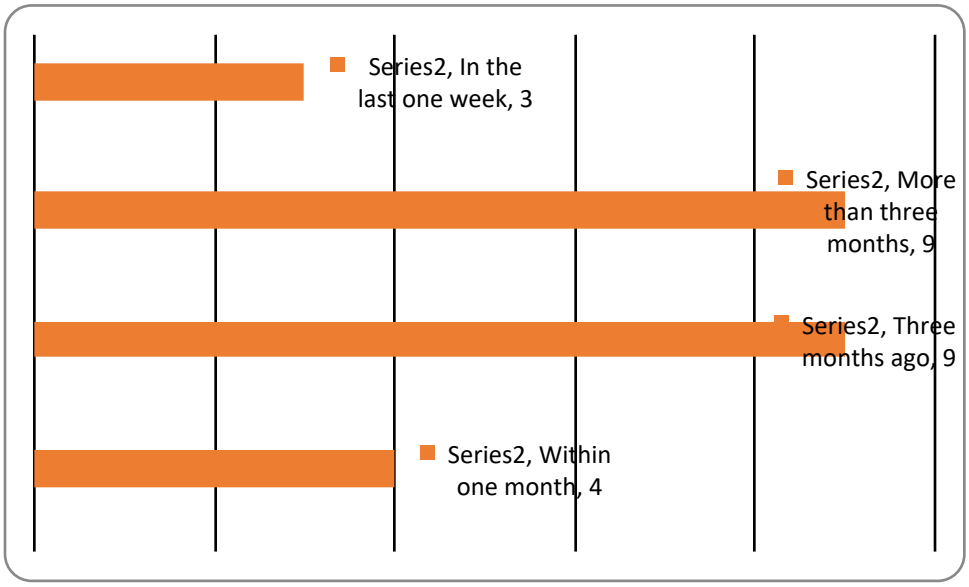
The health-seeking behaviors of the studied population are weak and needs some improvement. From the studies, only eight out of the twenty-five participants admitted to having accesses to healthcare providers. The remaining seventeen people lack any access to healthcare services. Seventeen respondents admitted to having healthcare insurance coverage while eight lack the same. The homeless individuals in Merced Country also utilize the emergency department (ED) compared to their counterparts who are non-homeless. Three of the participants admitted to having visited the ED in the last week. Only four individuals visited the ED within the previous month. Nine subjects visited the

ED within the previous three months. The remaining participants visited the ED in the past three months.

Table 1: Findings on health-seeking behaviors of the homeless

QUESTION	Absolutely	Not at all
Do you have a healthcare practitioner?	8	17
Do you have health insurance?	17	8
How long ago did you see…services at the Emergency Department • **In the last one week = 3** • **Within a month = 4** • **Within last 3 months = 9** • **More than 3 months ago = 9**		

Figure 2: Number of the homeless population visiting Emergency Departments at different rates



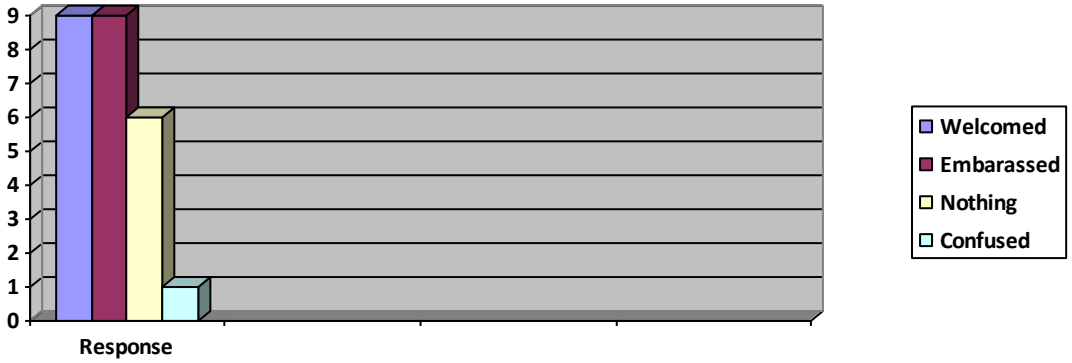
4.3: Attitudes towards healthcare services, immunization, and medication storage

Overall, the participants recorded underperformance on the areas of vaccination, secure medical storage, and attitudes towards medical services. Eleven respondents indicated that they did not receive the latest immunization. Fifteen participants confessed that they lacked safe storage means for prescribed medications. Nine people demonstrated a positive attitude towards healthcare services while the same number reported feelings of embarrassments when seeking care. Six people responded that they felt nothing towards finding healthcare services, while one confessed to experiencing confusion in seeking care services.

Table 2: Attitudes on healthcare services, immunization, and safe medication storage

QUESTION	**YES**	**NO**
Are you up to date on immunization	14	11
How do you feel when seeking healthcare services? • **Welcomed = 9** • **Embarrassed =9** • **Nothing = 6** • **Confused =1**		
Do you have a safe place to store prescribed medication?	10	15

Figure 3: Attitude on seeking health services



4.4: Mental health services and transportation to healthcare facilities

Another level of healthcare challenges faced by homeless people in Merced County comprises of mental health services and transport inconveniences. The majority of the subjects (13 people) indicated that they lack practitioners to address their psychological problems. The remaining twelve admitted to having access to services of mental health practitioners. Among the respondents, twenty people indicated that they experience transportation inconveniences when planning to visit healthcare facilities. Only five clarified that transportation was a non-issue to them when seeking care.

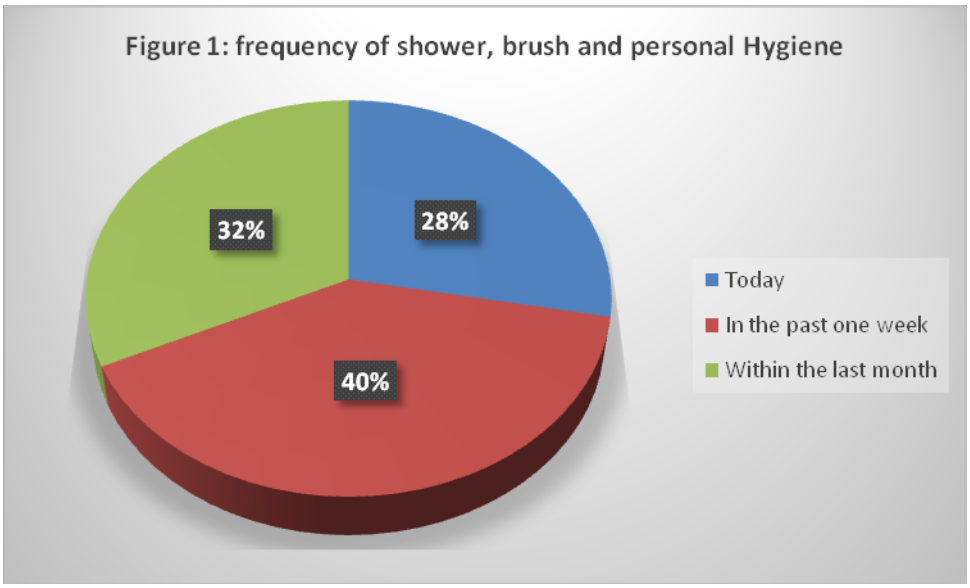
Table 3: Response to mental health services and transportation to healthcare facilities

QUERY	Absolutely	Not at all
Does your mental challenge get addressed by medical practitioners?	12	13
Do you face transportation challenges when seeking healthcare services?	20	5

4.5: Observation of personal hygiene practices

Hygiene is a critical area of personal, communal, and national healthcare. Poor hygiene is harmful because it exposes individual to conditions that support the survival of deadly microorganisms. Approximately 28% of the respondents admitted practicing daily personal hygiene that includes showering and teeth brushing. Ten participants or 40% of the studied population reported having practiced personal hygiene in the last one week. Approximately 32% or eight respondents confessed that one month lapsed since they last observed their body hygiene.

Figure 4: Observation of hygiene among homeless individuals



4.6: Mobile Clinics in addressing health care services

Figure 4: Benefits of mobile clinics in addressing health concerns.

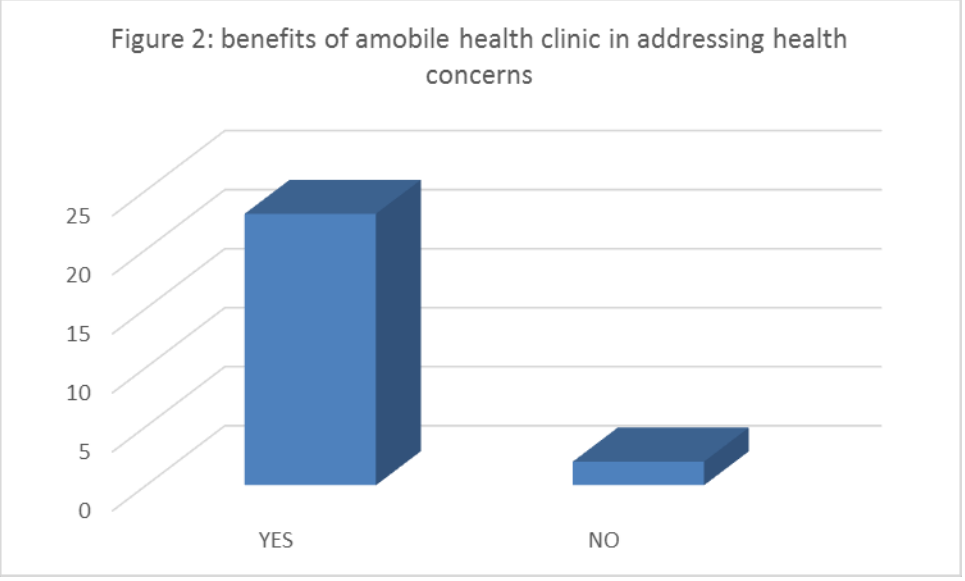


Figure 4 above clearly indicates if the mobile health clinic could help in addressing respondents' healthcare concerns. The result indicated that mobile clinics could benefit a large number of homeless individuals when addressing their health concerns. Twenty-three respondents out of the 25-total number of those examined agreed that mobile clinics could offer them some help in solving their health concerns, while two respondents declined to mobile clinics helping in solving their healthcare concerns.

CHAPTER FIVE: DISCUSSION

5.1: Summary

The United Nations defines homelessness as a condition where a particular group of people lacks shelters and lives along the streets, occupy abandoned building, under bridges, and cars among others (Hwang et al., 2001). Relative homelessness refers to a situation where people have physical shelter but do not meet the basic standards of health, safety, and drinking water among other primary human needs (Hwang et al., 2001).

5.2: Susceptibility to health dangers

Khandor et al. (2011) in a study concluded that few homeless people have access to essential healthcare services. The absence of healthcare insurance is the primary barrier to accessing necessary medical services (Khandor et al., 2011). According to Khandor et al. (2011), homeless individuals face numerous health challenges because of their vulnerability to acute and chronic illnesses. There are also nonfinancial challenges that bar homeless people from accessing healthcare services. Such challenges include limited or no knowledge of places to obtain healthcare services, transportation problems, and feelings of discrimination (Khandor et al., 2011).

Hwang et al. (2001) and Wilson (2005) clarify that the homeless population is vulnerable to many forms of feet and skin ailments like impetigo, cellulitis, and venous stasis diseases. Diseases like immersion foot, onychomycosis, and tinea pedis are due to walking barefoot along the streets. Proper medication on foot infections would require

early detection, education on foot hygiene and provision of socks as well as shoes to the homeless individuals.

The frequent use of drugs by the homeless people exposes them to dangers of mental health problems. A study conducted in Toronto revealed that about 6% of the homeless population suffers from schizophrenia (Hwang, 2001). In the United States, the prevalence of schizophrenia among homeless people ranges between 20% and 40% with an effective rate of 10% to 13% (Hwang et al., 2001).

Hwang et al. (2001), notes that homeless people develop health conditions of old age in their earlier 40s and 50s. The street condition subjects the group to harsh conditions that expedite aging. For instance, chronic obstructive pulmonary disease and arthritis are among the health problems faced by the homeless individuals (In Paaw, 2015). There are some conditions such as diabetes, hypertension, anemia, and respiratory tract infection that take long to detect, and under-controlled among this population (Hwang et al., 2001).

5.3: Fostering Healthcare Environment

About 99% of the subjects that participated in the study expressed desires for better care. The people understood that their living environments expose them to the risks of chronic illnesses. Medcalf (2014) emphasizes that the poor health statuses of homeless people persist because of their high poverty levels. The federal government effort to provide adequate healthcare access has fallen short, despite enrolling the homeless individuals in Medicaid and Medicare programs. However, some members of the populace still miss the opportunities probably because of misplaced identification cards (Cowan et al., 2010). According to Chrystal et al. (2015), many researchers have

confirmed that the homeless all over the world suffer the same fate of low access to healthcare facilities because of their chaotic lifestyles. Research conducted in the United States (US) affirmed that countries with universal healthcare system endure the limited access to healthcare services by the homeless people because healthcare facilities do not welcome them. The research also found that demeaning relationship develops when the homeless people are in contact with healthcare providers. Personal matters even frustrate the access of the homeless to adequate healthcare services. The homeless tend to feel lonely and neglected by others, which pushes them into social withdrawal (Duchon, 2014).

5.4: Easy Access to Healthcare Facilities and Transportation

The majority 80% of the surveyed group reported difficulty in accessing healthcare services to become of remoteness and lack of transportation. Only a few individuals could not respond to the issue of transportation as a challenge. According to Levinson, (2004), identified that lack of transportation was the primary challenge that homeless individuals face when access healthcare. In Denver, the problem with healthcare access has received a positive resolution. The Homeless Outreach Collaborative members pick forms for a variety of services. The clients fill the forms and return them to the office for processing purposes (Burt, 2010). Consequently, homeless individuals in Denver get their healthcare services at their conveniences along the County's streets (Burt, 2010).

According to Burt (2010), mobile services and clinics help provide a variety of services to homeless persons and have benefits to workers. There should be tolerant and flexible people that can endure bad experiences with the street families as Fischer and

Collins (2002) stated in the findings. Also, healthcare services can reach the homeless through outreach strategies (Burt, 2010). This technique would mean that workers who come from healthcare programs go out to shelters and meet homeless individuals in an unthreatening manner. Healthcare practitioners can create a long-term trusted relationship, and foster better health for the homeless population (Burt, 2010).

5.5: Insurance

The findings of this study have some similarities with the studies done in other places in the world on the difficulties the homeless population face when accessing healthcare. Duchon (2014) reports that one study conducted in the Kings County showed that only forty among 158 homeless kids had Medicaid cover. About 35% of the same group lacked any healthcare insurance plan. From the study in Merced County, the majority of persons interviewed had a similar challenge of acquiring health insurance. Afifi et al. (2013) reveal that most homeless people often abandon or fail to adhere to insurance programs. In a different survey, Wood et al. discovered that 43% of homeless families had discontinued welfare in the past year and only 23% addressed their insurance issues.

Duchon (2014) narrates that a nationwide study on homelessness in the U.S revealed that only 33% of women sampled accessed public health system for help in the last one month. During the 16-city research of homelessness, Wright and Weber found that more than 55% of homeless women received some form of assistance from the public (Duchon, 2014). Findings from this study suggest that public health insurance coverage is necessary but not enough to encourage the utilization of healthcare services

by homeless families. From the survey, insurance cover would be paramount to carter for health problems of the homeless persons (Duchon, 2014).

5.6: Resolving the Tension between the Homeless and Healthcare Facilities

About 91% of the interviewed population asserted that there was a bad experience between homeless individuals and healthcare providers. Due to the great need for healthcare and the challenges that individual homeless face on the streets in accessing healthcare services, Duchon (2014), advocates the easing of access of the services without the homeless feeling neglected. There are ways that stakeholders can reduce the tension between homeless people and healthcare providers. One of the measures is to bring services close to the homeless people like homeless shelters near healthcare centers and food facilities for street families. Levinson (2004) explains that the environment should be welcoming to the homeless who often perceive intimidation by the large institutions' setup. There also should be same day appointments and walk-in-services to facilitate easier access to medical services (Levinson, 2004). The essence of offering healthcare services close to the shelters of the homeless is to enhance screening and provide primary and preventive care services (Schanzer, Dominguez, Shrout, & Caton, 2007). Schutt and Goldfinger (2011) and Tischler, Rademeyer, and Vostanis (2015) warn that homelessness is exposing the victims to increased risks of mental illness because of unrestricted access to drugs. Their low conditions of depression and feelings of worthlessness also push them to abuse drugs that only worsen their health conditions. In that light, it is also paramount to emphasize the idea of building the homeless houses and resettling them.

Conclusion

Homelessness is a serious issue affecting people living on the streets. The condition exposes the victims to numerous health threats because of their chaotic lifestyles. This has a significant impact on individuals in the streets and distresses a considerable number of people of diverse origins across the world. Homelessness has proved to be defective to healthcare condition and quality for the affected group. Since the problem attributes to poverty, it affects people of all race and ethnic backgrounds. The close associations of homelessness with illnesses make their lifestyle expensive and burdensome to the victims. Mental and chronic diseases are evidence that people on the streets have a lot that they undergo daily. Authorities at the local, federal, and state levels, as well as non-governmental organizations, should treat homelessness and healthcare with utmost attention. Healthcare systems should find ways to help homeless individuals' improve access to better medical services, acquire insurance coverage, and live hygienically by observing every aspect of healthy living. Although the healthcare system has tried to meet the individual's needs, satisfactory levels are low.

Recommendations

It is worth acknowledging that homeless residents of Merced County are undergoing difficult experiences that require the necessary attention and resolution. One of the ways deemed viable in helping the residents is improving access to healthcare services through programs like mobile clinics and medical outreach. In so doing, homeless individuals shying away from healthcare facilities for fear of intimidation and ill-treatment will gain confidence to interact with care providers in a non-threatening environment. It is also vital to train healthcare providers about diversity and the need to

appreciate each person irrespective of their status. It is also crucial to remind healthcare providers on the doctrines of beneficence and non-maleficence. This undertaking may resolve the bad experiences faced by the homeless when visiting healthcare facilities.

The government also needs to run campaigns encouraging all low-income individuals and the vulnerable population to sign up for Medicaid services. Since the homeless are the most vulnerable, they should get the most excellent attention. Providing cover to this group will reduce the delays experienced in accessing healthcare services.

A long-term solution like housing facilities for the homeless population is the best way to tackle this threat. Housing will remove the individuals from the streets which will, in turn, avoid their health vulnerabilities. Housing facilities will help in reducing the amount of use of illicit drugs that are responsible for a significant part of the mental problems faced by the population. It is worth noting that harsh environmental conditions like cold and psychological fear encourages the homeless individuals to use drugs that make them numb to the reality.

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APPENDICES

Appendix A: Signed Consent

Appendix B: Demographics

Please, circle your answers to the following questions

1. What is your gender?

    a. Male

    b. Female

    c. Transgender female

    d. Transgender male

    e. Gender variant/Non-conforming

    f. Refer not to answer

2. Which age group most closely describe your current age?

    a. 21-30

    b. 31-40

    c. 41-50

    d. 51-60

    e. 61-75

3. How would you describe your race?

    a. African American

    b. American Indian

    c. Asian

    d. Caucasian

    e. Pacific Islander

f. Other (Please Specify):

g. I prefer not to answer

4. What Ethnicity do you consider yourself to be?

a. Hispanic/Latino

b. Non-Hispanic/Latino

c. I prefer not to answer

5. What is your highest level of education?

a. No high school diploma

b. High school diploma/GED

c. Some college

d. College degree or higher

6. What is your current living condition?

a. Homeless for less than three months

b. Homeless for more than three months

c. Never experienced homelessness

Appendix C: QUESTIONNAIRE

Please circle your answers, and provide answers where applicable

1. Do you have a primary care provider?

A) Yes B) No

2. Do you have health insurance?

A) Yes B) No

3) How long ago did you seek healthcare services at the Emergency Department?

A) Within the last one week B) Within the last one month C) Within the last three months D) More than three months ago

4) Are you up to date on immunization, like a flu shot?

A) Yes B) No

5) How do you feel when seeking healthcare services?

A) Welcomed B) Embarrassed C) Nothing

6) Do you have a safe place to store prescribed medication?

A) Yes B) No

7) Do healthcare providers address your mental health challenges?

A) Yes B) No

8) Do you face transportation challenges when seeking healthcare services?

A) Yes B) No

9) How often do you shower, brush or have proper personal hygiene?

A) Today B) In the past one week C) Within the last month

10) Do you think you could benefit from a mobile health clinic to address your healthcare concerns?

A) Yes B) No

11) Do you think you could benefit from a mobile free shower, toilet, and grooming center?

A) Yes B) No

12) Does being homeless affect the way you seek healthcare services?

A) Yes B) No

13) Any bad experiences when in contact with healthcare providers like doctors, nurse practitioner, physician assistants, registered nurses, medical assistants?

A) Yes B) No

14) Any suggestion on how to improve your healthcare experience? Please, write your answer below

15) What change are you looking for to address your healthcare needs and housing challenges?