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Access to Health Care Services: A Case Study in Hillsborough County, Florida

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Access to Health Care Services:
A Case Study in Hillsborough County, Florida

by

Jaime Nodarse

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts
Department of Applied Anthropology
College of Arts and Sciences
and Master of Public Health
Department of Children and Families
College of Public Health
University of South Florida

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Dedication

This thesis is dedicated to all the homeless mothers striving to provide happy and healthy lives for their children, and to all the people working enthusiastically and tirelessly on their behalf.

Acknowledgements

As with all research, this thesis would not have been possible without the guidance, knowledge, support, and involvement of many other people along the way. I would like to thank my committee members, Dr. Linda M. Whiteford, Dr. Martha Coulter, and Dr. Heide Castaneda, for their guidance in the development of this research project, support and patience throughout the research and writing processes, and helpful comments on the written thesis document. Special thanks goes to Dr. Whiteford who, in addition to being named Associate Vice President for Academic Affairs, Strategic Initiatives for the 2008 school year, remained committed to her advisees and made herself available to me. Her assistance in answering questions throughout research and brainstorming with me about initial findings was invaluable, and her feedback on early drafts of my thesis helped guide my writing process and clarify my thoughts. This thesis would not be what it is today without her moral support and expertise.

I am also indebted to Metropolitan Ministries as an organization, and to their UpliftU® counseling team specifically. From my very first days as a volunteer I was welcomed into Metropolitan Ministries, and as I began my own research as an intern with the UpliftU® program the counseling team and interns included me and valued my work and knowledge about health care resources. In particular, my supervisor Lisa Barden, was especially helpful in the early planning stages of my internship and research proposal, and she remained a key resource to whom I could turn with difficult situations and questions that arose throughout my internship. The entire counseling team led by example through their daily enthusiasm and tireless efforts to assist residents, and I owe much of my knowledge and understanding of working with homeless families to this

group of counselors. I thank them for kindly allowing me to join them in their daily work and for their patience with my many questions.

Of course this project would have been impossible if it were not for the residents of the UpliftU® program- especially the mothers who took time to talk with me about their experiences with being homeless and accessing health care services. I cannot express my gratitude for these residents enough. They allowed me to come into their lives, and shared with me their very personal experiences with homelessness and health care. It is my sincere hope that their involvement in this research project has not been in vain, and that their perspectives will be included in future efforts to improve the health care system. They, like everyone else, deserve to be treated fairly and to have access to health care services regardless of their housing situation or income.

Finally, I would like to thank my family and friends, not only for their unconditional love and support, but also for the inspiration and values that led me to a discipline and a research project that are about social justice and human rights at the very core. My parents and grandparents have always been my role models, and through their own lives have been the best examples of passionately and selflessly helping other people. Thank you for all you do and have done for me and others.

Previous versions of this thesis were presented at the Department of Anthropology Graduate Colloquium at the University of South Florida, Tampa on October 17th, 2008 and at the American Public Health Association's Public Health Without Borders annual meeting and expo on October 27th, 2008.

Note to the Reader

Metropolitan Ministries has given written permission to use the name of the organization and the name of the UpliftU® program in this thesis. All counselor and resident names have been changed in order to maintain confidentiality and respect for all research participants.

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Access to Health Care Services:
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Jaime Nodarse

ABSTRACT

The UpliftU® program is a long-term residential program for women and families who are homeless or at risk for homelessness. This program is one part of a larger, community-based non-profit organization serving low-income and homeless families in Hillsborough County, Florida for over 35 years. This program is not an emergency shelter program, but rather offers up to 18 months of participation in a self-sufficiency program to single women and families. The goal of the program is to prevent future homelessness for residents by helping them to reach their highest level of self-sufficiency. After volunteering at this organization for nine months, I completed an internship as the Health Specialist Case Manager for the UpliftU® program during the summer of 2008.

The internship was conducted using ethnographic research methods to understand counseling team members' and resident mothers' perceptions of access to health care resources and their experiences in utilizing area health care services. This thesis compares the perspectives of the counseling team members with the resident mothers' perspectives, and examines barriers to and gaps in service provision, as reported by both groups. Findings from qualitative data analysis suggest that counseling team members

conceptualize the barriers to health care as originating at the individual level with resident mothers' behaviors and actions, while resident mothers' expressed that they experience barriers to health care services at interpersonal and institutional levels. Resident mothers described how health professionals and staff treating them poorly leads to barriers to health care at an interpersonal level, and that at an institutional level the bureaucratic hassles associated with public insurance and public clinics also acted as barriers to care. Such differences in perception of causality of barriers to health care services between counseling team members and resident mothers have significant ramifications for resident mothers' health and ability to access health care services.

Chapter One

Introduction

“I think the community needs to be educated because I think the community thinks a lot of the homeless population are just the men. That there aren’t families. Because you don’t see them everyday, because they’re not out on the street corner.”

--UpliftU® counselor

This chapter will provide a brief overview of the themes, issues, and objectives central to this thesis. I will present a personal introduction to the organization where the internship was conducted, and then place this research project into the global and national context of health disparities. The issue of homelessness and the associated health consequences will also be briefly presented. Finally, I will summarize the research objectives and broader implications of this thesis research project and outline the findings and conclusions.

The Setting

The UpliftU® program is a long-term residential program for women and families who are homeless or at risk for homelessness. This program is one part of a larger, community-based, non-profit, faith-based organization serving low-income and homeless families in Hillsborough County, Florida for over 35 years. This program is not an emergency shelter program, but rather offers up to 18 months of participation in a self-sufficiency program to single women and families. The goal of the program is to prevent future homelessness for residents by helping them to reach their highest level of self-

sufficiency in several different related areas, such as employment, education, and relationships. During the summer of 2008, I completed an internship as the Health Specialist Case Manager for the UpliftU® program.

The Kitchen

Prior to starting my internship or even conceptualizing my fieldwork, I began to volunteer at Metropolitan Ministries in order to get a feel for the organization, see what types of services they offered and to whom these services were available, and to try and determine if homelessness was an issue I wanted to pursue for my thesis research. I decided to volunteer at Metropolitan Ministries specifically, because a cursory look into service providers in Hillsborough County indicated that this was one of the largest organizations in the community, offering many different types of services to a diverse population. I filled out the electronic volunteer form and within a week scheduled my first day of volunteer work. From August 2007 until May 2008 I worked as a volunteer at Metropolitan Ministries.

I offered to help out wherever they needed the most help. When I began volunteering in the summer of 2007, this just happened to be the kitchen. On my first day I was given a brief tour of the facilities, detailed instructions on how to find the kitchen and sign-in upon arrival, and told to come back next week to begin work. Finding the kitchen proved to be somewhat of a challenge initially because it is located behind the gate at the Family Residence Center way in the back of the building. Each day I would ring a buzzer, the person at the desk would push a button, the door would make a loud beeping sound, and then open for me to walk in. After signing in at the front

desk, I would then walk through the courtyard, past the childcare center, through another door, and into the cafeteria. In the back corner of the cafeteria was the kitchen, where I would sign in again, put on a hair net, apron, and rubber gloves, and get put to work by one of the main chefs. The approximately 100 shelter residents eat three meals a day at this cafeteria, and staff members and other low-income families also eat lunch here.

Overall, the kitchen serves approximately 200 people for lunch each day. As a volunteer in the kitchen, I mainly helped prepare dinner by cutting vegetables, making a salad, or stirring the soup. Other days I would help by cleaning the tables and chairs, washing fruit for the afternoon snack, or sorting through donated food.

The Outreach Center

While working in the kitchen did allow me to see what kind of food is donated to Metropolitan Ministries and what residents ate on a regular basis, it was not exactly the position on the front lines I had hoped for when I signed up. After a few months of working in the kitchen, I was transferred over to volunteer in the Outreach Center. My first day in Outreach was overwhelming, and I loved the work there immediately.

Outreach is best described as organized chaos. As you approach the doors to the Outreach Center, people are typically congregating outside, smoking, talking, reorganizing their bags of food or belongings, and just generally hanging out. Just about everyone says or nods hello as you pass and the atmosphere is friendly and comfortable, although also crowded and bustling. Inside Outreach you can feel the tensions rising, and if it is near the end of the month you can hear, smell, and see the stress on people. Crying children and the smell of dirty clothes greet you at the door, and solemn looks on

people's faces tell you how long they've been waiting. Despite all this, staff members, volunteers, and clients in Outreach tend to be upbeat and optimistic.

The Outreach Center is most people's first interaction with Metropolitan Ministries. The people who come here looking for services are as diverse and colorful as the variety of services they seek. Some come to get a new identification card, others need to use the restroom or the phone, and still others are here to ask for help with food, clothes, furniture, housing, or unpaid bills. As a volunteer counselor in Outreach, I quickly learned the eligibility requirements for receiving a food box, or clothing voucher, or referral to another agency, and I worked with people to address their needs as best as possible. The Outreach center staff is friendly and Christian-based in their interactions with everyone, yet stern if the rules are not followed. Food and drink are not allowed in the counselors' office area, arguing with or disrespecting counselors and volunteers is quickly reprimanded, and everyone is asked to wait as patiently as possible and talk in quiet voices. Because of the large number of people being seen in Outreach each day, and due to the variety of different services offered in Outreach, it is crucial that this order is maintained to some degree all day long.

There is no typical day in Outreach, but there is a process to being seen by Outreach staff and there are typical groups of people who come to Outreach for help. The front desk workers in the Outreach Center serve as a clearinghouse to ensure people have the required documentation for the services desired and to answer any immediate questions that arise. Many low-income families and individuals come to Outreach for an emergency food box, of which they can receive three each year. The majority of homeless individuals come to Outreach to request a clothing voucher from the Thrift

Store that gives them several clothing items free of charge each month, but many homeless individuals also come to use the phone or check their mail, which can be delivered to Metropolitan Ministries in their name. Other people need help accessing social service agencies for help with unpaid utility bills or addiction problems, and others are seeking assistance finding emergency shelter for the night. Counselors for their part do their best to connect clients with the appropriate resources, and everyone leaves with a copy of the yellow Community Guide brochure listing of local service agencies.

Despite the sometimes long wait in Outreach and stressful circumstances beyond the Outreach Center, the vast majority of people who come into Outreach are smiling, pleasant to work with, and genuinely thankful for the help Metropolitan Ministries offers. Within a few weeks of working there several of the regular homeless clients knew me by name and we would stop and catch up when I had a break. The Outreach staff members were also consistently cheerful, energetic, and friendly, and without fail remembered to thank the volunteers for their time and energy. It was refreshing to work in such a positive atmosphere, while helping people in dire situations. After several months of volunteering here, I knew I wanted to complete my thesis internship and research at this organization and began to take the steps necessary to make that a reality.

Health Disparities

Inequalities in access to quality health care services between developed and developing countries have been acknowledged for years and many anthropologists and nonprofit organizations have been working internationally in order to decrease such discrepancies. More recently however, health disparities within developed countries have

come to the attention of the media, researchers, and the general public, and increasingly the need to address gaps in health care within the United States has been emphasized as a critical issue. While the United States spends more on health care per person than any other country, millions of Americans do not have health insurance and consequently lack access to quality health care services. As Fort poignantly states, “the profit motive driving the US health care system is at odds with health care as a basic human right. Not surprisingly, under the current regime the most vulnerable— the poor, chronically ill, racial and ethnic minorities, children and the elderly— are suffering the most” (Fort et al. 2004:4). Research exploring access to health care for low-income and marginalized groups within the United States can explore possible solutions to such disparities.

Homelessness In The United States

According to the National Coalition for the Homeless (NCH), in a given year 2.5 million people in the United States are likely to experience homelessness (NCH 2006). Of those people, 1.35 million are children under the age of 18 (NCH 2006). The NCH has reported a steady rise in homelessness in the United States over the past 25 years and predicts that this pattern will persist due to increased shortages of affordable housing and climbing poverty rates (2006). On average, homeless people are staying in shelters longer today than they were ten years ago, with the average shelter stay now being seven months long (NCH 2006). In Florida specifically, it is estimated that over 83 thousand people are homeless and that 35 percent of these people are children under the age of 18 (Hillsborough County Homeless Coalition 2008). The number of people who are homeless in Florida has more than tripled in the past 15 years, and the state only has

shelter beds for fewer than four of every ten homeless people (Hillsborough County Homeless Coalition 2008). Homelessness in the United States is a growing trend and the country does not currently have services or programs to help the millions of Americans experiencing homelessness each year.

Not only is homelessness, in general, on the rise, but also the number of homeless families with children has increased over the past ten years (NCH 2006). This group is now the fastest growing segment of the homeless population in the United States (NCH 2006; Nunez 1996). One study cited by the NCH purports that 39 percent of homeless people are children under the age of eighteen (2006). While it is difficult to validate any number of homeless people, a NCH survey of 25 American cities found that 33 percent of the homeless population consisted of families with children (2006). Similar statistics have been reported for major metropolitan areas such as Boston, Trenton, and San Antonio (Nunez 1996), and it is estimated that 38 percent of the homeless population in Florida is made up of families with children (Hillsborough County Homeless Coalition 2007).

Homelessness is a critical issue in part due to the many documented negative health outcomes affecting people in this situation (Anderson and Koblinsky 1995; Burt and Cohen 1989; Burt et al. 2001; Clatts and Davis 1999; Desjarlais 1996; Lovell 1997; Tischler et al. 2007). Studies of homelessness have documented the health risks and problems that often accompany life on the street, and homeless mothers and their children are especially prone to experiencing negative health outcomes, partially due to a lack of access to necessary health services (Anderson and Koblinsky 1995; Burt and Cohen 1989; Hatton et al. 2001; Karim et al. 2006; Miller and Lin 1988; Tischler et al. 2007).

Illnesses such as asthma, pneumonia, conjunctivitis, malnutrition, and bronchial infections frequently plague homeless people, and infectious diseases such as sexually transmitted diseases, HIV, and tuberculosis are also prevalent among this population (Clatts and Davis 1999). Children living on the streets or in shelters are especially vulnerable to such illnesses and typically have high rates of acute and chronic health problems, as well as developmental delays (Burt et al. 2001; Clatts and Davis 1999). Unfortunately, illness is intimately tied to homelessness and this indicates an essential need for medical services among this population.

It appears that most anthropologists have focused either on homeless single adults or homeless children, but not homeless adults *with* children (Wolch and Rowe 1992; Clatts and Davis 1999). By focusing on homeless women who have children, this study addresses this void and adds breadth to anthropological studies of homeless people by including a section of the population previously overlooked. Since the end of the 19th century, anthropologists and social scientists have been studying poverty and homelessness to understand the sources of these issues and to find possible solutions (O'Connor 2001). Within medical anthropology, researchers have considered the medicalization of homelessness (Lyon-Callo 2000; Mathieu 1993), homelessness and mental illness (Desjarlais 1996; Hopper 2003; Lovell 1997), and substance abuse issues within the homeless population (Singer 2006). However, medical anthropologists have not fully researched the health *services* available to homeless people, especially those available to women with children. Furthermore, they have not examined barriers that restrict utilization of the available services by homeless mothers with children.

Public health researchers have investigated the negative health outcomes associated with homelessness and have also started examining the barriers that limit access to health care resources (Hatton et al. 2001; Kushel et al. 2001; Miller and Lin 1988; Weinreb et al. 2007). While this information is critical and lays the groundwork for future public health research, a major gap in the research exists. The majority of research on homeless mothers and their children and the health services available to them has been conducted in a top-down approach. Researchers have asked service providers to evaluate the health care homeless mothers receive (Tischler et al. 2007), but they have not yet asked the homeless mothers themselves what types of health services are needed and to evaluate services available to them. Whether or not service providers and homeless mothers agree on what services should be offered remains to be explored. A desperate need exists to find out what types of health services and support homeless mothers report needing and wanting in order to determine if these services are being offered. The simple fact that the health services offered have not been fully examined points to the potential for discontent by the homeless women with children.

Objectives, Broader Implications, and Findings

The overarching purpose of this project was to investigate the health services available and any barriers limiting access to these services from the viewpoint of homeless women and their children. The immediate goal of this thesis was to provide the UpliftU® program with specific recommendations for ways in which the program could begin to bridge gaps in service provision within the community and assist families in

overcoming barriers to accessing health care resources, and this was done through a Technical Report delivered directly to the program's lead counselor in November 2008.

However, while the project directly benefited the UpliftU® program and the homeless families participating in that program, it also broadened anthropological and public health research on homelessness by including the perspectives of the typically marginalized and growing population of homeless families. Anthropologists have not yet focused on homeless women with children or the health services available to this population and public health researchers have thus far approached the issue from a top-down framework that overlooks the opinions of homeless mothers themselves. This project addressed these gaps by providing anthropologically informed recommendations based on the perspectives of homeless women with children for improving access to health care resources for this population.

Data analysis identified major themes presented by both counselors and resident mothers from the UpliftU® program, and found that overall both groups are adequately satisfied with the health care services available to homeless mothers with children. However, counselors and resident mothers agreed that dental care is a critical gap for parents and children alike and that parents have more barriers to health care services than children. Qualitative data analysis also ascertained that counselors focused on barriers to health care as occurring at the level of the individual, while resident mothers reported interpersonal and institutional barriers that create greater challenges to accessing care.

Summary

In this chapter I provided an introduction to the organization at which research was conducted, the broader context of health disparities within which this research is situated, and cursory explanations of homelessness and the negative health outcomes experienced by homeless families. The overall research objective of examining access to health care services for homeless mothers with children was given along with the local outcomes of the research project and broader implications for the disciplines of anthropology and public health. In conclusion, I briefly stated the major findings from data analysis.

Chapter Two

Literature Review

“It upsets me because if there’s specialty doctors out there and you have Medicaid, you have whatever insurance, why can’t you help? And that frustrates me because you’re a professional. You know if I’m coming to you it’s not because I want to waste your time; it’s because my kid is in pain. You know and I’m trying to avoid it getting worse. Why can’t you just help?”
--Resident mother

This chapter will review the scholarly literature from anthropology and public health relevant to the issues, themes, and theories of this thesis research on access to health care services for homeless mothers. First, a review of anthropological contributions to the study of homelessness will be discussed. Then, in order to place homeless research into the broader theoretical context, a brief overview of anthropological studies and theories on poverty will be given, followed by a look at health disparities from an anthropological perspective.

I then move into a brief discussion on homeless families and how they are similar to and different from homeless single adults and poor, housed families. Finally, I present the public health literature relating to homeless families that examines access to health care services among homeless families with children and the health consequences of not having access to these services.

Anthropology on Homelessness

Overview

Many anthropological accounts relating to homelessness and health focus on mental illness (Desjarlais 1996; Lovell 1997) or substance abuse (Hopper 2003; Singer 2006). Other medical anthropologists have criticized the government and media tactics that medicalize homelessness by consistently associating homelessness with mental illness (Lyon-Callo 2000; Mathieu 1993). Another common focus for medical anthropologists studying homelessness is the examination of the streets or shelters where homeless people spend the majority of their time in order to understand how these places affect homeless people and their daily activities (Desjarlais 2000; Schutt 2003; Wolch and Rowe 1992).

Identity Construction and Power

While these topics cover a multitude of subjects associated with homelessness, they share a common focus on identity construction and power. Ethnographies of homeless people, shelters, and social services have explored the way in which shelter employees, government officials, and the media work to construct homelessness as pathological and deviant, as well as how homeless people accept or reject such characterizations (Desjarlais 2000; Lovell 1997; Lyon-Callo 2000 and 2001). Some researchers have found the homeless people they worked with created identities in opposition to what shelter employees, the government, and the media have assigned them in order to combat stigmatizing labels (Desjarlais 2000; Lovell 1997).

For example, one study found that the homeless people did not characterize themselves as mentally ill, while shelter employees continually referred to them as a type of mental illness and “treated” them according to what psychiatrists deemed appropriate for that problem (Desjarlais 2000). In other medical anthropological work, the repeated attempts to pathologize homelessness were seen as responsible for leading to homeless people creating their own self-identities that align with this discourse (Lyon-Callo 2000). In this case, well-intentioned shelter employees viewed homelessness as a social problem based on an individual’s deviant behavior, and the only way homeless people could resist was by being non-compliant and disagreeing with the shelter employees’ so-called diagnosis (Lyon-Callo 2000).

By investigating identity construction anthropologists have demonstrated that homeless people often have different self-characterizations than those ascribed to them by shelter employees and psychiatrists. Furthermore, these ethnographies exemplify how homeless people are often powerless to change inaccurate and involuntary identity constructions forced upon them. Not only are staff characterizations pushed on the homeless people utilizing shelter services, but there is also a staff agenda of the culture of therapy based on white, middle class American ideology that governs many shelters (Desjarlais 1996). This agenda tries to force a heterogeneous group of homeless people to take action and responsibility in pre-determined ways that may or may not be most appropriate to their situations and personalities (Desjarlais 1996). Anthropologists have shown how the dominant social and political communities use their power to maintain characterizations of homeless people as deviant (Desjarlais 1996; Lyon-Callo 2000;

Mathieu 1993), and this inhibits attempts to think about homelessness as a consequence of larger structural forces.

Poverty Studies

Overview

The anthropological literature on homelessness is part of a broader discussion within the discipline on poverty and socioeconomic inequalities. Much of the anthropological work on poverty in the last half century developed in response to the culture of poverty and underclass theories that influenced policy in the United States (Brin Hyatt 2001, Goode and Maskovsky 2001). Anthropologists have focused their poverty research on explicating the relationship between neoliberal ideologies and policies and the increasing gap in wealth and skyrocketing rates of poverty (Goode and Maskovsky 2001, Maskovsky 2001, Ruben 2001) in order to contest the recent paradigm that places poverty as the fault of the individual. The literature illustrates the role hegemonic policies play in creating and maintaining structural inequalities that reinforce poverty and limit chances at ending wealth disparities (Goode and Maskovsky 2001, Lyon-Callo 2001, Mullings 2001).

Neoliberal Politics and Poverty

Through widely disseminated works, Oscar Lewis' concept of a culture of poverty promoted the idea that poverty occurred due to behaviors and values passed down through generations of poor families (Lewis 1965). His work characterized poor people as failing to participate in society, lacking middle class values, and exhibiting feelings of

helplessness and dependency (Lewis 1965). “Indeed, it is the low level of organization which gives the culture of poverty its marginal and anachronistic quality in our highly complex, specialized, organized society” (Lewis 1965:xlvii). Lewis’ solution to this culture of poverty was thus to aim to change poor people’s values and behaviors (Goode and Maskovsky 2001).

Other anthropologists responded to Lewis’ work with rebuttals that gave ethnographic examples of highly organized social, political, and economic networks and refuted the culture of poverty theory by illustrating how, “assumptions about the social and personal incompetence of the poor were in and of themselves ideologically driven” (Goode and Maskovsky 2001:11). The poverty research and literature from anthropology focused on countering Lewis’ main idea that people are poor due to pathological habits, values, and lifestyle choices (Brin Hyatt 2001).

While the critique to Lewis’ work was not without its own shortcomings, the response led to more research focused on the connection between neoliberal ideologies and poverty. Today’s “new poverty studies” argue that poverty is a direct outcome of the uneven capitalistic development touted by neoliberal politics (Goode and Maskovsky 2001). “Neoliberalism opposes the New Deal-Keynesian model of direct government intervention in job creation, human service provision and community empowerment. Instead, it advocates a market-based program of deregulation, investment tax credits, downsizing, and outsourcing of public services, and an up-by-the-bootstraps philosophy” (Ruben 2001:436). Many of the anthropologists contributing to new poverty studies explain how this type of neoliberal ideology completely overlooks and ignores anyone who is not successful at navigating the market-based system (Ruben 2001).

Other anthropologists have criticized the assumptive nature of neoliberal politics that depict the capitalistic market-based system as the only and best method for economic development (Brin Hyatt 2001, Lyon-Callo 2001). There is, “an unquestioned acceptance of the claim that the free market is the most cost efficient and the fairest way of delivering services to both the poor and the nonpoor, the privatization of formerly public and state-sponsored amenities, and an emphasis on competition and consumerism in all spheres of life” (Brin Hyatt 2001:205). This assumption presumes that the free market will “solve” poverty, and as such no measures should be taken by the government to address social inequities (Goode and Maskovsky 2001). “Those whose social value cannot be defined in terms of the market are vilified as ‘irresponsible dependents,’ unworthy of state largesse or even charity” (Maskovsky 2001:470-471), and thus do not deserve assistance from the government.

Structural Inequalities vs. Personal Failings

In this milieu of culture of poverty and underclass theories and neoliberal ideologies where poverty is typically thought of as a result of personal failings and behaviors, anthropologists studying poverty have contributed significantly to the discussion by emphasizing the larger, structural factors that cause poverty, including the market-based system (Goode and Maskovsky 2001). Many have argued, in fact, that by constructing poverty as the failure of individuals, the role of structural factors is purposefully deemphasized. “By blaming these women for their own poverty and, indeed, for the economic ills of the entire nation, attention is diverted from the injustice of the racial and gendered labor market and from the ‘savage inequalities’ increasingly

characterizing U.S. society” (Mullings 2001:47). Anthropologists have worked to divert attention away from blaming poor people and shift it towards the systemic features that cause and sustain poverty.

Within this line of reasoning, anthropologists have also critiqued researchers and politicians who pathologize and medicalize poverty (Maskovsky 2001, Mullings 2001). “Not only do these labels obscure the political and economic basis of inequality by reinforcing psychologistic models of individual deviance; they and their associated assumptions also shape the ways in which poor people view themselves and their relation to the state” (Maskovsky 2001:474). These researchers point out that by pathologizing poverty, poor people are only further blamed for market-based processes that inherently create inequality (Maskovsky 2001, Mullings 2001). The important point that anthropologists studying poverty have stated time and time again is that structural inequities, found in the neoliberal social and economic policies, significantly contribute to maintaining rather than eliminating poverty for many Americans.

Health Disparities

Overview

Recently, an extension of poverty research has developed that explores the relationship between population groups that vary according to wealth, ethnicity, gender or other factors and how these factors impact health. Health disparities has become a popular research topic in public health and anthropology, in part due to the Healthy People 2010 goal of reducing such disparities in order to positively impact public health (Dressler et al. 2005). According to Dressler, Oths, and Gravlee, “‘health disparities’

refers to differences in morbidity, mortality, and access to health care among population groups defined by factors such as socioeconomic status, gender, residence, and especially ‘race’ or ‘ethnicity’” (2005:232). Another likely reason for the increased interest in health disparities by public health and anthropological researchers is recent data that suggest health disparities are increasing worldwide (Harrison 2007).

Anthropologists have been examining social inequalities and differences in lifestyle and health outcomes among different communities for many years, and several medical anthropologists have joined public health researchers by focusing on health disparities in recent years (Farmer 2003; Singer 2007). Paul Farmer’s concept of structural violence, as the “broad rubric that includes a host of offensives against human dignity: extreme and relative poverty, social inequalities ranging from racism to gender inequality, and the more spectacular forms of violence that are uncontestedly human rights abuses” (2003:1), has aided anthropologists in conceptualizing inequities and their health consequences (Singer 2007). Medical anthropology as a discipline is well situated to be a broker between the epidemiological descriptions of health disparities from public health and the theories of power and structural inequalities from anthropology. As this mediator between disciplines, medical anthropology can work to understand these disparities and their causes, find culturally appropriate ways to minimize such disparities, and advocate for policies that decrease structural violence and inequalities.

Socioeconomic Status

The majority of anthropological published research on health disparities focuses on disparities according to three categories: race and ethnicity, poverty and

socioeconomic status, and gender (Dressler et al. 2005; Harrison 1994; Rozen 2007; Singer 2007). While some researchers (Dressler et al. 2005) feel strongly that “race” and “ethnicity” are the cornerstone of understanding health disparities, other researchers are similarly convinced of the importance of poverty and socioeconomic status on unequal health outcomes (Leatherman 2005; Rozen 2007; Rylko-Bauer and Farmer 2002). For the purposes of this thesis, health disparities according to poverty and socioeconomic status will be explored more in depth as the other two categories are beyond the scope of this specific research project.

Through a biocultural framework, Leatherman (2005) hopes to address poverty and power issues at both the local and global levels as well as the relationship between these levels and their impact on health. He critiques previous, narrower approaches for focusing on either local *or* global inequalities by considering the environment as an external and autonomous factor (Leatherman 2005). Furthermore, on a note similar to Dressler (2005), he critiques past models for failing, “to explore the social and structural roots of the oppression and discrimination that lead to frustration, hopelessness, or despair (and physiological stress) in marginalized groups” (Leatherman 2005:49). This approach to studying health disparities and the impact of poverty on health is to equally study the structural context of human experiences and the local individual level of biological indicators in order to illustrate how structural inequalities are experienced by individuals living in poverty (Leatherman 2005).

Because Leatherman (2005) values the importance of addressing both structural causes and local realities of poverty and health disparities, he argues that the questions for anthropologists to consider are why some people are poor and why some people get

sick. “We need to ask how conditions of poverty and poor health are mutually causative and constituted; how each serves to (re)produce the other” (Leatherman 2005:50). To do so, he recommends identifying a “space of vulnerability” where poverty and ill health intersect and to then examine how individuals work in and construct this space (Leatherman 2005:51). This space is where people become vulnerable to exposure to stress, inadequate abilities to cope with that stress, and thus risk negative health outcomes due to this stressful situation and the lack of capability to deal with it (Leatherman 2005). Poor people are most vulnerable to these situations, according to Leatherman (2005), although other factors contribute to this vulnerability.

Through this idea of a space of vulnerability, anthropologists can examine the local meaning of poverty as well as the surrounding conditions that contribute to vulnerability and the ability to cope with stressors (Leatherman 2005). “This entails an examination of structured inequalities and social relations that underlie poverty, and how they affect not only levels of illness, but also coping capacities and hence the outcomes of poor health on the economic and social functioning of the household” (Leatherman 2005:51). Incorporated into this approach are anthropological theories of human agency, the interplay between the global and the local, and the way in which production structures class processes and structural inequalities (Leatherman 2005).

Market-Based Health Care in the United States

Another approach within anthropology for studying health disparities as they relate to poverty and socioeconomic status has been a critique of the health care system within the United States (Rozen 2007; Rylko-Bauer and Farmer 2002). Rylko-Bauer and

Farmer (2002) go as far as to argue that research on health disparities must be complimented by a serious critique of the market-based health care system through which such disparities are enacted and maintained. “In our view, health care as a right is not compatible with health care as commodity; the former is grounded in principles of justice and social good, whereas the latter is rooted in profit motives that pay lip service to the ‘laws’ of supply and demand” (Rylko-Bauer and Farmer 2002:477). They contend that managed care and other market-based health care strategies lack the ability to address health disparities caused by lack of access to health care by the poor and uninsured, and further, that market-based ideologies in medicine actually exacerbate the disparities that already affect these populations (Rylko-Bauer and Farmer 2002).

Rylko-Bauer and Farmer (2002) emphasize the role structural violence plays in creating and maintaining health disparities among poor populations. The authors describe the negative impacts of welfare reform and Medicaid coverage requirements on poor families. “This is just one among many examples of how socioeconomic inequalities, and poverty in particular, have complex negative consequences for both health status and health care access and use” (Rylko-Bauer and Farmer 2002:481). It is crucial to recognize that for-profit health care business ideologies are not designed with the intent of providing equitable care, but instead are concerned with the bottom line economic profits to be made through medical care (Rylko-Bauer and Farmer 2002). This means that within the United States market-based health care system, that health inequalities are not dealt with, or even of concern, because the system’s interest lies in its profits for shareholders.

Not only is the system not designed to address health disparities, but also the system actually works to worsen structural inequalities such as a lack of insurance or access to health care for people in low socioeconomic situations (Rylko-Bauer and Farmer 2002). “The bottom line increasingly dictates policy and practice in market-based medicine, and addressing disparities in access and delivery of health care does not mesh with a market ideology” (Rylko-Bauer and Farmer 2002:487). Evidence indicates that the evolution of Medicaid into a managed care system has had a deleterious impact on poor and uninsured people served by the program, in part because its health care providers receive very little reimbursement or incentive for caring for these populations (Rylko-Bauer and Farmer 2002). Instead, a need exists for more ethnographic research that analyzes the relationship between poverty, health, and access to health care by including the poor patient’s perspective of health care and the structural inequities they face (Rylko-Bauer and Farmer 2002; Whiteford 1990). “Achieving equity and eliminating inequalities in health care is unattainable in a competitive market structure where profits determine policy” (Rylko-Bauer and Farmer 2002:492).

Consequences

Other researchers have similarly critiqued the health care system in the United States for reinforcing health disparities among poor populations (Rozen 2007). Rozen (2007) cites statistics describing the negative health outcomes experienced by poor women, mothers, and children. “It is no surprise that poor women are more likely to have babies who die in infancy than middle class women...the sobering fact of child health inequality is that the disparity between poor and better off children is widening,

not narrowing” (Rozen 2007:39). Whereas other researchers (Rylko-Bauer and Farmer 2002) critique the market-based health care system, Rozen (2007) focuses on welfare reform and its negative consequences on the health of people with low socioeconomic status. He purports that replacing Aid to Families with Dependent Children (AFDC) with Temporary Assistance for Needy Families (TANF) created a two-tiered system where people in low socioeconomic ranges were forced into the lower tier associated with unemployment, lack of health insurance, and stigma (Rozen 2007).

“TANF doctrine accepts the culture of poverty as making the poor mother unfit to participate in the marketplaces of readily-available work. In essence her impoverished status is medicalized; her illness is the culture of poverty. If she does not assume the ‘sick role’ and accept the ‘treatment’ by TANF counselors, she is punished and her children’s benefits are terminated” (Rozen 2007:40).

According to Rozen (2007), medical anthropologists use two hypotheses to explain the relationship between poverty and health disparities, and he uses these hypotheses to link welfare reform to current inequalities in health. First, the social capital hypothesis explains that in more egalitarian societies social networks and social capital serve as a support for poor people and, thus, work to maintain or improve their health status (Rozen 2007). Contrastingly, welfare reform is responsible for deteriorating social networks by encouraging and rewarding women for being independent, working on their own, and ending trading services techniques (Rozen 2007). Second, biological pathways and stress sustain and augment health disparities for people of low socioeconomic levels (Rozen 2007). While welfare reform claims to decrease the amount of stress experienced by people through offering programs aimed at poor people, in actuality it reinforces health disparities through negative stereotypes and stigmatization (Rozen 2007).

Anthropologists can combat negative consequences of welfare reform by continuing to fight against culture of poverty theories, and by re-focusing attention on structural inequalities caused by welfare reform.

Themes and Theories

Two important trends are apparent when examining anthropological research on health disparities and are worth noting here. First, although some authors give certain factors (i.e. race and ethnicity or socioeconomic status) greater importance in the impact on health disparities, all authors are careful to admit that a complex relationship exists between all three factors (race and ethnicity, socioeconomic status and poverty, and gender), and that it is difficult to separate the role of one individual factor from the other two (Becker 2004; Dressler 1993; Leatherman 2005; Mullings 2002; Rozen 2007; Rylko-Bauer and Farmer 2002; Schneider 1999). These authors explain that for the sake of research it makes sense to try and control for certain variables in order to understand the effects of one variable on differences in health outcomes, but also that in reality it is impossible to separate the relationship between race, class, and gender and their combined effect on health. Additionally, some believe that these factors exist in a multiplicative relationship (Mullings 2002), whereby multiple oppressive characteristics combine to create “synergistic social inequalities” (Rylko-Bauer and Farmer 2002:490).

Secondly, across anthropological publications on health disparities each at least mentions, if not provides lengthy explanations, about the role of *structural* inequalities that lie at the root of all health disparities. It is this inclusion of broad global and institutional factors into the discussion of local individual level experiences that

Leatherman (2005) called for, and this critique of systemic problems is an important contribution for anthropologists to make to health disparities research.

Homeless Families

In order to study health disparities, researchers have recorded and reported the health indicators of marginalized groups of people and worked with such groups to understand the structural and local causes of inequities in health. In the United States, one such marginalized population is homeless people and families who often lack stable shelter, a reliable source of food, steady income, health insurance, and a primary care physician. People stereotypically think the homeless population in America is mainly comprised of single, adult men who are veterans or suffering from mental illness or substance abuse problems; unfortunately studies consistently indicate that the homeless population is increasingly made up of families with children.

Definitional Difficulties

The United States Department of Housing and Urban Development (HUD) defines homelessness according to the McKinney-Vento Homeless Assistance Act and this definition is used to determine eligibility for most services (HUD 2007). According to this definition a homeless person is anyone who lacks a regular nighttime residence and any individual whose primary nighttime residence includes a shelter, temporary residence for institutionalized people, or a public or private place not typically used as a place for sleeping (HUD 2007). While this definition includes many homeless people and families, researchers have repeatedly criticized the definition for not including

everyone experiencing homelessness (Anderson and Koblinsky 1995, Glasser and Bridgman 1999, Lewit and Schuurmann Baker 1996). This definition is more appropriate (though still not all inclusive) when describing homeless single adults, but homeless families oftentimes differ dramatically from homeless single adults, and thus this definition is especially narrow and inadequate for describing homeless families.

Whereas homeless single adults often come to shelters from living on the street, homeless families typically experience long periods of unstable housing prior to moving into shelters, such as moving back and forth between friends and family members' homes for brief stays (Shinn and Weitzman 1996). In order to account for families in these "doubled up" situations, some researchers have proposed other more inclusive definitions of homelessness that include the, "thousands of families precariously doubled-up with relatives or friends" (Anderson and Koblinsky 1995:13). One such definition involves defining two groups of homeless people: the literally homeless and the precariously housed population (Lewit and Schuurmann Baker 1996). This definition explains that the precariously housed are in imminent danger of becoming literally homeless and that children and families are often among the precariously housed group (Lewit and Schuurmann Baker 1996). While this definition is more inclusive, it still does not account for everyone experiencing homelessness.

Characteristics of Homeless Families

In addition to differing from homeless single adults according to their living situation prior to moving into a shelter, homeless families also differ from homeless single adults in other ways. In fact, some researchers have argued that homeless families

are more similar to housed poor families than they are to homeless single adults (Shinn and Weitzman 1996). While it is crucial to recognize that families experiencing homelessness are a heterogeneous and diverse group and that not *all* homeless families will fit the forthcoming descriptions, studies conducted in urban areas around the United States have consistently agreed on several characteristics that describe many of the families in homeless shelters.

Data indicate that homeless families, similar to many housed low-income families, tend to be headed by young, single mothers, and parents in homeless families are reported as being much younger than homeless single adults (Shinn and Weitzman 1996). Homeless mothers with children and housed poor mothers have reported similar levels of educational attainment and past employment experiences, but both groups tend to report lower levels of education and fewer past employment positions than homeless single adults (Shinn and Weitzman 1996). Research also suggests that a lower proportion of homeless parents and families have substance abuse and mental health problems than homeless single adults (Shinn and Weitzman 1996). These differences in characteristics between homeless families and homeless single adults have led to the obvious conclusion that homeless families have different needs and problems than homeless single adults, and thus may experience more success in shelter programs designed specifically for families.

Public Health on Homelessness

Access to Health Care

The public health literature relating to homeless families concentrates mostly on the negative health outcomes of homelessness, and recently has also investigated the health services available to this population. Health care access has been defined by Gulzar as the, “fit among personal, sociocultural, economic, and system-related factors that enable individuals, families, and communities to have timely, needed, necessary, continuous, and satisfactory health services” (Hatton et al. 2001:26). Unfortunately, health care access is unequal and homeless families have a more difficult time than most other groups in gaining such access. Many researchers have documented the lack of access to health services for homeless families and studies have even suggested that accessing health care is more difficult for homeless families than for housed low-income families (Hatton et al. 2001; Kushel et al. 2001; Miller and Lin 1988; Weinreb et al. 2007). Other researchers have reported a lack of access to mental health services for homeless mothers as well (Weinreb et al. 2007). The lack of health care access for homeless mothers is due to a variety of factors and has several important consequences for these women and their children.

If resources for both food and health care are not available to homeless people, food oftentimes is the more direct necessity. The immediate need to secure food and shelter can act as a barrier to accessing health care for homeless families (Kushel et al. 2001). Another major barrier to health care access for homeless mothers and their children is the lack of health insurance or Medicaid (Kushel et al. 2001; Miller and Lin 1988). Even many families that would likely qualify for Medicaid or other public

insurance are currently not covered (Kushel et al. 2001). Lack of insurance prohibits families from accessing many types of health care services.

For homeless mothers specifically, the risk of losing custody of their children if medical providers deem them unfit is a critical barrier, especially to accessing mental health services (Weinreb et al. 2007). The perception that children will be taken away if the mother is diagnosed with a mental illness can keep women from seeking the treatment they need. Other barriers to health care services facing homeless mothers include a lack of transportation and child care, no regular health care provider, reluctance of providers to care for homeless clients, and providers that blame homeless women for their own health problems (Hatton et al. 2001). Barriers to accessing health care services vary for homeless mothers depending on where they live geographically, where they live in comparison to the location of services, their social networks, and their access to information about service providers.

Health Consequences

Unfortunately, the consequences associated with being homeless and not having access to health care services are multifaceted and widespread. Homeless mothers and their children are more likely to experience negative health outcomes and to report their health as being fair to poor when compared to the average population of the United States or to the housed low-income population (Burt and Cohen 1989; Miller and Lin 1988). Similarly, homeless mothers consistently report having worse mental health than housed low-income mothers (Tischler et al. 2007).

One study done by Hatton, Kleffel, Bennett, and Gaffrey found that focus group participants reported a slew of acute and chronic health problems. “Conditions that affected primarily children included chicken pox, whooping cough, and head lice. Communicable conditions seen in both adults and children included hepatitis, tuberculosis, athlete’s foot, scabies, colds, flu, and sexually transmitted diseases” (2001:28). Other studies confirm these findings, documenting the health risks and problems that often accompany life on the street. Furthermore, both homeless women and their children have low health maintenance and preventive care (Hatton et al. 2001; Miller and Lin 1988). For example, Miller and Lin found a “disproportionate number of children are not receiving preventive services such as immunization and tuberculosis skin testing” (1988:672) in their study of sheltered homeless families. Correspondingly, another study found that changing locations frequently decreases the likelihood of receiving appropriate health care, especially preventive services (Karim et al. 2006). Not receiving preventive care increases the chance that homeless mothers and their children will experience continuous negative health outcomes.

On a broader scale, the consequences of homeless mothers lacking access to health care services have an economic affect. Researchers have suggested that without access to mental health services, women themselves become more overwhelmed and anxious leading to more serious psychological problems for both her and her children down the road (Tischler et al. 2007). Providing early counseling services and consistent emotional support to homeless mothers would lower costs by decreasing the severity of mental health problems and thus the quantity of services needed as well as by decreasing the number of mothers in need of mental health services.

Other research has found that homeless mothers without access to health care due to a lack of insurance tend to wait, “until health problems are so acute that they must seek help in costly emergency rooms” (Hatton et al. 2001:26). The government and taxpayers end up paying more for a visit to the emergency room than they would have paid for preventive and primary health care services. Furthermore, some research has hinted at the probability that without receiving necessary health care services, homelessness is perpetuated for homeless women with children because they are not healthy enough to work and their health problems do not significantly decrease even after re-housing (Karim et al. 2006). In a milieu of budget cuts and fewer resources for health care, the fact that not providing care to homeless mothers has proven to be more expensive than providing primary preventive health care services is an urgent message that changes need to be made.

Summary

This chapter began with a review of the academic anthropological literature on homelessness and explained how government officials, shelter and social service agency employees, and the media continue to depict homelessness as a deviant and pathological condition. These same groups are then able to use their positions of power to maintain constructions of homeless people in a pathological and medicalized perspective. Then I outlined the broader context of anthropological poverty studies and discussed the theories from this literature related to homelessness. From there, I presented a discussion of health disparities as differences in health and access to health care services according to socioeconomic status, and how these disparities are reinforced and exacerbated by the

market-based health care system in the United States. Consequently, government programs designed to alleviate poverty and suffering only result in continued negative health consequences due to stigmatization and stereotypes.

At the end of this chapter, I included a brief description of homeless families to explain how these families differ from homeless single adults: they most often come to shelter programs from precariously housed situations rather than from living directly on the street. Other characteristics of homeless families illustrated the importance of programs and research that are designed specifically for the unique situations and needs of homeless families. Finally, the public health literature on homelessness described how accessing health care services is often difficult for homeless families and the negative health outcomes that result from a lack of access to such services.

Chapter Three

Fieldwork Setting

“Insurance coverage doesn’t cover housing. So there’s nothing for the in-between people. And mostly adults, kids get taken care of. Or even if it’s just like, her kidneys are giving out, but they aren’t totally given out, so she doesn’t qualify for SSI but she can’t work and she’s on Hillsborough County HealthCare so she needs to pay for prescriptions, she needs to pay for treatment, just a little bit, but if you can’t work...there’s nowhere.”

--UpliftU® counselor on the resources available to terminally ill homeless people

This chapter describes Hillsborough County, Florida, Metropolitan Ministries, and the UpliftU® program as the fieldwork setting for this ethnographic research. Also described in this chapter is the process by which I found Metropolitan Ministries as a research location, and how my internship and research project with the UpliftU® program were developed. I then give a detailed description of Metropolitan Ministries’ UpliftU® program by outlining the program’s structure and purpose, the facilities, the counseling team, and the residents living there. Understanding the community within which this project was situated is important because the political milieu, economic situation, and community characteristics impact who experiences homelessness and how they experience it, and information about the organization as a whole, the UpliftU® program specifically, and Hillsborough County are included to provide a description of this context.

Hillsborough County

Geography and Demographics

Located on the west coast of Florida bordering the Gulf of Mexico, Hillsborough County is Florida's fourth largest county covering over one thousand square miles of land (U.S. Census Bureau 2008) and accounting for 6.4 percent of the state's total population (The Florida Legislature 2008). The Florida Legislature reports the estimated 2007 population for Hillsborough County as 1,192,861 people, and the population grew nearly 20 percent from 2000-2007 (The Florida Legislature 2008). The vast majority of this population growth (75%) is due to net migration (The Florida Legislature 2008). The area has warm, tropical weather year round with wet, rainy summers as is typical for the entire state of Florida.

Hillsborough County's population tends to be somewhat younger than the population of the state of Florida overall, with a median age of 35.1 years as compared to the state's median age of 38.7 years (The Florida Legislature 2008). In 2006, 25.2 percent of Hillsborough County's population was under 18 years of age, while only 22.4 percent of the state's population was under 18 years of age (The Florida Legislature 2008). The county also has a higher percentage of family households with children under the age of 18 living in the household (48.1%) than the state of Florida overall (42.3%) (The Florida Legislature 2008). Also, while the limitations of racial and ethnic categories of the census are known and understood, it is still worth noting that Hillsborough County is reported as having a higher percentage of the total population with Hispanic or Latino origins than the state overall (U.S. Census Bureau 2008).

Several of these factors influence the prevalence of homelessness in Hillsborough County, including the warm climate, a high growth rate due to net migration, and a younger population with a high percent of children. As far as access to health care services are concerned, in the last 12 months 9.6 percent of adults in Hillsborough County report being unable to get medical care (Florida Department of Health 2008). Furthermore, 16.4 percent of adults in Hillsborough County report not having health care coverage, and 23.1 percent report not having access to a personal health care provider (Florida Department of Health 2008). Understanding the geography, demographics, and health care statistics in Hillsborough County was critical to this research project.

Economy and Housing

Reports of average annual employment in Hillsborough County show that over 20 percent of people work in professional and business services, nearly 19 percent work in trade, transportation and utilities, 11.5 percent work for the government, and just over 10 percent are employed in education and health services (The Florida Legislature 2008). The average annual wage for all industries in Hillsborough County is \$40,392, which is just slightly higher than the average annual wage for the state of Florida overall (The Florida Legislature 2008). In addition, the most recently reported data from the year 2006, show that on average personal income, earnings, and per capita personal income had been increasing for Hillsborough County residents for the past several years (The Florida Legislature 2008).

However, as was true for the entire country during the summer of 2008, Hillsborough County was experiencing a tough economic situation throughout the period

of my fieldwork. Problems with the housing market, high gas prices, and increasing food prices were affecting Hillsborough County residents much like they were affecting people across the United States. The unemployment rate in 2007 was 4.0 percent (The Florida Legislature 2008) and by June of 2008 that rate had jumped to 5.5 percent (State of Florida 2008). A loss of 78,100 jobs, a 1.0 percent loss overall, was reported between June of 2007 and June of 2008 (State of Florida 2008). As recently as 2005 Hillsborough County had 13 percent of the population living below the Federal Poverty Level (FPL), and 17.9 percent of children ages zero to 17 were living below the FPL (The Florida Legislature 2008). Both of these percentages have continued to increase in recent years (U.S. Census Bureau 2008).

The housing situation in Hillsborough County was also difficult during this time. Between 2005 and 2006 the percent change in homes sold was -35.5 percent, and again in 2006 to 2007 the percent change in homes sold was -34.9 percent (The Florida Legislature 2008). The 2000 census data show that a large percentage of housing units in Hillsborough County are renter-occupied (35.9%), and that same census data report 8.1 percent of all housing units as being vacant (The Florida Legislature 2008). More recent data on vacant housing units were not available at the time of research, but with the housing market slump it is probable that the percent of vacant housing units in the county has increased over the last several years. Home sales, foreclosure rates, and vacancy rates all impact the prevalence of homelessness within a community, because a difficult housing situation means fewer families will be able to find and afford stable homes.

A 2007 report on the state of housing in Florida ranked Hillsborough County 41st out of 67 total counties in the state in terms of affordability (White et al. 2008), and a

closer look at housing costs quickly illustrates why. First, the percent change in the base rent for apartment homes from 2000-2008 was almost a 39 percent increase for one, two, and three bedroom apartments (Florida Housing Coalition 2008). Income and earnings did not increase at this same rate during this time period.

Secondly, HUD defines the Fair Market Rent (FMR) as, “the 40th percentile of gross rents for typical, non-substandard rental units occupied by recent movers in a local housing market” (HUD 2008). In Hillsborough County the 2008 FMR for a one-bedroom apartment is \$730, for a two-bedroom apartment is \$883, and for a three-bedroom apartment is \$1,119 (Florida Housing Coalition 2008). This means that in order to afford housing at the FMR rate, an annual income of \$29,200 is needed for a one-bedroom apartment, \$35,320 annual income is needed to afford a two-bedroom apartment, and an annual income of \$44,0760 is needed to afford a three-bedroom apartment (Florida Housing Coalition 2008).

Based on the area median income of \$56,500 for Hillsborough County in 2008, a family would have to pay 52 percent of their income for a one-bedroom apartment, 63 percent of their income for a two-bedroom apartment, and 79 percent of their income for a three-bedroom apartment (Florida Housing Coalition 2008). However, the estimated median renter household income for Hillsborough County in 2008 is only \$34,837, which means a family making this annual income would have to pay 101 percent of their income to afford a two-bedroom apartment (Florida Housing Coalition 2008). At the mean renter wage, a person would have to work 49 hours per week to afford a two-bedroom apartment or 62 hours per week to afford a three-bedroom apartment (Florida

Housing Coalition 2008). The Florida Housing Coalition (2008) estimates that 50 percent of renters are unable to afford a two-bedroom apartment at the FMR.

The costs are even more burdensome for wageworkers. In 2008, the minimum wage in Hillsborough County was \$6.79 (Florida Housing Coalition 2008). For a person earning minimum wage, the rent affordable according to the governmental definition is \$353 (Florida Housing Coalition 2008). A person earning minimum wage would have to work 83 hours per week to afford a one-bedroom apartment at FMR, 100 hours per week for a two-bedroom apartment, or 127 hours per week for a three-bedroom apartment (Florida Housing Coalition 2008). Worse yet, if a person is living on Supplemental Security Income (SSI) their monthly income is only \$637, which means the rent affordable for them is only \$191 (Florida Housing Coalition 2008). Clearly, the housing situation in Hillsborough County, Florida presents a problem for many working families, and these are the families who become homeless when they cannot find affordable housing or afford the available housing options.

To address some of the housing affordability issues, the Tampa Housing Authority offers a Section 8 Housing Choice voucher program that provides a federal rent subsidy to assist low-income families and households with monthly rent payments (Tampa Housing Authority 2008). With funds from HUD, the Tampa Housing Authority is able to distribute money in the form of Section 8 vouchers to eligible families (Tampa Housing Authority 2008). These vouchers help families and individuals rent housing that meets their needs at a price they can afford (Tampa Housing Authority 2008). With the Housing Choice program families are required to pay at least 30 percent, and no more than 40 percent, of their monthly-adjusted income towards their rent. If the rent at the

approved housing location is higher than 30 to 40 percent of their income, then Tampa Housing Authority makes up the difference and pays the landlord directly (Tampa Housing Authority 2008).

While the program has had some success and has helped many families find and sustain affordable housing, one shortcoming of the program is the limited number of vouchers available in comparison to the need for affordable housing in Hillsborough County. The federal government only provides 5,209 vouchers for Section 8 rental assistance for all of Hillsborough County (Tampa Housing Authority 2008), and unfortunately, the need is much greater. When the wait list for Section 8 vouchers was opened for five days at the end of October in 2006, the Tampa Housing Authority received over 10,000 preliminary applications (Tampa Housing Authority 2008). Currently over 15,000 people in Hillsborough County are on waiting lists for affordable housing and the numbers keep increasing each year (Hillsborough County Homeless Coalition 2007).

According to Carmen Nieves, the Housing Programs Manager at the Tampa Housing Authority, “because of the limited funds most of the families will be waiting years for rental assistance” (e-mail to author, July 22, 2008, used with author’s permission). She also explained that right now the Tampa Housing Authority is only issuing 50 to 75 replacement vouchers per month (e-mail to author, July 22, 2008). She stated, “These are replacement vouchers, not new vouchers or new funding or additional funding. When a family is terminated from the program, we replace it with a family from the waiting list” (e-mail to author, July 22, 2008). With a limited amount of funding and

vouchers available, the Tampa Housing Authority is restricted in how many families they can assist in Hillsborough County.

In addition to the Housing Choice voucher program, the Tampa Housing Authority also owns and manages 18 public housing developments throughout the Tampa area (Tampa Housing Authority 2008). Tampa Housing Authority currently has two housing developments for elderly residents and another 16 properties for families, that combined add up to more than 3,200 housing units (Tampa Housing Authority 2008). These units are designated as affordable housing and are available to more than 7,000 low-income families and individuals in Hillsborough County (Tampa Housing Authority 2008). Currently, the Tampa Housing Authority is investing \$13,000,000 into improving the physical conditions of these housing units and expanding the number of affordable housing units available (Tampa Housing Authority 2008).

Homelessness

While the previously mentioned statistics describing homelessness in the United States are grim, the numbers of homeless people living in Hillsborough County, Florida are worse. With the 6th largest percentage of homeless people in the United States, it is estimated that almost 10,000 people experience homelessness in a given year in Hillsborough County (Hillsborough County Homeless Coalition 2007). Worse yet, this number increased by more than 25 percent between 2003-2005 (Hillsborough County Homeless Coalition 2007). Of the homeless population in Hillsborough County, data collected indicate that 56 percent have a source of income, and of these, 37 percent are currently employed (Hillsborough County Homeless Coalition 2007). Among

Hillsborough County's homeless population, 91 percent became homeless while living in Florida, 43 percent are homeless for the first time, and 25 percent have been homeless for at least 4 times previously (Hillsborough County Homeless Coalition 2007).

Furthermore, estimates suggest that 16 percent of the homeless population in Hillsborough County is made up of children under the age of 18, and this percentage skyrocketed almost 50 percent between the years 2003-2005 (Hillsborough County Homeless Coalition 2007). On the day of a recent count, more than 1,500 children in Hillsborough County Public Schools were homeless at that time (Hillsborough County Homeless Coalition 2007). Unfortunately, the state of Florida has shelter beds for only approximately 4 out of every 10 homeless people on a given night, and Hillsborough County only has services to help approximately 15 percent of the homeless people living there (Hillsborough County Homeless Coalition 2007).

Given these conditions, Hillsborough County was (unfortunately) the prime location for this research project on homeless families access to health care services. Local service providers in the area are currently overloaded with homeless people needing assistance and the situation has continued to deteriorate with the recent economic downturn.

Metropolitan Ministries

Metropolitan Ministries is a large, community-based, non-profit, faith-based organization that has been serving low-income and homeless families in Hillsborough County, Florida for over 35 years. Funded almost entirely through donations and private grants, "Metropolitan Ministries' mission is to care for the homeless and those at risk of

becoming homeless in our community through services that alleviate suffering, promote dignity, and instill self-sufficiency...as an expression of the ongoing ministry of Jesus Christ” (Metropolitan Ministries 2008). Metropolitan Ministries’ website explains that their Guiding Values, serving as the foundation for all the work done at Metropolitan Ministries, are: Christian witness, dignity, responsibility, quality care, community involvement, stewardship, staff team, and cooperation (Metropolitan Ministries 2008).

Driving towards downtown Tampa on Florida Avenue or out of downtown on Tampa Street, it is hard not to notice the large, bright white sign for Metropolitan Ministries announcing an urgent need for diapers, peanut butter, or volunteers. However noticeable the sign, it is difficult to distinguish exactly which buildings belong to Metropolitan Ministries, and even after three months of almost daily fieldwork I still sometimes think I would miss the turn into the parking lot if it were not for the blue arrow on a smaller sign pointing the way. Spanning more than two city blocks and including several buildings of various shapes and sizes, Metropolitan Ministries is situated just outside downtown Tampa near several other social service agencies and homeless shelters. Bordering the outskirts of a wealthier, historic neighborhood on one side and the much smaller, run-down, inner city block homes on the other, Metropolitan Ministries is accessible to both people needing assistance and to those wanting to donate time, money, or resources.

This organization began in 1972 when 13 churches of various denominations throughout Tampa recognized that efforts to assist homeless and low-income people were being duplicated and that individual church efforts were overwhelmed by the increasing need in the community (Metropolitan Ministries, 2008). Together these churches joined

forces, coordinated their efforts, and consolidated to form Metropolitan Ministries (Metropolitan Ministries, 2008). Throughout the mid-1970s and the early 1980s, Metropolitan Ministries grew and expanded their services in order to meet the needs of the continuously growing population of homeless and hungry people in the Tampa area (Metropolitan Ministries, 2008). In 1986 a family residence was built to provide emergency shelter for nearly 40 families each night, and by 1996 a program had been developed for homeless men and women that provided food, emergency shelter, counseling services, and job placement (Metropolitan Ministries, 2008). Since then Metropolitan Ministries has continued to expand services and their programs have evolved to meet the ever-changing needs of the homeless population.

Today Metropolitan Ministries offers many services to families and individuals who are either homeless or at risk for homelessness through three major programs: the Outreach Center, Metropolitan Ministries Academy, and the UpliftU® program. In the Outreach Center families and individuals can receive guidance on how to obtain identification, where to find hot prepared meals, and how to navigate local social service agencies (Metropolitan Ministries 2008). The Outreach Center also offers food boxes to families and individuals that qualify, clothing vouchers for homeless clients, furniture vouchers for people with a referral from Red Cross, and Holiday Assistance in the form of food boxes and gifts for children (Metropolitan Ministries 2008).

Operating on an annual budget of \$8.7 million, Metropolitan Ministries spends over 80 percent of this budget on their programs and services (Metropolitan Ministries 2008). In the 2003-2004 fiscal year the Outreach Center helped an average of 70 families per day with food, clothing, and referrals to other social service agencies (Metropolitan

Ministries 2008). In that same year, over 1.25 million meals were served through Metropolitan Ministries at Community Partnership sites throughout the Tampa Bay area (Metropolitan Ministries 2008). Counselors and volunteers working in the Outreach Center can assist families and individuals in finding affordable accommodations, by making referrals to other service providers, and by explaining how to sign up for health insurance, cash assistance, and other governmental programs.

The Metropolitan Ministries Academy is a Hillsborough County Charter School for children in kindergarten through fifth grade who are homeless or at risk for homelessness. It is open to both residents living at Metropolitan Ministries and children living in the surrounding community. The UpliftU® program is a long-term residential program for women and families who are homeless or at risk for homelessness. Due in part to continually increasing numbers of homeless families with children, the program is unable to accommodate all families experiencing homelessness at one time in the community. A first-come-first-served wait list for the program means that most families wait anywhere from one to four months to enter the shelter. As is true for many homeless families, most of the families waiting for this program find shelter for the duration of their time on the wait list by staying with friends or family members.

This program has residential space for up to 40 families and 12 single women, and most people participate in the program for anywhere from six to 18 months. Typically, anywhere from 100 to 140 people are living at Metropolitan Ministries at a given point in time. The length of the program is designed to focus on long-term goals of self-sufficiency in order to end the cycle of repeated homelessness many people face.

More detailed, ethnographic information about this program is provided later in this chapter.

An Internship and Research Project

I began volunteering at Metropolitan Ministries almost nine months prior to beginning my thesis internship and research. As a volunteer in the Outreach Center, I would occasionally refer families or single women to Metropolitan Ministries' long-term residential UpliftU® program, although at the time I did not know what all the program entailed or how it worked. Talking to my supervisor in Outreach one day about my research interests and ideas for a thesis project, he recommended I speak to the head counselor for the UpliftU® program about an internship with that program since I wanted to focus on homeless women with children. I scheduled a meeting with the head counselor later that week and met with her to learn more about the UpliftU® program and internship possibilities.

When I met with the head counselor she gave me an overview of the UpliftU® program, confirmed that most of the residents in the program were families with children, and told me that they always welcome student interns. I explained to her my interest in exploring homeless mothers' access to health care services while at the same time providing some sort of needed assistance to the UpliftU® program, and she revealed that due to funding and staff constraints research of this sort is always desired but rarely able to be carried out. As we discussed how to best create an internship that addressed both my research interests and the program's most pressing needs, we created an intern position for me as a Health Specialist Case Manager.

As the Health Specialist Case Manager for the UpliftU® program, I acted as a resource for other counseling team members when they were working with a family needing medical care, having problems with medical care, not complying with the recommended medical care, or having other health related issues. The other counseling team members were able to refer these residents to me, and I then worked with these individuals or families to find appropriate, feasible solutions to their medical concerns. Furthermore, because I was informed about the health services available to homeless women and children in the community, I was able to direct and refer residents to appropriate service providers. In addition to my responsibilities as the Health Specialist Case Manager, the head counselor and I agreed that I would be also be able to gather information from resident mothers and UpliftU® counseling team members about residents' access to health care services in the community and any existing barriers that limit access to such services.

UpliftU® Program

Program Overview

The UpliftU® program at Metropolitan Ministries is not an emergency shelter program, but rather offers up to 18 months of participation in a self-sufficiency program to single women and families. The goal of the program is to prevent future homelessness for residents by helping them to reach their highest level of self-sufficiency. The program is made up of six distinct phases that are designed to improve self-sufficiency in the following areas: housing, finances, employment, recovery and sobriety, mental health and relationships, health and nutrition, education, and spirituality and community. The

idea behind this program organization is that each of these areas of life is related to the other areas, and if one area is weakened then it affects the other areas negatively.

In terms of homelessness, this framework implies that a person or family is homeless because one or more of these areas of their life is weak and needs to be improved in order to overcome homelessness. Thus, the program tries to improve the weaker areas of residents' lives in order to prevent future episodes of homelessness. This type of program model is widely used nationally, and exhibits the neoliberal ideology that individual deviancies or weaknesses are the root cause of homelessness and need to be treated or improved to end homelessness. The Assessment phase lasts about a month and is a probationary phase where the counseling team evaluates whether or not the family or individual is appropriate for the program while the family or individual decides if the program is right for them. Once both the counseling team and the family or individual have determined that the program is a good match for their needs, then the family or individual is "phased up" to Phase I.

Phase I begins the actual self-sufficiency program for UpliftU® participants with educational classes on parenting, finance, employment, and other topics and typically lasts for one to two months. During this time residents are also required to volunteer around Metropolitan Ministries for several hours each week. Once residents have finished attending the in-house classes and completed their volunteer hours, they are recommended for advancement to Phase II. In the second phase residents can pursue educational goals appropriate to their chosen career path and goals. Depending on the participant's current educational status they can strengthen their math and reading skills, finish a General Equivalency Degree (GED), or enter certificate programs at local

community and technical colleges. Each educational opportunity is offered to residents free of charge, and residents are encouraged to pursue educational goals of interest to them.

Because the time commitment for each education program varies, each resident spends a different amount of time in Phase II. Once the education curriculum has been completed, residents are considered for phase advancement again. Phase III is the employment phase where residents are expected to search for job opportunities, create a resume, and attend job fairs and interviews. This phase lasts a maximum of three months, and during this time residents meet frequently with the employment counselor to evaluate and re-evaluate their job search strategy and success. During these first few phases residents have several responsibilities around the shelter, such as classes and homework, 20 hours of volunteer work per week, group counseling sessions, and one-on-one counseling sessions. As residents advance through the phases and begin to take on greater responsibilities outside of the shelter, they gain more flexibility and freedom within the program.

For residents to be phased up to Phase IV they must have found employment, and during this phase they are expected to be working and saving their earnings. Because the UpliftU® program is still providing shelter, food, clothing, and other necessities, residents in the employment phase are expected to save at least 80 percent of their income in order to start preparing for living on their own. This phase is typically limited to a maximum of three months. Once a resident is working and saving money, the counselor and resident begin preparing that resident for life after the UpliftU® program. Phase V lasts only about one month as the resident transitions out of the

program. The hope is that by this phase the resident is actively participating not only in the UpliftU® community, but also in the new community they will be moving into. Counseling team members support and mentor residents through each phase of the program.

The Family Care Center

The building that houses all the residents in the UpliftU® program is officially called the Family Care Center, and staff and residents refer to it as the FCC. The FCC faces Tampa Street and from the outside it is impossible to tell for what the building is used. A locked metal gate guards the main entrance to the FCC, and a staff member working the front desk must buzz residents in and out. This helps to ensure that any residents leaving domestic violence situations are safe at the shelter and works to keep young children away from the busy streets surrounding the shelter. The majority of counseling team members and other employees have electronic cards that can be swiped at the gate to unlock it for entrance and exit. Just past the gate is the FCC front desk area with several chairs, a phone for residents to use, and the FCC front office.

The FCC front office is staffed 24 hours a day by Resident Staff Advisors and serves as the central command station for the residence hall. The director of the UpliftU® program and the FCC residence advisor have offices within this front office, and residents come to the front desk for a plethora of needs and concerns. Residents stop by for their mail, to take prescription or over-the-counter medications, request laundry detergent or bleach, and to retrieve a food item from their own personal food bin. The front desk staff can call residents in their rooms, page residents on the overhead

loudspeaker, and take incoming calls for residents. Being so near the entrance and exit to the FCC, the front desk staff is tuned in to the comings and goings of residents and have frequent interactions with all the residents of the program. At the same time, residents have easy access to the services offered by the front desk and the staff members working there.

All of the families and single women living at the FCC have their own personal room in this building, as well as several common space areas where residents can be found during their down time. A courtyard in the middle of the FCC has a continuous flow of people walking through to the kitchen, the daycare center, or their rooms. Outside, a designated smoking area contains a couple picnic tables and some chairs and this is a popular hangout for adult residents to congregate and relax. Around the corner from the smoking area is a playground for families to use and where children play during daycare and school recess.

The UpliftU® program only accepts families and single women into the program and has reserved three rooms in the FCC for the single women to share. Up to four single women can be living in one of these rooms together at one time, but the rooms were not filled to capacity during my internship at Metropolitan Ministries. The one to four women in each of these rooms share two sets of bunk beds and a bathroom with a toilet, shower, sink, and mirror. Each woman is also assigned a locker in which she can keep her personal belongings. Families are each assigned to their own room, and depending on the size of the family they are given a room with either two or three sets of bunk beds. Family rooms have bathrooms in them as well, and they have dressers for clothes and belongings. The rooms are not large by any standards and a single room with four

women or a family room with a family of six can end up quite crowded. That being said, the vast majority of residents are so thankful to have a place to live and a space to call their own that only rarely do complaints arise about the rooms.

The room situation was a little more hectic than normal during my fieldwork because the furniture in the rooms was being replaced and the rooms were being cleaned, repaired, and re-painted. This meant that most of the families had to move rooms over the course of the summer, in order that they could move into a newly renovated room and then the construction crews could renovate that old room. Having families moving and construction crews working added a little more noise and chaos to the FCC for the summer, and it also meant that the UpliftU® wait list for new families entering the program grew a little longer as no new families could be moved in until the room renovations were complete. Typically the wait list is approximately two months long, but during the summer counselors were told to explain to families applying to the program that it would likely be three to four months before they could expect to move in.

Despite the added hassles associated with refurbishing the rooms at the FCC, the new furniture and repairs were desperately needed. During my internship I heard horror stories from counselors and residents about hundreds of roaches living in the old wooden bunk bed posts and crawling all over residents as they slept. Another resident described to me how she always shook out her children's sheets and blankets before putting them to bed to get rid of the spiders, ants, and roaches that crawled into the bed during the day. The new furniture was metal, which would prevent bugs from living inside the posts, and during their repairs the construction crews went through and repaired holes in the walls where bugs were entering the rooms. The counseling team and residents were hopeful

that these updates would improve the quality of life in the FCC, and after the moves had all taken place everyone was pleased with the improvements that had been made.

The Counseling Team

The counseling team is the core group of people overseeing the UpliftU® program and working with clients through each phase of the program's curriculum. The director of the UpliftU® program is not necessarily part of the counseling team, but rather one step above the counseling team in the chain of command. He serves as the link between Metropolitan Ministries' upper level administrators and the counseling employees who work with the residents on a daily basis. As their supervisor he is often present for meetings about resident issues or problems and is actively involved in decisions about phase advancement or exiting for residents.

The counseling team itself is made up of five licensed counselors, one employment counselor, one education counselor, and one education and literacy specialist. Four of the licensed counselors work with the adult residents and the fifth licensed counselor is in charge of children's counseling services and group sessions. These counselors have a variety of degrees, mainly in marriage and family counseling, mental health counseling, and recovery and addiction counseling. The other three counselors are not licensed but have degrees and experience in their designated area of expertise. Residents are assigned one lead licensed counselor to work with throughout their stay at Metropolitan Ministries, and they will work one-on-one with the specialty counselors at various phases of the program.

Each member of the counseling team has an office located in the Outreach building next to the FCC. For the most part residents walk over to the Outreach building for meetings with their counselor, group counseling sessions, educational classes, and meetings with the specialty counselors. Most of the counselors make a concerted point of walking over to the FCC every once in awhile to check things out, see how their residents are getting along in their rooms, and understand the environment in which the residents live for most of the time. Going back and forth between the two buildings is only a short walk, but typically the Outreach building offices are where residents meet with the counseling team in a more formal setting while the FCC is where residents and counselors interact more spontaneously and informally.

The frequency of meetings with counselors varies for residents depending on their needs, current phase, and pace of advancement. Most lead licensed counselors try to meet with each of their assigned residents at least once per week, but meetings with the education or employment counselor may be more or less frequent depending on a resident's phase. For example, during Phase III when a resident is searching for employment opportunities, they are likely required to meet with the employment counselor several times each week to discuss opportunities and strategies for success. On the other hand, a resident in Phase II may not meet with the employment counselor for several weeks or months while they complete their education program, but instead may meet with the educational counselor every day. Counselors make themselves as available as possible to the residents, and generally let the residents determine how much or how little contact they want to have with their counselor in between assigned meeting times.

The Residents

The population of residents living at the FCC is fluid and ever changing for a variety of reasons. Some families or individuals find alternative housing during their stay with the program and move out, other families or individuals do not advance through the Assessment phase, and still others are “exited” or kicked out during other phases of the program for violating the house rules. Reasons for exiting during my internship included: alcohol usage, prescription drug addiction, failure to complete required school or work assignments, and lack of respect and motivation for the program. The Family Residence Census is a document updated daily that lists all the residents, their children, their room number and other identifying or important information. On the last day of my internship the Census showed that Metropolitan Ministries had six single women and 28 families (67 children and 33 parents) living at the FCC for a total of 106 residents. Of these 39 adult residents, seven were in the Assessment phase, nine were in Phase I, 16 in Phase II, three people were in Phase III, and one person was in Phase IV. Three residents were transferring out of the program at this time, or preparing to move out and live on their own.

The single residents ranged in age from 24 to 49 years old, three of the six women were recovering from substance-abuse problems, and one single woman had a physical disability. Among the families, the youngest parents were 22 years old and the oldest was 58 years old. The children ranged in age from newborn infants to teenagers. Five of the families were two-parent families, while the others were either a single mother or father and their children. Two of the families were single fathers and their children, while the others were all single mothers and children. The largest families living at the

FCC had two parents and four children all living together in one room. Most of the families, however, were a single parent with two or three children living together. Four parents were in the substance abuse recovery program and one had a physical disability.

Summary

Due to high rates of homelessness and a poor housing market during the summer of 2008, Hillsborough County, FL was well situated as the location for this research project. I was introduced to Metropolitan Ministries through a cursory exploration of homeless service providers in Hillsborough County, and was able to build a relationship with this organization through several months of volunteer work in the Outreach Center prior to beginning my internship and research project. By collaborating with the head counselor for the UpliftU® program I was able to develop an internship and research project that would both benefit the UpliftU® program and fulfill my research interests.

In this chapter I described Hillsborough County's demographics, economy, and housing situation, and reported estimates of the homeless population living in Hillsborough County. Additionally, this chapter explained that Metropolitan Ministries is a large community-based, non-profit organization serving homeless individuals and families through a faith-based mission, and that the UpliftU® program is a long-term, residential program aimed at helping homeless women and families break the cycle of homelessness by achieving self-sufficiency.

Chapter Four

Research Methods

“When you go to the emergency room they treat people who don’t have insurance really bad. It’s like we don’t matter to the ones who do have insurance. They need to treat the ones who don’t have insurance just as well as the ones who do. Because we’re here too. We’re not just like we want to be sick or we ask to be homeless...it happens.”
--Resident mother, on how she is treated by medical providers

In this chapter I state the research objectives guiding the study, explain why the project was conducted as a case study and ethnography, and describe the research methodology used to collect data. Finally, I conclude the chapter with information on how data were stored, conceptualized, and analyzed.

Research Objectives

The overarching objective of this study is to describe the health services available to mothers who are currently participating in the UpliftU® program at Metropolitan Ministries. The specific objectives that guided this project were (1) to elicit the perspectives of resident mothers and organization employees regarding available health services, (2) to explore barriers that limit access to health services from the perspectives of resident mothers and organization employees, (3) to determine what types of health services and support resident mothers report needing and wanting, (4) to determine gaps in service provision that limit resident mothers’ access to needed health care services, and (5) to provide recommendations to the UpliftU® program for addressing health care service provision gaps in order to improve resident mothers’ access to health care

resources. These objectives informed decisions made regarding the research design of this project.

A Case Study and Ethnography

The transient nature and the definitional variances of homelessness create a challenge for researchers. The most common problems exhibited in research on homelessness are those of sampling. These include, one-time studies interviewing chronically homeless people more than people who experience short terms of homelessness, not being able to give every homeless person in a given area the opportunity to participate due to difficulties in identifying and locating homeless people, and excluding homeless families and children from research due to their increased likelihood of living doubled up with another family (Glasser and Bridgman 1999). Furthermore, because an accurate count of the homeless population is unattainable, it is also virtually impossible to construct an appropriate sampling strategy because a reliable sample cannot be created without first knowing the total population. Additionally, the lack of a comprehensive definition of homelessness adds difficulty to research. Societal stigmatization of homelessness and negative stereotypes and attitudes towards homeless individuals may also make homeless people hesitant to participate in research projects.

In anticipation of the potential difficulties associated with researching homeless families, I used assignments from my graduate coursework in both anthropology and public health to begin designing a realistic thesis research project. Through my research methods class I had the opportunity to conduct preliminary exploratory research on agencies and social service resources available to homeless families in the Tampa area,

and during a grant writing course I carefully devised a potential research plan that was thoroughly critiqued by my professor and fellow colleagues. My volunteer work at Metropolitan Ministries allowed me to learn about the organization— their culture, programs, and residents— before I made the decision to carry out my research at this site. These opportunities gave me a chance to acknowledge and overcome some of the possible challenges that could have been faced when researching homelessness, and they put me in a position to have a successful research experience.

This project presented methodological challenges due to the short time frame available for conducting research and the requirement of completing an internship connected to the research topic. In order to plan a manageable project within the specified parameters while avoiding as many of the aforementioned challenges as possible, it was decided that a case study and ethnography (LeCompte and Schensul 1999) of one residential program for homeless families would be the most realistic and meaningful research design. As a case study and ethnography this project is not intended to be representative of all homeless people or even all homeless families in central Florida, but rather is meant to provide an in-depth cultural analysis of access to health care services for homeless mothers living at this shelter in Hillsborough County, Florida.

Data Collection

The research design of this project was exploratory in nature and intended to investigate the health services available in the community from the perspectives of the researcher, the counseling staff at Metropolitan Ministries, and resident mothers. From March to April 2008, prior to beginning my internship at Metropolitan Ministries, I

conducted extensive archival and secondary source research in preparation for my position as Health Specialist Case Manager with the UpliftU® program. University of South Florida Institutional Review Board approval was granted on April 25th, 2008 for the research protocol. Field research took place during my internship with Metropolitan Ministries from May 6th, 2008 through August 8th, 2008. During this time data collection methodologies typical of case study and ethnographic research were used: additional secondary source research, observation, participant observation, a quantitative survey, and semi-structured interviews (LeCompte and Schensul 1999). The initial research design was entirely qualitative and proposed using different types of qualitative data to gather data and verify results. The addition of a quantitative survey came about as part of my internship with the UpliftU® program, and was incorporated into the research design because of its potential to triangulate qualitative findings (LeCompte and Schensul 1999).

Ethical Considerations

Ethical considerations have been of the highest priority in the development and actualization of this internship and research project. The Institutional Review Board (IRB) at the University of South Florida reviewed and approved the internship proposal before any primary research was undertaken. The most important ethical consideration of this project is that I worked with a potentially vulnerable population— homeless women with children. While it was critical that I was constantly aware of the vulnerable position of the residents I worked with, it was also important to remember that as participants in the UpliftU® program these women are part of the “housed” homeless population. Having a safe, stable residence that includes meals, childcare, educational

opportunities, and positive social networks makes the residents of the UpliftU® program less vulnerable than homeless women living on the street.

However, the homeless mothers in the UpliftU® program are also vulnerable because they are socioeconomically disadvantaged and institutionalized (in the sense that they are residents of a shelter), and thus they lack the power to have complete control over their lives. According to the Belmont Report (1979), “when vulnerable populations are involved in research, the appropriateness of involving them should itself be demonstrated” (10). Because past studies have failed to incorporate the voices of homeless mothers and this failure only further exploits this population, I specifically focused on and included homeless mothers in my project to decrease further marginalization. By interviewing the homeless mothers who are residents of the UpliftU® program, I listened to their thoughts and included their voices in my research. It is my hope that this actually decreased the vulnerability of these women by giving them the opportunity to voice their opinions and empowering them by doing so.

The other major ethical consideration regarding this project was that the women and employees of the UpliftU® program needed to feel comfortable with my presence and confident in me as an ethical researcher in order for me to gather honest opinions about health services. If the homeless women had felt as though they would experience negative consequences, such as losing their place in the UpliftU® program, as a result of talking honestly with me or if the employees had felt as though their jobs would be put in jeopardy due to their conversations with me, then I would have been unable to gather reliable data. Therefore, building rapport with both groups of people through participant observation was vital to the success of my study.

The Belmont Report also suggests that the researcher, “adapt the presentation of the information to the subject’s capacity” (1979:8). In order to include women from a variety of literacy levels and to ensure maximum understanding of the project, I read through the informed consent form with all resident mothers. I emphasized that each person had the option of not participating in this project if they so chose and that they also had the option of stopping an interview or their involvement with the project at any time. It was also important to emphasize to both the resident mothers and the UpliftU® counseling team members who I interviewed that all information gathered through the course of the project would be kept in strict confidence and that I would not use their real names in any written material. All names used in this thesis have been changed to respect the confidentiality of everyone involved in this research project. All participants were given the opportunity able to ask questions about the project and I only included participants who voluntarily agreed to sign the informed consent.

Archival and Secondary Source Research

Beginning in March of 2008, I conducted archival and secondary source research (Schensul et al. 1999) on health care resources available to homeless or low-income individuals and families in Hillsborough County, Florida using the Internet, program brochures, and listings of service providers. Archival and secondary source data are, “qualitative or quantitative data collected for governmental, research, education, or service purposes and available to researchers in usable raw data forms and formats” (Schensul et al. 1999:201-202). In this study local archival data included, “information about social and geographic features of the community under study” (Schensul et al.

1999:204) and these data were searched to identify health service providers and resources.

The purpose of this search was twofold. First, having up to date and accurate knowledge about health services, programs, health insurance and other health related resources available to homeless women with children in the community was needed for my internship. As the Health Specialist Case Manager I was responsible for assisting residents of the UpliftU® program in accessing health care services, and to do so I needed a comprehensive understanding of these services. Second, because I was asking the organization's employees and residents what types of health care resources are available to homeless women with children in Hillsborough County, Florida, having completed extensive local archival and secondary source research on these health services allowed me to compare what services employees and residents knew about that I had not found in my searches and vice versa.

To find health care service providers in Hillsborough County, I searched the Internet, program brochures I had collected from various agencies, and community guides that provided exhaustive lists of community services. Geographic location, hours of operation, eligibility requirements, services provided, costs and fees, and the process for service provision were recorded for each service provider in a master Microsoft Word document titled Health Resource Guide (Appendix A) for easy retrieval and functionality. When complete information was lacking from websites or program brochures, I called the service provider to gain more complete information about their program. Phone calls were also made to service providers to verify the accuracy of information and to inquire about fees for specific services, accepted insurance plans, and appointment availability.

While this archival and secondary source research began in March and April of 2008 prior to starting my internship at Metropolitan Ministries, it did not end there. From my supervisor in the UpliftU® program I was able to gather additional resources, such as the Hillsborough County Community Resource Guide, to search through for health care resources. Many of the resources in the Community Guide had already been found through my other research, but in a few instances the Community Guide included supplementary information to which I would not have otherwise had access. Services found through these other reference materials during my internship from May through the beginning of August 2008 were added to the Microsoft Word document created prior to the internship.

In other words, this secondary source research was an iterative process that continued throughout the internship and research process. As I referred clients to certain services providers and assisted clients in making appointments for specific health problems, together the residents and I were able to gather firsthand information about the reality of service provision from these resources. For example, while several programs' websites and information in the Community Guide stated that Medicaid was accepted, clients soon found out that only some Medicaid HMOs were accepted. Another resource advertised offering dental services for low to no income families, but exploring this option for residents of the shelter soon revealed that dental services were only offered as long as funding was available, and funding typically ran out in May or June of each year. Any information gathered through interactions between myself or residents and service providers was noted and recorded in the Health Resource Guide.

Training and Observation

After months of volunteering at Metropolitan Ministries, my internship as the Health Specialist Case Manager began in early May 2008. In order to become familiar with the case manager position and the manner in which the other counselors and counseling interns work with families, I spent a significant amount of time during the first two weeks observing counseling sessions, intake interviews, and the day to day operations of the UpliftU® staff. I was able to observe a children's anger management group counseling session, several intake interviews with families applying to the UpliftU® program, and a call to the abuse hotline of the Department of Children and Families to report suspected neglect.

On these occasions I acted as a complete observer (Bernard 2002), and thus interacted very little with the counselors and clients involved in these events. As a complete observer I was able to watch, listen, and record the events transpiring without being personally involved other than by being present. In each of these situations I also acted as a direct observer, where all participants were aware of my position as a researcher and intentions to record the activities (Bernard 2002). Counseling staff members and clients were made aware of my position as both the Health Specialist Case Manager intern and as a researcher prior to each of these events and consented to my observing. Researchers recommend using observation to, "orient researchers to the field and enable them to begin to sort out major social and cultural dimensions in the field setting" (Schensul et al. 1999:97) and I used these observational experiences to do just that.

As a researcher I recorded detailed notes on the events occurring, as well as on the reactions and non-verbal cues of the participants involved. However, I also paid attention to the fact that my presence as a researcher inherently impacted the events I observed, just as my own research interests and expectations influenced my interpretation of these events (Bernard 2002; Schensul et al. 1999). That being said, direct observation of counseling sessions and intake interviews allowed me to experience firsthand two of the fundamental components of the UpliftU® program and provided me with more in-depth understanding of how the program operates and how counselors interact with clients.

Participant-Observation

Participant-observation has long been a hallmark of anthropological fieldwork and research because it allows researchers to establish rapport with participants and become immersed in a given culture (Bernard 2002). “Participant observation refers to a process of learning through exposure to or involvement in the day-to-day or routine activities of participants in the research setting” (Schensul et al. 1999:91). Because I am neither homeless nor a licensed counselor employed by the UpliftU® program, I was not a complete participant in the UpliftU® program. But, as an intern and volunteer within the shelter I was able to be more than a complete observer in many instances (Bernard 2002). Participant-observation allowed me to establish a balance between these two positions so that I could be honest with residents and organization employees about my research intentions, while at the same time giving me the opportunity to interact with both groups in their environment at the shelter. The majority of my time as an intern at the shelter can be classified as participant-observation. Some of the specific events in

which I was a participant-observer include: case review meetings every Tuesday afternoon, time spent working at the Outreach front desk, monthly house meetings, both formal and informal conversations and meetings at the Intern Office, and daily interactions with staff and residents in the FCC.

I used participant-observation as the Health Specialist Case Manager intern to build relationships, to establish myself as a researcher, and to form an intuitive and intellectual understanding of the milieu at Metropolitan Ministries (Schensul et al. 1999). Building relationships with both the residents and counseling staff of the UpliftU® program was essential to the quantity and quality of my research. The residents and employees needed to feel comfortable with my presence and confident in me as an ethical researcher in order for me to gather honest opinions about the health services offered. If the residents of the shelter had felt as though their place in the program was at risk or if the employees had felt as though their jobs would be put in jeopardy due to their conversations with me, then I would not have been able to gather reliable data. Therefore, building rapport with both groups of people through participant-observation was vital to the success of my study.

Quantitative Survey- Health Assessments

During the first week of my internship, my supervisor asked me to think about health related questions that should be included in the client application or counselor questionnaire for the UpliftU® program but that were currently not being asked. As we discussed my observations and suggestions for health related information that would be pertinent to collect from applicants, the idea of constructing a health assessment

instrument to administer to all new residents was developed. My supervisor wanted to create a document that would expand on the health questions currently asked during the intake process and more thoroughly collect health information from new residents, as well as from established residents with health problems. The inclusion of a quantitative survey into a mainly qualitative research design can be used to, “confirm and validate ethnographically defined patterns” (LeCompte and Schensul 1999:94). In this case, I decided to add the data collected from the Health Assessments to my initially entirely qualitative research strategy in order to validate data from participant-observation and semi-structured interviews.

To create the Health Assessment instrument, I compiled all the health related questions from the UpliftU® application, the counselor intake questionnaire, the initial counseling assessment questionnaire, and health portion of the Metropolitan Ministries Results Oriented Management and Assessment (ROMA) Scales. Those questions were expanded and a Health Assessment with six major sections based on the major themes from these documents (physical health status, self-care, health insurance coverage, access to health care services, family history, and child health and development) was developed (Appendix B). The purpose of the Health Assessment was to learn about the health of the residents in the UpliftU® program in order to help them access any health care services they may need now or in the future.

The inclusion criteria for the Health Assessments were broad; any adult resident in the UpliftU® program who was willing to participate qualified for the assessment. Per the request of my supervisor, the recruitment strategy for the Health Assessments was to target new residents when they moved in, as well as any other residents recommended by

counseling staff. Other residents could also participate in the Health Assessments if they expressed a desire to do so. In total 18 Health Assessments were conducted during my internship. Of the fourteen new residents or families that moved in during this time period, thirteen participated in Health Assessments. Institutional Review Board modification approval was granted on July 29th, 2008 for inclusion of the data collected from the Health Assessment.

Because of this sampling strategy, it is likely that the data gathered from these Health Assessments are biased toward new residents and residents with known health problems (likely have worse health and more health related problems than the average resident at Metropolitan Ministries). Residents who have lived at the shelter for more than a month have had the opportunity to address any immediate health concerns through the resources at the shelter and have had encouragement from their counselor to do so, whereas new residents have not had ample amount of time in the program yet to address such concerns. While this means that the Health Assessment data are likely not representative of all residents in the UpliftU® program, the data do accurately portray the health of all new residents who entered the program between May 12th and August 8th, 2008.

Qualitative Data- Semi-Structured Interviews

To further investigate the health services available to homeless women with children and the barriers that limit access to these resources, I conducted semi-structured interviews (Schensul et al. 1999) with homeless mothers with children who are residents in the UpliftU® program, as well as counseling team members working for the program.

Semi-structured interviews were chosen for this research project because they “combine the flexibility of the unstructured, open-ended interview with the directionality and agenda of the survey instrument to produce focused, qualitative, textual data” (Schensul et al. 1999:149). Commonly used for exploratory research (Bernard 2002; Schensul et al. 1999) where each participant will only be interviewed once (Bernard 2002), semi-structured interviews were the best interviewing method for exploring themes related to accessing health care resources and barriers that limit access to care and were thus utilized for these purposes in this study.

An interview guide (Bernard 2002) was developed and used for semi-structured interviews with both counseling staff members and shelter residents in order to gather reliable, comparative qualitative data. The interview guide (Appendix C and D) had specific open-ended questions that were asked of each participant, but the semi-structured format also allowed me to probe participants on their own health related experiences or perspectives mentioned during the interview in order to obtain deeper understanding. Separate interview guides for counseling staff members and shelter residents were developed; however, the topics covered and questions included in each guide are nearly identical and simply re-worded to be applicable to each group of participants. The questions focused on eliciting stories from the counseling staff members and the resident mothers that illustrate what types of health services are used, why the women use or do not use the available health services, perceptions of the available health services, and barriers that restrict access to these services.

For the semi-structured interviews two purposive samples (Bernard 2002) were used- one of counseling staff and another of resident mothers. Purposive sampling is

used when the researcher has a specific purpose for informants to serve, and finds participants who serve this purpose (Bernard 2002). In this case, I wanted to compare the perceptions held by counseling staff members and those held by resident mothers of the available health care services, so it was necessary to conduct interviews with one sample of counselors and another sample of resident mothers.

Within the two purposive samples, I utilized convenience sampling (Bernard 2002) to find residents and staff members for the semi-structured interviews. The counseling staff included in the sample all work for the UpliftU® program specifically, and consider themselves part of the counseling team associated with this program. Inclusion criteria for counseling staff were that the participant had worked on the counseling team for the UpliftU® program for at least six months and was willing to participate. Two pilot interviews were conducted with counseling team members in order to test the interview guide, and then six semi-structured interviews were conducted with other counseling team members. All but one member of the core counseling team who fit the inclusion criteria were interviewed in total.

The inclusion criteria for the resident mothers required that participants be female residents in the UpliftU® program, over the age of 18 years old, have at least one dependent child living with them at the shelter, and be willing and available to participate. To satisfy ethical requirements from the Institutional Review Board, pregnant women were excluded from participation. I planned on conducting interviews with resident mothers until a point of redundancy in information (Guest, Bunce, and Johnson 2006) was reached or until the end of my internship, and I ended up being able to conduct one pilot interview and eight interviews with resident mothers.

Data Storage

Data collected from archival and secondary source research were compiled and organized in a Microsoft Word document and saved to the shared computer server system at Metropolitan Ministries for easy access by all counseling team members. A small notebook was carried each day during my internship and notes from observations and participant-observation were jotted down in the notebook as the day progressed. Each night after returning home from the shelter, I typed up more detailed field notes based on these notes describing events and activities that had occurred that day as well as any questions, reflections, and perspectives from the day's experiences. My own thoughts and reactions were italicized within the field notes document to designate these from my descriptive field notes. Field notes were saved on my own password-protected computer daily and were electronically saved to a password-protected server for backup purposes once per week.

Health Assessment data were collected by hand on the survey instrument and more elaborate detailed notes were taken as soon after the Health Assessment occurred as possible. Data from the Health Assessments were entered into a Microsoft Excel spreadsheet, and electronic copies were saved to the shared computer server system at the shelter as well as to my personal computer each day. Hard copies of the Health Assessment instruments with hand-written data were stored in a locked file cabinet in my office.

Semi-structured interviews were digitally audio recorded and I simultaneously recorded notes during the interview for accuracy and deeper understanding. With the

exception of the pilot interviews, I fully transcribed each interview and saved the transcriptions in a Microsoft Word document. I also typed detailed notes directly following each interview into a Microsoft Word document to record my reactions and any questions raised. Each electronic document was saved daily to my personal password-protected computer and weekly to a password-protected server for backup purposes.

Data Analysis

As LeCompte and Schensul (1999) as well as Bernard (2002) are careful to point out, data analysis is rarely singularly an inductive *or* a deductive process.

“Ethnographers actually use both induction and deduction throughout their analysis” (LeCompte and Schensul 1999:46). This statement accurately describes the data analysis process for this research project. While again LeCompte and Schensul (1999) and Bernard (2002) recommend using a more inductive approach for exploratory research, I feel that using both approaches strengthened the analysis for this study. Because I had five specific objectives I hoped to achieve with this study, I began my data analysis by coding my field notes, interview notes, and interview transcriptions according to these five objectives. The fact that I chose these objectives in the first place and then that I chose to initially code my data from these objectives points to a deductive, or top-down, data analysis process (LeCompte and Schensul 1999). However, from the coded and uncoded data I also allowed themes and patterns to emerge from the text itself, using a grounded-theory approach to add new codes and identify concepts, and this portion of the data analysis was an inductive process (Bernard 2002; LeCompte and Schensul 1999).

While I used a combination of deductive and inductive data analysis, the majority of my analysis was based on grounded-theory, where a researcher comes to understand the themes that emerge from the text by becoming grounded in the data through a careful examination of interview transcripts (Bernard 2002). “The grounded-theory approach is a set of techniques for (1) identifying categories and concepts that emerge from text, and (2) linking the concepts into substantive and formal theories” (Bernard 2002:462-463). The process of grounded-theory includes searching through interview transcripts and identifying themes that arise from the text, comparing the categories and themes that arise, and using the relationships between categories to create theoretical models supported by exemplar quotations from interview transcripts (Bernard 2002). All of this is an iterative process where the researcher becomes more grounded in the data through the use of memoing, a running commentary about coding and analysis. ATLAS/ti is one software program used for grounded-theory text analysis, and I chose to use this program for my data analysis.

The process I used for my data analysis follows the grounded-theory approach very closely. I began by entering all interview transcripts in ATLAS/ti and reading through every transcript to further familiarize myself with the data. From there I began to code my data according to major themes based on my research objectives. As I continued to become more grounded in the data, I was able to identify emerging themes and code interview data according to those themes as well. Through the use of ATLAS/ti I was able to compare the coded interviews from the counselors to the coded interviews from the resident mothers to examine themes that appeared within and between the two

groups. In this way I was able to identify similarities and differences between counselors' and residents' views of access to health care services.

As I began to formulate initial theories about the findings emerging from the data, I kept record of these theories by utilizing the memo function within ATLAS/ti. The memos created during and after coding became the basis for my data analysis, and as I continued to analyze the coded data I added to the memos, creating a log of my logic and thinking throughout the iterative analysis process. After focusing in on several findings from the data, I was able to go back through the transcripts to pull out exemplar quotes that illustrate the theme behind each finding.

Limitations

A case study and ethnographic research design was appropriate given the time frame, scope, and purpose of this thesis research. However, as a case study and ethnography the data and findings are not representative of *all* homeless mothers with children or even all homeless mothers with children living in Hillsborough County, Florida. Because Health Assessments were collected from all but one of the families who moved into this shelter over the course of my internship, the quantitative data from that questionnaire are representative of resident families new to the shelter from May 12th and August 8th of 2008. However, these data are not representative of all resident families living at Metropolitan Ministries because residents who have lived at the shelter for some time have had encouragement and support from counseling team members to address health concerns and health related issues. Resident families new to the shelter have not

yet had this opportunity, and therefore likely are more apt to be uninsured and have unaddressed health care needs than established residents.

Qualitative interview data gathered for this study are also not representative of all homeless mothers with children living at this shelter due to the fact that participants were recruited for interviews after having completed a Health Assessment or by referral from a counselor. Due to this convenience sampling strategy, interview participants also tended to be newer shelter residents than the average resident mother and therefore it is possible that the qualitative data collected are biased in a manner similar to that of the quantitative data.

Summary

Designed to be a case study and ethnography of the UpliftU® program, this study utilized a mixed-method approach including qualitative and quantitative data to explore health care resources available to resident mothers at Metropolitan Ministries. I analyzed qualitative data from observations, participant-observation, and semi-structured interviews in addition to quantitative data from Health Assessments to explore access to health care services for homeless mothers. Data were primarily recorded, analyzed, and interpreted using ATLAS/ti and grounded-theory analysis methods.

Chapter Five

Data Analysis and Discussion

“I think that they don’t trust authority and they don’t get treated very nicely. At least at some of the clinics I’ve heard. And they also have abuse that’s happened to them and it might bring up some issues from the past.”

-- UpliftU® counselor on mothers’ barriers to health care

This chapter provides an analysis of the data collected during the three months of fieldwork. Through the data from secondary source and archival research, Health Assessments, and semi-structured interviews, I will examine three of the major findings from the analysis. First, counselors and resident mothers reported being mainly satisfied and pleased with the available resources and the health care services received by mothers. However, counselors and resident mothers also agree that dental care is the most critical gap in service provision and insurance coverage, and reported that a second gap in health care resources is that parents have a more difficult time obtaining public insurance and accessing health care services. Finally, despite agreeing on these two points, the data suggest that counselors and resident mothers have differing viewpoints on the causes of barriers to health care services. Each of these findings is supported with evidence from the data and discussed in depth in this chapter.

Satisfaction with Available Care

Data from semi-structured interviews and Health Assessments indicate that overall counseling team members and resident mothers perceive the available health care

services as adequately addressing resident mothers' health concerns. Both groups express that in general mothers tend to have access to the services they need and to be fairly satisfied with the care they receive. As one counselor said in her interview, "By and large, I have heard good feedback. They get the care they need; they get the prescriptions they need." Another counselor shared this sentiment when she said, "I can't think of a specific complaint. I think overall they have been satisfied with their doctors." Most of the counselors reported that it was their impression that residents were for the most part happy with the health care they received.

The data indicates that counselors tend to report this satisfaction with health care services as being due to the fact that most resident mothers and children have public health insurance through Medicaid, and thus Medicaid provides all the medical services they may need. As the employment specialist stated in her interview, "I think primarily most of our resident mothers are on Medicaid and they receive Medicaid services. When they don't have Medicaid that's when the barriers come into play. But as long as they have Medicaid there really aren't a lot of barriers." Other counselors also reported that most of the resident mothers have Medicaid and that they believe these residents have the majority of their health needs met through Medicaid coverage.

Residents similarly reported that by and large their health needs had been addressed by the available health care resources and stated that they were typically happy with the health care services they receive. For example, when I asked Miranda how well the available health care services address her and her son's health care needs, she replied, "The ones we have are good. They seem really good." She went on to say that all of their health care problems have been taken care of to an extent with which she was

pleased. Data from the interviews with resident mothers provide descriptions of positive interactions with health care providers and having access to services through their Medicaid group plan. For example, Lakeisha, a mother of three, described her experiences with her HMO group positively. “I’ve been dealing with CitrusCaid for years. And CitrusCaid is very; I mean they never denied me or my children of nothing. They’ve been really nice to me.” Other mothers similarly reported being generally satisfied with the health care coverage provided by their HMO group plan.

Data from the Health Assessments show that nine of the 14 women surveyed reported that everyone in their family is covered by health insurance. Furthermore, only four women said someone in their family had unmet health needs and just two women reported having immediate health concerns. These results support the qualitative data from the interviews suggesting that in general most resident mothers have public insurance, receive the health care they need, and are satisfied with this care. While counselors and resident mothers agree that on the whole mothers have access to the health care services they need and that they tend to be satisfied with the care they receive, the data also show some critical gaps in health care service provision for homeless

Gaps in Service Provision

Dental

One of the most profound gaps in service provision identified through my internship and this research project is the lack of dental services for uninsured and publicly insured homeless mothers and children. Counselors and resident mothers unanimously agreed in semi-structured interviews that dental services are the most

critical gap in service provision for shelter residents, and research for the Health Resource Guide helped to illustrate the scope of the problem. Limited coverage for dental services through Medicaid, a lack of providers willing to accept Medicaid for dental care, and long wait lists for dentists that do accept Medicaid all contribute to resident mothers and their children having a difficult time accessing the dental care they need.

The counseling team members were well aware of high need for dental services for the residents, but they explained that finding dental providers was a challenge they struggled to overcome. As one counselor stated,

“I don’t think dental exists the way it needs to exist. Yeah I think for free care dental it is non existent, and low cost dental is not as low cost as it needs to be in order to appear viable to our families. Medicaid covers children for dental expenses but it does not cover adults for dental expenses...Judeo Christian Clinic is one of the only ones that offers a dental clinic once a week and they yank them out, they don’t do anything else you know. That’s it; they’ll pull them for you. The neighborhood center down the street here by Salvation Army they offer a dental clinic when funding is available, and that funding usually lasts about five months and then it’s gone.”

The Director of Education and Literacy and the Director of the Promiseland Center for the shelter also discussed the challenges associated with accessing dental services. They explained that a lack of dental providers that offer services to Medicaid clients, limited Medicaid coverage for dental services, and difficulties in getting residents to go to the dentist all act as barriers to dental care.

“We have some real challenges with dental. And part of that is there’s just not very good service that we know of...The formularies for Medicaid seem to change *daily*, so because of that I can have a mom, because she had a preemie baby she got an abscess, chose not to go, but she

was nursing so it became an urgent situation, where if you don't go this will happen. And she went to the dentist and the providers themselves were fine, until Medicaid said they weren't going to pay, then that affected the follow up appointment. So you may be able to find a provider, but then parents are not going to deal with that.”

This quote illustrates the counselors' perception that the problem with a lack of dental provision is multifaceted and occurs due to a lack of providers, limited Medicaid coverage for dental services, and residents not wanting to deal with these hassles. These themes emerged from many of the interviews with counseling team members.

Interviews with resident mothers also illuminated the absolute lack of dental care available to mothers and children. Resident mothers with Medicaid described the dental services covered as being extremely limited and as not addressing their dental problems. Like the counselors, residents attributed the problem with dental care as having several causes. One mother told me that because she has Medicaid she is limited to certain services and providers. When probed she said, “I have a very limited dental plan.” She continued on to say that it only covers one cleaning per year, but that even getting that one cleaning can be difficult.

“Of course it's easy, but when you have other problems it's not so easy. They turn you down or they'll give you this huge bill telling you how much you have to pay. Of course I'm on Medicaid, I can't pay it...There's no problem finding the dentists but unfortunately they don't cover some things that I need to be done.”

This describes some of the very same challenges discussed by the counselors— that not only is Medicaid coverage for dental limited, but also that residents worry about the possibility of having to pay expensive bills for the dental services incurred.

Another mother explained that dental care is not covered for pregnant mothers on Medicaid and described the tooth pain she experienced during her last pregnancy.

“See this one here [points to a tooth] I had a bad tooth when I was pregnant with her and they would not pull it. So after I had her I pulled it myself. That’s how bad the pain was...See I had set up an appointment, I had my baby June 25th and I set up an appointment for July 3rd to get my tooth pulled and they said no your Medicaid don’t cover it.”

This mother went on to say that her Medicaid would cover one teeth cleaning per year, but no extractions or other dental work, so she had to live with the pain and the challenge of eating despite that pain throughout her last pregnancy. Many of the mothers interviewed had similar terrifying stories of their own or their children’s tooth pain and dental problems that were not addressed because Medicaid would not cover anything more than a cleaning.

Because of the widespread need for dental care among families and individuals at the shelter and their continued difficulties in finding dental providers, I contacted the state of Florida’s Medicaid office asking for assistance in locating dental providers in Hillsborough County that accept Medicaid. In response, the office sent me an electronic Excel spreadsheet with a list of 39 dental providers in Hillsborough County that they have recorded as accepting Medicaid patients. Unfortunately, as I found out through phone calls to each of the listed dental providers, the reality of the situation is much different than it initially appears on the spreadsheet.

Of the 39 total dentists listed on the document as located in Hillsborough County and accepting Medicaid insurance, 15 are specialists of some sort (oral surgeons, orthodontists, and denture specialists) and as such do not provide general dental services.

This means that 24 of the dentists on the list provide general services. Of these 24 dentists, 12 providers will only see children and three of these pediatric dentists are not currently accepting new patients. Thus, there are nine pediatric dentists that accept Medicaid and are accepting new patients currently in Hillsborough County.

From the 12 remaining general dentists that do see adults, seven have stipulations that limit service provision. One of these dentists only sees cancer patients, another only offers emergency extractions, one dentist is not accepting any new patients, and three others will only accept Medicaid for children even though they provide adult dental services for people with private insurance. This leaves five general dentists that will see adults on Medicaid and that are currently accepting new patients. Of these five dentists, one is located in Ruskin over 30 minutes away from Tampa, another is located in Dover over 20 minutes away from Tampa, and therefore only three are located in Tampa. With only three dental providers in Tampa for all adult Medicaid recipients, it is not surprising that so many residents have had trouble receiving the dental care they need.

Health Care for Parents

In addition to dental care, another gap in health care for shelter residents that came to light through semi-structured interviews and Health Assessments is that parents experience greater challenges in accessing health care services than children. Data suggest that in comparison to accessing health care services for their children, parents have more difficulty obtaining Medicaid coverage, finding a health care provider, and seeking treatment for health problems. Both counselors and residents indicated that

children have better health care coverage and are more likely to receive the health care they need from a primary care physician than parents.

The counseling team members explained in their interviews that parents are less likely to have Medicaid insurance coverage, and fathers have an especially difficult time signing up for public health care. As Jessica, one of the lead counselors, explained,

“I am always, I shouldn’t say flustered, because it makes sense that a child would be on Medicaid before a parent would, but it always sort of hurts my ears to hear the parent is not receiving Medicaid when the child is. But it’s harder for the parent to receive Medicaid because they have to go through a waiting period...and I think that in some cases it is hard for adults to get Medicaid. It’s much easier for the kids. Even parents have a hard time sometimes, you know their kids have been on Medicaid long before they have.”

Another counselor echoed these sentiments when she was asked how many residents have Medicaid coverage. “Just a wild guess, but I would say 50-50, I’m thinking about adults and children. Usually the dads don’t...I think the kids do get better care than the parents. People like kids. We’ve even had a dentist just a few months ago volunteered to bring a bus full of kids over to his clinic to just get dental care. People like kids.” These two quotes illustrate two ideas consistently presented in interviews with counselors- first, that parents are less likely to have Medicaid coverage because they have a harder time getting coverage, and second that kids receive better care than parents.

Counselors also perceive the tendency of parents to seek medical care for their children but not for themselves as another challenge limiting parents’ access to health care services. As one counselor said, “I wish I could say they would always go to the doctor. Typically, this is a strange phenomenon, they will get their kids, take their kids to the doctor, they will take their kids three times more than they go themselves.” Other

counselors agreed that mothers go to the doctor more quickly for their children and rarely go to the doctor for their own health problems. As Melissa, the Director of the Promiseland Center, explained,

“Do I think they go? I would say no, because that’s something we battle even now, it’s just not something that’s on the top of the list. I think it becomes, ‘I’m gonna get my children to the doctor, I’m gonna take care of my children, my husband, my whoever...my mother’s sick or something’. They become the last one to be taken care of. So I don’t think a primary [care physician] is the first thing they’re thinking about.”

These statements illustrate the counselors’ perception that resident mothers go to the doctor more often and more quickly for their children or other family members’ health problems than for their own. This theme of the counselors’ belief that mothers put off seeking medical care for themselves was evident throughout the interviews with counseling team members.

Several of the resident mothers interviewed also indicated that they do not access health care services as quickly or as often as they could. One mother without health insurance said that she had missed three follow up appointments after being diagnosed with spinal meningitis because she could not find childcare for her two kids while she had the spinal taps done. Amber, another mother with four children living at the shelter with her, described some of the barriers keeping her from going to the doctor in this dialogue taken from her interview transcript.

PI: “So today if you got sick, what would you do?”

Amber: “Live with it.”

PI: “Live with it? Until what point?”

Amber: “Until it went away I guess. Because I don’t really go to doctors.”

PI: “Yeah? How come?”

Amber: “Well I don’t like them. I don’t know, just a pain in the butt.”

PI: “Why?”

Amber: “You know, I’ve got four kids, I don’t have a vehicle, I’m trying to work on that. And just getting them on and off the bus and being good while I can be seen by the doctor. And I don’t want to just leave them here with someone else.”

Many of the mothers explained that they would address their own health problems or deal with it until they felt better because of the difficulties involved in going to the doctor for themselves. However, all the mothers agreed that if their children were sick they would not hesitate to call their pediatrician or take their child to get care.

Health Assessment data also suggest that mothers are less likely than children to have Medicaid coverage and a primary care physician that they see regularly. Of the five women who reported on the Health Assessments that not everyone in their family was covered by Medicaid, four of those women were themselves not insured and the fifth woman was insured but her husband was not. In other words, in families where not everyone had Medicaid insurance, parents were more likely than children to be uninsured. Additionally, of the 14 women surveyed, only four reported having a primary care doctor who they see on a regular basis. Of the remaining 10 women, four women did not have a provider at all, three women only had a provider for their children but not themselves, two reported using community clinics when needing medical care, and one woman said she would go to the hospital for medical services. These data support qualitative interview data that suggest mothers are less likely than children to be on Medicaid, to have a primary care physician, and to go to the doctor when they are sick.

Counselor and Resident Viewpoints

While data analysis suggests that counselors and residents agree when it comes to satisfaction with available care and gaps in service provision, it appears that these two groups view causality of the barriers to health care services from different levels.

Interview data indicate that counseling team members acknowledge systemic problems that act as barriers limiting mothers' access to health care services, but they still attribute a greater weight to individual actions and values of resident mothers as barriers to health care. Contrastingly, data from interviews with resident mothers suggest that mothers view barriers to accessing health care services as originating at either an interpersonal level or an institutional level, where interactions with health care providers and staff members or with the health care system in general act as key factors limiting access to available services.

Counselor Viewpoints

A theme that emerged from the counselor data is that while counselors will acknowledge systemic problems that create barriers for resident mothers trying to access health care services, they more frequently cite individual barriers to health care that lie at the responsibility of resident mothers. For example, one counselor said,

“It seems to me that sometimes they put their own barriers up. Like some people who don't like doctors. I have one resident who has been really resistant to getting looked at for high blood pressure and cholesterol and a leg problem that she's had for quite some time. She doesn't like to go to doctors, she's had bad experiences. So, my experience has been if they don't get treatment it's usually because they're not wanting it, not because they can't find a place to go for it.”

This quote illustrates the way in which the counselor acknowledges the client's past negative experiences with health care providers, but believes that the client is putting up her own barriers that limit her utilization of available health care services. This idea from counselors that it is a matter of the resident not wanting health care treatment that is preventing them from getting care resonates through many of the counselor interviews.

Another counselor similarly emphasizes the individual residents' role in not accessing the necessary care despite the fact that resources are available.

“Often when we see them they are severe, whatever it is. It can be that they end up with breast cancer, or that they end up with severe stomach ulcers, or they end up with poor leg circulation. So it can be a broad range of what we see, but it's often something that's been untreated for a long, long time. Not because they did not have medical coverage available to them, but because they simply opted not to follow-up, not to go and get the news because they were scared.”

This quote illustrates the counselors' belief that health care services are readily available but that women are choosing not to access those services, and further hints at the fact that because women are choosing not to access health care services they are contributing to the severity of their health problems. Another counselor more clearly states that by choosing not to access care mothers are failing to get their children the care they need when she said,

“You're seeing a three-year-old or a four-year-old that should have had developmental assessments happening way back when and I'm sure that if they had been taking them to a pediatrician on any course of a regular basis the pediatrician is noticing these delays. So again it's that failure of follow through, you know, to make those efforts, to move in the right direction to get your children help.”

Throughout the counselor interview data, the theme of counselors emphasizing the individual role of resident mothers as limiting access to health care services is present.

It is also important to point out the fact that most counselors did attribute some barriers in access to health care services to larger system-wide problems within the health care system. However, when counselors did mention systemic barriers they frequently also said that such barriers are exacerbated by mothers' actions or lack of action. For example, Julie, the employment counselor, said,

“So I think even sometimes the hospitals are getting away from doing as thorough a job of investigating as they used to do. And I think the residents feel that as a personal thing, which is some of their mental health and some of just their feeling of entitlement that some of them have, whereas I look at it as a systemic problem that is crossing boundaries and everybody's waiting and everybody walks into their doctor's office and waits for half an hour and goes back to their doctor's office and he spends three minutes with them where he says, 'oh well, you know I don't see anything wrong, you look fine, come back in a week if you don't feel better, you've got a cold.' I think it's happening everywhere, across boundaries, you know economic boundaries. But I think our residents, a lot of times, think they are being targeted. And honestly, that isn't the only thing they feel targeted about, it's not just health care they feel targeted about.”

Here, Julie attributes some of the difficulties in accessing care to time constraints and lower quality care that exist at some hospitals and provider offices, but she goes on to say that these systemic problems are intensified for resident mothers due to their perceptions, sense of entitlement, and mental health.

Another counselor makes the same point when she explains that if mothers fully accessed the available services, then the health care resources would be adequate for addressing resident mothers' health problems.

“I think that if they fully accessed what was available it would be, I’d say, moderate...because even especially if you think of WIC and WIC even has a nursing component and even they have the health care. If they access it. Because we advocate, I just used WIC because they have a health component, I can’t even get moms to do that. So if they access it. So part of it is access and part of it’s quality and availability.”

This counselor is making the point that while some of the problem with access to health care services is that the available services are only of moderate quality and availability, she adds that the other side of the problem is that mothers are not accessing the services that do exist and that she struggles to get them to use those services. Many counselors did mention macrolevel problems within the health care system that act as barriers to health care services for resident mothers, but more often than not they continued on to say that resident mothers’ reaction to systemic problems or their individual actions relating to health care exacerbated these broader issues.

Resident Viewpoints

Whereas counseling team members viewed many barriers to accessing health care services as originating at the individual level of the resident mothers, interview data suggest that in contrast resident mothers focus on interpersonal and institutional factors that create barriers to health care. Many mothers talked about being treated poorly by health care providers, staff members, and Medicaid in general, and explained that this bad treatment leads to feelings of frustration and impedes their ability and willingness to access care. Interview data also illuminate that mothers struggle with bureaucratic challenges associated with Medicaid and are thus limited on certain services, providers, and group HMO plans all of which contribute further to barriers of health care.

One mother, Amber, described how she had to re-apply for Medicaid after her experience at the Medicaid office in downtown Tampa.

“I just re-did everything because I didn’t know what else to do because nobody would help me. I think, my personal opinion, they need to hire a couple extra people. Because you can’t have a room full of people and everybody is on a computer except the lady at the window and she ain’t helping nobody...you know, I got family too, just like everybody else. My kids need to eat just as much as your kids need to eat. My kids need to see the doctor just as much as your kids need to see the doctor, you know? And you know nobody is more important than nobody, I think. I think everybody is equal...I was sitting there in plain view, and he [Medicaid office employee] just kept walking past me, walking past me, walking past me. I got so aggravated that I just left because I don’t want to be sitting there being ignored knowing I’m being ignored by somebody who is supposed to help you.”

Amber’s story is not unique; many mothers shared similar experiences at the Medicaid office or doctor’s offices where employees ignored them, never stopped to ask them what they needed help with, or asked them to wait for hours before being helped. Amber clearly explains how the employees at the office refused to help her, how she felt ignored and as if by not helping her the employees were implying that her children’s needs are not important, and how she finally had to leave the office and simply start the whole application process over from the beginning because she could not get help.

Resident mothers also consistently shared stories about health care providers and staff members treating them with a lack of respect and a lack of kindness. One mother described in her interview how she dreaded going to the doctor because he made her feel bad about being overweight, even when she had lost some weight since her last visit.

“You know he will see that I’ve lost weight from one visit to the next but instead of realizing that I take his advice and I lose weight, you know which was quite a bit of weight, he

would make it seem to me that I didn't do enough...it was just really depressing and at times I don't even want to go there when I get sick because I know what I'm going to hear...you know, have a heart. Don't they teach you that in medical school? You know if they don't, this isn't [the television show] *Nip/Tuck* you know. Have some compassion. Not everybody can look like Angelina Jolie. We wish we could but we can't. Take into consideration that I've had one kid after another. I mean literally was pregnant half my life, you know. Take that into consideration and understand that I am a female and I don't want to leave trying to get on anti-depressants."

Several other residents described being hesitant to go to the doctor because they had been treated poorly by the provider or by the office staff in the past and did not want to go through that disrespect again.

Mothers also explained that they felt as though Medicaid does not treat them well. As Miranda said, "It's just frustrating to know, I guess it's because it's Medicaid you know, you have to be poor to be on Medicaid so it's almost like they treat you bad because you're poor basically." This idea that Medicaid treats resident mothers badly because they are poor emerged in several interviews with mothers. As Lakeisha explained when she was asked what she would do with unlimited resources to improve the health of herself and her children, she said she would change to a private insurance because of the way Medicaid is treated.

"You know Medicaid being for the poor, they treat it poor. They treat it poor...It's like they really, it's really not a concern because you don't have the money. But they with the funds they do have they good and everything but I seen people without Medicaid get treated better."

The two quotes illustrate the theme that appeared throughout the interviews with resident mothers — that not only can negative interpersonal relationships with providers create

barriers to accessing health care, but also the way they perceive Medicaid as treating poor people badly interferes with their access to health care services.

In addition to viewing barriers to accessing health care services at an interpersonal level as just described, interview data suggest that resident mothers also experience institutional barriers to care and struggle to overcome these issues as well. The problems mothers discussed that relate to the health care system centered around Medicaid because the vast majority of mothers and children have public health insurance coverage.

Common themes running through interviews with resident mothers about institutional barriers include the lack of service and provider coverage through Medicaid, difficulties calling the Medicaid office to ask questions or request a new card, and trouble changing HMO group plans within Medicaid.

Several mothers described their dissatisfaction with the limited health care coverage and provider options offered by many Medicaid group plans. As one mother said, “I have Medicaid, so I’m always limited to certain places or certain things. So it can be sort of frustrating.” When asked what she would do with unlimited resources to improve the health of herself and her children, another mother answered that she would change her insurance. Probed to explain what her ideal insurance would do that Medicaid does not, she said,

“Give my family a great dental plan and more options to find better doctors and less hassle...Finding a doctor close by instead of sending me to one that’s miles away from home. You know you’ll get a card and they’ll send you one [the name of a provider] that’s actually in New Port Richey and you live in Tampa. You know that’s a big hassle to get it changed and you can’t see any other doctor because the card has that doctor on it. So that’s a huge hassle.”

Limited coverage of certain health problems and having a Medicaid-assigned provider with whom resident mothers are discontented are two institutional level barriers frequently mentioned by resident mothers.

Resident mothers also commonly shared stories about the problems they have reaching Medicaid on the phone. Mothers wanted to get in touch with the Medicaid customer service representatives for a variety of reasons, but most often they wanted a replacement Medicaid Gold Card if theirs had been lost, to switch Medicaid HMO group plans, assistance with finding a provider covered by their plan, or to ask questions about their coverage. Unfortunately, getting an actual person at the Medicaid office either nationally or locally on the phone proved to be a major challenge for resident mothers.

As Miranda explained,

“I had all these things I had to do and one of the things was to call and try to get a new Medicaid card for my son. So I found the number from somewhere else, the Medicaid number, and they gave me another number, so I called them and I was on hold for like 15 minutes. I get this guy on the phone and I start talking to him and I hear him say, ‘what?’ and I say something back to him and he hung up on me! I was like, I just sat there for 15 minutes on hold just for you to hang up on me! And I’ve also had it happen where I’ve been on hold for a long time and all of a sudden the line just disconnects me. So I still haven’t been able to order him a new one [Gold Card]!”

Other residents had similar experiences waiting on hold for Medicaid and never getting through or having to hang up before their call was answered because of other responsibilities requiring their time and attention.

Other mothers had similar problems with Medicaid not sending them provider information they requested or a new Gold Card or just in general making the process of applying for Medicaid very complicated. As Amber said,

“They kept giving me the runaround. Asking for things that I didn’t have, I couldn’t submit because I wasn’t working. They just gave me a lot of runaround. You gotta go see this one person, now they might tell you they can’t help me, then you gotta go back to this person then they tell you they can’t help you.”

This “runaround” or sitting on hold on the phone for more than 15 minutes can be especially difficult for resident mothers who do not have transportation, must use a public phone at the shelter for most calls, and are trying to also complete the program requirements at the shelter. Several resident mothers felt that the bureaucratic challenges associated with the Medicaid system acted as major barriers to accessing health care services.

Discussion

While interview data indicate that counselors attribute many barriers to health care as stemming from the individual residents and that residents tend to attribute barriers to health care as being caused by poor interpersonal relations and institutional bureaucracy problems, ethnographic fieldwork during my internship indicated that barriers exist at individual, interpersonal, and institutional levels. As the Health Specialist Case Manager I engaged continuously in participant observation and through this position I was able to witness barriers at each of these levels contributing to problems for resident mothers in accessing health care services.

On the one hand, as the Health Specialist Case Manager working with the counseling team members, I talked to and worked with mothers who seemingly had support and very few barriers in place, but who still did not get the health care they needed. On the other hand, I spoke to health care providers’ office staff that were rude

when I asked if they accepted Medicaid insurance, and I have sat on hold with the Medicaid office for over 45 minutes without ever reaching a representative. Based on interview and ethnographic research data, it appears as though barriers to health care services exist for resident mothers on all three levels— the individual, interpersonal, and institutional.

The data suggest that the two groups, counselors and residents, assign more importance to barriers at different levels and that both groups have not yet recognized or legitimized the other's perspective. For example, I previously pointed out the counselors' perception that mothers with Medicaid coverage for them and their children experience very few barriers to health care. However, I also illustrated that the resident mothers consistently reported barriers to health care that originated with the Medicaid system and Medicaid customer service limitations. This points to the fact that counselors have not yet recognized resident mothers' frustrations with Medicaid and the mothers' perception that Medicaid acts as a barrier to care.

Furthermore, many counselors also stated that they had heard from resident mothers about problems reaching Medicaid on the phone, finding providers who accept Medicaid, and navigating the Medicaid system. That counselors have heard these complaints and barriers from mothers but still believe that mothers with Medicaid experience few barriers to health care, suggests that counselors have not legitimized the perspectives of resident mothers. On the other hand resident mothers rarely mentioned barriers to health care that occurred due to their own individual choices or actions, indicating that they are not willing to acknowledge and validate the counselors' perspective of individual level barriers to care. I posit that the two groups not

recognizing and legitimizing each other's differing position creates additional barriers that limit resident mothers' access to health care services unnecessarily.

Summary

This chapter explained findings from data analysis of Health Assessments, Health Resource Guide research, and semi-structured interviews. My findings indicate that overall residents are typically happy with the health care services they receive, but that dental care is a critical gap in service provision. Additionally, through my analysis I showed that parents tend to be less likely to have health insurance and experience greater barriers to accessing health care services when compared to their children. Finally, I illustrated how the counseling team members and residents conceptualize the causes of barriers to health care as occurring at different levels, and surmised that these differing viewpoints can lead to further barriers to health care services for resident mothers when left unrecognized and unacknowledged.

Chapter Six

Conclusions and Recommendations

“I would want them to get a taste of what we get so they could understand the full amount of what it means to us. That we don’t have no money don’t mean you need to treat us with limits of visits and stuff like that. I would want them to be in the same shoes so they would see, then they would have a better understanding about it. They don’t really understand right now because they ain’t been in our shoes and everything. But I would want them to be in our shoes and go through what we have to go through and I wish that Medicaid would get a whole lot better.”

--Lakeisha, mother of 3, on how she would improve the health care system

This chapter will summarize the findings discussed in the last chapter and relate those findings to the anthropological and public health literature on homelessness and access to health care services. I also describe in this chapter how this research project has contributed to the disciplines of applied anthropology and public health. Furthermore, I will explain the recommendations made to the counseling team of the UpliftU® program for ways the program can assist resident mothers in overcoming existing barriers to health care services. The chapter concludes with a brief overview of the suggestions for broader program and policy changes and ideas for future research.

Findings Related to Literature

One of the most positive findings in this study is that counselors and resident mothers are generally pleased with the care mothers receive and their access to health care services. However, the literature fails to mention this or the major gap in dental care for homeless families and housed families on Medicaid. The extent to which dental care

is a critical need for almost every family in the UpliftU® program suggests that a similar need likely exists nationwide for families on Medicaid insurance plans. Given the important relationship between dental health and overall health, specifically for pregnant mothers and children, the lack of research on access to dental care for Medicaid recipients is an especially significant gap in research and policy efforts.

Although access to dental care is not thoroughly covered in the anthropological and public health literature, the difficulties that parents face in accessing health care is discussed. Research has shown that homeless families need better access to timely care and a consistent health care provider (Shinn and Weitzman 1996), which agrees with the findings from this project that parents need more timely care and are less likely to have a primary care provider than children. Based on findings from studies that acknowledge that parents have a more difficult time than children in accessing health care services, some researchers have recommended that low-income families must have access to a health insurance system that operates efficiently and smoothly and provides coverage to all family members (Burton and Lein 2006). Similarly, other researchers have argued for policies that assist low-income families in finding and maintaining a medical home (Shinn and Weitzman 1996). Due to the transient nature of family's experiences just prior to entering the shelter, maintaining a medical home may prove to be difficult, but public health insurance policies that allow for greater flexibility in provider coverage would help to ensure all family members maintain continuous medical care as they move from place to place.

The anthropological literature appears to have not yet adequately focused on access to health care services for homeless mothers with children. However,

anthropological studies on the causes and consequences of homelessness have suggested that organization employees tend to see the individual factors causing a person's homelessness while homeless residents have a different viewpoint and cite the institutional barriers leading to their homeless situation (Bell 2006, Henrici 2006, Lyon-Call 2004). While studies mentioning interpersonal barriers could not be found, researchers do tend to agree that organization workers view barriers to overcoming homelessness as lying at the fault of the homeless individuals (Bell 2006). The findings from these studies are very similar to findings in this study that suggest counselors saw barriers to health care as originating from mothers' actions or lack of education.

Some research has shown that organization employees view homeless mothers as "in need of improvement" (Henrici 2006:173), and this is similar to the counselors in this thesis project saying that mothers needed more education about health or better time management skills in order to have better access to health care services. The idea behind each of these sentiments is that if only homeless mothers had better job skills or understood the importance of health, then they would not be homeless or would have access to health care services, respectively. Unfortunately, the logic behind these frameworks turns out too many times to be false due to larger systemic problems creating further difficulties in finding a job that pays a livable wage or health care insurance without provider and service restrictions (Lyon-Callo 2004).

In the last chapter examples were given of how counselors oftentimes acknowledge larger systemic barriers to health care, but emphasize the individual level factors that contribute to barriers. Other researchers looking at the causes of homelessness have found similar results where organization employees lay the blame on

individual characteristics rather than the structural or systemic factors (Henrici 2006, Lyon-Callo 2004). “When all attention is focused on reforming the individual, coping with exploitative conditions, feeling powerless, or trying to simply increase the number of shelter beds and subsidized housing, more systemic and structural factors often go unchallenged” (Lyon-Callo 2004:46). In other words, other researchers suggest that in their attempt to deal with the immediate needs of homeless families, organization employees often overlook or temporarily suspend focus on the larger systemic barriers that come into play. Given the genuine desire of counselors at the UpliftU® program to help residents access needed health care and to assist them as much as possible, this is a very possible explanation for why the counselors focus on individual level barriers.

Another possible explanation for why organization employees attribute causes of homelessness to individuals is the hegemonic neoliberal discourse that values individual responsibility and thus suggests that individual deviancy is at the root of causes to homelessness (Bell 2006, Lyon-Callo 2004). It makes sense that working within this neoliberal framework, with a program mission of helping people to achieve self-sufficiency, the counselors of the UpliftU® program would see barriers to health care primarily as the fault of the individual.

But let us not focus solely on the counseling team members’ perspectives, as the resident mothers similarly reflected a specific viewpoint of causality of barriers to health care- interpersonal and institutional factors. Researchers have also suggested that clients do tend to blame providers, just as many resident mothers said their barriers to health care stemmed from health care providers and staff and the Medicaid system. “Clients may also blame ‘the system,’ or caseworkers as its representatives, for their failures. It should

be noted that in some cases clients' problems, like human problems generally, really are a matter of noncompliance, lack of motivation, or other personal failing" (Bell 2006:170).

In the case of findings from my thesis research, resident mothers did tend to attribute barriers in health care to providers treating them badly or the Medicaid system not providing them with the things they needed to access health care. Other researchers have indicated that homeless people often embrace shelter employees' rhetoric and end up blaming themselves for their homeless situation (Lyon-Callo 2004). However, it appears that in this case the resident mothers have not turned to blaming themselves, and may in fact be resisting the dominant discourse of neoliberal ideologies in so doing.

The neoliberal ideology holds that it is the individual failings of homeless people that keep them from finding and maintaining housing, and similarly that it is the values and actions of individual homeless mothers that act as the primary barriers to health care services. In the case of this project, homeless mothers did not come to agree with this dominant discourse, but instead they emphasized that poor relationships with providers and bureaucratic hassles with the health care system were the major barriers to health care they faced. By not agreeing with the neoliberal ideological views, these homeless mothers may be exerting their own individual agency and working against the dominant framework. This is of critical importance because all too often marginalized groups are considered passive recipients of their situations, and this would illustrate homeless mothers' active resistance of the ideological views of people in power.

Overall, researchers have shown that despite the fact that clients tend to blame providers and providers tend to blame clients, individual *and* institutional barriers exist and therefore neither group is completely wrong in their assessment of the situation.

However, “service providers and clients, are related to each other in such a manner that the power held by one helps limit that of the other. As long as they remain divided, they are relatively helpless in comparison to the larger neoliberal system with which both of them must contend” (Henrici 2006:187). Recognizing the other groups’ viewpoint and acknowledging that viewpoint as legitimate is one way organization employees and residents can come together to decrease barriers to health care and housing and to increase the quality of life for everyone involved.

Contributions

This thesis project attempts to fill a gap in anthropological research and literature by providing an examination of health disparities through ethnographic research with homeless mothers and shelter employees on access to health care. It also contributes to current anthropological theories by describing the lived experiences of homeless mothers and further exploring the impacts of neoliberal-influenced policies and programs on the lives of homeless families. Furthermore, this research adds to public health research on access to health care for homeless mothers and children by including the voices and perspectives of homeless mothers, in addition to the perspectives of organization employees. This is a critical contribution given the major finding of this project that organization employees and homeless mothers have such different viewpoints of the barriers to health care services.

Similarly, this project attempts to answer Rylko-Bauer and Farmer’s (2002) call for further ethnographic analysis of the relationship between poverty, health, and access to health care. By including the perspectives of not only organization employees, but

also of homeless mothers, this project adds another voice to the discussion on health disparities and structural inequalities that plagues this country. Finally, the findings from this research project can also be used to inform health policies relating to the growing number of homeless women and children, and public health professionals and anthropologists can advocate for sufficient funding for service organizations that cater to the direct health needs of this population.

Recommendations

To fulfill the agreed upon components of my internship with the UpliftU® program, a Technical Report (Appendix E) summarizing the research objectives, methods, and findings of this project was compiled and given to the counseling team. It is my hope that the findings and recommendations provided in this Technical Report will be used by the counseling team to assist resident mothers in overcoming barriers to health care services at the individual, interpersonal, and institutional levels. The recommendations provided to the counseling team in that Technical Report include both immediate, direct changes that can be implemented fairly quickly, as well as broader, longer-term changes that will require further brainstorming, planning, and effort to implement. These recommendations are summarized here.

Direct Changes

To address the gap in dental care, counseling team members can utilize two documents created during my internship to find the most up-to-date information on dental providers. First, they should continue to use the Health Resource Guide to find dental

services for uninsured adults. For example, on the Health Resource Guide counselors can see that the Judeo Christian Clinic offers tooth extractions for uninsured adults or that the Hillsborough County Health Department offers dental services to adults on Medicaid who have infectious diseases. In addition, counselors should also begin to consistently refer to the excel spreadsheet entitled Dental Medicaid Information, which is also located on the shared drive at Metropolitan Ministries. This spreadsheet was provided by the state Medicaid office and lists all the dentists in Hillsborough County that provide services to adults and children on Medicaid. Comments have been inserted into the spreadsheet alerting counselors as to which providers are currently accepting new patients. Counselors should refer to this document in order to provide residents with a list of dental providers who accept Medicaid and are accepting new patients.

Not only should counselors use this document consistently to refer residents with dental needs to providers, but also the counseling team must continue to update this document bi-annually to keep the information current and accurate. It is recommended that someone be assigned to contact the state Medicaid office for an updated version of the spreadsheet, and then go through and contact the providers on the list to ensure the accuracy of the spreadsheet. Providers should be asked if they accept Medicaid for adults and children, which groups they accept for adults, and if they are currently accepting new Medicaid patients. All information gathered from these phone calls should be recorded on the spreadsheet so that the entire counseling team has access to this important information.

It is also recommended that counseling team members be more cognizant that parents experience a greater number of barriers to accessing health care than children.

Intake interviews should be amended to include questions about the family's health insurance coverage and whether or not all family members have Medicaid or other health insurance. Program procedures should also be updated to include requiring all family members to apply for Medicaid or other health insurance upon moving into the shelter. Findings do suggest that counselors and residents agree that despite the barriers Medicaid creates, residents with health insurance coverage do have better access to care than those without. Finally, counselors should also be encouraged to continue using the Health Resource Guide to find providers, group health classes, and other health-related information pertinent to parents' health care needs.

Finally, the counseling team must also acknowledge the interpersonal and institutional level barriers to health care services that exist for resident mothers, and they should work with residents in order to overcome these barriers together. For example, if a resident has had bad experiences with doctors in the past and is hesitant to go to another doctor despite having an immediate health concern, a counselor could sit with that resident while she calls providers' offices to schedule an appointment or could work with the resident to create a list of positive effects of going to the doctor. These types of actions would acknowledge and legitimize the resident's perceived barriers more so than putting the resident on a contract that requires them to go to the doctor, as is often the current response.

Broad Changes

In addition to these immediate, direct changes that may work to decrease resident mothers' barriers to health care services, several longer-term, broader changes would also

benefit residents of the UpliftU® program. First, as many counselors proposed in their interviews, it is recommended that the program explore forming additional partnerships with providers (similar to that established with the Ronald McDonald van that visits Metropolitan Ministries once a week) in order to find providers that are consistently willing to serve residents. It is also recommended, based on suggestions by counselors, that community providers are educated about who is homeless and how to respectfully work with homeless families. Counseling team members or other Metropolitan Ministries employees need to explain to providers what are the residents' health care needs and what specific barriers or challenges exist limiting access to that care.

Counseling team members and the UpliftU® program overall must also acknowledge the importance of including residents' perspectives and should strive to include these perspectives in decisions made about how to best serve residents. The counseling team should continue to seek out residents' input about health care services, classes on health-related topics, and ideas about how counselors can help decrease barriers to health care services. Including the voices of the residents is key in successfully decreasing existing barriers to health care services.

To address structural and systemic barriers to health care, Metropolitan Ministries must begin to advocate and lobby at the local and state level for policy changes that improve the health of their residents. Supporting or proposing policies that include better dental coverage by Medicaid and expanded health care coverage of parents and pregnant women, and demanding improved customer service from national and local Medicaid and provider offices would initiate the conversation about the larger factors contributing to limited access to health care services for homeless mothers and children.

Finally, as suggested by many counselors, creating a position within the counseling team of a Health Specialist would be one way of realistically implementing many of the proposed recommendations and ensuring that residents' access to health care services remains a priority of the counseling team. As it is now, counselors are not always able to keep up with each resident's health care needs or problems, much less to stay up-to-date on Medicaid policies and to advocate for broader scale changes. Having a position designated specifically to focus on the health of residents, similar to the positions focused on education and employment, would centralize the coordination of health needs of the residents with one person on the counseling team and maximize utilization of area service providers and resources.

Future Directions

Overall, the research for this thesis highlights the importance of health policy that addresses the bureaucratic barriers to social services and improves the public insurance system. More employees are needed at social service agencies and within the Medicaid system to lower caseloads and to allow for more accessible customer service representatives. The process of getting a new Medicaid Gold Card must be simplified, and Medicaid must make adjustments in order to ensure an entire family receives insurance coverage and can receive needed dental care.

A paradigm shift away from the neoliberal individual deviancy ideology that places too much emphasis on individual actions and values as barriers to health care is necessary in order to close the gap in health disparities that exist based on income. Organization employees and clients must move away from blaming the other group if the

system is to move towards creating programs that operate with the active involvement and input from the people they are meant to serve. Future research must also examine health care providers' views on Medicaid, health disparities, and access to health care services in order to include their perspectives in this multifaceted, complex topic.

Unfortunately, these changes need to be made in the midst of the major economic downturn and financial crisis impacting the United States and world markets. The already large federal deficit accumulated during President Bush's administration will soon become a *huge* federal deficit with the financial bailout of \$700 billion coming from the federal government. For most middle and working class Americans this will mean an even greater financial strain on their daily lives, and for social service agencies this will mean operating with less money while helping more people in need.

In addition, it is critical to remember the health care crisis affecting Americans throughout this fiscal predicament. Before the financial situation was fully recognized or publicized, 47 million Americans were without health insurance and another 25 million Americans were considered under-insured, where out-of-pocket medical expenses are a significant portion of their total income despite being insured (Timmins and Cookson 2008). Since the year 2000, insurance premiums have increased 91 percent, while salaries only increased 24 percent during that same period (Timmins and Cookson 2008).

Furthermore, the Congressional Budget Office is now forecasting that Medicare and Medicaid costs will account for up to 10 percent of the Gross Domestic Product (GDP) within the next 20 years, an increase of nearly 6 percent from the current budget (Leonhardt 2008). These costs would add an additional \$900 billion to the deficit each year- an unfathomable price even in comparison to the recent bailout costs (Leonhardt

2008). Clearly, the health care crisis remains a challenge of epic proportions and is only exacerbated by the current fiscal situation of the United States and countries around the world. An affordable, sustainable health care system will be a necessary policy change in the foreseeable future for this country.

Summary

This chapter tied the findings from this project to the anthropological and public health literature that indicate that organizations employees often view causes of homelessness as the fault of individuals, while clients blame the system for their homeless situation. Similarly, counselors in this project placed more emphasis on individual level barriers to health care than did the resident mothers who placed more focus on the interpersonal and institutional barriers to health care services. In this chapter, I also included an explanation of how this research has benefited applied anthropology and public health research by including the perspectives of homeless mothers and conducting ethnographic research that examines the relationship between poverty and access to health care. The chapter is concluded by explaining the recommendations made to Metropolitan Ministries for decreasing barriers to health care for resident mothers and by suggesting macrolevel policy changes and directions for future research on access to health care services.

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Appendices

Appendix A: Health Resource Guide

A Woman's Place

Contact Information/Locations

2901 Busch Lake Blvd

Tampa, FL 33614

813.931.1804

Toll Free 800.267.7900

www.awpm.net

Services Offered

- Free pregnancy tests only
- Do not offer Pap smears
- On-site limited ultrasounds by certified medial team
- Health and safety checklist for pregnant women
- Referrals for medial and social services
- Support groups
- Paraprofessional counseling
- Pregnancy, childbirth, parenting and life skills education classes
- Verification of pregnancy for Medicaid

Eligibility Requirements

- Must be a pregnant woman

Costs

- All services are free to pregnant women

Achieve Tampa Bay

Contact Information/Locations

2215 E. Henry Ave.

Tampa, FL 33610

813.239.1179

www.advanceability.org

Services Offered

- Inclusive development pre-school and childcare
- Physical, occupational, and speech therapy
- Family support
- Parenting classes
- Respite

Eligibility Requirement

- Serves children, adults and families with any disabilities
- Children birth to six years of age, with or without disabilities

Appendix A: (Continued)

Costs

- Call for fee information

All Women's Health Center

Contact Information/Locations

14401 Bruce B. Downs Blvd.

Tampa, FL 33613

813.978.1919

Toll Free 800.733.7909

Hours

Monday through Friday 8:30-5:30pm

Saturday 9-12pm

Services Offered

- Licensed medical facility provides quality health care for women
- Family planning
- Contraceptives
- Pregnancy testing
- Gynecological care
- HIV/STD testing

Eligibility Requirement

- Women in need of services are eligible

Costs

- Free pregnancy testing
- Fees for other services vary
- Do not accept Medicaid

Birth Certificates

Contact Information/Locations

Department of Health

Office of Vital Statistics

P.O. Box 210

1217 Pearl Street

Jacksonville, FL 32231-0042

<http://www.doh.state.fl.us>.

Appendix A: (Continued)

Services Offered

- State office has some birth records dating back to April 1865. The majority of records date from January 1917. (If the exact date is unknown, the fee is \$9.00 for the first year searched and \$2.00 for each additional year up to a maximum of \$50.00. Fee includes one certification of record if found or certified statement stating record not on file.) Additional copies are \$4.00 each when requested at the same time.
- Personal check or money order should be made payable to Office of Vital Statistics. To verify current fees, the telephone number is (904) 359-6900. This will be a recorded message. Information on how to obtain certified copies is also available via the Internet at
- All letters or applications must include the signature, relationship/eligibility stated, and a valid PICTURE ID of the applicant.

Costs

- \$9.00

Breast and Cervical Cancer Hotline and Early Detection Program

Contact Information/Locations

813.307.8015 ext. 3502

813.426.5533

Toll Free 800.451.2229

Services Offered

- Reduced-cost or free mammograms, clinical breast exams and Pap smears

Eligibility Requirement

- Low-income, uninsured women between the ages of 50 and 64 years of age

Costs

- Sliding fee scale and/or Medicaid

Cancer Society, Greater Tampa Unit

Contact Information/Locations

1001 S. MacDill Ave.

Tampa, FL 33629

813.254.3630

Toll Free 800.227.2345

www.cancer.org

Services Offered

- Support groups for cancer patients, family members and friends

Appendix A: (Continued)

Eligibility Requirements

- General public

Costs

- No costs

Center for Family Health

Contact Information/Locations

912 E. Sligh Ave.

Tampa, FL 33604

813.237.6988

Hours

Monday through Wednesday 8:30-4pm

Thursday 8:30-6:30pm

Some Saturdays 8:30-12:30pm

Services Offered

- General medical services
- Gynecological services

Eligibility Requirements

- Family income must be under 150% of the Federal Poverty Level
- Must meet Volunteer Health Provider Program guidelines
- Services provided for immigrants

Costs

- No costs for available services
- \$150 lab fee for Pap smear

Centre for Women

Contact Information/Locations

305 S. Hyde Park Ave.

Tampa, FL 33606

813.251.8437

www.centreforwomen.org

Hours

Monday through Thursday 8:30-5pm

Friday 8-4:30pm

Services Offered

- Mental health counseling
- Substance abuse counseling
- Educational classes about medical problems

Appendix A: (Continued)

Eligibility Requirements

- Services available to all low-income women and any woman in need

Costs

- Sliding fee scale or no fee scale for services

Children and Families, Florida Department of ACCESS Florida

Contact Information/Locations

1) 9393 N. Florida Ave.

Tampa, FL 33612-7907

813.558.5500

Toll Free 1.866.762.2237

www.myflorida.com/accessflorida

Hours

Monday through Friday 8-5pm

2) 2301 N. Tampa St.

Tampa, FL 33602

813.209.1200

Hours

Monday through Friday 9-5pm

Services Offered

- Online application for food stamps, Temporary Assistance for Needy Families, and Medicaid
- For a new Medicaid or Medipass card, call the toll free number to reach the customer call center

Eligibility Requirements

- All members of the general public are welcome to apply for assistance

Costs

- No fees for online applications

Children's Medical Services

Contact Information/Locations

13101 N. Bruce B. Downs Blvd.

Tampa, FL 33612

813.396.9696 Press 1-main phone

www.cms-kids.com

Appendix A: (Continued)

Services Provided

- Case management services for children up to 21 years of age who have chronic medical conditions or developmental delays
- Family centered, managed system of care for children with special health care needs
- Prevention, early intervention and primary care services, including: inpatient and outpatient hospital services, specialty care physician services, pharmacy, lab testing, home health care, medical foster care, respite care, medical equipment, case management, rehabilitation, medical day care, radiology, dental, skilled nursing facility care

Eligibility Requirements

- Must be a child up to the age of 21 years old
- Must have a special health care need as defined as: those children whose serious or chronic physical or developmental conditions require extensive preventive and maintenance care beyond that required by typically healthy children

Costs

- Will accept Medicaid eligible patients
- Call for cost information

Community Doula Program

Contact Information/Locations

2215 E. Henry Ave.

Tampa, FL 33610

813.239.1179

Toll Free 800.749.5155

www.achievetampabay.org

Services Offered

- Provides trained doulas to offer emotional, education, and physical support to expectant mothers during pregnancy
- Helps promote breast-feeding and mother-infant bonding
- Provides support for pregnant women before, during and immediately after birth
- Childbirth education classes in English and Spanish

Eligibility Requirements

- Must be a pregnant woman

Costs

- None

Appendix A: (Continued)

Covenant House of Tampa

Contact Information/Locations

8611 N. 11th St.

Tampa, FL 33604

813.500.4286

www.covenanthouseministries.net/home.html

Services Offered

- Faith-based substance abuse counseling
- Newly partnered with Tampa Family Community Health Centers and Hillsborough County Health to provide medical services, including:
 - Licensed mental health counseling
 - Licensed substance abuse counselors
 - HIV/STD prevention
 - Health workshops
 - Smoking cessation classes
 - Direct medical services

Eligibility Requirements

- No eligibility requirements; everyone is eligible regardless of income or housing status

Costs

- No costs for available services

Dental Clinic

Contact Information/Locations

4001 Tampa Bay Blvd.

Tampa, FL 33614

813.253.7527

Hours

Monday, Tuesday, and Thursday 8-4pm

Wednesdays 8-12:30

Services Offered

- Comprehensive dental services and preventive services
- Exams, cleaning, fluoride, sealants, and x-rays
- Restorative services, including: fillings, crown and bridgework, and dentures
- Extractions, root canals, and periodontal surgery procedures

Eligibility Requirements

- Services available to the general public

Appendix A: (Continued)

Costs

- Sliding fee scale
- Medicaid accepted

Family Care Medical Center

Contact Information/Locations

5906 N. 30th St.

Tampa, FL 33610

813.272.6420

www.hillsboroughcounty.org/hss/

Hours

Monday and Wednesday 7:30-7pm

Tuesday, Thursday, and Friday 7:30-4pm

Services Offered

- Licensed doctors, nurses and other health care workers provide ongoing health care
- Referrals to specialists and hospitalization
- Limited dental, visual, and mental health services

Eligibility Requirements

- Low-income
- Can apply in person or bring referral from DCF, health professionals or other social service agencies

Costs

- No costs for available services

Family Support and Resource Centers

Contact Information/Locations

1) 1401-A E. Fowler Ave.

Tampa, FL 33612

813.558.1877

www.familysupporthc.org/index.cfm

Hours

Monday through Friday 8-5pm

2) 7520 W. Waters Ave.

Suite 8

Tampa, FL 33615

813.356.1703

Hours

Monday through Friday 8-5pm

Appendix A: (Continued)

3) 1277 Kingsway Road
Brandon, FL 33510
813.740.4634
Hours
Monday through Friday 8-5pm

Services Offered

- Childbirth/Breastfeeding Classes
- Child Developmental Play Groups
- Parent-to-Parent Support Groups
- Parenting Education Classes
- Family Health and Safety Classes
- Prenatal Classes

Eligibility Requirements

- Services are available to the general public, no eligibility requirements

Costs

- No costs for available services

Francis House, Inc.

Contact Information/Locations
4703 N. Florida Ave
Tampa, FL 33603
813.237.3066

www.francishouse.org

Hours
Monday through Friday 8-5pm

Services Offered

- Mental health counseling
- Substance abuse counseling
- Group counseling sessions
- Day respite center for persons with HIV/AIDS

Eligibility Requirements

- Target audience is “people at risk”, although services typically designed for persons with HIV/AIDS
- Clients must be “present” and willing to participate

Costs

- No costs for available services

Appendix A: (Continued)

Greater Tampa Lions Sight Fund, Inc.

Contact Information/Locations

PO Box 6321

Sun City Center, FL 33571-6321

813.651.1010

Hours

Monday through Friday 8-5pm

Services Offered

- Application for vision examination and eyeglasses funding

Hillsborough County HealthCare Insurance Plan

Contact Information/Locations

601 E. Kennedy Blvd.

25th Floor

Tampa, FL 33602

813.272.5555

www.hillsboroughcounty.org/hss/hhcprogram/

Hours

Monday through Friday 8-5pm

Services Offered

- Combination of disease management and prevention programs
- Primary and specialty health care services
- Inpatient and outpatient treatment
- Pharmaceuticals
- Diagnostic and hospital services
- Vision
- Dental
- Home health
- Other medically necessary services

Eligibility Requirements

- US citizen or documented legal residents
- Not eligible for any other health care coverage, including Medicare and Medicaid
- Resident of Hillsborough County

Appendix A: (Continued)

- Income and assets that met the following criteria:

# of People	Net Monthly Household Income	Assets
1	\$867	\$5000
2	\$1167	\$6000
3	\$1467	\$6000
4	\$1767	\$6500
5	\$2067	\$7000
6	\$2367	\$7500
7	\$2667	\$8000
8	\$2967	\$8500
9	\$3267	\$9000
10	\$3567	\$9500

 - for each additional person, add \$283 in income and \$500 in assets
 - household consists of applicant and persons related by blood or marriage or who choose to combine income and assets
- To apply:
 - Proof of monthly income (pay stub, letter from social security or veterans administration) for all household members
 - Social Security card for all household members
 - Two residency documents (see www.hillsboroughcounty.org/hss/hhcprogram.cfm for list of approved documents)
 - Proof of assets (bank statement or credit union statement)
 - Any insurance policies with loan value
 - Fill out the application worksheet and the application forms (see www.hillsboroughcounty.org/hss/hhcprogram/applicationform.cfm)
 - Take all materials to a Neighborhood Service Center (see www.hillsboroughcounty.org/hss/hhcprogram/servicecenters.cfm)

Costs

- No premium payments
- Some co-payments for certain services (such as pharmaceuticals)

Judeo Christian Health Clinic

Contact Information/Locations

4120 1/2 MacDill Ave.

Tampa, FL 33607

813.870.0395

Located behind St. John's Presbyterian Church

Hours

Call for hours of operation. Sign in daily at 4pm and return at 9am the next morning.

Appendix A: (Continued)

Services Offered

- Diagnostic and primary medical treatment
- Eye care
- Dental treatment (basic emergency extractions only)
- Asthma and allergy
- Dermatology
- Gynecology
- Pediatrics
- Podiatry
- Nutrition

Eligibility Requirements

- Unable to afford insurance but ineligible for government assistance
- Call for eligibility information

Costs

- No costs for the available services

KidCare, Florida

Contact Information/Locations

1105 E. Kennedy Blvd.

Tampa, FL 33602

813.307.8015- ext. 3502

813.272.5285

www.floridakidcare.org

Hours

Monday through Friday 8-5pm

Services Offered

- Affordable health insurance to Hillsborough County's uninsured children 0-18 years old
- Offers full range of medical services, including:
 - Well-child check ups
 - Prescription drugs
 - Referrals to specialists
 - Lab tests
 - Hospital care
 - Behavioral and mental care
 - Emergency services and emergency transportation
 - Vision and hearing
 - Outpatient services

Appendix A: (Continued)

Eligibility Requirements

- Children from 0 to 18 years old not covered by any other health insurance
 - Ages 0-4 years old: MediKids
 - Ages 5-18: Healthy Kids
- Meet income requirements (See website <http://www.doh.state.fl.us/AlternateSites/KidCare/eligibility.html>)
- US Citizen
- Not living in an institution

Costs

- Costs depend on household size and income
- No costs for KidCare Medicaid
- Most families pay between \$15 and \$20 per month in premiums

Mercy House

Contact Information/Locations

2021 E. Busch Blvd.

Tampa, FL 33612

813.631.4370

Hours

Monday through Friday 24 hours per day

Services Offered

- Safe and supporting living environment for HIV-positive women and mothers with young children
- Support services, including: support groups, respite and child day care, medical services, case management, and limited transportation

Eligibility Requirements

- Medical diagnosis of HIV or AIDS
- Woman or family must be homeless, living in a marginal housing situation or transitioning from another residential setting

Costs

- Each woman covers a small portion of her living expenses based upon her ability to pay

Pediatric Ambulatory Care Center

Contact Information/Locations

17 Davis Blvd.

Tampa, FL

813.272.2799

Appendix A: (Continued)

Hours

Monday through Friday 8-5pm

Saturday and Sunday 8:30- Noon

Services Offered

- General pediatric care
- Pediatric specialists offer treatment in the following areas: new and premature babies, allergies, pre- and post-surgical care, infections, lung diseases, immune system diseases, endocrinology, neurology, bone and joint problems, pain management, genetics, and blood diseases
- Treatment for minor emergencies

Eligibility Requirements

- Children ages 0 to 21 years old

Costs

- Call for cost information

Pregnancy Care Center

Contact Information/Locations

14620 N. Nebraska Ave.

Unit C

Tampa, FL 33613

813.978.9737

Hours

Tuesday and Friday 10-2pm

Thursday 10-2pm, 6-9pm

Services Offered

- Pregnancy test
- Childbirth and parenting support education
- Community provider referrals

Eligibility Requirements

- Services available to the general public

Costs

- No costs for available services

Appendix A: (Continued)

St. Joseph's Treatment and management Program for AIDS Care

Contact Information/Locations

4200 N. Armenia Ave.

Suite 3

Tampa, FL 33607

813.870.4460

Hours

Monday through Friday 8-4:30pm

Services Offered

- Medical services related to AIDS care provided by a nurse practitioner and five physicians
- Holistic, rational ambulatory medical care

Eligibility Requirements

- Must be an adult living with HIV or AIDS

Costs

- Call for cost information

Sunshine Line

Contact Information/Locations

4023 N. Armenia Ave.

Suite 300

Tampa, FL 33607

813.272.7272

Hours

Monday to Friday 6am-5pm

Saturdays 8am-5pm

Services Offered

- Bus pass program
- Door-to-door service for people unable to ride the HARTline bus

Eligibility Requirements

- Doctor's statement explaining medical condition and how it prevents you from riding the bus is required to qualify you for door-to-door service

Costs

- Most clients will not be charged a fee, some will be required to pay a co-payment

Appendix A: (Continued)

Tampa Family Health Centers, Inc.

Contact Information/Locations

1) 1514 N. Florida Ave.

Suite 300

Tampa, FL 33602

813.490.1957

Hours

Tuesday, Wednesday, and Friday 8-5pm

Monday and Thursday 8-7pm

Dental Hours

Monday through Friday 8-5pm

2) 1401 East 22nd Ave.

Tampa, FL 33605

813.248.6263

Hours

Monday, Tuesday, Thursday, Friday 8-5pm

Wednesday 10-7pm

3) 1502 E. Fowler Ave.

Tampa, FL 33612

813.866.0950

Hours

Monday, Wednesday, and Friday 8-5pm

Tuesday and Thursday 8-7pm

Dental Hours

Monday through Friday 8-5pm

Pharmacy Hours

Monday through Friday 8:30-5:30pm

4) 2103 North Rome Ave.

Tampa, FL 33607

813.490.1426

Hours

Monday through Friday 8-5pm

Pharmacy Hours

Monday through Friday 8:30-5:30pm

Appendix A: (Continued)

5) 3402 North 22nd St.

Tampa, FL 33605

813.272.6240

Hours

Monday and Friday 8-5pm

Tuesday, Wednesday and Thursday 8-7pm

Saturday 9-1pm

Dental Hours

Monday through Friday 8-5pm

Pharmacy Hours

Monday through Friday 8:30-5:30pm

6) 8213 West Waters Ave.

Tampa, FL 33615

813.490.5420

Hours

Monday through Friday 8-5pm

Pharmacy Hours

Monday through Friday 8:30-5:30pm

Services Offered

- Comprehensive medical services, including:
 - Internal medicine
 - Obstetrics and gynecological services
 - Family planning
 - Pharmacy with delivery services
 - X-ray
 - Dental

Eligibility Requirements

- Must live in Hillsborough County
- Must have documentation from a homeless shelter on shelter letterhead and signed by a shelter employee verifying residence in a shelter

Costs

- Sliding fee scale or free to non-funded homeless clients
- No one will be turned away due to inability to pay
- Accepts many types of insurance, public and private

Appendix A: (Continued)

US Veterans Administration

Contact Information/Locations

10770 N. 46th St.

Suite C-100

Tampa, FL 33612

813.979.3562

Services Offered

- Two Registered Nurses on staff to provide mental and physical health assessments
- Mental health counseling
- Triage services
- Referrals to the Veterans Administration Hospital

Eligibility Requirements

- Must be an honorably discharged female veteran
- The Veterans Administration rule is that person must have serviced for at least two years, or seven years in the reserves, or have been sent to active duty for qualify for services

Costs

- No cost for female veterans who qualify per Veterans Administration requirements

Appendix B: Health Assessment

Hi, my name is Jaime and I am the Health Specialist Case Manager here at Metropolitan Ministries. The purpose of this interview is for me to learn about your health and the health of your family in order to help you access any health care services you might need now or in the immediate future. Some of the questions I am going to ask you are personal and private, and I understand that talking about these things can be difficult. However, answering these questions will help me connect you with the available resources so that you and your family can be as healthy as possible. Your confidentiality will be protected and maintained within our counseling team here at Metropolitan Ministries. Do you have any questions before we get started?

- I. Physical Health Status
 - a. Describe your physical health for me. On a scale from 1 to 10, with 1 being poor and 10 being excellent, how would you rate your physical health?
 - b. Do you have any physical limitations? Can you stand, sit, lift or bend without difficulty?
 - c. Have you ever had a general health physical? What did the doctor tell you at that visit?
 - d. Do you think you might be pregnant? What is the approximate due date?
 - e. Have you ever been diagnosed HIV positive or with AIDS? When was the last time you were tested? What were those results? Did the doctor talk to you about HIV/AIDS and the importance of being tested?
 - f. Tell me about your medical history. Do you have any long-term health problems or disabilities? Have you ever had major pain or major illnesses? Were you ever in the hospital? For what and when? Are you allergic to anything?
 - g. What medications are you currently taking? Which medications have you taken in the past? Are there any medications you should be taking right now but for some reason are not? Why are you no longer taking those medications?
 - h. Can you think of any improvements you would like to make to feel better physically? Do you have any goals you would like to work towards in order to be healthier?
 - i. Are you worried about your health or the health of any of your family members? What worries you? What health concerns do you have about yourself? What things about your health worry you?

Appendix B: (Continued)

- II. Self-Care
 - a. Tell me about what you eat during a typical day. What do your children eat during the day and where do you get it?
 - b. Do you exercise? What types of exercise do you do? Do you enjoy them? How often do your children exercise? What types of exercise do your kids enjoy?
 - c. Do you have any problems sleeping, falling asleep or staying asleep? What about your children?
 - d. On a scale from 1 to 10, 1 being poor and 10 being excellent, how would you rank your hygiene on a typical day? What about your children's hygiene?
 - i. Be sure to write down their self-report as well as your own evaluation of hygiene
- III. Health Insurance Coverage
 - a. Do you currently have any private health insurance?
 - b. Are you covered by any medical insurance?
 - c. Which health insurance do you have?
 - d. Is everyone in your family covered?
 - e. Tell me about your experience with this health insurance program. Have all your health care needs been met?
- IV. Access to Health Care Services
 - a. Do you or your family have any medical problems that need immediate attention?
 - b. Are you currently receiving medical care somewhere? Where? Tell me about your experience with this medical provider. What does it cost you? How do you get there?
- V. Family History
 - a. Now we're going to draw your family tree.
 - b. Did your mother have any health problems? What kinds of health problems did she have?
 - c. What about your father?
 - d. Are your siblings healthy? Do they have any health problems?
 - e. What health problems or illnesses "run in your family"? What patterns or trends do you see in the medical history of your family? What does this mean for your own health and the health of your children?
- VI. Child Health and Development
 - a. ***Be sure to ask these questions for each child or specify which child the illness pertains to.

Appendix B: (Continued)

- b. Tell me about your pregnancy/pregnancies?
 - i. How was your delivery? Complications?
- c. Describe each of your child's physical health for me. On a scale from 1 to 10, with 1 being poor and 10 being excellent, how would you rate each child's physical health?
- d. Do any of your children have any physical limitations?
- e. When was the last time each of your children saw a doctor for a health physical when they were not sick? What did the doctor tell you at that visit?
- f. Have your children been immunized? Do you have their immunization records or information with you?
- g. Tell me about each child's medical history. Do any of your children have any long-term health problems or disabilities? Have any of your children ever had major pain or major illnesses? Were any of the children ever put in the hospital? For what and when? Are any of the children allergic to anything?
- h. Are any of the children on medication right now? Which medication and for what reason? Which medications have the children taken in the past? Are there any medications any of your children should be taking right now but for some reason are not? Why are they not taking those medications?
- i. Can you think of any health goals you have for your children?
- j. What health concerns do you have about your children? What things about your children's health worry you?
- k. Have you ever been told that any of your children have developmental problems? Can you tell me about that? Have any of your children been placed in special education classes? Which child and in what type of program?
- l. Have your kids ever had problems enrolling in school? Can you tell me what happened and what the barriers to enrollment were at that time?

Appendix C: Counselor Interview Guide

I'd like to start the interview learning about you and your work with the UpliftU® program at Metropolitan Ministries.

1. How long have you worked here as a counselor for the UpliftU® program?
2. Have you worked any other jobs other than as a counselor for the UpliftU® program?
3. How did you come to work as a counselor with this program?
 - a. Probes
 - How did you decide to become a case manager?
 - Do you have any degrees or licenses related to this job?
 - Why did you decide to come work for the UpliftU® program?

My goal with this project is to better understand the health services used by residents in the UpliftU® program, specifically those residents with children. Since you have worked with these residents for some time now, I would like to hear your perspective about the health services resident mothers use and your understanding about their experiences with these services.

4. Where can resident mothers go if they are sick or need to see a doctor?
 - a. Probes
 - Have you ever visited these places? What was it like?
5. What do mothers do when they are sick or need to see a doctor?
 - a. Probes
 - Where do they go?
 - How many have a specific doctor they see?
 - Do they go to the same place every time they are sick?
 - Does where they go depend on what type of health problem they have?
2. Where can resident mothers *go* if their children get sick or need to see a doctor?
 - a. Probes
 - Have you ever taken visited there? What was it like?
3. What do resident mothers *do* when their children get sick or need to see a doctor?
 - a. Probes
 - Where do they take them?
 - Do children have a specific doctor they see?
 - Do resident mothers take their children to the same place every time they are sick?
 - Does where resident mothers take their children depend on what type of health problem they have?

Appendix C: (Continued)

4. Tell me about your perception of the experiences the resident mothers you work with have with (fill in the blank with the place named as where resident mothers go to receive care).
 - a. Probes
 - What do they like about going to (name of place)?
 - What do they dislike about going to (name of place)?
 - Do resident mothers feel like their or their child's health problem was taken care of? Why or why not?
 - What could (name of place) have done better to take care of resident mothers and their children?
 - What did (name of place) do well in taking care of resident mothers and their children?
5. How well do the available health care services address resident mothers and children's health care problems?
 - a. Probes
 - Are there any specific health problems that are not taken care of through the available resources?
 - Which health problems are typically well taken care of through the available resources?
6. If you could do anything to improve the health of UpliftU® resident mothers and children, what would you do?
7. If you could do anything to improve the health care services available to UpliftU® resident mothers and children, what would you do?

Appendix D: Resident Mother Interview Guide

I'd like to start the interview by learning about you and your family and your experiences participating in the UpliftU® program here at Metropolitan Ministries.

8. Can you tell me about yourself and your family?

a. Probes

- How old are you?
- How many kids do you have? How old are your kids?
- Do your children live here at Metropolitan Ministries with you?
- How long have you lived here?

9. How did you find the UpliftU® program?

a. Probes

- Where were you and your children living before you moved into Metropolitan Ministries?
- Why did you decide to participate in this program?

I hope you can help me learn about your experiences here at UpliftU®, and about the health care services you and your children use here in Hillsborough County. I want to learn if there are any health services that you or your children need but do not have access to.

10. Where can you go if you are sick or need to see a doctor?

a. Probes

- Have you ever been there? Why not?
- What was it like there?

11. If you do not go there (above) what do you do when you are sick or need to see a doctor?

a. Probes

- Where do you go?
- Do you have a specific doctor you see?
- Do you go to the same place every time you are sick?
- Does where you go depend on what type of health problem you have?
- How do you get there?
- Do you have to pay for the ride/doctor's visit/medicine?

12. Where can you go if your children get sick or need to see a doctor?

a. Probes

- Have you ever taken your children there? Why not?
- What was it like there?

Appendix D: (Continued)

13. What do you do when your children get sick or need to see a doctor?
- a. Probes
- Where do you take them?
 - Do your children have a specific doctor they see?
 - Do you take your children to the same place every time they are sick?
 - Does where you take your children depend on what type of health problem they have?
14. Tell me about your experiences with (fill in the blank with the place they named as where they go to receive care).
- a. Probes
- What did you like or dislike about going to (name of place)?
 - Was your health problem or your child's health problem taken care of the way you wanted it to be? Why or why not?
 - What did (name of place) do well or what could they have done better to take care of you or your child?
15. How well do the available health care services address you and your children's health care problems?
- a. Probes
- What health problems are not taken care of?
 - Which health problems are typically well taken care of through the available resources?
16. If you could do anything to improve the health of yourself and your children, what would you do?
17. If you could do anything to improve the health care services available to you and your children, what would you do?

Appendix E: Technical Report

Access to Health Care Services: A Case Study in Hillsborough County, Florida

Jaime Nodarse

EXECUTIVE SUMMARY

The UpliftU® Program is a long-term residential program for women and families who are homeless or at risk for homelessness. This program is one part of a larger, community-based non-profit organization serving low-income and homeless families in Hillsborough County, Florida for over 35 years. This program is not an emergency shelter program, but rather offers up to 18 months of participation in a self-sufficiency program to single women and families. The goal of the program is to prevent future homelessness for residents by helping them to reach their highest level of self-sufficiency. After volunteering at this organization for nine months, I completed an internship as the Health Specialist Case Manager for the UpliftU® program during the summer of 2008 and conducted a research project examining access to health care services for resident mothers.

The research completed during this internship was conducted using ethnographic research methods to understand counseling team members' and resident mothers' perceptions of access to health care resources and their experiences in utilizing area health care services. Data analysis compared the perspectives of the counseling team members with the resident mothers' perspectives, and examined barriers to and gaps in service provision, as reported by both groups. Findings suggest that counseling team members conceptualize the barriers to health care as originating at the individual level with resident mothers' behaviors and actions, while resident mothers expressed that the barriers to health care services were at an interpersonal level. The resident mothers recounted their belief that health professionals treat them poorly, and that they experience barriers at an institutional level, with the bureaucratic hassles associated with public insurance and public clinics. Such differences in perception of causality of barriers to health care services between counseling team members and resident mothers likely have

Appendix E: (Continued)

significant ramifications for resident mothers' health and ability to access health care services.

This Technical Report briefly introduces the academic literature relating to homeless families and access to health care services, and then proceeds to outline data collection methods utilized during research, findings from research, and recommendations for decreasing barriers to health care for resident mothers.

Appendix E: (Continued)

Part One

Introduction

“I think the community needs to be educated because I think the community thinks a lot of the homeless population are just the men. That there aren’t families. Because you don’t see them everyday, because they’re not out on the street corner.”

--UpliftU® counselor

The UpliftU® Program is a long-term residential program for women and families who are homeless or at risk for homelessness. This program is one part of a larger, community-based, non-profit, faith-based organization serving low-income and homeless families in Hillsborough County, Florida for over 35 years. This program is not an emergency shelter program, but rather offers up to 18 months of participation in a self-sufficiency program to single women and families. The goal of the program is to prevent future homelessness for residents by helping them to reach their highest level of self-sufficiency. During the summer of 2008, I completed an internship as the Health Specialist Case Manager for the UpliftU® program and conducted an independent research project examining access to health care services for resident mothers.

The overarching purpose of this project was to investigate the health services available and any barriers limiting access to these services from the viewpoint of homeless women and their children. The immediate goal of this study was to provide the UpliftU® program with specific recommendations for ways in which the program could begin to bridge gaps in service provision within the community and assist families in overcoming barriers to accessing health care resources. This Technical Report briefly introduces the academic literature relating to homeless families and access to health care services, and then proceeds to outline data collection methods utilized during research, findings from research, and recommendations for decreasing barriers to health care for resident mothers.

Appendix E: (Continued)

Health Disparities

Health disparities within the United States have come to the attention of the media, researchers, and the general public, and increasingly the need to address gaps in health care has been emphasized as a critical issue. Health disparities has become a popular research topic, in part due to the Healthy People 2010 goal of reducing such disparities in order to positively impact public health (Dressler et al. 2005), and also because recent data suggest health disparities are increasing worldwide (Harrison 2007). According to Dressler, Oths, and Gravlee, “‘health disparities’ refers to differences in morbidity, mortality, and access to health care among population groups defined by factors such as socioeconomic status, gender, residence, and especially ‘race’ or ‘ethnicity’” (2005:232). While the United States spends more on health care per person than any other country, millions of Americans do not have health insurance and consequently lack access to quality health care services (Fort et al. 2004). Research exploring access to health care for low-income and marginalized groups within the United States can explore possible solutions to such disparities.

Homelessness in the United States

According to the National Coalition for the Homeless (NCH), in a given year 2.5 million people in the United States are likely to experience homelessness (NCH 2006). Of those people, 1.35 million are children under the age of 18 (NCH 2006). The NCH has reported a steady rise in homelessness in the United States over the past 25 years and predicts that this pattern will persist due to increased shortages of affordable housing and climbing poverty rates (2006). In Florida specifically, it is estimated that over 83 thousand people are homeless and that 35 percent of these people are children under the age of 18 (Hillsborough County Homeless Coalition 2008). Homelessness in the United States is a growing trend and the country does not currently have services or programs to help the millions of Americans experiencing homelessness each year.

Not only is homelessness, in general, on the rise, but also the number of homeless families with children has increased over the past ten years (NCH 2006). This group is now the fastest growing segment of the homeless population in the United States (NCH

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2006; Nunez 1996). One study cited by the NCH purports that 39 percent of homeless people are children under the age of eighteen (2006). While it is difficult to validate any number of homeless people, a NCH survey of 25 American cities found that 33 percent of the homeless population consisted of families with children (2006). Similar statistics have been reported for major metropolitan areas such as Boston, Trenton, and San Antonio (Nunez 1996), and it is estimated that 38 percent of the homeless population in Florida is made up of families with children (Hillsborough County Homeless Coalition 2007).

“It upsets me because if there’s specialty doctors out there and you have Medicaid, you have whatever insurance, why can’t you help? And that frustrates me because you’re a professional. You know if I’m coming to you it’s not because I want to waste your time; it’s because my kid is in pain. You know and I’m trying to avoid it getting worse. Why can’t you just help?”
--Resident mother

Homeless Families

People stereotypically think the homeless population in America is mainly comprised of single, adult men who are veterans or suffering from mental illness or substance abuse problems; unfortunately studies consistently indicate that the homeless population is increasingly made up of families with children.

Definitional Difficulties

The United States Department of Housing and Urban Development (HUD) defines homelessness according to the McKinney-Vento Homeless Assistance Act and this definition is used to determine eligibility for most services (HUD 2007). According to this definition a homeless person is anyone who lacks a regular nighttime residence and any individual whose primary nighttime residence includes a shelter, temporary residence for institutionalized people, or a public or private place not typically used as a place for sleeping (HUD 2007). While this definition includes many homeless people and families, researchers have repeatedly criticized the definition for not including everyone experiencing homelessness, and because homeless families oftentimes differ

Appendix E: (Continued)

dramatically from homeless single adults, this definition is especially narrow and inadequate for this portion of the homeless population (Anderson and Koblinsky 1995, Glasser and Bridgman 1999, Lewit and Schuurmann Baker 1996).

Whereas homeless single adults often come to shelters from living on the street, homeless families typically experience long periods of unstable housing prior to moving into shelters, such as moving back and forth between friends and family members' homes for brief stays (Shinn and Weitzman 1996). In order to account for families in these "doubled up" situations, some researchers have proposed other more inclusive definitions of homelessness that include the, "thousands of families precariously doubled-up with relatives or friends" (Anderson and Koblinsky 1995:13). One such definition involves defining two groups of homeless people: the literally homeless and the precariously housed population (Lewit and Schuurmann Baker 1996). This definition explains that the precariously housed are in imminent danger of becoming literally homeless and that children and families are often among the precariously housed group (Lewit and Schuurmann Baker 1996). While this definition is more inclusive, it still does not account for everyone experiencing homelessness.

Characteristics of Homeless Families

In addition to differing from homeless single adults according to their living situation prior to moving into a shelter, homeless families also differ from homeless single adults in other ways. In fact, some researchers have argued that homeless families are more similar to housed poor families than they are to homeless single adults (Shinn and Weitzman 1996). While it is crucial to recognize that families experiencing homelessness are a heterogeneous and diverse group and that not *all* homeless families will fit the forthcoming descriptions, studies conducted in urban areas around the United States have consistently agreed on several characteristics that describe many of the families in homeless shelters.

Data indicate that homeless families, similar to many housed low-income families, tend to be headed by young, single mothers, and parents in homeless families are reported as being much younger than homeless single adults (Shinn and Weitzman

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1996). Homeless mothers with children and housed poor mothers have reported similar levels of educational attainment and past employment experiences, but both groups tend to report lower levels of education and fewer past employment positions than homeless single adults (Shinn and Weitzman 1996). Research also suggests that a lower proportion of homeless parents and families have substance abuse and mental health problems than homeless single adults (Shinn and Weitzman 1996). These differences in characteristics between homeless families and homeless single adults have led to the obvious conclusion that homeless families have different needs and problems than homeless single adults, and thus may experience more success in shelter programs designed specifically for families.

Access to Health Care

Health care access has been defined by Gulzar as the, “fit among personal, sociocultural, economic, and system-related factors that enable individuals, families, and communities to have timely, needed, necessary, continuous, and satisfactory health services” (Hatton et al. 2001:26). Unfortunately, health care access is unequal and homeless families have a more difficult time than most other groups in gaining such access. Many researchers have documented the lack of access to health services for homeless families and studies have even suggested that accessing health care is more difficult for homeless families than for housed low-income families (Hatton et al. 2001; Kushel et al. 2001; Miller and Lin 1988; Weinreb et al. 2007). The lack of health care access for homeless mothers is due to a variety of factors and has several important consequences for these women and their children.

If resources for both food and health care are not available to homeless people, food oftentimes is the more direct necessity. The immediate need to secure food and shelter can act as a barrier to accessing health care for homeless families (Kushel et al. 2001). Another major barrier to health care access for homeless mothers and their children is the lack of health insurance or Medicaid (Kushel et al. 2001; Miller and Lin 1988). Even many families that would likely qualify for Medicaid or other public

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insurance are currently not covered (Kushel et al. 2001). For homeless mothers specifically, the risk of losing custody of their children if medical providers deem them unfit is a critical barrier, especially to accessing mental health services (Weinreb et al. 2007). Other barriers to health care services facing homeless mothers include a lack of transportation and child care, no regular health care provider, reluctance of providers to care for homeless clients, and providers that blame homeless women for their own health problems (Hatton et al. 2001). Barriers to accessing health care services vary for homeless mothers depending on where they live geographically, their social networks, and their access to information about service providers.

Health Consequences

Homelessness is a critical issue in part due to the many documented negative health outcomes affecting people in this situation (Anderson and Koblinsky 1995; Burt and Cohen 1989; Burt et al. 2001; Clatts and Davis 1999; Desjarlais 1996; Lovell 1997; Tischler et al. 2007). Studies of homelessness have documented the health risks and problems that often accompany life on the street, and homeless mothers and their children are especially prone to experiencing negative health outcomes, partially due to a lack of access to necessary health services (Anderson and Koblinsky 1995; Burt and Cohen 1989; Hatton et al. 2001; Karim et al. 2006; Miller and Lin 1988; Tischler et al. 2007). Illnesses such as asthma, pneumonia, conjunctivitis, malnutrition, and bronchial infections frequently plague homeless people, and infectious diseases such as sexually transmitted diseases, HIV, and tuberculosis are also prevalent among this population (Clatts and Davis 1999). Children living on the streets or in shelters are especially vulnerable to such illnesses and typically have high rates of acute and chronic health problems, as well as developmental delays (Burt et al. 2001; Clatts and Davis 1999). Unfortunately, illness is intimately tied to homelessness and this indicates an essential need for medical services among this population.

Unfortunately, the consequences associated with being homeless and not having access to health care services are multifaceted. Homeless mothers and their children are more likely to experience negative health outcomes and to report their health as being fair

Appendix E: (Continued)

to poor when compared to the average population of the United States or to the housed low-income population (Burt and Cohen 1989; Miller and Lin 1988). One study done by Hatton, Kleffel, Bennett, and Gaffrey found that focus group participants reported a slew of acute and chronic health problems. “Conditions that affected primarily children included chicken pox, whooping cough, and head lice. Communicable conditions seen in both adults and children included hepatitis, tuberculosis, athlete’s foot, scabies, colds, flu, and sexually transmitted diseases” (2001:28). Furthermore, both homeless women and their children have low health maintenance and preventive care (Hatton et al. 2001; Miller and Lin 1988). Correspondingly, another study found that changing locations frequently decreases the likelihood of receiving appropriate health care, especially preventive services (Karim et al. 2006). Not receiving preventive care increases the chance that homeless mothers and their children will experience continuous negative health outcomes.

On a broader scale, the consequences of homeless mothers lacking access to health care services have an economic affect. Researchers have suggested that without access to mental health services, women themselves become more overwhelmed and anxious leading to more serious psychological problems for both her and her children down the road (Tischler et al. 2007). Providing early counseling services and consistent emotional support to homeless mothers would lower costs by decreasing the severity of mental health problems and thus the quantity of services needed as well as by decreasing the number of mothers in need of mental health services.

Other research has found that homeless mothers without access to health care due to a lack of insurance tend to wait, “until health problems are so acute that they must seek help in costly emergency rooms” (Hatton et al. 2001:26). The government and taxpayers end up paying more for a visit to the emergency room than they would have paid for preventive and primary health care services. In a milieu of budget cuts and fewer resources for health care, the fact that not providing care to homeless mothers has proven to be more expensive than providing primary preventive health care services is an urgent message that changes need to be made.

Appendix E: (Continued)

Part Two

Fieldwork Setting and Research Methods

“Insurance coverage doesn’t cover housing. So there’s nothing for the in-between people. And mostly adults, kids get taken care of. Or even if it’s just like, her kidneys are giving out, but they aren’t totally given out, so she doesn’t qualify for SSI but she can’t work and she’s on Hillsborough County HealthCare so she needs to pay for prescriptions, she needs to pay for treatment, just a little bit, but it you can’t work...there’s nowhere.”

--UpliftU® counselor on the resources available to terminally ill homeless people

The overarching objective of this study was to describe the health services available to mothers who are currently participating in the UpliftU® program at Metropolitan Ministries. The specific objectives that guided this project were (1) to elicit the perspectives of resident mothers and organization employees regarding available health services, (2) to explore barriers that limit access to health services from the perspectives of resident mothers and organization employees, (3) to determine what types of health services and support resident mothers report needing and wanting, (4) to determine gaps in service provision that limit resident mothers’ access to needed health care services, and (5) to provide recommendations to the UpliftU® program for addressing health care service provision gaps in order to improve resident mothers’ access to health care resources. These objectives informed decisions made regarding the research design of this project.

As a case study and ethnography, this project is not intended to be representative of all homeless people or even all homeless families in central Florida, but rather is meant to provide an in-depth cultural analysis of access to health care services for homeless mothers living at this shelter in Hillsborough County, Florida. Understanding the community within which this project was situated is important because the political milieu, economic situation, and community characteristics impact who experiences homelessness and how they experience it, and information about Hillsborough County is included to provide a description of this context.

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Hillsborough County

Geography and Demographics

Located on the west coast of Florida bordering the Gulf of Mexico, Hillsborough County is Florida's fourth largest county covering over one thousand square miles of land (U.S. Census Bureau 2008) and accounting for 6.4 percent of the state's total population (The Florida Legislature 2008). The Florida Legislature reports the estimated 2007 population for Hillsborough County as 1,192,861 people, and the population grew nearly 20 percent from 2000-2007 (The Florida Legislature 2008). The vast majority of this population growth (75%) is due to net migration (The Florida Legislature 2008).

Hillsborough County's population tends to be somewhat younger than the population of the state of Florida overall, with a median age of 35.1 years as compared to the state's median age of 38.7 years (The Florida Legislature 2008). In 2006, 25.2 percent of Hillsborough County's population was under 18 years of age, while only 22.4 percent of the state's population was under 18 years of age (The Florida Legislature 2008). The county also has a higher percentage of family households with children under the age of 18 living in the household (48.1%) than the state of Florida overall (42.3%) (The Florida Legislature 2008).

Several of these factors influence the prevalence of homelessness in Hillsborough County, including: a warm climate, a high growth rate due to net migration, and a younger population with a high percent of children. As far as access to health care services are concerned, in the last 12 months 9.6 percent of adults in Hillsborough County report being unable to get medical care (Florida Department of Health 2008). Furthermore, 16.4 percent of adults in Hillsborough County report not having health care coverage, and 23.1 percent report not having access to a personal health care provider (Florida Department of Health 2008). Understanding the geography, demographics, and health care statistics in Hillsborough County was critical to this research project.

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Economy and Housing

Reports of average annual employment in Hillsborough County show that the average annual wage for all industries is \$40,392, which is just slightly higher than the average annual wage for the state of Florida overall (The Florida Legislature 2008). In addition, the most recently reported data from the year 2006, show that on average personal income, earnings, and per capita personal income had been increasing for Hillsborough County residents for the past several years (The Florida Legislature 2008). However, as was true for the entire country during the summer of 2008, Hillsborough County was experiencing a tough economic situation throughout the period of my fieldwork. Problems with the housing market, high gas prices, and increasing food prices were affecting Hillsborough County residents much like they were affecting people across the United States:

- The unemployment rate in 2007 was 4.0 percent (The Florida Legislature 2008) and by June of 2008 had jumped to 5.5 percent (State of Florida 2008).
- A loss of 78,100 jobs, a 1.0 percent loss overall, was reported between June of 2007 and June of 2008 (State of Florida 2008).
- As recently as 2005 Hillsborough County had 13 percent of the population living below the Federal Poverty Level (FPL), and 17.9 percent of children ages zero to 17 were living below the FPL (The Florida Legislature 2008). Both of these percentages have continued to increase in recent years (U.S. Census Bureau 2008).

The housing situation in Hillsborough County was also difficult during this time. A 2007 report on the state of housing in Florida ranked Hillsborough County 41st out of 67 total counties in the state in terms of affordability (White et al. 2008), and a closer look at housing costs quickly illustrates why.

- The percent change in the base rent for apartment homes from 2000-2008 was almost a 39 percent increase (Florida Housing Coalition 2008). Income and earnings did not increase at this same rate during this time period.

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- HUD defines the Fair Market Rent (FMR) as, “the 40th percentile of gross rents for typical, non-substandard rental units occupied by recent movers in a local housing market” (HUD 2008). In Hillsborough County the 2008 FMR for a one-bedroom apartment is \$730, for a two-bedroom apartment is \$883, and for a three-bedroom apartment is \$1,119 (Florida Housing Coalition 2008).
- In order to afford housing at the FMR rate, an annual income of \$29,200 is needed for a one-bedroom apartment, \$35,320 is needed to afford a two-bedroom apartment, and \$44,0760 is needed for a three-bedroom apartment (Florida Housing Coalition 2008).
- The estimated median renter household income for Hillsborough County in 2008 was \$34,837, which means a family making this annual income would have to pay 101 percent of their income to afford a two-bedroom apartment (Florida Housing Coalition 2008).
- In 2008, the minimum wage in Hillsborough County was \$6.79 (Florida Housing Coalition 2008). For a person earning minimum wage, the rent affordable according to the governmental definition is \$353 (Florida Housing Coalition 2008).
- A person earning minimum wage would have to work 83 hours per week to afford a one-bedroom apartment at FMR, 100 hours per week for a two-bedroom apartment, or 127 hours per week for a three-bedroom apartment (Florida Housing Coalition 2008).

To address some of the housing affordability issues, the Tampa Housing Authority offers a Section 8 Housing Choice voucher program that provides a federal rent subsidy to assist low-income families and households with monthly rent payments (Tampa Housing Authority 2008). With the Housing Choice program families are required to pay at least 30 percent, and no more than 40 percent, of their monthly-adjusted income towards their rent. If the rent at the approved housing location is higher than 30 to 40 percent of their income, then Tampa Housing Authority makes up the difference and pays the landlord directly (Tampa Housing Authority 2008). While the

Appendix E: (Continued)

program has had some success, one shortcoming of the program is the limited number of vouchers available in comparison to the need for affordable housing in Hillsborough County. The federal government only provides 5,209 vouchers for Section 8 rental assistance for all of Hillsborough County (Tampa Housing Authority 2008), and unfortunately, the need is much greater. Currently over 15,000 people in Hillsborough County are on waiting lists for affordable housing and the numbers keep increasing each year (Hillsborough County Homeless Coalition 2007).

Homelessness in Hillsborough County

The numbers of homeless people living in Hillsborough County, Florida are worse than the United States in general.

- With the 6th largest percentage of homeless people in the United States, it is estimated almost 10,000 people experience homelessness in a given year in Hillsborough County (Hillsborough County Homeless Coalition 2007).
- This number increased by more than 25 percent between 2003-2005 (Hillsborough County Homeless Coalition 2007).
- An estimated 16 percent of the homeless population in Hillsborough County is made up of children under the age of 18, and this percentage skyrocketed almost 50 percent between the years 2003-2005 (Hillsborough County Homeless Coalition 2007).
- On the day of a recent count, more than 1,500 children in Hillsborough County Public Schools were homeless at that time (Hillsborough County Homeless Coalition 2007).
- Hillsborough County only has services to help approximately 15 percent of the homeless people living there (Hillsborough County Homeless Coalition 2007).

Given these conditions, Hillsborough County was (unfortunately) the prime location for this research project on homeless families access to health care services. Local service providers in the area are currently overloaded with homeless people needing assistance and the situation has continued to deteriorate with the recent economic

Appendix E: (Continued)

downturn. Understanding the community in which research took place was critical to understanding who is homeless, how they experience homelessness, and how their health is affected by homelessness.

“When you go to the emergency room they treat people who don’t have insurance really bad. It’s like we don’t matter to the ones who do have insurance. They need to treat the ones who don’t have insurance just as well as the ones who do. Because we’re here too. We’re not just like we want to be sick or we ask to be homeless...it happens.”
--Resident mother, on how she is treated by medical providers

Data Collection

The research design of this project was exploratory in nature and intended to describe the health services available in the community from the perspectives of the researcher, the counseling staff at Metropolitan Ministries, and resident mothers. Institutional Review Board approval was granted on April 25th, 2008 for the research protocol, and research took place during the internship from May 6th, 2008 through August 8th, 2008. During this time data collection methodologies typical of case study and ethnographic research were used: secondary source research, observation, participant observation, a quantitative survey, and semi-structured interviews (LeCompte and Schensul 1999).

Beginning in March of 2008, archival and secondary source research (Schensul et al. 1999) was conducted on health care resources available to homeless or low-income individuals and families in Hillsborough County, Florida. To find health care service providers in Hillsborough County, the Internet, program brochures from various agencies, and community guides with lists of community services were searched thoroughly. Geographic location, hours of operation, eligibility requirements, services provided, costs and fees, and the process for service provision were recorded for each service provider in a master document titled Health Resource Guide (Appendix A) for easy retrieval and functionality. Phone calls were made to service providers to verify the accuracy of information and to inquire about fees for specific services, accepted insurance plans, and appointment availability.

Appendix E: (Continued)

Participant-observation has long been a hallmark of anthropological fieldwork because it allows researchers to establish rapport with participants and become immersed in a given culture (Bernard 2002). “Participant observation refers to a process of learning through exposure to or involvement in the day-to-day or routine activities of participants in the research setting” (Schensul et al. 1999:91). Participant-observation allowed for honesty with residents and organization employees about research intentions, while at the same time provided the opportunity for interaction with both groups in their environment at the shelter. Building relationships with both the residents and counseling staff of the UpliftU® program was essential to the quantity and quality of this research.

In order to expand on the health questions currently asked during the intake process and more thoroughly collect health information from residents, a Health Assessment instrument was created. The Health Assessment included all the health related questions from the UpliftU® application, the counselor intake questionnaire, the counseling assessment questionnaire, and health portion of the Metropolitan Ministries Results Oriented Management and Assessment (ROMA) Scales. Those questions were expanded and a Health Assessment with six major sections (physical health status, self-care, health insurance coverage, access to health care services, family history, and child health and development) was developed (Appendix B). The purpose of the Health Assessment was to learn about the health of the residents in the UpliftU® program in order to help them access any health care services they may need now or in the future.

In total 18 Health Assessments were conducted during the internship. Of the fourteen new residents or families that moved in during this time period, thirteen participated in Health Assessments. The data gathered from these Health Assessments are biased toward new residents and residents with known health problems because these two groups were purposefully targeted for completing a Health Assessment. While this means that the Health Assessment data are likely not representative of all residents in the UpliftU® program, the data do accurately portray the health of all new residents who entered the program between May 12th and August 8th, 2008.

To further investigate the health services available to homeless women with children and the barriers that limit access to these resources, semi-structured interviews

Appendix E: (Continued)

(Schensul et al. 1999) were conducted with resident mothers with children in the UpliftU® program, as well as counseling team members. Commonly used for exploratory research (Bernard 2002; Schensul et al. 1999) where each participant will only be interviewed once (Bernard 2002), semi-structured interviews were the best interviewing method for exploring themes related to accessing health care resources and barriers that limit access to care and were thus utilized for these purposes in this study. The interview guide (Appendix C and D) had specific open-ended questions that focused on eliciting stories that illustrate what types of health services are used, why the women use or do not use the available health services, perceptions of the available health services, and barriers that restrict access to these services.

Data Analysis

A combination of deductive and inductive data analysis was used, but the majority of analysis was based on grounded-theory, where a researcher comes to understand the themes that emerge from the text by becoming grounded in the data through a careful examination of interview transcripts (Bernard 2002). The process of grounded-theory includes searching through interview transcripts and identifying themes that arise from the text, comparing the themes that arise, and using the relationships between themes to create theoretical models supported by exemplar quotations from interview transcripts (Bernard 2002). One software program used for grounded-theory text analysis is ATLAS/ti, and this program was utilized for this project.

The data analysis process used in this project follows the grounded-theory approach very closely. First, all interview transcripts were entered into ATLAS/ti and every transcript was read thoroughly. Then, data were coded according to major themes based on the stated research objectives. As emerging themes were identified, interview data were coded according to those themes as well. Through the use of ATLAS/ti the coded interviews from the counselors were compared to those from the resident mothers to examine themes that appeared within and between the two groups. In this way similarities and differences between counselors' and residents' views of access to health care services were identified.

Appendix E: (Continued)

As initial theories about the findings emerging from the data were formulated, a record of these theories was kept by utilizing the memo function within ATLAS/ti. The memos created during and after coding became the basis for data analysis, establishing a log of the logic used throughout the iterative analysis process. After focusing on several findings from the data, exemplar quotes that illustrate the theme behind each finding were chosen from interview transcripts.

Appendix E: (Continued)

Part Three

Findings and Discussion

“I think that they don’t trust authority and they don’t get treated very nicely. At least at some of the clinics I’ve heard. And they also have abuse that’s happened to them and it might bring up some issues from the past.”

-- UpliftU® counselor on mothers’ barriers to health care

Through the data from secondary source and archival research, Health Assessments, and semi-structured interviews, three of the major findings from the analysis will be examined. First, counselors and resident mothers reported being mainly satisfied and pleased with the available resources and the health care services received by mothers. However, counselors and resident mothers also agree that dental care is the most critical gap in service provision and insurance coverage, and reported that a second gap in health care resources is that parents have a more difficult time obtaining public insurance and accessing health care services. Finally, despite agreeing on these two points, the data suggest that counselors and resident mothers have differing viewpoints on the causes of barriers to health care services. Each of these findings is supported with evidence from the data and discussed in-depth.

Satisfaction with Available Care

Data from semi-structured interviews and Health Assessments indicate that overall counseling team members and resident mothers perceive the available health care services as adequately addressing resident mothers’ health concerns. Both groups express that in general mothers tend to have access to the services they need and to be fairly satisfied with the care they receive. As one counselor said in her interview, “By and large, I have heard good feedback. They get the care they need; they get the prescriptions they need.” Another counselor shared this sentiment when she said, “I can’t think of a specific complaint. I think overall they have been satisfied with their doctors.” Most of the counselors reported that it was their impression that residents were for the most part happy with the health care they received.

Appendix E: (Continued)

The data indicate that counselors tend to report this satisfaction with health care services as being due to the fact that most resident mothers and children have public health insurance through Medicaid, and thus Medicaid provides all the medical services they may need. As the employment specialist stated in her interview, “I think primarily most of our resident mothers are on Medicaid and they receive Medicaid services. When they don’t have Medicaid that’s when the barriers come into play. But as long as they have Medicaid there really aren’t a lot of barriers.” Other counselors also reported that most of the resident mothers have Medicaid and that they believe these residents have the majority of their health needs met through Medicaid coverage.

Residents similarly reported that by and large their health needs had been addressed by the available health care resources and stated that they were typically happy with the health care services they receive. As the employment specialist stated in her interview, “I think primarily most of our resident mothers are on Medicaid and they receive Medicaid services. When they don’t have Medicaid that’s when the barriers come into play. But as long as they have Medicaid there really aren’t a lot of barriers.” Other counselors also reported that most of the resident mothers have Medicaid and that they believe these residents have the majority of their health needs met through Medicaid coverage.

Gaps in Service Provision

Dental

One of the most profound gaps in service provision identified is the lack of dental services for uninsured and publicly insured homeless mothers and children. Counselors and resident mothers unanimously agreed in semi-structured interviews that dental services are the most critical gap in service provision for shelter residents, and research for the Health Resource Guide helped to illustrate the scope of the problem. Limited coverage for dental services through Medicaid, a lack of providers willing to accept Medicaid for dental care, and long wait lists for dentists that do accept Medicaid all contribute to resident mothers and their children having a difficult time accessing the dental care they need.

Appendix E: (Continued)

The counseling team members were well aware of high need for dental services for the residents, but they explained that finding dental providers was a challenge they struggled to overcome. As one counselor stated,

“I don’t think dental exists the way it needs to exist. Yeah I think for free care dental it is non-existent, and low cost dental is not as low cost as it needs to be in order to appear viable to our families. Medicaid covers children for dental expenses but it does not cover adults for dental expenses...Judeo Christian Clinic is one of the only ones that offers a dental clinic once a week and they yank them out, they don’t do anything else you know. That’s it; they’ll pull them for you. The neighborhood center down the street here by Salvation Army they offer a dental clinic when funding is available, and that funding usually lasts about five months and then it’s gone.”

The Director of Education and Literacy and the Director of the Promiseland Center for the shelter also discussed the challenges associated with accessing dental services. They explained that a lack of dental providers that offer services to Medicaid clients, limited Medicaid coverage for dental services, and difficulties in getting residents to go to the dentist all act as barriers to dental care.

“We have some real challenges with dental. And part of that is there’s just not very good service that we know of...The formularies for Medicaid seem to change *daily*, so because of that I can have a mom, because she had a premie baby she got an abscess, chose not to go, but she was nursing so it became an urgent situation, where if you don’t go this will happen. And she went to the dentist and the providers themselves were fine, until Medicaid said they weren’t going to pay, then that affected the follow up appointment. So you may be able to find a provider, but then parents are not going to deal with that.”

This quote illustrates the counselors’ perception that the problem with a lack of dental provision is multifaceted and occurs due to a lack of providers, limited Medicaid

Appendix E: (Continued)

coverage for dental services, and residents not wanting to deal with these hassles. These themes emerged from many of the interviews with counseling team members.

Interviews with resident mothers also illuminated the absolute lack of dental care available to mothers and children. Resident mothers with Medicaid described the dental services covered as being extremely limited and as not addressing their dental problems. Like the counselors, residents attributed the problem with dental care as having several causes. One mother told me that because she has Medicaid she is limited on certain services and providers in general. When probed she said, “I have a very limited dental plan.” She continued on to say that it only covers one cleaning per year, but that even getting that one cleaning can be difficult.

“Of course it’s easy, but when you have other problems it’s not so easy. They turn you down or they’ll give you this huge bill telling you how much you have to pay. Of course I’m on Medicaid, I can’t pay it...There’s no problem finding the dentists but unfortunately they don’t cover some things that I need to be done.”

This describes some of the very same challenges discussed by the counselors- that not only is Medicaid coverage for dental limited, but also that residents worry about the possibility of having to pay expensive bills for the dental services incurred.

Another mother explained that dental is not covered for pregnant mothers on Medicaid and described the tooth pain she experienced during her last pregnancy.

“See this one here I had a bad tooth when I was pregnant with her and they would not pull it. So after I had her I pulled it myself. That’s how bad the pain was...See I had set up an appointment, I had my baby June 25th and I set up an appointment for July 3rd to get my tooth pulled and they said no your Medicaid don’t cover it.”

This mother went on to say that her Medicaid would cover one teeth cleaning per year, but no extractions or other dental work, so she had to live with the pain and the challenge of eating despite that pain throughout her last pregnancy. Many of the mothers interviewed had similar terrifying stories of their own or their children’s tooth pain and

Appendix E: (Continued)

dental problems that were not addressed because Medicaid would not cover anything more than a cleaning.

Because of the widespread need for dental care among families and individuals at the shelter and their continued difficulties in finding dental providers, I contacted the state of Florida's Medicaid office asking for assistance in locating dental providers in Hillsborough County that accept Medicaid. In response, the office sent me an electronic Excel spreadsheet with a list of 39 dental providers in Hillsborough County that they have recorded as accepting Medicaid patients. Unfortunately, as I found out through phone calls to each of the listed dental providers, the reality of the situation is much different than it initially appears on the spreadsheet.

Of the 39 total dentists listed on the document as being located in Hillsborough County and accepting Medicaid insurance, 15 are specialists of some sort (oral surgeons, orthodontists, and denture specialists) and as such do not provide general dental services. This means that 24 of the dentists on the list provide general services. Of these 24 dentists, 12 providers will only see children and three of these pediatric dentists are not currently accepting new patients. Thus, there are nine pediatric dentists that accept Medicaid and are accepting new patients currently in Hillsborough County.

From the 12 remaining general dentists that do see adults, seven have stipulations that limit service provision. One of these dentists only sees cancer patients, another only offers emergency extractions, one dentist is not accepting any new patients, and three others will only accept Medicaid for children even though they provide adult dental services for people with private insurance. This leaves five general dentists that will see adults on Medicaid and that are currently accepting new patients. Of these five dentists, one is located in Ruskin, another is located in Dover, and therefore only three are located in Tampa. With only three dental providers in Tampa for all adult Medicaid recipients, it is not surprising that so many residents have had trouble receiving the dental care they need. With only three dental providers in Tampa for all adult Medicaid recipients, it is not surprising that so many residents have had trouble receiving the dental care they need.

Appendix E: (Continued)

Health Care for Parents

In addition to dental care, another gap in health care for shelter residents that came to light through semi-structured interviews and Health Assessments is that parents experience greater challenges in accessing health care services than children. Data suggest that in comparison to accessing health care services for their children, parents have more difficulty obtaining Medicaid coverage, finding a health care provider, and seeking treatment for health problems. Both counselors and residents indicated that children have better health care coverage and are more likely to receive the health care they need from a primary care physician than parents.

The counseling team members explained in their interviews that parents are less likely to have Medicaid insurance coverage, and fathers have an especially difficult time signing up for public health care. As Jessica, one of the lead counselors, explained,

“I am always, I shouldn’t say flustered, because it makes sense that a child would be on Medicaid before a parent would, but it always sort of hurts my ears to hear the parent is not receiving Medicaid when the child is. But it’s harder for the parent to receive Medicaid because they have to go through a waiting period...and I think that in some cases it is hard for adults to get Medicaid. It’s much easier for the kids. Even parents have a hard time sometimes, you know their kids have been on Medicaid long before they have.”

Another counselor echoed these sentiments when she was asked how many residents have Medicaid coverage. “Just a wild guess, but I would say 50-50, I’m thinking about adults and children. Usually the dads don’t...I think the kids do get better care than the parents. People like kids. We’ve even had a dentist just a few months ago volunteered to bring a bus full of kids over to his clinic to just get dental care. People like kids.” These two quotes illustrate two ideas consistently presented in interviews with counselors- first, that parents are less likely to have Medicaid coverage because they have a harder time getting coverage, and second that kids receive better care than parents.

Counselors also perceive the tendency of parents to seek medical care for their children but not for themselves as another challenge limiting parents’ access to health care services. As one counselor said, “I wish I could say they would always go to the

Appendix E: (Continued)

doctor. Typically, this is a strange phenomenon, they will get their kids, take their kids to the doctor, they will take their kids three times more than they go themselves.” Other counselors agreed that mothers go to the doctor more quickly for their children and rarely go to the doctor for their own health problems. As Melissa, the Director of the Promiseland Center, explained,

“Do I think they go? I would say no, because that’s something we battle even now, it’s just not something that’s on the top of the list. I think it becomes, ‘I’m gonna get my children to the doctor, I’m gonna take care of my children, my husband, my whoever...my mother’s sick or something’. They become the last one to be taken care of. So I don’t think a primary [care physician] is the first thing they’re thinking about.”

These statements illustrate the counselors’ perception that resident mothers go to the doctor more often and more quickly for their children or other family members’ health problems than for their own. This theme of the counselors’ belief that mothers put off seeking medical care for themselves was evident throughout the interviews with counseling team members.

Several of the resident mothers interviewed also indicated that they do not access health care services as quickly or as often as they could. One mother without health insurance said that she had missed three follow up appointments after being diagnosed with spinal meningitis because she could not find childcare for her two kids while she had the spinal taps done. Amber, another mother with four children living at the shelter with her, described some of the barriers keeping her from going to the doctor in this dialogue taken from her interview transcript.

“PI: So today if you got sick, what would you do? Amber: Live with it. PI: Live with it? Until what point? Amber: Until it went away I guess. Because I don’t really go to doctors. PI: Yeah? How come? Amber: Well I don’t like them. I don’t know, just a pain in the butt. PI: Why? Amber: You know, I’ve got four kids, I don’t have a vehicle, I’m trying to work on that. And just getting them on and off the bus and being good while I can be seen by the doctor. And I don’t want to just leave them here with someone else.”

Appendix E: (Continued)

Many of the mothers explained that they would address their own health problems or deal with it until they felt better because of the difficulties involved in going to the doctor for themselves. However, all the mothers agreed that if their children were sick they would not hesitate to call their pediatrician or take their child to get care.

Health Assessment data also suggest that mothers are less likely than children to have Medicaid coverage and a primary care physician that they see regularly. Of the five women who reported on the Health Assessments that not everyone in their family was covered by Medicaid, four of those women were themselves not insured and the fifth woman was insured but her husband was not. In other words, in families where not everyone had Medicaid insurance, parents were more likely than children to be uninsured. Additionally, of the 14 women surveyed, only four reported having a primary care doctor who they see on a regular basis. Of the remaining 10 women, four women did not have a provider at all, three women only had a provider for their children but not themselves, two reported using community clinics when needing medical care, and one woman said she would go to the hospital for medical services. These data support qualitative interview data that suggest mothers are less likely than children to be on Medicaid, to have a primary care physician, and to go to the doctor when they are sick.

Counselor and Resident Viewpoints Regarding Barriers

While data analysis suggests that counselors and residents agree when it comes to satisfaction with available care and gaps in service provision, it appears that these two groups view causality of the barriers to health care services from different levels. Interview data indicate that counseling team members acknowledge systemic problems that act as barriers limiting mothers' access to health care services, but they attribute a greater weight to individual actions and values of resident mothers as barriers to health care. Contrastingly, data from interviews with resident mothers suggest that mothers view barriers to accessing health care services as originating at either an interpersonal level or an institutional level, where interactions with health care providers and staff

Appendix E: (Continued)

members or with the health care system in general act as key factors limiting access to available services.

Counselor Viewpoints

A theme that emerged from the counselor data is that while counselors will acknowledge systemic problems that create barriers for resident mothers trying to access health care services, they more frequently cite individual barriers to health care that lie at the responsibility of resident mothers. . For example, one counselor said,

“It seems to me that sometimes they put their own barriers up. Like some people who don’t like doctors. I have one resident who has been really resistant to getting looked at for high blood pressure and cholesterol and a leg problem that she’s had for quite some time. She doesn’t like to go to doctors, she’s had bad experiences. So, my experience has been if they don’t get treatment it’s usually because they’re not wanting it, not because they can’t find a place to go for it.”

This quote illustrates the way in which the counselor acknowledges the client’s past negative experiences with health care providers, but believes that the client is putting up her own barriers that limit her utilization of available health care services. This idea from counselors that it is a matter of the resident not wanting health care treatment that is preventing them from getting care resonates through many of the counselor interviews.

Another counselor similarly emphasizes the individual residents’ role in not accessing the necessary care despite the fact that resources are available.

“Often when we see them they are severe, whatever it is. It can be that they end up with breast cancer, or that they end up with severe stomach ulcers, or they end up with poor leg circulation. So it can be a broad range of what we see, but it’s often something that’s been untreated for a long, long time. Not because they did not have medical coverage available to them, but because they simply opted not to follow-up, not to go and get the news because they were scared.”

Appendix E: (Continued)

This quote illustrates the counselors' belief that health care services are readily available but that women are choosing not to access those services, and further hints at the fact that because women are choosing not to access health care services they are contributing to the severity of their health problems. Another counselor more clearly states that by choosing not to access care mothers are failing to get their children the care they need when she said,

“You're seeing a three-year-old or a four-year-old that should have had developmental assessments happening way back when and I'm sure that if they had been taking them to a pediatrician on any course of a regular basis the pediatrician is noticing these delays. So again it's that failure of follow through, you know, to make those efforts, to move in the right direction to get your children help.”

Throughout the counselor interview data, the theme of counselors emphasizing the individual role of resident mothers as limiting access to health care services is present.

It is also important to point out the fact that most counselors did attribute some barriers in access to health care services to larger system-wide problems within the health care system. However, when counselors did mention systemic barriers they frequently also said that such barriers are exacerbated by mothers' actions or lack of action. For example, Julie, the employment counselor, said,

“So I think even sometimes the hospitals are getting away from doing as thorough a job of investigating as they used to do. And I think the residents feel that as a personal thing, which is some of their mental health and some of just their feeling of entitlement that some of them have, whereas I look at it as a systemic problem that is crossing boundaries and everybody's waiting and everybody walks into their doctor's office and waits for half an hour and goes back to their doctor's office and he spends three minutes with them where he says, 'oh well, you know I don't see anything wrong, you look fine, come back in a week if you don't feel better, you've got a cold.' I think it's happening everywhere, across boundaries, you know economic boundaries. But I think our residents, a lot of times, think they are being targeted. And honestly, that isn't the only thing they feel targeted about, it's not just health care they feel targeted about.”

Appendix E: (Continued)

Here, Julie attributes some of the difficulties in accessing care to time constraints and lower quality care that exist at some hospitals and provider offices, but she goes on to say that these systemic problems are intensified for resident mothers due to their perceptions, sense of entitlement, and mental health.

Another counselor makes the same point when she explains that if mothers fully accessed the available services, then the health care resources would be adequate for addressing resident mothers' health problems.

“I think that if they fully accessed what was available it would be, I'd say, moderate...because even especially if you think of WIC and WIC even has a nursing component and even they have the health care. If they access it. Because we advocate, I just used WIC because they have a health component, I can't even get moms to do that. So if they access it. So part of it is access and part of it's quality and availability.”

This counselor is making the point that while some of the problem with access to health care services is that the available services are only of moderate quality and availability, she adds that the other side of the problem is that mothers are not accessing the services that do exist and that she struggles to get them to use those services. Many counselors did mention macrolevel problems within the health care system that act as barriers to health care services for resident mothers, but more often than not they continued on to say that resident mothers' reaction to systemic problems or their individual actions relating to health care exacerbated these broader issues.

Resident Viewpoints

Whereas counseling team members viewed many barriers to accessing health care services as originating at the individual level of the resident mothers, interview data suggest that in contrast resident mothers focus on interpersonal and institutional factors that create barriers to health care. Many mothers talked about being treated poorly by health care providers, staff members, and Medicaid in general, and explained that this bad

Appendix E: (Continued)

treatment leads to feelings of frustration and impedes their ability and willingness to access care. Interview data also illuminate that mothers struggle with bureaucratic challenges associated with Medicaid and are thus limited on certain services, providers, and group HMO plans all of which contribute further to barriers of health care.

One mother, Amber, described how she had to re-apply for Medicaid after her experience at the Medicaid office in downtown Tampa.

“I just re-did everything because I didn’t know what else to do because nobody would help me. I think, my personal opinion, they need to hire a couple extra people. Because you can’t have a room full of people and everybody is on a computer except the lady at the window and she ain’t helping nobody...you know, I got family too, just like everybody else. My kids need to eat just as much as your kids need to eat. My kids need to see the doctor just as much as your kids need to see the doctor, you know? And you know nobody is more important than nobody, I think. I think everybody is equal...I was sitting there in plain view, and he [Medicaid office employee] just kept walking past me, walking past me, walking past me. I got so aggravated that I just left because I don’t want to be sitting there being ignored knowing I’m being ignored by somebody who is supposed to help you.”

Amber’s story is not unique; many mothers shared similar experiences at the Medicaid office or doctor’s offices where employees ignored them, never stopped to ask them what they needed help with, or asked them to wait for hours before being helped. Amber clearly explains how the employees at the office refused to help her, how she felt ignored and as if by not helping her the employees were implying that her children’s needs are not important, and how she finally had to leave the office and simply start the whole application process over from the beginning because she could not get help.

Resident mothers also consistently shared stories about health care providers and staff members treating them with a lack of respect and a lack of kindness. One mother described in her interview how she dreaded going to the doctor because he made her feel bad about being overweight, even when she had lost some weight since her last visit.

Appendix E: (Continued)

“You know he will see that I’ve lost weight from one visit to the next but instead of realizing that I take his advice and I lose weight, you know which was quite a bit of weight, he would make it seem to me that I didn’t do enough...it was just really depressing and at times I don’t even want to go there when I get sick because I know what I’m going to hear...you know, have a heart. Don’t they teach you that in medical school? You know if they don’t, this isn’t Nip/Tuck you know. Have some compassion. Not everybody can look like Angelina Jolie. We wish we could but we can’t. Take into consideration that I’ve had one kid after another. I mean literally was pregnant half my life, you know. Take that into consideration and understand that I am a female and I don’t want to leave trying to get on anti-depressants.”

Several other residents described being hesitant to go to the doctor because they had been treated poorly by the provider or by the office staff in the past and did not want to go through that disrespect again.

Mothers also explained that they felt as though Medicaid does not treat them well. As Miranda said, “It’s just frustrating to know, I guess it’s because it’s Medicaid you know, you have to be poor to be on Medicaid so it’s almost like they treat you bad because you’re poor basically.” This idea that Medicaid treats resident mothers badly because they are poor emerged in several interviews with mothers. As Lakeisha explained when she was asked what she would do with unlimited resources to improve the health of herself and her children, she said she would change to a private insurance because of the way Medicaid is treated.

“You know Medicaid being for the poor, they treat it poor. They treat it poor...It’s like they really, it’s really not a concern because you don’t have the money. But they with the funds they do have they good and everything but I seen people without Medicaid get treated better.”

The two quotes illustrate the theme that appeared throughout the interviews with resident mothers- that not only can interpersonal relationship with providers create barriers to accessing health care, but also the way they perceive Medicaid as treating poor people badly interferes with their access to health care services.

Appendix E: (Continued)

In addition to viewing barriers to accessing health care services at an interpersonal level as just described, interview data suggest that resident mothers also experience institutional barriers to care and struggle to overcome these issues as well. The problems mothers' discussed that relate to the health care system center around Medicaid because the vast majority of mothers and children have public health insurance coverage. Common themes running through interviews with resident mothers about institutional barriers include the lack of service and provider coverage through Medicaid, difficulties calling the Medicaid office to ask questions or request a new card, and trouble changing HMO group plans within Medicaid.

Several mothers described their dissatisfaction with the limited health care coverage and provider options offered by many Medicaid group plans. As one mother said, "I have Medicaid, so I'm always limited to certain places or certain things. So it can be sort of frustrating." When asked what she would do with unlimited resources to improve the health of herself and her children, another mother answered that she would change her insurance. Probed to explain what her ideal insurance would do that Medicaid does not, she said,

"Give my family a great dental plan and more options to find better doctors and less hassle...Finding a doctor close by instead of sending me to one that's miles away from home. You know you'll get a card and they'll send you one [the name of a provider] that's actually in New Port Richey and you live in Tampa. You know that's a big hassle to get it changed and you can't see any other doctor because the card has that doctor on it. So that's a huge hassle."

Limited coverage of certain health problems and having a Medicaid-assigned provider with whom resident mothers are discontented are two institutional level barriers frequently mentioned by resident mothers.

Resident mothers also commonly shared stories about the problems they have reaching Medicaid on the phone. Mothers wanted to get in touch with the Medicaid customer service representatives for a variety of reasons, but most often they wanted a replacement Medicaid Gold Card if theirs had been lost, to switch Medicaid HMO group

Appendix E: (Continued)

plans, assistance with finding a provider covered by their plan, or to ask questions about their coverage. Unfortunately, getting an actual person at the Medicaid office either nationally or locally on the phone proved to be a major challenge for resident mothers. As Miranda explained,

“I had all these things I had to do and one of the things was to call and try to get a new Medicaid card for my son. So I found the number from somewhere else, the Medicaid number, and they gave me another number, so I called them and I was on hold for like 15 minutes. I get this guy on the phone and I start talking to him and I hear him say, ‘what?’ and I say something back to him and he hung up on me! I was like, I just sat there for 15 minutes on hold just for you to hang up on me! And I’ve also had it happen where I’ve been on hold for a long time and all of a sudden the line just disconnects me. So I still haven’t been able to order him a new one [Gold Card]!”

Other residents had similar experiences waiting on hold for Medicaid and never getting through or having to hang up before their call was answered because of other responsibilities requiring their time and attention.

Other mothers had similar problems with Medicaid not sending them provider information they requested or a new Gold Card or just in general making the process of applying for Medicaid very complicated. As Amber said,

“They kept giving me the runaround. Asking for things that I didn’t have, I couldn’t submit because I wasn’t working. They just gave me a lot of runaround. You gotta go see this one person, now they might tell you they can’t help me, then you gotta go back to this person then they tell you they can’t help you.”

This “runaround” or sitting on hold on the phone for more than 15 minutes can be especially difficult for resident mothers who do not have transportation, must use a public phone at the shelter for most calls, and are trying to also complete the program requirements at the shelter. Several resident mothers felt that the bureaucratic challenges associated with the Medicaid system acted as major barriers to accessing health care services.

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Discussion

While interview data indicate that counselors attribute many barriers to health care as stemming from the individual residents and that residents tend to attribute barriers to health care as being caused by poor interpersonal relations and institutional bureaucracy problems, ethnographic fieldwork during my internship allowed me to see that barriers exist at individual, interpersonal, and institutional levels. As the Health Specialist Case Manager, I engaged continuously in participant observation and through this position I was able to witness barriers at each of these levels contributing to problems for resident mothers in accessing health care services.

On the one hand, as the Health Specialist Case Manager working with the counseling team members, I talked to and worked with mothers who seemingly had support and very few barriers in place, but who still did not get the health care they needed. On the other hand, I spoke to health care providers' office staff that were rude when I asked if they accepted Medicaid insurance, and I have waited on hold with the Medicaid office for over 45 minutes without ever reaching a representative. Based on interview and ethnographic research data, it appears as though barriers to health care services exist for resident mothers on all three levels- the individual, interpersonal, and institutional.

The data suggest that the two groups, counselors and residents, assign more importance to barriers at different levels and that both groups have not yet recognized or legitimized the other's perspective. For example, I previously pointed out the counselors' perception that mothers with Medicaid coverage for them and their children experience very few barriers to health care. However, I also previously illustrated that the resident mothers consistently reported barriers to health care that originated with the Medicaid system and Medicaid customer service limitations. This points to the fact that counselors have not yet recognized resident mothers' frustrations with Medicaid and the mothers' perception that Medicaid acts as a barrier to care.

Furthermore, many counselors also stated that they had heard from resident mothers about problems reaching Medicaid on the phone, finding providers who accept Medicaid, and navigating the Medicaid system. That counselors have heard these

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complaints and barriers from mothers but still believe that mothers with Medicaid experience few barriers to health care, suggests that counselors have not legitimized the perspectives of resident mothers. On the other hand resident mothers rarely mentioned barriers to health care that occurred due to their own individual choices or actions, indicating that they are not willing to acknowledge and validate the counselors' perspective of individual level barriers to care. I posit that the two groups not recognizing and legitimizing each other's differing position creates additional barriers that limit resident mothers' access to health care services unnecessarily.

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Part Four

Recommendations

“I would want them to get a taste of what we get so they could understand the full amount of what it means to us. That we don’t have no money don’t mean you need to treat us with limits of visits and stuff like that. I would want them to be in the same shoes so they would see, then they would have a better understanding about it. They don’t really understand right now because they ain’t been in our shoes and everything. But I would want them to be in our shoes and go through what we have to go through and I wish that Medicaid would get a whole lot better.”

--Lakeisha, mother of 3, on how she would improve the health care system

It is my hope that the findings and recommendations provided in this Technical Report will be used by the counseling team to assist resident mothers in overcoming barriers to health care services at the individual, interpersonal, and institutional levels. These recommendations include both immediate, direct changes that can be implemented fairly quickly, as well as broader, longer-term changes that will require further brainstorming, planning, and effort to implement. The recommendations are summarized here.

Recommendations

Direct Changes

1. To address the gap in dental care, counseling team members can utilize two documents created to find the most up-to-date information on dental providers. Both documents can be found in the shared H drive at Metropolitan Ministries.
 - a. Health Resource Guide
 - i. First, continue to use the Health Resource Guide to find dental services for uninsured adults.
 - ii. For example, on the Health Resource Guide counselors can see that the Judeo Christian Clinic offers tooth extractions for uninsured adults or that the Hillsborough County Health Department offers dental services to adults on Medicaid who have infectious diseases.
 - b. Dental Medicaid Information

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- i. This Excel spreadsheet was provided by the state Medicaid office and lists all the dentists in Hillsborough County that provide services to adults and children on Medicaid. Comments have been inserted into the spreadsheet alerting counselors as to which providers are currently accepting new patients.
 - ii. Counselors should refer to this document in order to provide residents with a list of dental providers who accept Medicaid and are accepting new patients.
2. The counseling team should continue to update this Dental Medicaid Information document bi-annually to keep the information current and accurate.
 - a. It is recommended that someone be assigned to contact the state Medicaid office for an updated version of the spreadsheet, and then go through and contact the providers on the list to ensure the accuracy of the spreadsheet.
 - b. Providers should be asked if they accept Medicaid for adults and children, which groups they accept for adults, and if they are currently accepting new Medicaid patients.
 - c. All information gathered from these phone calls should be recorded on the spreadsheet so that the entire counseling team can access this information.

Update and utilize the Dental Medicaid Information document located on the shared H: drive to find dental providers for adults and children that accept Medicaid.

3. It is also recommended that counseling team members be more cognizant that parents experience a greater number of barriers when accessing health care than children.
 - a. Intake interviews should be amended to include questions about the family's health insurance coverage and whether or not all family members have Medicaid or other health insurance.

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- b. Program procedures should also be updated to include requiring all family members to apply for Medicaid or other health insurance upon moving into the shelter. Findings do suggest that despite the barriers Medicaid creates, residents with health insurance coverage do have better access to care than those without.
 - c. Continue using the Health Resource Guide to find providers, group health classes, and other health-related information pertinent to parents' health care needs.
4. The counseling team should also acknowledge the interpersonal and institutional level barriers to health care services that exist for resident mothers, and they should work with residents in order to overcome these barriers together.
- a. For example, if a resident has had bad experiences with doctors in the past and is hesitant to go to another doctor despite having an immediate health concern, a counselor could sit with that resident while she calls providers offices trying to get an appointment or could work with the resident to create a list of positive effects of going to the doctor.
 - b. These types of actions would acknowledge and legitimize the resident's perceived barriers more so than putting the resident on a contract that requires them to go to the doctor, as is often the current response.

Broad Changes

In addition to these immediate, direct changes that work to decrease resident mothers' barriers to health care services, several longer-term, broader changes would also benefit residents of the UpliftU® program. Counselors suggested many of these changes during their interviews.

1. Explore forming additional partnerships with providers (similar to that established with the Ronald McDonald van that visits once a week) in order to find providers that are consistently willing to serve residents.
2. Educate community providers about who is homeless and how to respectfully work with homeless families.

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- a. Counseling team members or other Metropolitan Ministries employees should explain to providers what are the residents' health care needs and what specific barriers or challenges exist limiting access to that care.

Work to create and strengthen ties with community partners that could improve resident mothers' access to health care services, and simultaneously educate new and existing partners about the unique health care needs of shelter residents.

3. Counseling team members and the UpliftU® program overall should also acknowledge the importance of including residents' perspectives and should strive to include these perspectives in decisions made about how to best serve residents.
 - a. Continue to seek out residents' input about health care services, classes on health-related topics, and ideas about how counselors can help decrease barriers to health care services.
 - b. Including the voice of the residents is key in successfully decreasing existing barriers to health care services.
4. To address structural and systemic barriers to health care, Metropolitan Ministries should begin to advocate and lobby at the local and state level for policy changes that improve the health of their residents.
 - a. Supporting or proposing policies that include better dental coverage by Medicaid and expanded health care coverage of parents and pregnant women, and demanding improved customer service from national and local Medicaid and provider offices would initiate the conversation about the larger factors contributing to limited access to health care services for homeless mothers and children.
5. Creating a position within the counseling team of a Health Specialist would be one way of realistically implementing many of the proposed recommendations and ensuring that residents' access to health care services remains a priority of the counseling team.

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- a. Current practice is that counselors are not always able to keep up with each resident's health care needs or problems, much less to stay up-to-date on Medicaid policies and to advocate for broader scale changes.
- b. Having a position designated specifically to focus on the health of residents, similar to the positions focused on education and employment, would centralize the coordination of health needs of the residents with one person on the counseling team and maximize utilization of area service providers and resources.

Think about broad programmatic changes that could be made to decrease systemic barriers that limit resident mothers' access to health care services.

Future Directions

The research for this project highlights the importance of health policy that addresses the bureaucratic barriers to social services and improves the public insurance system. More employees are needed at social service agencies and within the Medicaid system to lower caseloads and to allow for more accessible customer service representatives. The process of getting a new Medicaid Gold Card must be simplified, and Medicaid must make adjustments in order to ensure an entire family receives insurance coverage and can receive needed dental care.

A paradigm shift away from the neoliberal individual deviancy ideology that places too much emphasis on individual actions and values as barriers to health care is necessary in order to close the gap in health disparities that exist based on income. Organization employees and clients must move away from blaming the other group if the system is to move towards creating programs that operate with the active involvement and input from the people they are meant to serve.

Unfortunately, these changes need to occur in the midst of the major economic downturn and financial crisis impacting the United States and world markets.

Thankfully, changes such as these can be not only beneficial directly to the health of

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homeless mothers and their children, but also they can be financially beneficial to social service agencies and governmental health programs by providing cost-effective, user-friendly, preventive health care services.