CLOSING THE GAP IN HEALTH CARE SERVICES FOR HOMELESS PERSONS ON MAUI

A DOCTOR OF NURSING PRACTICE PROJECT SUBMITTED TO THE OFFICE OF GRADUATE EDUCATION OF THE UNIVERSITY OF HAWAIʻI AT MĀNOA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF NURSING PRACTICE

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By

Carol Petith-Zbiciak

DNP Committee:

Maureen Shannon, Chairperson
Pualani Gandall Yamamoto
Richard MacDonald

Abstract

Background: Homeless persons are at risk for unmet health needs and carry a higher burden of chronic disease than the population at large, which results in unnecessary emergency department visits, and increased acute care hospital lengths of stay. Hawaii has the highest per capita rate of homeless persons of any state in the United States. Homeless persons on Maui lack health care services that are available in other geographic areas, and appear to have unmet needs for health care services. The goals of this DNP Project are to provide equity in the provision of health care services for homeless persons on Maui, and improve how well health care needs are met for homeless persons on Maui.

Method: Phase 1 of the DNP Project included a needs assessment. A literature search was conducted to identify ways to meet homeless persons' health care needs. The Iowa Model was used as a conceptual framework. Institutional Review Board exempt status was granted. Semi-structured interviews with 32 individual homeless persons (IHPs), 12 individual key stakeholder service providers (IKSs), and one group of hospital social workers (GS) were conducted over a 5 month period on Maui. Interviews were transcribed, coded, and analyzed for themes for source of health care service, unmet health care service needs, barriers to health care service access, and ideas for solutions.

Outcomes: The IHPs reported no primary care service (n = 22), and use of the emergency department for services (n = 28). Frequently identified unmet needs were services for wound care, prescription medications, dental care, mental health, substance abuse treatment, vision and others needs such as hygiene and housing. Barriers included lack of basic requirements for health care services, lack of enabling services, stigma, attitudes and behaviors. Ideas for solutions included promoting attitude and behavioral change, opening access to primary care, health outreach, enabling services, and medical respite.

Conclusions: Strategies to reduce barriers and meet unmet needs for homeless persons on Maui during Phase 2 planning and Phase 3 implementation are suggested.

Executive Summary

Introduction

Background. More than 564,000 people in the United States experienced homelessness on a given night in 2015, and Hawaii had the highest per capita rate of homeless persons of any state in the nation, which was 53.7 per 10,000 persons (NAEH, 2016). On one night in January of 2016 on Maui, 1145 homeless persons were identified in the Point-in-Time Count, and 661 or 58% of them were unsheltered. The number of homeless persons on Maui has increased by 31% since 2012. The proportion of those who are unsheltered has also increased (Partners in Care, 2016). Homeless persons on Maui appear to have unmet needs for health care services.

Conceptual framework. The conceptual framework for this DNP Project is the Iowa Model of Evidence-Based Practice to Promote Quality Care (Titler et al., 2001). There was not enough evidence about what the health care service needs of homeless persons on Maui were to initiate a practice change. To identify the needs, the DNP student conducted a needs assessment as Phase 1 of the Project.

Literature review and synthesis. Literature databases searched included PubMed, CINAHL, the Cochrane Database, Google Scholar, and gray literature, such as government publications, resources of the National Health Care for the Homeless Council, and the world wide web.

A strong body of quality evidence, including a number of Level I studies, supports the perception that homeless persons have an increased burden of disease, multiple co-morbidities, a decreased life expectancy, unmet health care needs, and that homelessness is in, and of itself, a risk factor for unmet health care needs; and that unmet health care needs of homeless persons result in increased emergency department use, acute care hospitalizations, and increased costs.

Objectives. The goals of this DNP Project are to provide equity in the provision of health care services for homeless persons on Maui, and improve how well health care needs are met for homeless persons on Maui. Phase 1 of the DNP Project occurred prior to graduation and includes a needs assessment, Phase 2 and Phase 3 will occur after graduation and include planning based on the results of the needs assessment, and implementation of practice changes.

Methods

Design of the DNP Project. A needs assessment of unmet health care service needs of

homeless persons on Maui was conducted as part of Phase 1 of the DNP Project. The study received exempt status from the University of Hawaii Institutional Review Board.

Setting and sample. The purposive sample included 32 individual homeless persons (IHPs) who were over the age of 18 years, most of whom were unsheltered (n = 24), or staying at an overnight shelter (n = 6), 12 individual key stakeholders (IKSs) familiar with health care needs of homeless persons on Maui, and a group of hospital social workers who were designated as group stakeholders (GS).

Data collection. Over five months in 2015, the DNP student conducted semi-structured interviews with participants who consented. Personally identifying information was not collected from the participants. The main topic areas of the interviews were sources of health care services, unmet health care service needs, barriers to getting health care services, and ideas for solutions to meet health care service needs of homeless persons on Maui. Interviews were audio recorded with just two exceptions. The DNP student transcribed the interviews.

Data analysis. NVivo software sold by QSR International was used for transcription and coding of the interview data. Queries were done on the data to analyze what participants said on themes. Transcripts were reviewed individually when more information was needed. Frequencies of sources who identified themes were noted.

Results Data Analyses Findings.

Eighteen of 32 IHPs had health insurance that was accepted in the State of Hawaii. Sixty-nine percent of IHPs said they had no access to primary care services. Eighty-eight per cent of IHPs said they had used the emergency department (ED) for services while only 38% said they had ever used the federally qualified health center Malama I Ke Ola Health Center (MIKOHC) for services. All the IKSs had comments on problem use of the ED by homeless persons, and many commented on difficulties homeless persons have in getting services at MIKOHC. A large number of sources in all groups agreed that wound care, prescription medications and other needs were unmet. Unmet needs for dental care services and for vision care services were named by a large number of IHPs but not by a large number of IKSs and the GS. Unmet needs for substance abuse treatment and mental health or counseling services were named by all IKSs, but not as often by IHPs. Some IKSs expressed concern that improving services would worsen the problem of homelessness. Other barriers many IHPs face are a lack of basic requirements for accessing health care services such as identification, insurance, money, phone communication,

transportation and keeping appointments. In addition lack of follow-up and lack of a support system were often barriers. A lack of facilities and of providers that will treat homeless persons was identified by IKSs. Primary care, specialty care, substance abuse treatment, mental health and medical respite services are lacking. Care from service providers that is trauma-informed is needed. Attitudes, behaviors and poor skills that function as barriers were identified. Ideas participants had for solutions include walk-in clinics with mental health and wound care services, health outreach, opening up access at MIKOHC, and enabling services.

Discussion

Interpretation of results. Housing is good medicine. Service improvements that would help to close the gap in care are topics for Phase 2 planning. These topics include opening access to primary care services at MIKOHC, insuring homeless persons have the basic requirements for getting health care services outside the ED or emergency medical services, and health care outreach with streamlined referral connection to primary care; walk-in clinic services that include wound care and mental health, increased access to dental care services at MIKOHC; outpatient substance abuse treatment, public hygiene facilities, and medical respite facilities following hospital discharge. Other important service improvements include training in trauma-informed care and the culture of homelessness for service providers, and coaching homeless persons on attitudes and behaviors consistent with accessing health care services.

Implications. Evidence-based service changes can be developed to improve the quality of care for homeless persons on Maui.

Strengths and limitations. A strength of the Project is that it elicits information on what the gaps in health care services for homeless persons on Maui are from people on Maui rather than assuming that the unmet needs are what researchers have found them to be in other geographic areas. Another strength is that the sample of IHPs were mostly unsheltered and, therefore, represent some of the most vulnerable of homeless persons.

A limitation of the study may be that some homeless persons some service providers identified as being the most problematic (e.g., those with repeated ED admissions for intoxication) may have been a different subset of homeless persons than the ones the DNP student interviewed. That difference may account to a small extent for a difference in perspective between IHPs and IKSs on unmet health care service needs of homeless persons.

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Chapter 1. Background and Conceptual Framework

Background

The overall topic area for this Doctor of Nursing Practice Project (DNP Project) is closing the gap in health care services for homeless persons on Maui. Due to the amount of time allocated to attain the goal of improving health care services for homeless persons living on Maui, the DNP Project will specifically focus on the planning phase of this endeavor. This will provide a foundation for subsequent phases of the overall goal of the project.

In order to appreciate the population that this project is focusing on, a definition of being a "homeless person" is necessary. A homeless person has been described as a person without permanent housing who may live on the streets, stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation (HRSA, 2011). A chronically homeless person or family has been identified as a person or family that has been homeless for one year, or homeless on at least four separate occasions in the last three years, with each occasion lasting at least 15 days (HUD, 2014). In 2012, community-based health centers across our nation served more than 1.1 million persons experiencing homelessness (HRSA, 2013). More than 630,000 people experience homelessness on any given night in the United States (U.S.) (National Alliance to End Homelessness, 2013). The Center on the Family at the University of Hawai`i (U.H.) documented that in Maui County, from June 2011 to June 2012, 2,358 homeless people utilized shelter and outreach services (U.H. Center on the Family, 2012).

According to the National Council of Healthcare for the Homeless (2013), homelessness is related to poor health outcomes. Living in shelters or living unsheltered can create new health problems or worsen existing chronic health problems such as asthma, hypertension, diabetes, and mental disorders. Acute problems such as infections, injuries, and pneumonia are more difficult to heal when there is not a safe place to rest. Living in shelters or on the street brings the risk of exposure to tuberculosis, sexually transmitted infections, and violence. Medications may be lost, stolen, or damaged by weather or other happenstance (National Council for the Health Care for the Homeless, 2013). Mortality disparities between homeless adults and adults who are not homeless in the population at large are dramatic with one study finding mortality rates for homeless persons nine times higher in 25 to 44 year olds, and four and a half times higher in 45 to 64 year olds (Baggett et al, 2013).

Among community health center users, homelessness is an independent risk factor for unmet healthcare needs and emergency department use (Lebrun-Harris et al., 2013). Lack of health insurance is a financial barrier to receiving care. Non-financial barriers include not knowing where to obtain care, lack of transportation, lack of child care, chronic homelessness, long wait times, and a perception of discrimination from health professionals (Khandor et al., 2011).

Outreach has been identified as a critical function of health centers serving people who are low-income, uninsured, and/or members of underserved populations (National Outreach Guidelines for Underserved Populations, 2012). Mobile healthcare outreach is a strategy used for reducing unsheltered homeless persons' barriers to care. The Street Medicine Institute is an organization, started in Pittsburgh, Pennsylvania by Dr. Jim Withers in 2008, that facilitates and enhances health care to the street homeless where they live in communities around the globe, supports the development of Street Medicine Programs and provides practice education (Street Medicine Institute, 2014). From qualitative analysis of Street Medicine program components presented by teams at the 2007 and 2008 International Street Medicine Symposia, Howe et al identified three context elements that influence quality of care as: a) unconventional living situations and lack of financial resources; b) transient circumstances with inconsistent contact; and c) informal clinical settings (Howe et al, 2009). They also identified four best practices for mobile health care outreach teams: a) use of mobile clinic vans; b) use of adapted electronic medical records; c) collaboration with community clinics and providers from these clinics; and d) provision of comprehensive social support by establishing links to resources such as housing, income, and health insurance (Howe et al., 2009).

In Honolulu, the Waikiki Health Center has a multidisciplinary mobile outreach team that includes a nurse practitioner or a physician assistant, and consistently operates using these identified best practices (Dr. Valerie Foree, personal communication, 2013). Currently, homeless persons living on Maui do not receive the services of a multidisciplinary mobile outreach team including a nurse practitioner, physician assistant, or physician (Dr. Richard MacDonald, personal communication, September 11, 2013). As a result, it appears many persons in this population remain untreated for disorders that could be addressed in primary care such as wound infections, resulting in increased visits to the emergency department and increased acute care

admissions to Maui Memorial Hospital each year because conditions have progressed to a more complex and critical stage.

The ultimate goals of this DNP Project are to provide equity in the provision of health care services for homeless persons on Maui, and improve how well health care needs are met for homeless persons on Maui. The Project is divided into three phases. The short term outcome of Phase 1 will be the completion of a needs assessment to address gaps in care for homeless persons living on Maui. Phase 1 will be completed during the DNP Program as the DNP Project. Phase 2 includes planning of interventions based on the results of the needs assessment. Phase 3 includes piloting and implementing outreach and inreach interventions and evaluating the outcomes of these. The long term outcomes after the DNP Project (Phase 1) and after the completion of Phases 2 and 3 include increased access to primary care services, decreased unmet health care service needs, decreased unnecessary emergency department visits, decreased acute care hospital lengths of stay and readmissions, decreased health costs, and improvement in quality of life. This quality improvement project expands on previous U.H. Maui College Nursing Program projects for the homeless. This DNP Project is affiliated with U.H. Maui College Nursing Program and Health Center.

Conceptual Framework

The conceptual framework for this DNP Project is the Iowa Model of Evidence-Based Practice to Promote Quality Care (see Figure 1.1) (Titler et al., 2001). The Iowa Model is a revision of an earlier research utilization model. The purpose of the Iowa model is to guide nurses and other healthcare professionals in the process of the use of current best evidence to improve patient care. The term "evidence" encompasses a broader range of human knowing and experience than the term "research". Besides research evidence, the term "evidence" also includes patients' values, and providers' clinical judgments.

Triggers. The Iowa Model identifies both problem-focused and knowledge-focused triggers. Triggers are catalysts for nurses to seek evidence and think critically about operational efficiency and clinical effectiveness. Problem-focused triggers include data from risk management, quality assurance, continuous quality improvement, and identification of a clinical problem. Knowledge-focused triggers include new information in the literature, standards and guidelines from national agencies and organizations, questions from institutional standards committees, and philosophies of care.

Problem-focused triggers for this project include the observation that there is a disparity in available mobile outreach healthcare services for homeless persons between Maui and Oahu, and between Maui and other geographic areas. Problem-focused triggers also include the DNP student's personal observation of homeless persons living on Maui at annual health fairs for the homeless and conversations with them about their unmet healthcare needs, as well as multiple conversations with other professionals who provide services to the homeless persons living on Maui. What is not available at the moment is a quantitative and qualitative report of unmet healthcare needs that would constitute a gap in services for homeless persons living on Maui which might be alleviated by a multidisciplinary, mobile health outreach service as has occurred in other areas presented in the background section.

Knowledge-focused triggers for this project include information from research about the health disparities of homeless adults. Results from a cross-sectional study of federally funded health centers across the nation found that homelessness is an independent risk factor for poor access to health care (Lebrun-Harris et al., 2013). That same study found that homeless patients have a higher burden of mental health, substance abuse, and are generally in poorer health than their housed counterparts. The study also found that homeless persons have a higher number of emergency department visits and are more likely to use the emergency department as their primary source of health care. Another study found that the all-cause mortality rates were higher among homeless adults in Boston than the population at large (Baggett et al., 2013). Additional knowledge-focused triggers include information that, by law, 8.7% of community health center budgets are designated for healthcare for the homeless projects (Health Resources Services Administration [HRSA], 2013). The Affordable Care Act provides expanded Medicaid coverage in 2014 to any adult less than 65 years of age, with qualified residency or citizenship, and income under 138% of the federal poverty level irrespective of their assets (State of Hawaii Department of Human Services, 2013) which should reduce lack of insurance as a financial barrier to health care services.

Organizational Priority. A decision point is embedded early in the Iowa Model which requires an assessment of organizational support for the topic area, followed by team formation (Titler et al., 2001). How the topic fits into the organizational setting and the organizational priorities can be essential to gaining the support of nurse managers, nursing leaders,

administrators, and physicians. A good fit may bring widespread support and resources. A poor fit may bring opposition and no resources.

This DNP Project topic area is a priority for some individual faculty members at the U.H. Maui College. It is a priority for Dr. Richard MacDonald board member of the Salvation Army Maui, and there are indications of support from physicians at Maui Memorial Medical Center and nurses in the community.

Form a Team. A team is responsible for the development, implementation, and evaluation of the evidence-based practice project (Titler et al., 2001). The team composition is tailored to the topic selected, and should include multidisciplinary stakeholders interested in the delivery of that care who have diverse perspectives and a richness of expertise.

Effective teams have a complementary mix of skills and problem-solving abilities, as well as someone skilled with Excel (Kamai, 2013). Roles include Project Director who is someone who understands the whole project and oversees the whole process - which would be the DNP student; and Opinion Leaders, respected and influential persons who are passionate about the topic – which would be Mrs. Nancy Johnson RN, MS, APRN who is a Professor of Nursing at the University of Hawaii Maui College and former Chair of the Allied Health Department, who led the start of the Maui Oral Health Center; and Mrs. Rosemary Perreira RN MS CNS who is an Associate Professor of Nursing at University of Hawaii Maui College, Nursing Program Second Year Coordinator and originator of the annual Health Fair for the Homeless on Maui, and on the Board of Salvation Army Maui. External Advisor, Dr. Richard MacDonald, vocation rehabilitation psychologist at the Veterans' Administration Clinic on Maui, and Board member of Salvation Army Maui, has provided important support to the team. The team also includes Change Champions who are informal leaders. The team should include a Mentor who may provide expertise when needed. Dr. Valerie Foree, DNP at Waikiki Health Care-A-Van Program has provided some expert advice, given a presentation on Maui about multidisciplinary mobile health outreach, and may be available for mentoring as the project is implemented. The team will expand when the project is implemented.

PICO Question. The Iowa Model (Titler et al., 2001) of evidence-based practice to promote quality care calls for a clinical question in the form of a PICO question. The PICO question for this DNP Project is:

Among adult homeless persons living on Maui, how do evidence-based outreach interventions or evidence-based outreach interventions including a nurse practitioner, compared to no evidence-based outreach interventions, effect outcomes of quality of life, infection complications, emergency department visits, and acute care hospitalizations?

Assemble and Critique the Literature. Once a team is formed, and a PICO question is developed, relevant research and related literature is retrieved from electronic health databases such as the Cochrane Database, PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and grey literature such as government and expert organization publications (Titler et al., 2001). Particular attention is given to the level, quality, and strength of the evidence.

Another decision point occurs then because the question is asked "Is there a sufficient evidence-base to guide a practice change?". Considerations include the a) consistency of findings across studies, b) the type and quality of studies, c) the clinical relevance of the findings for practice, d) the number of studies with characteristics similar to the application being considered, e) the feasibility of the findings for practice, and f) the risk versus benefit ratio. If the answer to the question "Is there sufficient research to guide practice?" is "no", the appropriate option would be to conduct a study. If the answer is "yes", practice modifications may be warranted (Titler et al., 2001). The literature synthesis addresses evidence for closing the gap in health care services for the homeless. The information that is not available is what the particular unmet health care service needs of homeless persons on Maui are. A needs assessment is needed.

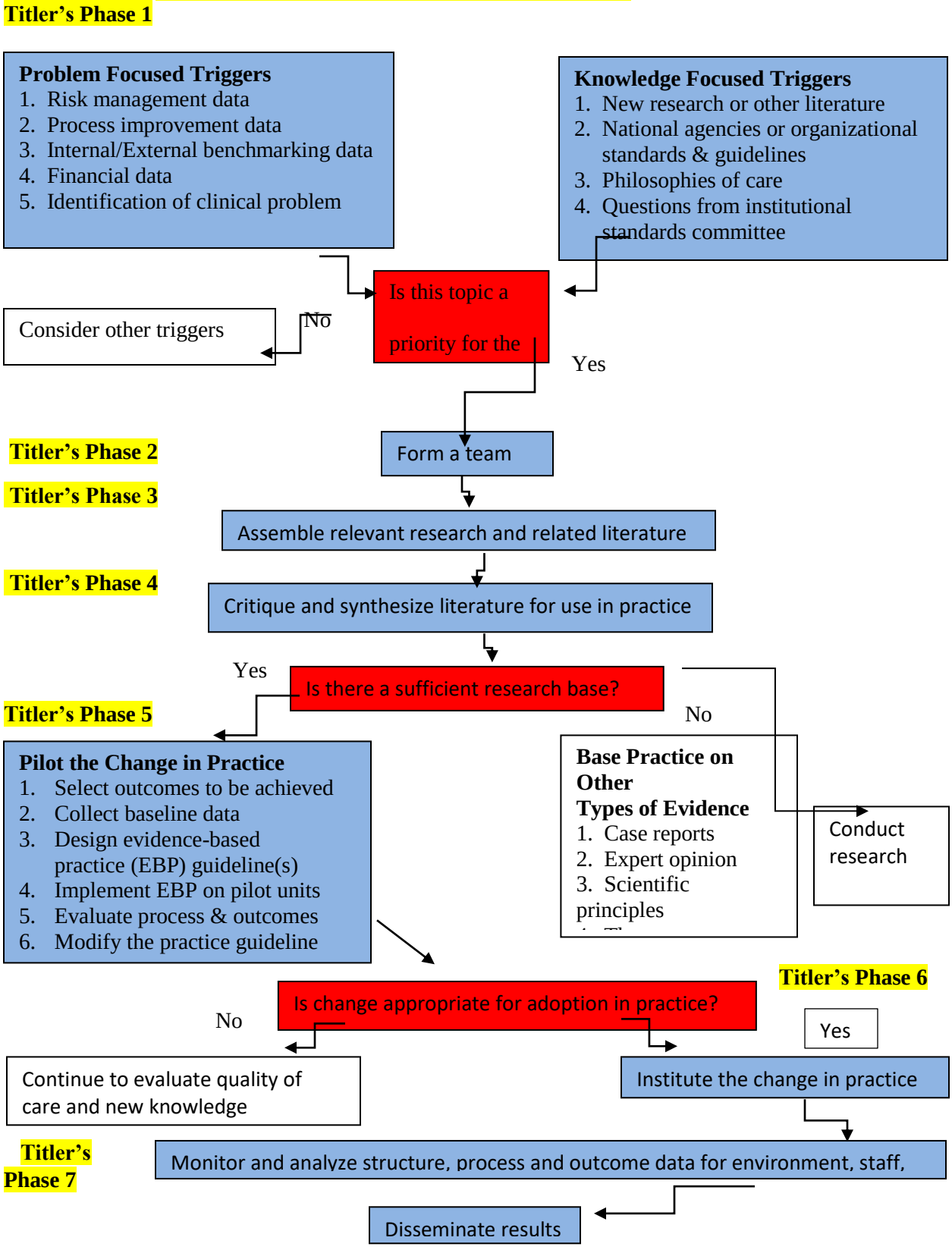
Pilot the Practice Change. The pilot indicates whether rolling out the practice change in the larger clinical setting is feasible. It also indicates what adjustments might be needed to refine the practice change (Titler et al., 2001).

Institute the Practice Change. Another decision point occurs after the pilot has been evaluated. The question asked is "Is the practice change appropriate for adoption in practice?". If the answer is "no" then efforts are refocused on quality of care and evaluating new knowledge. If the answer is "yes", then the practice is adopted and integrated into care. Factors that can facilitate the adoption of a practice include a) organizational support, b) staff education, c) staff acceptance by nursing and all discipline effected, d) perception of the staff that the price of change improves quality of care, and e) sufficient staff time to carry out the practice change (Titler et al, 2001).

Monitor Structure, Process, and Outcome Data. Outcomes for patients, families, staff, institution and finances should be monitored. Results give information beyond what is available in the literature. (Titler et al., 2001)

Disseminate Results. It is important to disseminate the results (Titler, et al, 2001) to benefit others in similar practice situations by way of conferences, newsletters, and journal publication as the results may include findings beyond what is in the research literature about cost, and practical implementation.

Figure 1.1 Illustration of Dr. Titler's Iowa Model of Evidence-Based Practice to Promote Quality Care (Titler et al, 2001)



Chapter 2. Literature Synthesis

Literature Synthesis

Search strategies. Literature databases searched included PubMed, CINAHL, the Cochrane Database, Google Scholar, and gray literature, such as government publications, resources of the National Council for Health Care for the Homeless, and the world wide web.

PubMed clinical queries were conducted with the Mesh term “homeless persons”. Filters included English language and a 10-year time span. Sixty-four systematic review articles were identified. Articles were excluded that pertained specifically to children or did not pertain to the PICO question. Nine of the 64 articles were retained for closer review and critique.

PubMed keywords were refined using the Mesh headings and Boolean operators and were searched with the following keywords: “homeless persons”, “length of stay”, “emergency service", and "hospital”; “patient care team”, “community-institutional relations”, and “health status”; “health status indicators”, “health disparities”, and “outcome assessment”; “outcome and process assessment”, “quality of life”, and “communicable diseases”; “infection control”, “wound infection”, and “early medical intervention”; “intervention studies”, “nurse practitioner”, and “crisis intervention”; “emergencies”, “evidence-based emergency medicine” , “evidence-based practice”, and “controlled clinical trial”. Filters include a ten year time span, humans, English language, adult 19 + years, adult 19-44 years, and aged 65 + years. Four hundred and seventy-two articles were identified. Articles were excluded that were primarily about children, and unrelated to the PICO question. Of those 472 articles, 18 were selected for further review and critique.

CINAHL full text was searched with keywords that were refined by consulting CINAHL Headings. Keywords that were used included “homeless persons”, “emergency services”, and “length of stay”; “street medicine”, “health services for the indigent”, and “interventions”; “quality of life”, “preventive health care”, and “health outcomes”; “interventions”, “infection”, and “wound”; “therapy”, “prevent* complications”, and “nurse practitioner”. Boolean operators and truncated terms (asterisk as in prevent*) were used. Filters included articles that were published within ten years, English language, peer reviewed, research article, and age groups (19-44, 45-64, over 65, and over 80). Ninety-three articles were identified. Nineteen were selected for closer review and critique.

A search of the Cochrane Database with the keyword "homeless persons" yielded only one review and was retained for the synthesis. Gray literature was searched including government websites, specialty organizations, Google Scholar, and the world wide web, all of which yielded additional articles and information.

Grading the evidence. Mosby's Level and Strength of Evidence grading tool was used (Mosby, retrieved from https://laulima.hawaii.edu/portal/site/MAN.1342.201413). The levels of evidence are defined in Table 2.1 below. The strength of the study is also evaluated as good, poor, or fair based on the study design. Studies are considered together for the quantity and the consistency of their findings.

Table 2.1. *Mosby's Level of Evidence*

Level	Description
Level I	Meta-analysis
Level II	Experimental Design, Randomized Controlled Trial
Level III	Quasi-experimental design
Level IV	Case controlled, Cohort Studies, Longitudinal Studies
Level V	Correlation Studies
Level VI	Descriptive Studies including: • Surveys • Cross-sectional Design • Developmental Design • Qualitative Studies
Level VII	Authority Opinion or Expert Committee Reports
Other	Performance Improvement, Review of Literature

Literature synthesis

For this paper, 20 articles were synthesized. Hawaii had the second highest per capita rate of homelessness in the nation in 2012 with 45 per 10,000 in the Point-In-Time Count, falling only behind Washington D.C. (National Alliance to End Homelessness, 2013). According to the Homeless Service Utilization Report Hawaii 2013, some 13,639 individuals received shelter or outreach program services in Hawaii in fiscal year 2013 (Center on the Family University of Hawaii, 2013). In Maui County, 2272 individuals received shelter or outreach program support. The Point-In-Time Count done on the night of January 22, 2013, identified 421 sheltered and

455 unsheltered persons, on that night in Maui County – a 0.2% increase from 2012 (State of Hawaii Department of Human Services, Homeless Programs Office, 2013).

Homeless persons suffer from a shorter life expectancy than the population in general. Baggett et al. (2013) found that homeless persons aged 25 to 44 studied over a five year period in Boston had nine times the mortality rate, and those 45 to 65 years old had four and a half times the mortality rate of the general population in Massachusetts. In a secondary analysis of the 2003 Health Care for the Homeless User Survey, Baggett et al. (2010) found that 73% of homeless persons surveyed had at least one unmet health care need including an inability to obtain needed medical or surgical care (32%), prescription medications (36%), mental health care (21%), eyeglasses (41%), and dental care (41%).

Lebrun-Harris et al. (2013), based on the HRSA 2009 Patient Survey of users of Community Health Centers, found that homelessness in and of itself is an independent risk factor for poor health status, that homeless persons had twice the odds of their housed counterparts of having unmet health needs, and were twice as likely to have had an emergency department visit in the last year. In addition, they found that homeless persons were likely to have a higher lifetime disease burden of chronic illnesses such as mental health problems and substance abuse than their housed counterparts. Poor access to primary care is related to increased costly emergency department visits and acute care hospitalizations. Reid et al (2008) found housing instability to be related to increased unmet health needs, lack of health insurance, postponing needed medical care, and postponing medications.

Housing instability may cause people to prioritize food and shelter over access to medical care. Unstable housing was associated with increased emergency department use and was significantly related to increased acute care hospitalization. Hwang et al (2011) found the costs for acute care hospitalization of homeless persons to be higher than those of non-homeless persons, because they required longer lengths-of-stay in medical and surgical services. Housing appears to be good medicine according to two systematic reviews (Hwang et al 2005; Fitzpatrick-Lewis et al, 2011).

Health insurance alone did not resolve the unmet health care needs of homeless persons in Toronto Canada. In a cross-sectional analysis of homeless persons where universal health insurance is available, Khandor et al (2011) found homeless persons still experienced barriers to care by not having a health card, because of issues of discrimination, or poor treatment which

resulted in unmet health needs. Burra et al.'s (2009) systematic review revealed cognitive deficits in verbal, memory, attention, speed of information processing, and executive function among homeless persons likely effected retention of health care information and skills training for rehabilitation. The perspective that barriers to health care are not eliminated by insurance alone is crucial when considering our homeless persons on Maui, who with the Affordable Care Act, now potentially have unprecedented access to primary care to address unmet health needs (State of Hawaii, 2013).

Interventions. Of the literature reviewed so far, 14 studies have identified interventions that reduced the gap in health care services for homeless persons. Table 2 shows the intervention studies grouped in the categories of Mosby's Level of Evidence.

Table 2.2. *Intervention Studies Grouped by Mosby's Level of Evidence*

Level	Description	Number	Article
Level I	Meta-analysis	5	(Althaus et al., 2011; Fitzpatrick-Lewis et al, 2011; Hwang et al, 2005; Lutge et al., 2012, O'Campo et al., 2009)
Level II	Experimental Design, Randomized Controlled Trial		
Level III	Quasi-experimental design		
Level IV	Case controlled, Cohort Studies, Longitudinal Studies		
Level V	Correlation Studies		
Level VI	Descriptive Studies including: • Surveys • Cross-sectional Design • Developmental Design • Qualitative Studies	4	(Howe et al., 2009; Khandor et al., 2011; McGraw et al, 2009; Muirhead et al., 2011)
Level VII	Authority Opinion or Expert Committee Reports	4	(Health Care for the Homeless Network, 2010; Health Outreach Partners, 2012; O'Connell et al., 2010, Shortt et al 2008)
Other	Performance Improvement, Review of Literature	1	(Schneller, 2012)

In a health policy analysis, Shortt et al. (2008) identified effective ways to deliver primary care to homeless persons. They identified four models of delivering primary care to homeless persons: 1) in a doctor's office; 2) in a fixed clinic specifically for homeless persons; 3) in a fixed outreach site; and 4) and in a mobile clinic. The first strategy showed poor results. Strategies two through four all performed well. Shortt et al (2008) developed goals, objectives, and evaluative criteria for primary care to the homeless. Their work is paraphrased in Table 2.3.

Table 2.3. *Goals, Objectives, and Evaluation Criteria for Primary Care Provided to Homeless Persons*

Goals	Objectives	Evaluation Criteria
Health improvement of homeless persons through the provision of primary care	Access to primary health care through a regular primary care provider	• Care available without entitlement documents • Services available at locations likely to suit homeless persons
	Primary Care oriented to the homeless population	• Collaboration with public health on harm reduction strategies
	Comprehensive care	• Multidisciplinary team care • Establishing pathways to specialty care
	Integrated approach to care on a 24 hour basis	• Service available at times convenient for homeless persons • Evidence of reduced emergency department use
	Quality primary health care	• Special expertise in areas germane to the clinical conditions of homeless persons, e.g. substance abuse, sexually transmitted diseases
	Patient–focused care	• User involvement in service planning and operation
	Continuity of care through integration and coordination	• Electronic medical records available to multiple providers • Mechanisms to contact patients • Hospital liaison for planning discharge

Others have cited the need for multidisciplinary care that accounts for particular needs of homeless persons (Proffitt, 2010; Health Outreach Partners, 2012; Howe et al, 2009; O'Campo et al, 2009; O'Connell et al, 2010; Schneller, 2012). In a systematic review, O'Campo et al identified program strategies with the homeless that were effective in reducing mental health problems, and, to a lesser degree, substance abuse problems. The strategies were client choice in decision-making, positive interpersonal relationships between client and provider, assertive community treatment approaches, housing, and non-restrictive programs.

O'Connell et al (2010) described the 25 year history of the Boston Health Care for the Homeless Program that serves some 11,000 homeless persons per year with clinics in two teaching hospitals, 80 shelters and soup kitchens, a 104-bed medical respite unit, and dental services. In addition, they have a multidisciplinary street medicine team that delivers care where people are found – in parks, in doorways, on campgrounds. They have a weekly hospital clinic especially for the homeless that provides meal vouchers and trusted familiar clinicians. An electronic medical record keeping system allows them to not only keep track of homeless patients at multiple sites, but also identify emerging diseases. A Consumer Advisory Board of homeless or formerly homeless persons meets monthly to participate in governance, evaluation and service development.

Howe et al (2009) identified contextual themes and best practices from urban street medicine providers. They found that contextual challenges that influence care delivery are patients' unconventional living situations and lack of financial resources, transient lifestyle leading to inconsistent contacts with patients, and informal clinical settings. They identified four current best practices in street medicine including mobile clinic vans, electronic medical records, integration with community clinics and providers from those clinics, and provision of comprehensive social support by establishing links to resources such a housing, insurance, and sources of income.

Health Outreach Partners (2012) collaborated with other organizations expert in caring for the homeless and developed a practice guideline for outreach services that has three sections Person-Focused Guidelines, Community-Focused Guidelines, and Program-Focused Guidelines that reiterate some of the already mentioned themes and also emphasize culturally and linguistically appropriate care. Healing Hands provides information on the delivery of trauma-informed care and recognizes that clients may arrive estranged with a sense of isolation or

disconnection, powerlessness, shame, fear, or guilt. The expert advice is to emphasize a safe environment of "do no harm", being trustworthy, honoring autonomy, collaborating in decision-making, and mobilizing their strengths (Proffitt, 2010).

Schneller (2012), in a pilot project clinic managed by a clinical nurse specialist with social workers, project workers, and weekly physician clinic hours, demonstrated that an intermediate care service in London in a hostel for the homeless reduced the number of ambulance calls, emergency department visits, acute care hospitalizations, and costs in a one year time. However, McGraw et al (2009) in a qualitative study identified pitfalls of multidisciplinary care. Pitfalls included incomplete or underdeveloped staff teams, inconsistent understanding of models of care, e.g. client-centered care, interagency teams with different missions, or missions different than the funding agency.

A systematic review from the Cochrane Database found that material incentives for homeless persons may increase the rate at which persons return for reading of tuberculin skin tests (Lutge et al., 2012). Althaus et al. (2011) found that case management services targeting frequent users of emergency department services may decrease emergency department use, improve clinical outcomes, and result in less homelessness. Muirhead et al. (2011) surveyed homeless persons receiving nurse practitioner foot care services at a faith-based community kitchen. Participants in the survey were sensitive to the condition of their feet, shoes, socks, odor, and appearance. Respondents appreciated opportunities to clean their own feet.

Summary

Strengths/quality/consistency of the body of literature. A strong body of quality evidence, including a number of Level I studies, supports the perception that homeless persons have an increased burden of disease, multiple co-morbidities, a decreased life expectancy, unmet health care needs, and that homelessness is in, and of itself, a risk factor for unmet health care needs; and that unmet health care needs of homeless persons result in increased emergency department use, acute care hospitalizations, and increased costs.

The body of literature that identifies interventions to close the gap on unmet health care needs for homeless persons ranges in strength from Level I to Level VI and Other. There are systematic reviews as well as expert opinion grounded in extensive experience and performance improvement accounts. Themes include support of a multidisciplinary approach to address the

complex needs of patients with services that are particularly tailored to the needs of homeless persons.

Weaknesses/gaps/limitations. Weaknesses in the body of literature on interventions and outcomes include few randomized controlled trials, and a preponderance of expert opinion. Challenges for conducting randomized controlled trials with homeless persons include losing participants to follow-up due to unstable lifestyles. A gap in the body of literature is that studies conducted have been conducted in Canada or the United Kingdom, nationally in the U.S. or in specific geographic areas within the U.S.. Studies on the particular unmet health care needs of homeless persons on Maui and particular barriers to care experienced by them, and intervention studies particularly for homeless persons on Maui are not available, as far as the author knows. There may be grey literature available, and there is expert opinion available. Studies of outcomes of quality of life, and studies of outcomes of the particular costs of emergency department visits and acute care hospitalizations of homeless persons compared to the costs for the population of Maui in general, are not available, to the author's knowledge.

Recommendations for practice changes. Recommendations include continued exploration and critique of the literature. Recommendations also include surveying homeless persons on Maui for what, from their standpoint, would close the gap in their access to primary care, and likewise surveying health care providers to identify difficulties they have identified providing care to the homeless on Maui that might be alleviated. Small adjustments might result in a large reduction in the gap in health care services by reaching into care facilities to smooth access, and reaching out to homeless persons to bring them in. The literature cites barriers to homeless persons receiving primary care such as shame about the poor and dirty condition of their feet, embarrassment sitting in waiting rooms, discriminatory treatment, inconvenient hours of operation, lack of transportation, food insufficiency, cognitive difficulties, lost health identification cards, lack of health insurance (Burra et al, 2009; Khandor et al., 2011; Muirhead et al., 2011; Reid et al, 2008). Homeless persons on Maui have reported reasons for skipping needed health care to this author as due to not wanting to miss a free meal, having no money for bus transportation, fear of going through withdrawal, fear of how they might be treated at the health care facility (multiple personal communications). Targeting identified barriers could help close the gap in health care access. Likewise targeting identified frustrations or difficulties caring for the homeless that providers experience could facilitate care delivery. Schneller (2012)

reported on the success of escorting patients to their medical appointments to advocate for them, and Althaus et al of the success of emergency department case management services (2011). Existing services might be compared to the evaluative criteria developed by Shortt et al (2008) and services modified to come closer to the criteria.

Preliminary recommendations included support for systems change to consider an outreach service similar to the Waikiki Care-A-Van for Maui, associated with the Malama I Ke Ola Clinic. Initial responses, however, from administrators at Malama I Ke Ola Clinic do not show any interest in participating in a mobile health outreach project (Multiple personal communications, 2014). Administrators at existing outreach projects that currently do not have a health care component, at Salvation Army Maui and A Cup of Cold Water, have shown excited interest in partnering to add health care services (Multiple personal communications, 2013 and 2014). The Salvation Army Care-A-Van distributes food, water, clothing, and spiritual assistance to the homeless. A Cup of Cold Water is a faith-based service, which started services in the fall of 2013, and provides services similar to the Salvation Army Outreach. The Salvation Army Captains are receptive to upgrading the care provided through their outreach services with nurses and nurse practitioners, and have also worked to coordinate timing of care with A Cup of Cold Water Ministries to enhance services (Captain Robert Steiner, personal communication, November 4, 2013). The recommendation then is to create a volunteer health outreach by partnering with an existing outreach service – specifically, the Salvation Army.

Recommendations also include support of organizations' efforts to provide for the multiple needs of homeless persons. The Maui Homeless Alliance is a nonprofit organization of homeless service providers on Maui. Participating in the Maui Homeless Alliance provides an opportunity to network with other service providers and support their particular endeavors, and promote housing availability. One example is the need for additional shelter beds on Maui as housing is associated with improved health outcomes (Fitzpatrick-Lewis et al., 2009; Hwang et al., 2005; Lebrun-Harris, 2013, O'Campo et al, 2009). Salvation Army Maui previously had a shelter of about 18 beds which closed more than one year ago (Dr. Richard MacDonald, personal communication, July 2013) The Family Life Center in Kahului provides nightly shelter and is routinely full, having to turn persons away (Maude Cumming, personal communication, July 2013).

Chapter 3. Methods

Introduction to Chapter Contents

The goals of this Doctor of Nursing Practice Project (DNP Project) are to provide equity in the provision of health care services for homeless persons on Maui, and improve how well their health care needs are met. The DNP Project is divided into Phase 1, Phase 2, and Phase 3. Phase 1 occurs during the course of the DNP Program. Phase 2 and Phase 3 will occur after the student has graduated from the DNP Program. The goal for Phase 1 of this DNP Project is to increase understanding of the unmet health care service needs of homeless persons on living Maui. A needs assessment in Phase 1 of the DNP Project will provide the information that will be a foundation for development of a plan in Phase 2. The goal for Phase 2 is to develop a plan to improve how well the health care needs of homeless persons living on Maui are met. During Phase 3, the plan will be implemented. The goal for Phase 3 is to implement the plan. Long term planned outcomes of Phase 3 for homeless persons living on Maui are: 1) an increase in access to primary care services; 2) a decrease in unnecessary emergency department visits; 3) decrease in acute care hospital lengths of stay and readmissions; 4) decreased health costs; and 5) improved quality of life. The Conceptual Model for this quality improvement project is the Iowa Model of Evidence-Based Practice to Promote Quality Care (Titler et al, 2001), elements of the Diffusion of Innovation Model (Rogers, 2003) influence design of the project, features of the Logic Model (CDC, 2011) structure project evaluation of effectiveness.

The clinical question for the DNP Project is: "Among adult homeless persons on Maui, how do evidence-based interventions or evidence-based interventions with a nurse practitioner, compared to usual care, effect outcomes of met needs for healthcare services, access to primary care services, frequency of unnecessary emergency department visits, and acute care hospital lengths of stay?". The literature review and synthesis documented potential solutions that are broad in scope, require stakeholder backing, involve system change, financial commitment, and are rolled out over a time period that exceeds the two years of the DNP Project. Turning from the grand view of what might be possible in the ideal setting, to what the evidence shows is a good approach for achieving incremental progress in two years is consistent with the concrete evidence-based practice change focus of the Iowa Model. According to the Iowa Model, if the answer to the question "Is there sufficient research to guide practice?" is "no", the appropriate

option would be to conduct a study. In this application of the Iowa Model the study is a needs assessment in Phase 1.

Overview of the DNP Project Phase 1

The goal for Phase 1 of the DNP Project is to increase understanding of the unmet health care service needs of homeless persons on Maui. Four process objectives pertain to this goal. One process objective of the DNP Project Phase 1 is a survey of 30 homeless persons on Maui. Thirty homeless persons on Maui will be asked to complete a survey to assess what their unmet health care needs are, what barriers to receiving services they experience including what their knowledge of available services is, what their use of available resources is, and what ideas for solutions they have for meeting their health care needs. A second process objective for Phase 1 is a survey of five key stakeholders in the care of the homeless on Maui. Five key stakeholders will be asked to complete a survey of what the unmet health care service needs of homeless persons on Maui are, what barriers homeless persons experience in receiving care, and what their ideas for solutions are. A third process objective for Phase 1 is a survey of groups of key stakeholders involved in the care of homeless persons on Maui. Groups of key stakeholders will be asked to complete a survey of what the unmet health care service needs of homeless persons on Maui are, what barriers homeless persons experience in receiving care, and what their ideas for solutions are. Survey results will be analyzed. Results will be used to produce a report summarizing the needs assessment. The short-term outcome of Phase 1 is a needs assessment that will be used in Phase 2. The needs assessment will influence the planning and piloting of evidence-based outreach and inreach interventions in Phase 2.

Plan for Phase 1 Needs Assessment Evaluation

Overview of the Project plan. Evidence from the literature supports multidisciplinary mobile health outreach, inreach to facilities to improve access for homeless persons, medical respite options after discharge from acute care hospitalization, and increased housing opportunities as interventions to meet unmet health care needs of homeless persons (Althaus et al. 2011; Fitzpatrick-Lewis et al, 2011; Howe et al, 2009; Hwang et al 2005; National Outreach Guidelines for Underserved Populations, 2012; O'Campo et al, 2009; O'Connell et al. ,2010; Schneller, 2012; Shortt et al. 2008).

A homeless person has been defined as a person without permanent housing who may live on the streets, stay in a shelter, mission, single room occupancy facility, abandoned building,

or vehicle; or in any other unstable or non-permanent situation (HRSA, 2011). Unsheltered homeless persons have been distinguished from sheltered homeless persons. Unsheltered homeless persons reside in places not meant for human habitation such as vehicles, parks, sidewalks, abandoned buildings, and the street. Sheltered homeless persons reside in emergency shelters, or transitional or supportive housing for homeless persons who originally came from the streets or emergency shelters (HUD, 2004).

A community needs assessment that identifies the geographic area of the target population and barriers to accessing care for that target population is at the heart of any well planned program that matches services to needs in order to close gaps in care for the homeless. (National Health Care for the Homeless Council, 2014). A community needs assessment provides specific problem-focused triggers for use of the Iowa Model (Titler et al, 2001) and information about which of many potential interventions mentioned in the literature that would be feasible and effective.

The geographic area is the island of Maui. The target population is homeless persons on the island of Maui. The January 2013 Point-in-Time Count on Maui identified some 421 sheltered homeless persons and some 455 unsheltered homeless persons on Maui (State of Hawaii, May 2013). The January 2014 Point-in-Time Count on Maui showed 445 sheltered homeless persons, an increase of 5.70% from 2013, and 514 unsheltered persons, an increase of 12.97% over 2013 (State of Hawaii, May 2014).

This DNP Project is not a research project. It is an evidence-based practice quality improvement project. The evaluation of the evidence-based practice project will be a pre and post intervention design. The needs assessment, rather than a broad-based community needs assessment, will be specifically focused on topic areas. The needs assessment will include semi-structured interviews with individual key stakeholders in the care of homeless persons on Maui, with groups of key stakeholders such as hospital case managers and hospital social workers, and with 30 homeless persons themselves. The purpose is to identify unmet health care service needs, identify barriers to care including knowledge deficits, underutilization of services and other barriers, and identify possible solutions to unmet health care service needs. During Phase 2, after the student graduates from the DNP Program, interventions that increase access to primary care services will be planned. During Phase 3 interventions will be implemented. After the interventions are implemented in Phase 3, a post assessment survey will be done.

As part of the step of setting the direction for the assessment, it is important to consider both assets and needs (See Table 3.1), what is to be learned, and why this information is important. It is important to consider if this information will move the project closer to the vision of homeless people with unmet health needs becoming housed people with met health care needs; where this information is, and if the information has already been collected (National Health Care for the Homeless Council, 2013).

The information to be learned is what the unmet health care needs are, what the barriers to accessing care are, and what solutions there might be. The reason this is important is to offer effective interventions to meet the needs. Some quantitative information for Maui has been collected in terms of numbers of homeless persons, use of available community services (U.H. Center on the Family, 2012), numbers of individuals treated at Malama I Ke Ola Health Center (HRSA, 2012). What apparently is not available is qualitative data from local key stakeholders, and from the homeless persons themselves. More particulars on data collection for this DNP Project are presented in the data collection section.

Lebrun-Harris et al (2013) examined the data of the 2009 Health Resources Service Administration (HRSA) Health Center Patient Survey and identified homelessness alone as a risk factor for unmet health needs among HRSA community health center patients. The data was collected nationally and the methods included computer assisted personal interviews with more than 2600 patients that lasted about 50 minutes each and gathered comprehensive quantitative data. Acosta and Toro (2000) commented that homeless service agencies have rarely relied on systematic needs assessments but, rather, have traditionally provided assistance to homeless persons according to what they intuitively believe are the basic needs of the homeless. They did a longitudinal study of 301 homeless persons. The initial needs assessment survey gathering quantitative data was about three hours in length. The follow-up survey was about two hours in length. For the purpose of this DNP Project, the interviews will be abbreviated by comparison to those two studies, by focusing selectively on more specific areas. The target time for the interview will be 20 minutes.

Healthy People 2020 has identified access to health services as a leading health indicator (Healthy People 2020). One of the targets for this leading health indicator is 100% of the population with health insurance. Another target is that 83.9% of persons have a usual primary care provider. Questions on the survey will address these health indicators. Questions will also

include homelessness status. Answers to questions about homelessness status will clarify if the person is homeless or not to determine if the individual is part of the population to be surveyed, if the person is sheltered or unsheltered, and the duration of the person's homelessness. The survey questions will address whether the person has health insurance, and a usual primary care provider; the person's use of health care services including the number of emergency department visits in the last year, hospital stays, and the type of place the person stayed when discharged from the hospital. Another open-ended question will address the person's unmet health care service needs. Possible categories of answers include: unmet needs for medical care, surgical care, or prescription medication; services for vision (e.g., for eyeglasses), dental care, or mental health or counseling; for substance abuse treatment, wound and skin care; and other needs. Another open-ended question will address barriers to accessing health care and related resources. Possible categories of answers include: knowledge deficit about available services, disinterest in use of available services, and inconvenient appointment times; difficulty with communication, (e.g., no phone), difficulty with transportation, or no insurance; no money for the co-pay, attitudes of those providing service, fears about receiving service; attitude of "I don't care anymore", competing priorities (e.g., for food, alcohol, or drugs, and other items).

Likely program components that will be planned in Phase 2, and implemented in Phase 3 include health outreach which includes assisting persons who are not yet signed-up for medical insurance to sign-up, and addressing common health care concerns that can be addressed in a simplified outreach setting such as wound care, in addition to concerns broached in the survey. Inreach interventions are likely to include working with providers to develop services adapted to the needs of homeless persons (e.g., appointment times), navigators to facilitate access, and education about the culture of homelessness.

During Phase 3 post intervention surveys will be done. Pre-intervention and post-intervention data will be compared and analyzed. Those who experience interventions during Phase 3 will be surveyed about the intervention. Results will be used to modify Phase 3 interventions. Interventions for this DNP Project also include actions to support development of multidisciplinary health outreach associated with a health clinic, housing initiatives, and medical respite. The three semi-structured surveys are included in Appendix A. Assets in the community include items in Table 3.1.

Goals and objectives for project evaluation. The goals for this DNP Project are to provide equity in the provision of health care services for homeless persons living on Maui, and improve the provision of health care services to meet homeless persons' needs. The goal for Phase 1 of the DNP Project is to increase understanding of the unmet health care service needs of homeless persons living on Maui.

The outputs for Phase 1 of this project evaluation are as follows: quantitative and qualitative needs assessment on homeless needs for health care services and access to primary care services with 30 homeless persons, five key stakeholders, and two stakeholder groups in Phase 1 in spring of 2015.

Table 3.1. *Assets in the Community for Health Care for the Homeless*

Type of Asset	**Name of Organization**
Outreach Services	Salvation Army
	A Cup of Cold Water
	Mental Health Kokua
Community Health Center	Malama I Ke Ola Health Center
	Satellite Services in Lahaina
	Satellite Services at Ka Hale A Ke Ola Homeless Resource Center
Hospital	Maui Memorial Medical Center
Shelters	Ka Hale Ake Ola Homeless Resource Center
	Family Life Resource Center Kahului
	Women Helping Women
Hygiene	Salvation Army, Kahului
Nutrition and Meals	Maui Food Bank
	Salvation Army, Kahului
	St. Teresa Church Hale Kau Kau, Kihei
	Good Shepherd Church, Wailuku

The process objectives for Phase 1 output 1 appear in Table 3.2 and are as follows: the DNP student, during 2015, will perform a semi-structured mixed methods survey of a purposive sample of 30 homeless persons on Maui to assess their met and unmet health care service needs; perceived barriers to obtaining health care services; and ideas about interventions that would help them meet their health care service needs; the DNP student, during 2015, will perform a semi-structured qualitative survey conversation with a purposive sample of five knowledgeable stakeholders about homeless persons' on Maui met and unmet health care service needs; barriers to obtaining health care services; and their ideas about interventions that would help homeless

persons on Maui meet their health care service needs; the DNP student, during 2015, will perform a semi-structured qualitative survey conversation with two groups of key stakeholders involved in the care of homeless persons on Maui about homeless persons' met and unmet health care service needs; barriers to obtaining health care services; and their ideas about interventions that would help homeless persons living on Maui meet their health care service needs; and the DNP student utilizes the survey results, in combination with the DNP Project literature synthesis, and expert consultation, to draw conclusions about unmet health care service needs, barriers to care, and ideas for solutions. The short-term outcome is a needs assessment report. This is addressed in Table 3.3.

Phase 2 begins following the student's graduation from the DNP Program. The goal for Phase 2 is to develop a plan to meet homeless persons unmet health care service needs. A preliminary plan that will be modified after the needs assessment report is completed during Phase 2 is included later in this document. Supplemental materials can be found in Appendix B: Phase 2 and Phase 3. See Table B.1 *Phase Medium Term Outcome* in Appendix B-1. Phase 3 follows Phase 2. The goal of Phase 3 is to improve how well health care service needs for homeless persons on Maui are met and increase health equity. During Phase 3, post intervention survey data will be collected and compared to data collected during Phase 1. See Tables B.2 *Phase 3 Goals Output 2,* and Table B.3 *Phase 3 Goals Output 3* in Appendix B-2.

The outputs for Phase 3 are quantitative and qualitative needs assessment on homeless needs for health care services and access to primary care services following provision of health outreach and inreach services, with open-ended questions about further ideas for solutions. Surveys will be conducted with 30 homeless persons, five key stakeholders, and two stakeholder groups during 2016. Data will be analyzed, results identified, and conclusions drawn to modify outreach and inreach interventions. The Logic Model in Table 3.7 lays out the structure and connections of the phases of the Project.

Table 3.2 ***PHASE 1 GOAL: Increase Understanding of Unmet Health Care Service Needs of Homeless Persons on Maui***

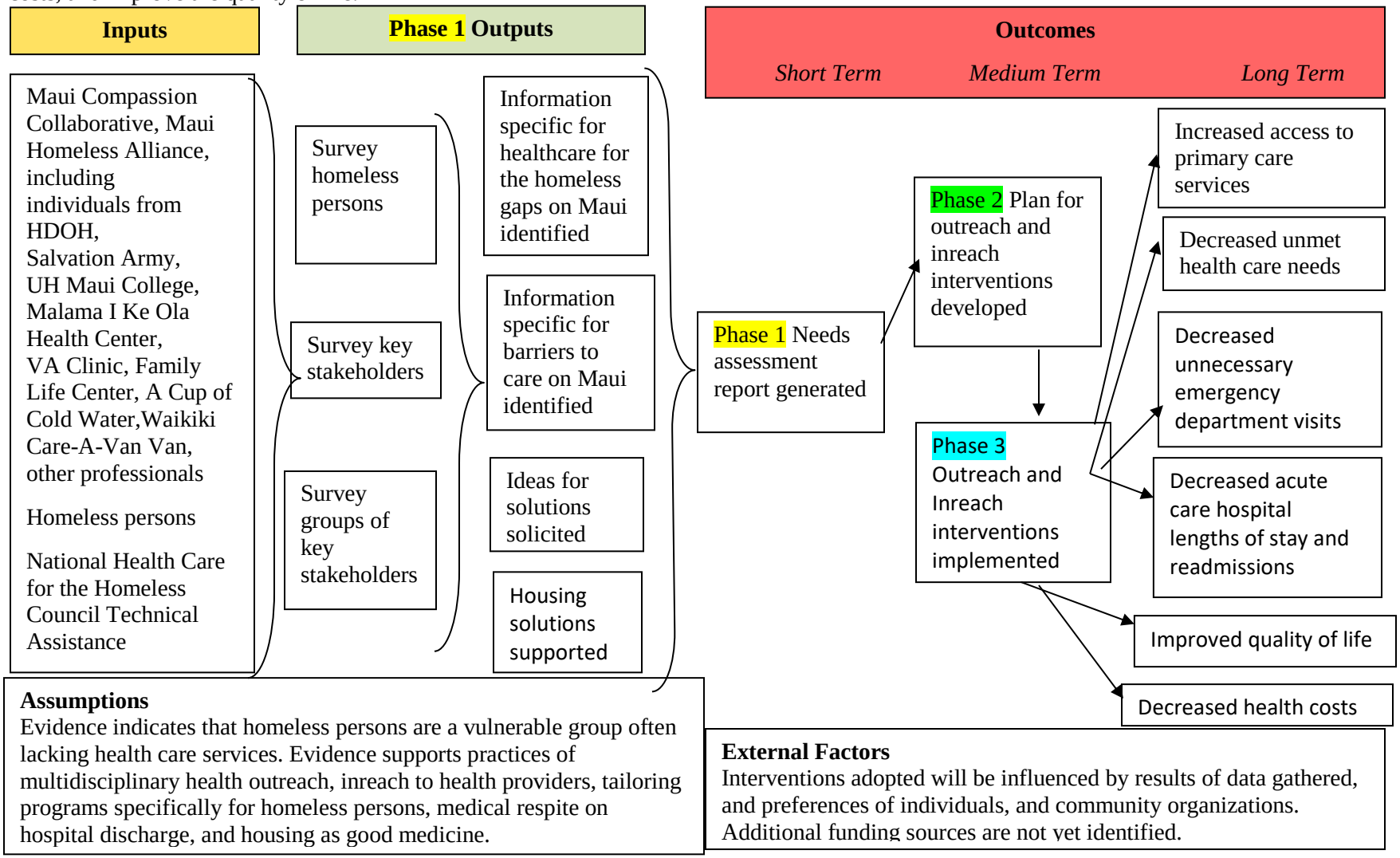
Outputs	SMART Objectives	Evaluation data				Timeframe
		Measure	Baseline	Target	Data Source	
OUTPUT 1 Conduct quantitative and qualitative needs assessment on homeless needs	PROCESS OBJECTIVE1The DNP student, during 2015, will perform a semi-structured mixed methods survey of a purposive sample of 30 homeless persons on Maui to assess their met and unmet health care service needs; perceived barriers to obtaining health care services; and ideas about interventions that would help them meet their health care service needs.	Number of surveys administered	No baseline available. This is Phase 1 pre-intervention survey.	30 surveys	Mixed methods face-to-face survey	Spring 2015
	PROCESS OBJECTIVE 2 The DNP student during 2015, will perform a semi-structured qualitative survey with a purposive sample of 5 knowledgeable stakeholders about Maui homeless persons' unmet health care service needs; barriers to obtaining health care services; and their ideas about interventions that would help homeless persons on Maui meet their health care service needs.	Number of Qualitative face-to-face survey of view of homeless persons unmet needs, barriers, ideas for solutions	No baseline available. This is Phase 1 pre-intervention survey.	5 interviews	Qualitative face-to-face survey	Spring 2015
	PROCESS OBJECTIVE 3 The DNP student during 2015, will perform a semi-structured qualitative survey conversation with two groups of key stakeholders involved in the care of homeless persons on Maui about homeless persons' on Maui met and unmet health care service needs; barriers to obtaining health care services; and their ideas about interventions that would help homeless persons on Maui meet their health care service needs.	Number of Qualitative face-to-face group survey of view of homeless persons unmet needs, barriers, ideas for solutions	No baseline available. This is Phase 1 pre-intervention survey.	5 interviews	Qualitative face-to-face group survey	Spring 2015
	PROCESS OBJECTIVE 4 The DNP student will analyze the survey results, in combination with the DNP PROJECT literature synthesis, to draw conclusions about unmet health care needs, barriers to receiving care, and ideas for solutions for homeless persons on Maui	Results of surveys analyzed	No Baseline	Data interpreted	Survey results	Spring 2015

Table 3.3*: Phase 1 Project Evaluation Short Term Outcome*

PHASE 1 GOAL:	**Increase Understanding of Unmet Health Care Service Needs of Homeless Persons on Maui**					
Short Term Outcomes	**SMART Objectives**	**Evaluation data**				**Timeframe**
		Measure	**Baseline**	**Target**	**Data Source**	
OUTCOME 1 Needs assessment of unmet health care service needs of homeless persons on Maui	OBJECTIVE 1 The DNP student, during 2015 produces a needs assessment report for post-graduation work in Phase 2.	Interpretation of results for needs, barriers, and solutions	No baseline data	Conclusions for intervention development	Survey data	2015

Table 3.4 Logic Model

Situation: The purpose of this program is to increase health equity and increase met health care needs by identifying and closing gaps in healthcare services for homeless persons on Maui, and increasing access to primary care services. In the long term, increased access to primary care services should reduce unnecessary emergency department visits, acute care hospital lengths of stay and readmissions, decrease health system costs, and improve the quality of life.



Evaluation Design

Overview of design of evaluation. The evaluation design for this DNP Project, Closing the Gap in Health Care Services for Homeless Persons on Maui, is non-experimental. Needs assessment data will be pre-intervention Phase 1 data collected during the DNP Program. Post-intervention data will be collected after graduation from the DNP Program during Phase 3 after outreach and inreach interventions have been implemented. The evaluation design is consistent with the evidence-based quality improvement project design of the DNP Project. Data for participants will be de-identified and aggregated for comparison between pre-intervention participants and post-intervention participants.

There are two reasons for de-identifying and aggregating data for this evaluation: the unstable living arrangements of homeless persons makes contact for follow-up with a post-intervention survey with designated individuals who have completed a pre-intervention survey, highly uncertain (Howe et al, 2009); and aggregating survey and interview data in this evidence-based quality improvement project may allow IRB exemption, or expedited IRB review (Selwitz et al., 2011).

Data collection plan. Some quantitative data has been collected on numbers of homeless persons in Maui (State of Hawaii, May 2014), use of available community services (U.H. Center on the Family, 2012), and numbers of individuals treated at Malama I Ke Ola Health Center (HRSA, 2012). Qualitative data from local key stakeholders, and from the homeless persons themselves on their needs, are not available.

The needs assessment in Phase 1 will be specifically focused on topic areas. The needs assessment will include semi-structured interviews with key stakeholders, groups of stakeholders such as nurse case managers, and hospital social workers, and with homeless persons themselves. All study participants will speak the English language. The purpose is to identify unmet health care service needs, barriers to accessing services, and ideas for solutions. After the interventions are implemented in Phase 3, a post survey will be administered.

How to obtain the data with sampling and recruitment. Participants are from a purposive sample: key stakeholders knowledgeable about care of the homeless on Maui, case managers and social workers familiar with challenges of discharging homeless persons from the hospital, and homeless persons themselves. For key stakeholders, a semi-structured interview based on a guide will be used to ensure that the interviewee has a chance to answer all of the

questions. Individuals will be given a flyer with information about the study. Questions about the study will be addressed prior to the person agreeing to participate and be interviewed. The interviewees' verbal permission will be obtained prior to the interview. Notes will be taken during the interview. The interviewer may probe to encourage the interviewee to talk about related issues. This approach leaves room for pursuing a topic that may not be directly related to the formal list of questions but is crucial (University of Kansas Community Toolbox, 2013). The interview will be arranged at the convenience of the interviewee (N=5 stakeholders), span a minimum of 5 to 10 minutes, and be longer if the interviewee is agreeable to sharing additional commentary

If their permission is obtained, qualitative data will be gathered by interviewing groups of nurse case managers (N=5) and social workers (N=5) at the hospital who address discharge of homeless persons from Maui Memorial Medical Center. A nurse case manager typically performs the following services: verifies coverage and benefits with the health insurers to ensure the provider is appropriately paid; coordinates services associated with discharge or return home; provides patient education and follow-up; and coordinates services with other health care providers (Wikipedia, 2014). A hospital social worker typically has an advanced degree in social work, and assists patients with discharge by connecting patients and families to necessary resources and supports in the community; providing psychotherapy, supportive counseling, or grief counseling; or helping patients to expand and strengthen their network of social supports (Wikipedia, 2014).

A verbal consent will be requested for the interview. A brief survey form with open-ended questions will be combined with a group interview with open-ended questions on unmet health care needs of homeless persons on Maui, barriers to access, barriers to discharge, perceived solutions.

A mixed methods survey of homeless persons will be administered (N=30). The target population is unsheltered homeless persons. Purposive sampling will be used at locations and events where homeless people congregate, once permission is obtained, such as from the Salvation Army Maui, centers where free meals are available, and where groups of people seen by outreach workers in locations around the island. Verbal consent for the survey will be obtained. A modest incentive such as a ten dollar prepaid gift card to Long's Drug Store or Walgreens Pharmacy, insect repellant spray, hand sanitizer, new socks, bandaids, ponchos, or

fruit will be offered to those who agree to participate. No name, gender, age, or ethnicity data will be collected. Data will be aggregated. Persons who decline being interviewed will not be penalized in any way. Notes on the interview will be taken. The plan is to complete the data collection during the spring of 2015. Volunteers may be recruited and trained to assist with data collection. Training will include background information on homelessness such as Health Care for the Homeless 101 (National Health Care for the Homeless Council, 2013) and trauma-informed care (Proffitt, 2010). See Table 3.6 *Data Collection.*

Data collection tools. Three data collection tools for the Phase 1 needs assessment survey are in Appendix A: Survey Forms. There is one survey for each of the categories of interviewees. These three tools will also be used for the post-intervention survey in Phase 3.

In addition, during Phase 3, a survey will be given to individuals who receive the intervention after the intervention, about their attitudes and experiences regarding intervention. Likely interventions under nurse practitioner supervision include health outreach which includes assisting persons who are not yet signed-up for medical insurance to sign-up, and addressing common health care concerns that can be addressed in a simplified outreach setting such as wound care, offering over the counter medications, and vitamins in addition to addressing concerns broached in the survey. More advanced practice interventions can be added in time. Inreach interventions are likely to include working with providers to develop services adapted to the needs of homeless persons – e.g., appointment times, and navigators to facilitate access. Post-intervention data would be collected in late spring 2015.

Reason for choosing this data to collect. The survey includes an open-ended question about unmet health care service needs. Some categories that will be included consistent with Lebrun-Harris et al (2013) and Baggett et al (2010) are: unmet medical and surgical needs, unmet need for prescription medications, unmet need for dental care, unmet need for mental health care, unmet need for substance abuse treatment, unmet need for eyeglasses.

The survey will include an open-ended question about usual source of care: community clinic, doctor's office, HMO, or emergency department. The survey will include an open-ended question about barriers to accessing primary care, including knowledge deficit about available services. Check boxes with common reasons will be included on the form for the ease of the surveyor. The survey will include an open-ended question about perceived solutions to meet

unmet health care needs and reduce barriers to primary care access. The survey will be trialed and revised prior to widespread use.

Interviews will be audio recorded. Audio recording will be done on a small Sony mp3 player, with dimensions approximately one and one half inches wide by four inches long. Recordings in mp3 format will be uploaded to a computer and then saved in NVivo software for transcription.

Objectives and how they are measured in Phase 1. Output one is a quantitative and qualitative assessment of homeless persons health care service needs on Maui. The measures for the first three process objectives for this output are number of surveys conducted. The measure for process objective four is one plan for outreach and inreach interventions. Output two is a quantitative and qualitative assessment of homeless persons health care service needs on Maui. The measures for the first three process objectives for this output are number of surveys conducted. The measure for the fourth process is the analysis of the results. The short term outcome for Phase 1 is a needs assessment report. Post-intervention data is collected in Phase 3. Measures are similar to the measures in Phase 1.

Information on validity and reliability. The design of the program evaluation is non-experimental so that causal linkages of interventions and program outcomes cannot be proved, but can only be described and suggested (Sy, February 2014). Internal validity in program evaluation rules out rival hypotheses that might explain the linkage between an intervention and a program outcome (McDavid et al, 2013). Historical threats can be accounted for by considering what external events or factors might have coincided with the intervention and account for the outcome. Other co-occurring factors for homeless persons during the time span of the pre-intervention and post-intervention surveys will be taken into account. Maturation, because of the time span of the program, is unlikely to be a concern. Testing is unlikely to be a concern as the instrument is a survey. Attrition is unlikely to be a problem as the data is de-identified and aggregated.

Construct validity has to do with how well outcomes in the logic model are represented by the variables in the evaluation (McDavid et al, 2013). Data to conduct the needs assessment as an outcome in the logic model is collected by the pre-intervention survey. The measure has face validity in that on the surface, it addresses unmet health needs. For content validity, the measure of the construct should match the full theoretical range of content for the construct (McDavid et

al, 2013). Matching the full theoretical range of content for the construct is beyond the range of this quality improvement project. Content for the construct is borrowed from published surveys (Baggett et al, 2010, Lebrun-Harris et al, 2013). Response process validity gauges the engagement and sincerity with which participants have responded.

The plan to approach participants with an awareness of the culture of homelessness and trauma-informed care sets up the possibility of a sincere an engaged response. Viable validity is the extent to which an evaluation provides evidence that an intervention is successful in the real world with ordinary clients and viewed by stakeholders and clients as helpful (Chen, 2009). The surveys query stakeholders and the recipients of interventions which provides the real world relevance. Based on this discussion, the surveys will have construct, face and viable validity.

Reliability is defined as the extent that a measurement instrument produces consistent results over repeated applications (McDavid et al, 2013). The reliability of the surveys has not been tested as they are new instruments.

Transcription. The DNP student will transcribe all of the audio recordings using NVivo software. NVivo software is sold by QSR International for use in qualitative and mixed methods research and is particularly adapted to organize, analyze and display semi-structured interview data (NVivo QSR, 2015). Transcription will be close-to-verbatim, meaning that interviews will be transcribed as close as possible to word for word, except when there is disruption by noise, the words are indecipherable, or when passages are summarized, such as the consent process.

Coding. Qualitative data will be coded and analyzed for themes supported by the NVivo software. NVivo software is recommended by McDavid et al (2013) for efficient organization and management of qualitative and mixed-methods data derived from surveys and interviews. A *node* is described as a container that allows the gathering of themes and cases in the data (NVivo QSR International, 2015). Each interviewee will be designated as a *case node*. Themes will also be designated as nodes. Each transcription passage will be coded for a theme and also coded to the case node for the interviewee to allow for comparison, for example between themes of homeless persons and themes of stakeholders. The node structure will parallel the structure of the interview format. Themes will be counted to present as frequencies. Themes will be identified by raw frequency and also by relative frequency. Raw frequencies are the actual number of persons who express a given theme. Relative frequency is a percent value calculated by the raw frequencies divided by the total raw frequencies identified (Kellar & Kelvin, 2013). More

importance will be assigned to themes with a higher relative frequency than those with lower relative frequency, as higher relative frequencies are indicative of themes expressed by higher numbers of individuals. Themes expressed by higher numbers of individuals represent common concerns. Higher relative frequency themes identified in the results will be included when selecting evidence-based interventions. A higher raw frequency theme would be defined as a theme with a raw frequency greater than one. Frequencies of themes identified in the post-intervention surveys will be compared to frequencies in the pre-intervention surveys. Quantitative data will be computed as frequencies. Frequencies of closed ended responses in the post-intervention surveys will be compared with pre-intervention results.

Queries. As part of the data analysis, queries of the coded data will be run with NVivo software to examine the relationship between coded nodes. Interview transcripts will be checked when questions arise about the material coded, or when more information is needed.

Results reporting and use

Interpretation and sharing of results. The Phase 1 needs assessment results that will be reported will be from analysis of data collected in the semi-structured survey interviews with five key stakeholders, representatives from two groups of stakeholders i.e. the hospital case managers, and hospital social workers, and 30 homeless individuals. Results will contribute to developing the plan for outreach and inreach interventions during Phase 2. Phase 3 post-intervention results also include patient satisfaction surveys. Developing an Effective Evaluation Plan (CDC, 2011) suggests using a table format to lay out a plan for communication of results. See Table 3.5 for a communication plan of Phase 1 needs assessment report. The report will in include tables, graphs, and a description of the data analysis, along with interpretation and discussion.

Address unmet objectives. Unmet objectives will be addressed in *developmental evaluation* style. McDavid et al (2013) explain developmental evaluation as an alternative to formative and summative evaluations. They are evaluations that take place in complex, evolving environments. Team members work with evaluative information in real time so that programs and policies can take advantage of a range of dynamic information. If an objective is unmet, there may be a better approach to meet the objective, or a better objective to replace the unmet objective with.

Table 3.5. *Communication of Results*

Audience	Goal	Tools	Timetable
Key individual stakeholders who were interviewed	Sustain interest and involvement in the DNP Project	Method preferred by individual to receive communication: Face-to-face, phone, email	April 2015
Groups of key stakeholders	Sustain interest and involvement in the DNP Project	Method preferred by contact person in the group to receive communication: face-to-face, phone, email	April 2015
Health Outreach Team Members	Discuss interventions, Sustain interest and involvement in the DNP Project, delegate activities	Face-to-face, meetings, phone, email	Monthly at least but more frequently as needed
Academic Adviser	Report progress, receive feedback	Email	Monthly
External Adviser	Report progress, collaborate, receive guidance and feedback	Email, phone, face-to-face meetings	Monthly at least but more frequently as needed
Maui Compassion Collaborative / Maui Homeless Alliance	Sustain interest and involvement in the DNP Project, collaborate	Email, meetings	As needed and April 2015

How to determine whether the purpose of the evaluation was accomplished in Phase 1. The purpose of Phase 1 is an increase in understanding of unmet health care service needs of homeless persons on Maui. If the results identify patterns of unmet needs, barriers to accessing care, and feasible ideas for solutions then the purpose is accomplished. The needs assessment will guide Phase 2 planning.

Timeline. The DNP student has requested relief from some work responsibilities during spring 2015 in order to create time for Phase 1 of the DNP Project. Maui Health Outreach Volunteers will continue to develop outreach and inreach services for homeless persons on Maui after the DNP student has graduated (see Table 3.7).

Table 3.6. *Data Collection*

Variables	**Instruments**	**Data Collection Points**	**Data Analysis**
Homeless persons unmet health care needs, perceived barriers to obtaining health care services, ideas about interventions to meet health care needs	Face-to-Face pre-intervention survey interview	30 homeless persons during spring 2015 during Phase 1	Theme identification and Descriptive statistics
Homeless persons unmet health care needs, perceived barriers to obtaining health care services, ideas about interventions to meet health care needs	Face-to-Face pre-intervention survey interview	5 key stakeholders during spring of 2015 during Phase 1	Theme identification and Descriptive statistics
Homeless persons unmet health care needs, perceived barriers to obtaining health care services, ideas about interventions to meet health care needs	Face-to-Face pre-intervention survey interview	2 groups of key stakeholders with 5 persons in each group: case managers, social workers during spring of 2015 during Phase 1	Theme identification and Descriptive statistics
Homeless persons satisfaction with interventions	Patient satisfaction survey	Collected after each encounter during Phase 3	Theme identification and Descriptive statistics
Interventions provided	Intervention records	Collected after each encounter during Phase 3	Theme identification and Descriptive statistics
Funds received, Costs expended	Bookkeeping record	Collected as received and expended	Arithmetical
Homeless persons unmet health care needs, perceived barriers to obtaining health care services, ideas about interventions to meet health care needs	Face-to-Face post-intervention survey interview	30 homeless persons during 2016	Theme identification and Descriptive statistics
Homeless persons unmet health care needs, perceived barriers to obtaining health care services, ideas about interventions to meet health care needs	Face-to-Face post-intervention survey interview	5 key stakeholders during 2016	Theme identification and Descriptive statistics
Homeless persons unmet health care needs, perceived barriers to obtaining health care services, ideas about interventions to meet health care needs	Face-to-Face post-intervention survey interview	2 groups of key stakeholders with 5 persons in each group: case managers, social workers during 2016	Theme identification and Descriptive statistics

Table 3.7. *Timeline Task Table*

Timeline Task Table	2014					2015							2015			2016				
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Proposal Defense	*																		
Phase 1 Interview Key Stakeholders, Groups, homeless persons		*	*	*	*														
Phase 1 Collect Data		*	*	*	*														
Phase 1 Enter Data		*	*	*	*	*													
Phase 1 Analyze Data						*	*	*	*										
Phase 1 Needs Assessment Report										*									
Phase 1 Evaluation										*									
Final Project Defense											*								

	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Phase 2 Plan											*	*	*	*					
Phase 2 Educate Team											*	*	*	*					
Phase 2 Pilot Interventions											*	*	*	*					
Phase 2 Prepare Intervention											*	*	*	*					
Phase 3 Implement Interventions															*	*	*	*	*
Phase 3 Interviews Collect Data															*	*	*	*	*
Phase 3 Analyze Data															*	*	*	*	*
Phase 3 Evaluate Program																			*

Ethical Considerations

Ethical tenets. This proposal has been designed in such a way as to protect the rights of any human subjects involved in the project. According to the Belmont Report (Department of Health & Human Services, 1979), ethical principles include *respect for persons, beneficence,* and *justice.* Respect for persons includes treating persons as autonomous agents. To treat a person as an autonomous agent includes giving weight to that person's considered opinions and choices, and not taking actions to obstruct them, unless they are clearly detrimental to others. Some persons have a reduced capacity for self-determination due to developmental stage, illness, mental disability, or circumstances that restrict their freedom. Respect for such persons includes protecting them while they are incapacitated. Homelessness in itself has been identified as a risk factor for unmet health needs, and homeless persons have a higher burden of substance abuse and mental illness than the population at large, so some might have limited capacity (Lebrun-Harris et al, 2013). All persons interviewed during phase 1 or offered services during Phase 3 in this Project can accept or decline as they decide with no resulting penalty.

The principle of beneficence can be understood as efforts undertaken to secure another's well-being (Department of Health & Human Services, 1979). This DNP Project arises from a recognition of unmet health needs among homeless persons living on Maui. It has been planned to alleviate unmet health needs. As such, the DNP Project is, at the core, beneficent.

The principle of justice has to do with the fairness of distribution of a benefit (Department of Health & Human Services, 1979). This DNP Project arises from a recognition of the lack of access to health care services among homeless persons living on Maui compared to the population at large, and has been planned to diminish that inequity. It is then consistent with the ethical principle of justice.

Ethical considerations for a quality improvement project. The Belmont Report (Department of Health & Human Services [DHHS], 1979) addresses the distinction between practice and research. According to that Report, "the term 'research' designates an activity designed to test a hypothesis, permit conclusions to be drawn, and thereby to develop or contribute to generalizable knowledge (expressed, for example, in theories, principles, and statements of relationships). Research is usually described in a formal protocol that sets forth an objective and a set of procedures designed to reach that objective" (p. 2). This definition of research does not fit the design of this DNP Project.

In contrast, the Belmont Report's (p. 2) description of a practice intervention does describe the DNP Project: "the term 'practice' refers to interventions that are designed solely to enhance the well-being of an individual patient or client, and that have a reasonable expectation of success. The purpose of medical or behavioral practice is to provide diagnosis, preventive treatment or therapy to particular individuals".

There are no plans to randomize subjects to different treatments. Person-identifiable information will not be collected. Data will be aggregated. Standard-evidence-based practices will be implemented. There is no additional risk beyond standard practice. With regard to research with vulnerable populations, the Belmont Report (1979) asserts that other subjects should be selected unless the nature of the research is specifically related to the conditions of the vulnerable population involved. This practice Project with this vulnerable population specifically pertains to their condition and represents an effort to alleviate unmet health care needs. The author of this DNP Project has taken the University of Hawaii required Collaborative Institutional Training Initiative (CITI) course in Human Subjects Protection. This proposal has been reviewed by a committee consisting of faculty and clinical experts to ensure there is adequate human subjects protection. The study received exempt status from the University of Hawaii Institutional Review Board on February 2, 2015 prior to the initiation of recruitment of participants.

Limitations

This DNP Project is initiated in a fluid and changing environment in which conditions are not held constant. During Phase 1, Interviews will be conducted in varied and uncontrolled settings such as stakeholder offices, the Salvation Army Safe Haven, hospital meeting rooms, and outreach destinations such as beach parks.

During Phase 3, interventions will be evidence-based and shaped also by the results of interviews with key stakeholders, groups of stakeholders, and homeless persons. Varied interventions will be offered depending on individual person's needs and health care provider team composition at the time. Interventions include partnering with existing non-health care outreach services, assistance with application for health insurance, education about disease management, wound care, support for mental health counseling, and substance abuse treatment referral, screening for health problems, gifts of over the counter items, and referral to primary care or emergency department services. If persons report more of their health care needs are met

during Phase 3, a causal linkage cannot be established between the interventions and the met health care needs. Interventions are limited by the lack of strong outreach support from the HRSA supported clinic on Maui.

The interview sample size of 30 homeless persons is small. The instruments, though developed by referencing existing research surveys, are specific to this improvement project. Data will be analyzed for frequency and trends. The interventions will be piloted in fall 2015, and then conducted weekly in spring of 2016. Individual post-intervention patient satisfaction surveys will be examined to inform service modification.

Summary

The goals of this DNP Project are to provide equity in the provision of health care services for adult homeless persons living on Maui, and improve how well their health care needs are met. The Conceptual Model for the Project is the Iowa Model of Evidence-Based Practice to Promote Quality Care. Evidence from the literature supports multidisciplinary mobile health outreach, inreach to facilities to improve access for homeless persons, medical respite options after discharge from acute care hospitalization, and increased housing opportunities as interventions to meet unmet health care needs of homeless persons. The goal of Phase 1 is to increase understanding of unmet health care service needs of homeless persons on Maui. The planned outcome of Phase 1 is a needs assessment report. During Phase 1, interviews with stakeholders on Maui, including homeless persons, will clarify which are the most suitable interventions for the Maui setting. Phase 2 planning, and Phase 3 implementation follow graduation. During Phase 3, a team of Health Outreach volunteers will collaborate with existing outreach services to enhance the services available. The planned outcome of this multiple phase DNP Project for homeless persons on Maui is to increase access to primary care services, and decrease unmet health care needs. Later planned outcomes are a decrease in unnecessary emergency department visits, and a decrease in acute care hospital lengths of stay and readmissions, decreased health costs, and improved quality of life.

Chapter 4. Results

Introduction to Chapter Contents

A needs assessment of health care service needs of homeless persons on Maui was conducted. The needs assessment was part of Phase 1 of the Doctor of Nursing Practice (DNP) Project Closing the Gap in Health Care Services for Homeless Persons on Maui.

Description of Sample

The sample was a purposive sample of 32 individual homeless persons (IHPs) over the age of 18 years, and 12 individual key stakeholders (IKSs) who were professionally familiar with homeless persons with health care needs on Maui. Additional input was received from one group of hospital social workers (GS).

Individual homeless persons. The IHPs were recruited at the Salvation Army Safe Haven in Kahului, or in Lahaina; locations the Salvation Army Outreach van visited in central, south, and upcountry Maui; or the Family Life Center in Kahului. In the interest of allowing participants anonymity, personal identifying data were not collected. Participants were not asked to provide their name, age, place of origin, length of time in Hawaii, social security number or actual locations where they stayed. They were not asked to sign anything in order to participate. Several persons expressed appreciation for this approach including one participant who said, "you know how you got me to 'You don't have to sign anything' … cuz that's the kind of people we are sometimes. We think maybe the system's a little nuts. And so we … don't have to participate in it." (IHP 9).

Eighteen of the IHPs interviewed were male, and 14 were female. Twenty-five of 32 IHPs interviewed fit the definition of chronically homeless. A chronically homeless person or family is identified as a person or family that has been homeless for one year, or homeless on at least four separate occasions in the last three years, with each occasion lasting at least 15 days (HUD, 2014). Twenty-four of 32 IHPs interviewed were unsheltered. Unsheltered homeless persons and families use a primary nighttime residence that may be public or private that is a place not normally used as a regular sleeping accommodation for human beings such as a car, park, abandoned building, bus or train station, airport or camping ground (Snow, 2014). Types of sleeping locations identified by those who were unsheltered included the beach, a campsite and tent, the street, the park, underground, a graveyard, an abandoned vehicle, out in the open under

the stars, and a “dry place”. Sheltered individuals were at the Family Life Center, staying in a garage, or in a shed.

Individual key stakeholders. Twelve IKSs were recruited based on their familiarity with homeless persons on Maui with health care needs. Their professional roles included outreach worker, case worker, emergency nurse, nurse manager, nurse case manager, physician, Emergency Medical Services (EMS) paramedic and facilities manager. Ten of the IKSs were male, and two were female. Interviews took place at times and locations convenient for them.

Groups of stakeholders. Hospital social workers (GS) reviewed the interview format and provided written feedback from their group on it. Nurse case managers were not able to be interviewed; however, one nurse case manager agreed to be interviewed as an individual key stakeholder.

Interview Process

All interviewees, except one IHP, gave consent for audio recording and for the interview. The one IHP who declined the audio recording agreed to be interviewed. The DNP student conducted all of the interviews. For some interviews, an Associate Degree in Nursing (ADN) student or a graduate ADN nurse were also present. Interviews with IHPs were conducted where there were often interruptions or noise in the environment from wind, waves, cars, trucks, motorcycles, people conversing or yelling, birds, and other mechanical noise. In addition, the DNP student wrote some notes during the interviews.

Twenty-one hours and 48 minutes of audio recordings of interviews were transcribed. Audio recordings of interviews varied in length from as short as 13 minutes to as long as one hour and 14 minutes. The interviews took place between February and July of 2015.

Results Data[d1]

Coded data. A *node* is described as a container that allows the gathering of themes and cases in the data (NVivo QSR International, 2015). The node structure initially paralleled the structure of the interview format. While coding, it became apparent to the DNP student that additional theme nodes were needed such as “lack of follow-up”, and “rule averse”. When new nodes were added, previously coded material was reviewed to see if the newly added nodes should also be coded in transcripts that had already been reviewed for coding.

Parent nodes are the main node groupings. Parent nodes sit above other nodes known as *child nodes* in a node hierarchy. The child nodes are narrower subgroupings of a parent node. A

source is a particular IHP, IKS or GS interviewed. Each of the persons interviewed is considered one source. A *reference* is a segment from a transcript coded to a node. Table 4.1 displays parent nodes, sources and references.

Queried data. Table 4.1 displays the names of the parent nodes, the number of individual sources who referenced them, and the number of references coded to the parent nodes. A summary of each of the parent nodes and their related child nodes are presented in the following sections. During data analysis, transcripts were re-examined to identify themes that might have been missed during the coding process, and include those references, in addition to the references mentioned in Table 4.1. Commentaries by the participants are presented as examples of the issues that they identified in the text and in appendices.

Table 4.1. *Theme Parent Nodes*

Name of Parent Node	Number of Sources	Number of References Coded
Source of Health Care Services	45	754
Unmet Health Care Needs	45	1042
Actual Barriers	45	2025
Ideas for Solutions	45	743

Analysis of Source of Health Care Services Node

Individual homeless persons and health insurance status. Eighteen IHPs had medical insurance that could be used in the State of Hawaii. Fourteen did not have medical insurance that could be used in Hawaii. Two of those fourteen, who were not insured in Hawaii, were insured in another state – one in California, and one in Massachusetts.

Use of self-care.

Use of self-care per individual homeless persons. Twenty-one of 32 IHPs commented on their own self-care strategies. Self-care strategies that IHPs reported to maintain their health are displayed in Table 4.2.

Table 4.2. *Self-Care Strategies of Individual Homeless Persons* (IHPs) (n=21)

Self-Care Strategies	**IHP**	**Number**	**Total**
Prevent wound infection:	IHP 1, 2, 3, 8, 10, 11, 13, 14, 15	9	9
• Puts own saliva in wound to prevent MRSA and wears shoes	IHP 1	1	
• Keeps wounds covered and applies antibiotic ointment	IHP 2	1	
• Uses Hawaiian herbs and aloe vera on wounds	IHP 3	1	
• Takes care of her own small wounds	IHP 8	1	
• Applies Neosporin and silver water from church outreach	IHP 10	1	
• Applies mustard to wounds to prevent staph	IHP 13	1	
• Purchases oral antibiotics on the street	IHP 14	1	
• Keeps wounds clean and applies neosporin	IHP 11, 15	2	
Manage pain:	IHP 7, 29, 30	3	3
• Chronic pain with acetaminophen, ibuprofen and beer	IHP 7	1	
• Chronic pain with marijuana, methamphetamine and alcohol	IHP 30	1	
• Chronic dental pain with vodka rinses	IHP 29	1	
• Chronic musculoskeletal pain and lethargy with marijuana, yoga, glucosamine, acetaminophen, ibuprofen and caffeine	IHP 29	1	
Substance abuse treatment:	IHP 31	1	1
• Reads King James Bible for counseling for marijuana, beer and tobacco use			
Hygiene:	IHP 7, 24, 25, 27	4	4
• Showers daily	IHP 7, 24, 25	4	
• Washes clothes out	27		
	IHP 7	1	
Hydration	IHP 1	1	1
Nutrition:	IHP 1,13, 14, 24	4	4
• Fruits and vegetables when he can	IHP 1, 13	2	
• Meats, low fat, no sweets	IHP 13	1	
• Cuts food small or grinds up nuts because he has no teeth	IHP 24	1	
Nature is her mother, and she uses herbs, water, fresh air, and purification to heal herself	IHP 9	1	1
Blood sugar control for diabetes:	IHP 17	1	1
• Keeps sweets in her bag in case her blood sugar drops low			
Exercise:	IHP 13, 17, 29	3	3
• For weight loss	IHP 17	1	
• Yoga for pain relief	IHP 29	1	
• Walking for health	IHP 13	1	

Table 4.2. (Continued) *Self-Care Strategies*

Independence:	IHP 11, 12, 28	3	3
• Treats self even if bones are broken	IHP 12	1	
• Wants to be independent not needy	IHP 11	1	
• Raised to be self-reliant	IHP 28	1	
Medication:	IHP 14, 17, 20	3	3
• Gets prescription medication when he needs it by buying it on the street	IHP 14	1	
• Takes her blood pressure medication regularly	IHP 17	1	
• Checks blood glucose and takes insulin, uses inhalers	IHP 20	1	
Dental:	IHP 8, 20	2	2
• Pulled own tooth	IHP 20	1	
• Tries to keep up with brushing	IHP 8	1	

Note. Some IHPs have more than one strategy so appear in more than one category.

An example of a strategy that one IHP used was maintaining personal hygiene activities. "Just because you [you're] homeless, doesn't mean you cannot take one shower. Or, you know, keep yourself in check" was a comment by IHP 7. For additional commentary from IHPs on the use of self-care see Appendix C, entitled Commentary from Individual Homeless Persons on the Use of Self-Care.

Use of self-care by homeless persons per individual key stakeholders. Eleven of 12 IKSs commented on homeless persons' self-care strategies; however, the majority of these focused on homeless persons' lack of self-care. Table 4.3 displays what IKSs said about self-care strategies of homeless persons.

Table 4.3. *Comments of Individual Key Stakeholders (IKSs) on Homeless Persons' Self-Care Strategies* (n=11)

Self-Care Strategies	IKS	Number	Total
Inattentive to self-care:	IKS 1-10, 12	11	11
• Substance abuse and mental illness interfere with self-care	IKS 4, 6, 7, 9, 10, 12	6	
• Inattention to basic hygiene creates complications	IKS 4, 10, 12	3	
• Need more education on self-care	IKS 2, 3	2	
• Don't follow self-care instructions	IKS 5	1	
• Hesitant to seek health care when they need it due to provider attitudes	IKS 1	1	
• Have given up trying	IKS 6	1	
• Miss opportunities for follow-up	IKS 8	1	
• Associations interfere with self-care	IKS 10	1	
Resourceful:			2
• Homeless persons are resourceful in meeting their needs	IKS 4, 8	2	

Note. Some IKSs commented on more than one strategy so appear in more than one category

Substance abuse and mental illness interfere with attention to self–care, according to IKS 12. He said:

> Cuz I think with all these people, if you could get their substance abuse controlled, they'll follow the rest of it. They'll get their drugs back on. [He referred to their use of medication for psychiatric problems.] They'll get their wound care. But I think they're just, by noon, they're wasted and it's another day of insanity for them.

See Appendix D, entitled Commentary from Individual Key Stakeholders on Homeless Persons' Use of Self-Care for more comments.

Use of Malama I Ke Ola Health Center for services.

Use of Malama I Ke Ola Health Center for services per individual homeless persons.

Malama I Ke Ola Health Center (MIKOHC), also known as Community Clinic of Maui (MIKOHC, 2016) is a federally qualified health center (FQHC) that receives homeless service grantee funds through Waikiki Health Center (NHCHC, 2016). The Health Resources and Services Administration (HRSA) describes FQHCs as follows:

> Federally Qualified Health Centers are community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board

that includes patients. Federally Qualified Health Centers may be Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Centers for Residents of Public Housing.

Twelve IHPs reported using MIKOHC services at some time. Both IHP 29 and IHP 30 stated they were suspected, by MIKOHC providers, of misuse of prescription opioid analgesics and were not allowed to return there for services. If they are subtracted from those using MIKOHC, ten of 32 IHPs interviewed used MIKOHC. Twenty-two of 32 did not use MIKOHC. Table 4.4 describes IHPs self-reported use of MIKOHC.

Table 4.4. *Individual Homeless Persons' (IHPs) Self-Reported Use of Malama I Ke Ola Health Center (MIKOHC)* (n=12)

Reason for Use	**IHP**s	**Number**
No reason given	IHP 21, 23, 28	3
Asthma	IHP 4, 18	2
Cannot return due to suspicion of misuse of prescription opioids	IHP 29, 30	2
Tooth extraction	IHP 11, 27	2
Staph	IHP 18	1
Prenatal care	IHP 26	1
Spider bites	IHP 11	1
Mental health care	IHP 31	1

Note. Some IHPs are reported in more than one category

In addition, IHPs provided reasons for not using the services available through the MIKOHC. These are presented in Table 4.5.

Table 4.5. *Individual Homeless Persons' (IHPs') Self-Reported Nonuse of Malama I Ke Ola Health Center (MIKOHC)* (n=22)

Reason for Nonuse	**IHPs**	**Number**
Goes to ED	IHP 1, 3, 7, 8	4
Does self-care	IHP 1, 2, 9, 13	4
Goes to Maui Medical Group	IHP 17, 20, 21, 22	4
No reason given	IHP 15, 16	2
Does not have identification	IHP 5, 24	2
Cannot make appointments or arrange transportation	IHP 10, 32	2
Cannot go there due to suspicion of inappropriate use of prescription opiates	IHP 29, 30	2
Never heard of it	IHP 14	1
Thinks it is only for girls	IHP 6	1
Could not be seen because of no insurance	IHP 19	1

Note. IHP 29 and 30 were also reported in Table 4.4 as users.

The majority of IHPs who did not use MIKOHC shared the reasons why. For IHP 18 not feeling heard was an issue. She has asthma and feels that the staff at the health center do not listen to her requests for affordable inhalers and a nebulizer machine. Other IHPs noted having health insurance was a barrier to receiving services there (IHP 17), while IHP 19 said that not having health insurance prevented her from receiving care there. Lack of awareness about the clinic's services was noted by IHP 14. For more comments see Appendix E, Comments from Individual Homeless Persons on Use and Nonuse of Malama I Ke Ola Health Center.

Use of Malama I Ke Ola Health Center for services by homeless persons per individual key stakeholders. Eleven of 12 IKSs commented on homeless persons' use of MIKOHC. Themes of their comments are listed in Table 4.6.

Table 4.6. *Themes in Comments of Individual Key Stakeholders (IKSs) on Homeless Persons Use of Malama I Ke Ola Health Center (MIKOHC)* (n=11)

Themes of IKSs on Use of MIKOHC	**IKS**	**Number**
Cumbersome admission process: • Application process and appointment are on different days • "Red tape" if someone has no money or Medicaid is pending • May wait several weeks for an appointment • Hard to get in there	IKS 1, 5, 6, 7 IKS 1 IKS 7 IKS 6 IKS 5	4
Demand for service: • MIKOHC is overwhelmed with patients • Homeless persons sleep in the MIKOHC parking lot	IKS 6, 8, 11 IKS 6, 8 IKS 11	3
Chronic pain patients are not accepted	IKS 3, 11	2
Limited service availability: satellite clinic in West Maui closure impacts whole community	IKS 12	1
Homeless persons discharged from hospital do not follow-up for appointments at MIKOHC	IKS 8	1
Homeless persons may experience bias when seeking services	IKS 2	1
Has never heard of MIKOHC	IKS 9	1
MIKOHC is a "last stop" and tries not to turn anyone away	IKS 11	1

Note. Some IKSs expressed more than one theme, therefore they appear in more than one category.

According to IKS 7, it was his experience that it has not been very easy to get people into MIKOHC. He commented:

> … every time we try to refer somebody over there that clearly doesn't have any money… or is Quest pending, or Medicaid pending and stuff, you know they seem to have a ton of red tape… "you gotta jump through this hoop, you gotta give us this form, you gotta give us that form" [his imitation of statements from clinic personnel] , before they'll actually,

see somebody in their clinic. I'm just like wait a minute. [His response to them] "Aren't you getting money from the federal government to help us?... You know with these people who really do need health services. So how come it's so difficult [emphasis], once we even have our hands on these people to get you to follow-up--you know once we've had them in the acute care setting in the hospital."… I don't know the key to unlock that.

With regard to homeless persons' use of MIKOHC, IKS 11 said:

> We don't really like to turn away people, ... or not see somebody. I'd say like this is like the last...a lot of other places, tell people, you know what, go see us. We're the only ones on the island that see this type of patients. Last stop.

For more comments by IKSs on homeless persons' use of MIKOHC see Appendix F, Comments of Individual Key Stakeholders on Homeless Persons' Use of Malama I Ke Ola Health Center.

Use of emergency medical services by homeless persons.

Use of emergency medical services per individual homeless persons. Only four of 32 IHPs commented on their use of EMS. Table 4.7 displays IHPs self-reported reasons for using EMS.

Table 4.7. *Individual Homeless Persons' (IHPs') Self-Reported Reasons for Using Emergency Medical Services* (EMS) (n=4)

Reasons for Using EMS	**IHP**	**Number**
Asthma	IHP 5, 18, 20	3
Diabetes complications	IHP 20	1
Avoidance of long wait time in ED waiting room	IHP 11	1

Note. One IHP gave more than one reason so appears in more than one category

According to IHP 11, the wait to see a doctor in the ED is so long that he feels it is better to just call the ambulance, because then he will be taken directly into the patient care area. For more comments from IHPs on use of EMS, see Appendix G, Comments of Individual Homeless Persons on Use of Emergency Medical Services.

Use of emergency medical services by homeless persons per individual key stakeholders. Six of 12 IKSs commented on EMS use by homeless persons. Themes of their comments are displayed in Table 4.8 *Themes of Individual Key Stakeholders on Homeless Persons Use of Emergency Medical Services.*

Table 4.8. *Themes of Individual Key Stakeholders (IKSs) on Homeless Persons Use of Emergency Medical Services (EMS)* (n=6)

Theme of IKSs on Homeless Persons Use of EMS	**IKS**	**Number**
Common reasons for transport:		
• Altered mental status with apparent intoxication	IKS 3, 4, 12	3
• Same intoxicated person may be transported frequently	IKS 3, 4, 12	3
• No other means of transport	IKS 12	1
• Infected wounds	IKS 12	1
• Suicidal ideation	IKS 12	1
• Pneumonia	IKS 12	1
• Chest pain	IKS 12	1
• Urinary tract infection	IKS 12	1
• Pain	IKS 12	1
• Choking on marijuana blunt	IKS 6	1
Persons are dropped off by EMS in community:		
• Intoxicated and unresponsive	IKS 1	1
• Wheelchair bound person with no wheelchair	IKS 1	1
• Person refused treatment at ED	IKS 2	1
Delayed response to location with repeated callers	IKS 6	1
Bias against homeless persons	IKS 1, 2	2
EMS is tied up by homeless patients who should have their needs met elsewhere:	IKS 4, 12	2
• Lack of primary care services burdens EMS with homeless persons' care	IKS 12	1
• Transport makes EMS unit unavailable for other true emergencies which can delay delivery of emergency care to people who really need it and result in poor outcome for them	IKS 4, 12	2
• Homeless persons know what complaint will trigger a transport to the ED	IKS 12	1
• Frequent users are a small subset of homeless persons	IKS 12	1

Note. Some IKSs expressed more than one theme so appear in more than one category

According to IKS 12:

> I think we feel the impact more than anybody. Because most people don't know what's going on. They see the homeless on the side of the road. They see them everywhere, but they don't realize how sick these people really are, both mentally and physically from not being medicated for normal ailments like blood pressure and diabetes, to not being able to do simple care of a wound.

He further elaborated that EMS services are being diverted to the care of homeless persons who are not getting their health care service needs met in primary care settings. That strain on EMS has resulted in delays in the delivery of life-saving treatment to people who experience medical emergencies. He said: "We've had people actually die because there was no ambulance there to

cover while we took care of a homeless minor event". See Appendix H, Comments of Individual Key Stakeholders on Homeless Persons' Use of Emergency Medical Services, for more commentary.

Use of the emergency department for health care services.

Use of the emergency department for health care services per individual homeless persons. Twenty-eight of 32 IHPs interviewed reported using the emergency department (ED) for health services with the remaining four IHPs reporting that they did not use the ED for services. All twelve of the IKSs interviewed commented on homeless persons' use of the ED. Table 4.9 displays IHPs' self-reported reasons for their use of the ED. Staph infections were the most frequently cited reason followed by injuries.

Table 4.9. *Individual Homeless Persons' (IHPs') Self-Reported Reasons for Emergency Department (ED) Use* (n=28)

Reason	**IHP**	**Number IHPs**	**Total IHPs**
Staph infection	IHP 10, 11, 14, 25, 27, 29, 31, 32	8	8
Injury:	IHP 2, 6, 7, 11, 21, 30	6	6
• Due to assault: head	IHP 2, 21	2	
rib pain	IHP 6	1	
• Lacerations	IHP 11, 30	2	
• Fracture	IHP 7	1	
Renal problems:	IHP 1, 5, 15, 19, 21	5	5
• Urinary tract infections	IHP 5, 15, 19	3	
• Acute kidney injury dehydration	IHP 1	1	
• Flank pain hematuria	IHP 21	1	
No other place to go	IHP 8, 14, 19, 24, 7	5	5
Asthma	IHP 4, 17, 18, 20	4	4
Prescription refills	IHP 5, 15, 26	3	3
Diabetes	IHP 20, 22	2	2
Chest pain, pneumonia	IHP 3	1	1
Abdominal pain	IHP 20	1	1
Centipede sting	IHP 17	1	1
Syncope	IHP 16	1	1
Methamphetamine overdose	IHP 7	1	1

Note. Some IHPs used the ED for more than one reason so are reported in more than one category

With regard to ED use, IHP 3 said he had been seen at the ED for chest pain. He said: "I just go ER. It's better. You get seen and they know what is wrong with you." Individual homeless person 14 had no health insurance or personal identification. He was planning to go to the ED for treatment of his hand that was swollen after an injury because he suspected that his hand was infected with staph. He had been treated at the ED previously for staph infection of leg wounds. He said:

> They have to see you, I know. They have to. Last time I went, they sent me a $900 bill for a two hour IV and a couple of sticks. That was it. Because I had infections on my legs. The same kind of staph… That's the only place I can go.

Individual homeless person 7 went to the ED for a fractured clavicle and said: "If anything ever happen, I would just go to the E.R.". For an additional account of what IHPs said about their reasons for going to the ED, see Appendix I, Individual Homeless Persons' Self-Reported Reasons for Emergency Department Use.

Use of the emergency department for health care services per individual key Stakeholders. All twelve of the IKSs interviewed commented on homeless persons' use of the ED. Table 4.10 displays frequent themes in interviews with IKSs on homeless persons' use of the ED.

Table 4.10. *Individual Key Stakeholders' (IKSs') Themes on Homeless Persons' Use of Emergency Department (ED) for Health Care Services* (n=12)

Themes	**IKS**	**Number IKSs**
Inappropriate use is overwhelming the ED	IKS 3, 4, 7, 8, 9, 12	6
Homeless persons often don't go to the ED until they are really sick with complications	IKS 1, 2, 4, 7, 10, 12	6
Homeless persons are sent to ED because people don't know where else to send them	IKS 3, 4, 8, 9, 12	5
Homeless persons go to ED instead of going to primary care for services	IKS 5, 6, 7, 11, 12	5

Note. Some IKSs had comments of more than one theme so are reported in more than one category

Individual key stakeholder 3 commented that: "I think this E.R… I think people get very, very good care. If anything, they get excessive care". With regard to homeless persons delaying getting services until they suffer unnecessary complications, IKS 4 said:

> The incentive to feel better isn't necessarily that much of a priority because you don't feel that bad to begin with. [IKS 4 imitated what an IHP might say.] "I can sit here under this coconut tree and split a 40 [referring to a 40 ounce beer] with my friend, or I can go see someone about my leg here. Ah, my leg's okay. Let's finish the 40." You know, that population, their mind sets are very different than ours. You say something like...that's very reasonable - and it may be very reasonable to me and you, but to them it's not - because their priorities are totally different. You know it's like "Well what kind of an idiot would do this?" An idiot who would rather get drunk.

The hesitancy of some homeless persons, with obvious medical needs requiring a visit to the ED was noted by IKS 1. He thought that they feel it is pointless to go to the ED because they are labeled by the staff, and therefore will not get the care that they need, regardless of how long they sit and wait in the ED.

People are sent to the ED because others in the community do not know what to do with them. Individual key stakeholder 3 said that people are brought to the ED because they are an eyesore, an inconvenience, inebriated and sleeping in a public place. One person, IKS 3 knew of, had 300 visits over a six year time period for inebriation.

Homeless persons go to the ED because they may be unable to get primary care services for their needs. According to IKS 7, the ED is extremely busy and the staff cannot address all the primary care needs and provide all the services homeless persons need. Misuse of EMS for primary care needs impacts the whole community. Persons having emergencies may have their treatment delayed if the paramedic ambulance unit is tied transporting a non-emergent homeless person to the hospital. Additional comments from IKSs on homeless persons' use of the ED are presented in Appendix J, Individual Key Stakeholders' Comments on Homeless Persons use of the Emergency Department.

Use of other sources of health care services by homeless persons.

Use of other sources of health care services per individual homeless persons. Table 4.11 includes other sources of health care services other than the ED, MIKOHC and EMS that IHPs used. See Appendix K, Comments from Individual Homeless Persons on Use of Other Sources of Health Care Services, for comments from IHPs.

Table 4.11. *Other Sources of Health Care Services per Individual Homeless Persons (IHPs)* (n=20)

Other Sources	IHP	Number
Maui Medical Group	IHP 17, 20, 21, 22, 23, 27	6
Private MD	None	0
Kaiser	None	0
Veterans Administration Clinic	None	0
Mental Health Kokua	IHP 15, 18, 30	3
Wailuku Mental Health	IHP 25	1
Psychiatrist or psychologist	IHP 6, 23, 26, 27	4
Received services during incarceration	IHP 14, 21, 25, 29, 30	5
Formerly seen by private MD	IHP 10, 16	2
Attempting to see private MD specialist	IHP 5	1
Formerly seen by Kaiser	IHP 32	1
Attempting to renew services from Mental Health Kokua	IHP 4	1

Note. Some IHPs have more than one source so appear in more than one category

Use of other sources of health care services by homeless persons per individual key stakeholders. The IKSs had some additional input about other sources of health care services for homeless persons. Other sources are represented in Table 4.12. The IKSs comments about the services can be found in Appendix L, Comments from Individual Key Stakeholders on Use of Other Sources of Health Care Services.

Table 4.12. *Use of Other Sources of Health Care Services per Individual Key Stakeholders (IKSs)* (n=6)

Other Sources of Health Care Services	IKS	Number
Chronic pain management: some physicians accept private pay patients	IKS 3	1
Residential substance abuse treatment: Aloha House	IKS 4	1
Mango Clinic: accepts Medicaid patients	IKS 8	1
Veterans Administration Clinic: does not accept dishonorably discharged veterans	IKS 4	1
Mental Health: • Crisis Line: phone resource for counseling • Partial Program at Molokini Unit: day program for selected insured patients • Wailuku Mental Health: does not accept dual diagnosis patients	IKS 4	1

Note. Some IKSs commented on more than one source so appear in more than one category

No source of health care.

No source of health care per individual homeless persons. All 32 IHPs interviewed were aware of the emergency department as a source of health care. Four chose not to see health care providers. Twenty-two were unable to get primary care services, or specialty services. Many

commented on having no source for dental care services. For themes from IHPs, see Table 4.13 *No Source of Health Care Services per Individual Homeless Persons.*

Table 4.13. *No Source of Health Care Services per Individual Homeless Persons (IHPs)* (n=32)

No Source of Health Care Services	**IHP**	**Number**	**Total**
Aware of emergency department as a source of health care	IHP 1-32	32	32
Choose not to use health care services	IHP 2, 9, 11, 13	4	4
Do not have a primary care provider	IHP 1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 19, 21, 24, 28, 29, 30, 32	22	22
Do not have a source of dental care services	IHP 1, 3, 4, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 25, 26, 28, 29, 30, 31, 32	26	26
Cannot get specialty services	IHP 5, 10, 15	3	3
• Urology	IHP 5	1	
• Psychiatry	IHP 10, 15	2	
• Neurology	IHP 15	1	

Note. Some IHPs appear in more than one category.

See Appendix M, Commentary from Individual Homeless Persons on Having No Source of Health Care Services for additional information. Comments on a lack of a source for dental care services can be found under unmet health care service needs for dental care.

No source of health care services per individual key stakeholders and group stakeholders. Six IKSs commented on the lack of services that result in homeless persons not getting care. Group stakeholders also commented on the lack of resources. See Table 4.14 *No Source of Health Care per Individual Key Stakeholders (IKSs) and Group Stakeholders (GS)*.

Table 4.14. *No Source of Health Care Services per Individual Key Stakeholders (IKSs) and Group Stakeholders (GS)* (n=7)

No Source of Health Care	IKS	Number	Total
Lack primary care services	IKS 6, 7, 9, 12	4	4
Insufficient detox facilities and substance abuse treatment services	IKS 6, 9	2	2
Lack of shelters homeless persons can be discharged to, where they can recuperate and receive care	IKS 8, GS	2	2
No wound care clinic	IKS 8	1	1
No pain management clinic	IKS 8	1	1
Mental Health • No walk-in mental health clinic • No intensive outpatient case management	IKS 9	1	1
Primary care services unavailable in some geographic areas	IKS 12	1	1
Hesitation on the part of providers to provide care to this population	IKS 10, 12	2	2

Note. Some IKSs appear in more than one category

Putting himself in the place of a homeless person on Maui, IKS 7 commented that he would have no idea where to go to get care for substance abuse, hypertension, heart problems, or any other health care needs. See Appendix N for more Commentary of Individual Key Stakeholders and Group Stakeholders on Homeless Persons Having No Source of Health Care Services.

Analysis of Unmet Health Care Need Node

Unmet health care needs from all interviewees. All sources identified unmet health care needs for homeless persons. The parent node unmet health care need can be exploded to show child nodes. See Table 4.15 *Unmet Health Care Need Node Exploded to Show Child Nodes* for a display of the number of IHPs, IKSs, and GS who identified unmet needs.

Table 4.15. *Unmet Health Care Needs Node Exploded to Show Child Nodes* (n=45)

Parent Node: Unmet Health Care Need **Child Nodes below**	**Number of Sources**
Other health matter or medical need	45
Wound and skin care	30
Dental care	28
Prescription medications	28
Pain management	19
Mental health and counseling	18
Substance abuse treatment	16
Vision services	16
Observed needs of pregnant women	13
Observation of needs of other non-pregnant adults by IHPs	12
Observed needs of children	11
Nutrition	11
Surgical services	2

Note. Interviewees likely appear with more than one theme

Other health or medical need, dental care, wound and skin care, and prescription medications were discussed by the most sources. There were a variety of other health and medical matters that were noted by IHPs, IKSs, and GS including urinary tract infections, contraceptive care, gynecologic care, and mammography; hypertension, congestive heart failure, and post-operative coronary artery bypass graft care; chronic obstructive pulmonary disease, asthma and pneumonia; chronic back pain, arthritis, diabetes and gastrointestinal problems due to spoiled food. In addition, some noted seizures, neuropathy, twitching and sequelae of old head injuries secondary to assault; lack of hygiene, sleep deficit, and lack of privacy; lack of durable medical equipment, lack of clothing and toiletries.

Unmet health care needs compared by number of sources who cited them. There is some agreement and some discrepancies between IHPs' and IKSs' perceptions of what the unmet health care needs of homeless persons are. See Table 4.16, *Comparison of Number of Sources for Unmet Health Care Needs* for a display of the number of sources who identified the different unmet health care needs.

The IHPS, IKSs, and GS were in agreement about three of the top five health care problems that remain unmet including: for wound and skin care, prescription medication, and other health matters and other unmet medical need. Dental care and vision service needs were noted by more IHPs compared to IKSs, while mental health or counseling and substance use/abuse treatment were noted more often by IKSs compared to IHPs.

Table 4.16. *Comparison of Number of Sources for Unmet Health Care Need* (n=45)

IHP Unmet Need	**Sources**	**IKS Unmet Need**	**Sources**	**GS Unmet Need**	**Sources**
Other and other medical	32	Mental health and counseling	12	Other and other medical	1
Dental care	24	Substance abuse treatment	12	Prescription medication	1
Prescription medication	17	Wound and skin care	12	Wound and skin care	1
Wound and skin care	17	Other and other medical	12		
Vision services	14	Prescription medication	10		
Observed needs of other non-pregnant adults	12	Pain management	8		
Pain management	11	Observed needs of children	6		
Observed needs of pregnant women	9	Nutrition	5		
Nutrition	6	Observed needs of pregnant women	4		
Mental health and counseling	6	Dental care	4		
Observed needs of children	5	Vision services	2		
Substance abuse treatment	4	Surgical services	1		
No unmet needs	3	No unmet Needs	0		
Surgical services	1	Other non-pregnant adults	Not applicable		

Unmet dental care needs.

Unmet dental care needs per individual homeless persons. Table 4.17 *Unmet Dental Care Needs of Individual Homeless Persons* displays some needs IHPs reported. Unmet need for dental care services was second most frequently identified by IHPs as an unmet health care need.

Table 4.17. *Unmet Dental Care Needs of Homeless Persons* (IHPs) (n= 26)

Unmet Dental Care Needs	IHP	Number	Total
Ongoing Unmet dental care needs	IHP 1, 3, 7, 8, 10, 12, 13, 14, 15 16, 17, 18, 19, 20, 21, 22, 23, 25, 26, 27, 28, 29, 30, 31	24	24
• Broken Teeth	IHP 1, 16, 25	3	
• Cavities	IHP 21, 26, 27, 30	4	
• Needs dentures	IHP 15, 17, 20, 22, 31	5	
• Needs extraction	IHP 30	1	
• Pain	IHP 8, 23, 29	3	
• Needs Braces	IHP 28	1	
• Needs cleaning and care	IHP 3, 7, 8, 12, 14, 22, 31	7	
• Oral infection	IHP 18, 27, 30	3	
Many years without dental care	IHP 4, 7, 8, 9, 13, 15, 21	7	7
History of extractions	IHP 9, 11, 17, 24, 27, 29	6	6

Note. Some IHPs appear in more than one category

The IHPs' responses were full of references to longstanding dental problems, wishes that they could get care, and frustration with inability to get services other than tooth extraction. For commentary from IHPs about their unmet needs for dental care, see Appendix O, Commentary on Unmet Dental Care Needs from Individual Homeless Persons.

Unmet dental care need of homeless persons per individual key stakeholders. Dental care service was identified by only four IKSs as an unmet health care service need of homeless persons. Those who cited it emphasized the lack of available services, other than extraction, (on Maui), for adults without dental care insurance coverage. See Appendix P, Commentary on Unmet Dental Care Needs of Homeless Persons by Individual Key Stakeholders, for additional commentary.

Unmet substance abuse treatment needs.

Unmet substance abuse treatment needs per individual homeless persons. For a display of unmet needs related to substance abuse treatment, see Table 4.18 *Unmet Substance Abuse Treatment Needs of Homeless Persons.*

Table 4.18. *Unmet Substance Abuse Treatment Needs of Individual Homeless Persons* (IHPs) (n=30)

Unmet Substance Abuse Treatment Needs	**IHPs**	**Number**	**Total**
Unmet need for substance abuse treatment for self	IHP 4, 7, 16, 26	4	4
• IHP is willing to enter treatment	IHP 7, 16	2	
• Has considered substance abuse treatment but is not willing to do it at the time of the interview	IHP 4, 26	2	
Current substance use	IHP 3, 4, 6, 7, 10, 11, 14, 16, 21, 22, 26, 29, 30, 31	14	14
• Currently uses alcohol	IHP 3, 4, 7, 10, 11, 14, 21, 26, 30, 31	10	
• Currently uses drugs	IHP 6, 7, 26, 29, 30, 31	6	
• Currently uses tobacco	IHP 10, 16, 22, 31	4	
Knows other homeless persons with unmet substance abuse treatment needs	IHP 3, 7, 11, 12, 28	5	5
Alcoholics Anonymous (A.A.) meeting participation	IHP 7, 16, 26, 32	4	4
• Participates in A.A. meetings	IHP 7, 26, 32	3	
• Willing to participate in A.A. meetings	IHP 16	1	
IHP does self-treatment with Bible study	IHP 31	1	1
Previous substance use	IHP 3, 7, 16, 21, 23, 25, 29	7	7
• Previously drank alcohol heavily	IHP 3, 16, 21, 23, 25, 29	6	
• Previously did drugs	IHP 7, 23, 25	3	
Previous substance abuse treatment	IHP 1, 6, 7, 21, 23, 25, 27, 29	8	8
• Previous substance abuse treatment was not helpful	IHP 7	1	
Denial of need for substance abuse treatment	IHP 1, 3, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 20, 21, 22, 23, 25, 27, 30, 32	22	
• Does not drink alcohol	IHP 8, 12, 15, 20, 22, 23, 24	7	
• Does not do drugs	IHP 8, 12, 14, 15, 20, 22, 23, 24	8	

Note. Some IHPs appear in more than one category

Unmet needs for substance abuse treatment for self were only cited by four IHPs. Two of these, IHP 7 and IHP 16, said they would be interested in having substance abuse treatment for themselves, although neither had health insurance. Individual homeless person 4, and IHP 26 were thinking over the devastating impact of substance abuse on their circumstances, but were not ready to commit to treatment. Individual homeless person 4 had lost custody of her son. Individual homeless person 26, who did not have her three children with her, said she was pregnant. It was not clear if IHP 26 had lost custody of the children. Individual homeless persons three, seven, 11, 12, and 28 spoke of the need for substance abuse treatment they see in other homeless persons.

Four IHPs either go to an Alcoholics Anonymous (A.A.) meeting at times, or are ready to go. One, IHP 31, does self-care treatment for substance abuse by reading the King James Bible. See Appendix Q, Commentary on Unmet Substance Abuse Treatment Needs by Individual Homeless Persons.

Unmet substance abuse treatment needs of homeless persons per individual key stakeholders. For a display of unmet needs related to substance abuse treatment, see Table 4.19 *Unmet Substance Abuse Treatment Needs per Individual Key Stakeholders*. One hundred per cent of the IKSs identified substance abuse treatment as an unmet health care need among homeless persons on Maui, compared to only 12.5 per cent of IHPs who identified it as an unmet need for themselves (four). The idea that substance abuse leads to homelessness and poor health was expressed by many IKSs, as well as that homelessness can lead to substance abuse. They also expressed frustration with attempts to treat homeless persons with substance abuse disorders. Comments from IKS 7 follow:

> IKS 7: And then there's a huge population with substance abuse problems predominantly alcohol, which you know again because their disease of addiction is active and they're not seeking any help for it, uh… that in itself is a problem because they get thrown in jail all the time for it, and, and [emphasis] it's a problem because they don't pay attention to any of the other medical problems, particularly skin and soft tissue. So we end up admitting them endlessly to the hospital because of skin and soft tissue infections. And their primary problem is their alcohol which keeps them on the street.

Table 4.19. *Unmet Substance Abuse Treatment Needs per Individual Key Stakeholders* (IKSs) (n=12)

Unmet Substance Abuse Treatment Needs	IKSs	Number	Total
Homeless persons have an unmet need for substance abuse treatment	IKS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	12	12
Substance abuse leads to homelessness and poor health	IKS 1, 2, 3, 4, 7, 8, 10, 12	8	8
Homelessness can lead to substance abuse	IKS 6, 9, 10, 12	4	4
Many homeless persons have combined problems of substance abuse and mental illness	IKS 2, 4, 5, 6, 7, 9, 10, 11, 12	9	9
Unmet need for substance abuse treatment services. More substance abuse treatment services are needed on Maui	IKS 3, 4, 6, 7, 9, 10, 11, 12	8	8
Homeless persons substance abuse strains the health care system	IKS 3, 4, 6, 7, 9, 12	6	6
Homeless persons abuse the health care system with drug-seeking behavior	IKS 3, 12	2	2
Homeless persons' substance abuse creates problems:	IKS 1, 2, 4, 6, 7, 8, 10, 11, 12	9	9
• Substance abuse complicates medical problems	IKS 1, 6, 7, 12	4	
• Substance abuse results in poor compliance with treatment plans	IKS 4, 8, 10, 11, 12	5	
• Substance abuse interferes with getting shelter	IKS 1, 11, 12	3	
• Substance abusers don't want to change	IKS 4	1	
• Substance abuse repels health care professionals	IKS 1, 4, 11, 12	4	
• Some homeless persons have given up hope that they can recover from substance abuse	IKS 2	1	

Note. Some IKSs appear in more than one category

For more commentary by IKSs on unmet substance abuse treatment needs, see Appendix R, Commentary on Unmet Substance Abuse Treatment Needs by Individual Key Stakeholders.

Unmet mental health or counseling needs.

Unmet mental health or counseling needs of individual homeless persons. Many IHPs reported a history of mental health problems and a need for services. Almost half of the IHPs denied interest in receiving mental health care or counseling services. See Table 4.20 *Unmet Mental Health or Counseling Needs of Individual Homeless Persons* for a display of themes of their comments.

Table 4.20. *Unmet Mental Health or Counseling Needs of Individual Homeless Persons* (IHPs) (n=32)

Unmet Mental Health or Counseling Need	**IHPs**	**Number**	**Total**
Unmet need for mental health or counseling services. Not receiving currently, but would accept mental health or counseling services	IHP 2, 4, 10, 16, 19, 28	6	6
Self-reports extensive psych history	IHP 4, 6, 15, 18, 19, 26, 28	**7**	**7**
Self-reports being a victim of abuse	IHP 15, 16, 19	3	3
Self-description consistent with mental health needs	IHP 4, 6, 9, 10, 13, 14, 20, 28	8	8
• Depression	IHP 4, 20	2	
• Unresolved grief	IHP 4, 20	2	
• Wants to harm self	IHP 6	1	
• Overwhelming personal stressors	IHP 10, 14	2	
• Everyone else is crazy	IHP 9	1	
• Off usual psych medication	IHP 28	1	
• Undergoing spiritual transformation	IHP 13	1	
Reports difficulty making arrangements for mental health or counseling services	IHP 4, 10, 15, 28	4	4
Currently receiving mental health or counseling services	IHP 6, 15, 18, 23, 25, 26, 27, 30, 31	9	9
Not interested in mental health or counseling services	IHP 3, 5, 7, 8, 9, 11, 12, 13, 14, 17, 20, 21, 22, 24, 32	15	15
Uncertain if interested in mental health or counseling services	IHP 29	1	1
Interest in mental health or counseling services not elicited	IHP 1	1	1

Note. Some IHPs appear in more than one category

Six IHPs identified a personal unmet need for mental health or counseling services. Fifteen of 32 persons interviewed didn't feel a need for counseling or mental health services. Despite his desperate situation, including his apparently infected wounds, lack of resources, the loss of his professional standing, his substance use, losing track of time, his history of incarceration, and the threat of being incarcerated again, IHP 14 did not feel he had mental health issues. He just felt he was facing some stressors as noted in an excerpt from his interview:

> *CPZ: How about any needs for counseling, talking to somebody, mental health care?*
>
> IHP 14: Mental health... I don't know if I'm mentally there...but uh...just right now my only major mental issue is the fact that I'm probably going to be really, really on the streets soon. They're actually going to kick me to the curb.
>
> *CPZ: Because of the security on the property?*
>
> IHP 14: Just because of the fact that I can't go back there anymore. They're going to

literally make sure that we can't go back there or we'll be arrested.

CPZ: Oh.

IHP 14: So I'm literally, like a couple of nights ago

CPZ: You need an alternative.

IHP 14: I slept behind Times over there because I couldn't get back. It was just, it was just, you know...I can't get arrested. Because that's so stupid. I'm not going to go to jail [emphasis] for trying to get into my house, my place. [He referred to an abandoned van which he did not own that was in a dry gulch on someone's else's private property as his place.] They were down there today with cops and roll out dumpsters. It was a situation. So...that's where we're at now. But other than that, my attitude's good.

A little overcome, but still this is a problem, it's not going...

CPZ: It's a stress

IHP 14: Yeah it's a stress. But other than that, mentally, I don't think I have any problem.

For more commentary from IHPs on unmet needs for mental health or counseling services, see Appendix S, Commentary on Unmet Mental Health and Counseling Service Needs by Individual Homeless Persons.

Unmet mental health or counseling needs of homeless persons per individual key stakeholders. All 12 IKSs identified mental health problems as a major issue for homeless persons. For a display of themes of their comments see Table 4.21 *Unmet Mental Health or Counseling Service Needs of Homeless Persons per Individual Key Stakeholders*.

Table 4.21. *Unmet Mental Health or Counseling Service Needs of Homeless Persons per Individual Key Stakeholders* (IKSs) (n=12)

Unmet Mental Health or Counseling Need	IKSs	Number	Total
Homeless persons have an unmet need for mental health or counseling services	IKS 1-12	12	12
Homelessness is a stressor on mental health	IKS 1, 6, 9, 10	4	4
Homeless persons have combined mental health and substance abuse problems	IKS 2, 4, 5, 6, 7, 9, 10, 11, 12	9	9
Behavioral problems are difficult to treat	IKS 10	1	1
• Persons have poor social skills and problems with anger management			
Unmet need for mental health or counseling services. Available services are inadequate	IKS 3, 4, 6, 8, 9, 10	6	6
• No adolescent unit at hospital	IKS 3, 4	2	
• Wailuku Mental Health Center does not treat those with alcohol problems	IKS 4	1	
• Services are overwhelmed so patients may be misdiagnosed and given wrong medication	IKS 6	1	
• Need for more mental health outreach	IKS 8	1	
• Need a community mental health service that will actually take patients	IKS 9	1	
• Need walk-in mental health services with case management to stabilize persons before they need to be in the ED	IKS 9	1	
• Need county funding for mental health services	IKS 9	1	
• Need long term housing with support services	IKS 9	1	
• Inadequate follow-up services	IKS 9	1	
• Inadequate funding for case management services	IKS 10	1	
• Inadequate number of mental health providers	IKS 3	1	
	IKS 3, 4	2	
Follow-up is inadequate	IKS 4, 8, 9, 10	4	4
• No contact information for homeless person interferes with follow-up	IKS 4	1	
• Need assistance with transportation to appointments and filling prescriptions to bring about follow-up	IKS 9	1	
• Persons don't comply with appointments and medications	IKS 8, 10	2	

Table 4.21. (Continued) *Unmet Mental Health*			
Homeless persons with mental health problems have traits that make treatment difficult	IKS 2, 4, 5, 7, 9, 10, 12	7	7
• Persons have given up hope of recovery	IKS 2	1	
• Persons may be off their medications and destabilized	IKS 5, 7, 9, 12	4	
• Poor compliance effects treatment outcomes	IKS 4	1	
• Services are available but persons are selective about using them	IKS 4	1	
• Personality disorders	IKS 10	1	
• Persons' friends and associations complicate their treatment	IKS 10	1	
• Persons manipulate the health care system with threats of suicide	IKS 9, 12	2	
• Persons' substance abuse problems must be addressed to make progress in mental health treatment	IKS 12	1	
• Persons express entitlement to services	IKS 5	1	
Expectations about what homeless mentally ill persons can accomplish functionally should be raised	IKS 9	1	1

Note. Some IKSs appear in more than one category

In contrast to the IHPs, nearly half of whom said they did not need mental health or counseling services, all of the 12 IKSs interviewed acknowledged that homeless persons on Maui have unmet needs for mental health and counseling services. Six of twelve noted the inadequacy of available services on Maui. Individual key stakeholder 9 described the lack of any county or state walk-in mental health service where individuals might be smoothed-out and stabilized. He said the lack of such a service results in persons with mental health needs going to the ED for care. Seven of 12 IKSs thought that homeless persons with mental health problems have traits that make it difficult to treat them. For homeless persons with schizophrenia or other psychiatric diagnoses, the disorder itself may lead the person away from treatment, and instead, to being out wandering the streets, per IKS 7.

Nine of twelve IKSs noted that homeless persons commonly have both substance abuse and mental health problems. Per IKS 12, their substance abuse interferes with compliance with treatment for their mental health problems. Four noted that lack of follow-up with homeless persons may interfere with their treatment. Per IKS 9, there is not adequate case management

follow-up to be sure patients fill their medication prescriptions and have transportation to their appointments. The group stakeholders did not address mental health or counseling service needs. For more commentary, see Appendix T, Commentary on Unmet Mental Health and Counseling Service Needs of Individual Homeless Persons by Individual Key Stakeholders.

Unmet wound and skin care needs.

Unmet wound and skin care needs per individual homeless persons. Many IHPs described wound care problems and needs they have had while being homeless – either currently, or in the past. They also described wound care needs they have seen in other homeless persons. For a display of these results, see Table 4.22 *Unmet Wound and Skin Care Needs per Individual Homeless Persons*.

Table 4.22. *Unmet Wound and Skin Care Needs per Individual Homeless Persons* (IHPs) (n=32)

Unmet Wound Care Needs	**IHPs**	**Number**	**Total**
Current unmet wound or skin needs	IHP 2, 6, 10, 11, 14, 15, 16, 18, 19, 20, 21, 22, 25, 26, 27, 28, 31	17	17
• Open wound	IHP 2, 10, 11, 14, 15, 16, 21, 27, 28	9	
• Infected wounds	IHP 10, 14, 21	3	
• Insect bites	IHP 14, 16, 22, 28	4	
• Sunburn	IHP 19	1	
• Assault injury	IHP 6	1	
• Chronic wound	IHP 18, 19, 21	3	
• Dry skin	IHP 25, 26	2	
• Need supplies for wound care	IHP 2, 10, 14, 22, 31	5	
No current unmet wound or skin needs	IHP 1, 3, 4, 5, 7, 8, 9, 12, 13, 17, 23, 24, 29, 30, 32	15	15
Other homeless persons have unmet wound care needs	IHP 1, 7, 11, 22, 24, 25	6	6
Risk of staph infections is a great concern	IHP 1, 2, 10, 11, 14, 15, 27, 29, 32	9	9
Past ED visit or hospitalization for infected wounds while homeless	IHP 10, 14, 27, 29, 32	5	5
Past ED visit or hospitalization for wounds from assault while homeless	IHP 2, 6, 7, 21, 25, 30	6	6
Challenge of keeping wounds clean while homeless	IHP 2, 7, 9, 11	4	4
Wound care is the number one unmet health care need of homeless persons	IHP 7	1	1

Note. Some IHPs appear in more than one category

Seventeen of 32 IHPs had some unmet wound or skin care need. Both IHP 10 and IHP 14 had swollen, erythematous wounds with purulent drainage that appeared to the DNP student and to the IHPs, to be infected. Both IHP 10 and IHP 14 had barriers to getting treatment for their wounds. Here is some notable commentary from IHP 10.

During the interview, IHP 10 was drinking from an open beer container. She described being under a great deal of stress with lack of transportation due to her car break down, having problems with her boyfriend, having her dog taken away and put to sleep, and losing her daughter to foster care. Here is an excerpt of the dialogue with her during her interview:

CPZ: Do you have any unmet health care service needs?

IHP 10: Do I have any unmet?

CPZ: Any health care service needs?

IHP 10: Yeah. I fell off my bike.

CPZ: Oh.

IHP 10: And I burned my hand really bad. So, I wanted to go in today because I'm getting infected.

CPZ: Oh. Oh.

IHP 10: And I can't grab anything. Can't use my hands. I'm like Ahhh.

CPZ: They hurt when you move your joints?

IHP 10: Yeah. And I have a really bad burn on my thumb. And my palms are like useless.

CPZ: Is it like from a campfire?

IHP 10: Yeah. I grabbed a pot.

CPZ: Oh. Uh oh.

IHP 10: Like, you know, it was like half way covered up this part, and then what I used wasn't covering my hand all the way.

CPZ: How long ago?

IHP 10: Couple days now. But now it hurts really bad. So.

CPZ: I wonder if it's infected.

IHP 10: You know it's starting, like how burns do that anyway.

CPZ: Sure looks that way.

IHP 10: They’re starting to turn like green.

CPZ: Yeah. So let's see. You got 'em on your hand, on your

thumb, on your knuckles there. And anywhere else.

IHP 10: These are just scrapes from

CPZ: Those are from your bike…

CPZ: [Pointing to a bruise near her eye] *Looks like you have a little bruise there. Was that the same day you burned your hands?*

IHP 10: Yeah.

CPZ: And it sounds like you've been at the emergency department recently.

IHP 10: Ah. Yeah.

CPZ: For...

IHP 10: A staph infection.

For more commentary, see Appendix U, Commentary on Unmet Wound and Skin Care Needs by Individual Homeless Persons.

Unmet wound and skin care needs of homeless persons per individual key stakeholders. All of the IKSs commented on unmet needs for wound and skin care, so that it ranked in the top three unmet needs named by IKSs. See Table 4.23, *Unmet Wound and Skin Care Needs of Homeless Persons per Individual Key Stakeholders*, for a display of themes.

Table 4.23. *Unmet Wound and Skin Care Needs of Homeless Persons per Individual Key Stakeholders* (IKSs) (n=12)

Unmet Wound and Skin Care Needs	**IKSs**	**Number**	**Total**
Wound and skin problems are one of the most common unmet health problems of homeless persons	IKS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	12	12
Need for homeless person behavior change: homeless persons often don't adequately tend to their own wound and skin problems	IKS 1, 2, 3, 4, 5, 6, 7, 8, 10, 12	10	10
Need for homeless persons' behavior change: unwillingness to go in for medical treatment results in wound complications	IKS 1, 4, 7, 12	4	4
• Has resulted in maggot infested wounds	IKS 1, 12	2	
Need for health care provider behavior change: unwillingness of homeless persons to go in for medical treatment results in wound complications	IKS 1, 2	2	2
• Experience of prejudice and judgment from health care providers makes them unwilling to seek services	IKS 2	1	
• Recollection of unsatisfactory health care experiences may make them unwilling to go in	IKS 1	1	
Homeless person need for behavior change: substance abuse interferes with wound treatment	IKS 4, 6, 7, 11, 12	5	5
Mental illness complicates wound treatment	IKS 7, 9	2	2
Need for homeless person behavior change: homeless persons have poor compliance with wound treatment plans	IKS 4, 5, 6, 8	4	4
• Poor compliance with antibiotic therapy and dressing orders	IKS 5	1	
• Health care providers may not understand incompatibility of treatment instructions with homeless way of life	IKS 6	1	
• Poor follow-up with hospital discharge instructions	IKS 8	1	
Lack of good hygiene effects wound and skin complications	IKS 2, 4, 6, 10	4	4
Sick from lack of basic health care	IKS 7, 12	2	2
Need more focus on encouraging self-care of wounds	IKS 1, 2, 3	3	3

Table 4.23. (Continued) *Unmet Wound and Skin*			
Unmet need for wound care services	IKS 6, 7, 8, 9, 12	5	5
• No walk-in clinic	IKS 9, 12	2	
• No wound care clinic	IKS 8, 12	2	
• If IKS were homeless, he wouldn't know where to get care on Maui	IKS 7	1	
• No clean, short-term place to stay and heal wounds after hospitalization	IKS 7, 8	2	
○ Prolongs hospital length of stay	IKS 8	1	
○ Difficult to place	IKS 8	1	
• Results in revolving door hospital readmissions	IKS 7, 8	2	
• Homeless persons take advantage of cellulitis to get admission to hospital stay	IKS 3	1	
• No home health services currently available for the homeless	IKS 8	1	
• Lack of providers who will accept them as outpatients	IKS 8, 12	2	
Homeless persons wound and skin complications impacts others	IKS 3, 6, 12	3	3
• Cost of prolonged hospital stay	IKS 3	1	
• Homeless persons not concerned about costs to others	IKS 3, 6	2	
• Ties up ambulance, delaying emergency response to others and resulting in loss of life to others having emergencies	IKS 12	1	

Note. Some IKSs appear in more than one category

According to IKS 6, he encountered a high prevalence of wound infections that appeared to him to be staph infections, during his work with homeless persons. Here is an excerpt from the interview with him:

> IKS 6: I know that I have to be very cautious because I work directly with uh houseless people, and I work with a lot, probably 70% have staph infections.
>
> *CPZ: So you see 70% of people with pussy looking wounds that aren't healing.*
>
> IKS 6: Yup. At least.
>
> *CPZ: They're just getting worse.*
>
> IKS 6: Just getting worse. Uh…it's more the alcoholics, the drunks that I deal with that have that issue more than other people because just simply, they're inebriated half the time, so they don't take care of themselves, until it gets too late and then they can't hardly walk… Or you know, they find themselves so fatigued from the infection, that they wind up using an ambulance to go up to the hospital. You know typically, after a

> couple of days at the hospital, they're better because they've detoxed and you know, they've gotten some treatment on whatever it is. But even that client that I mentioned from Kihei, you know, he just…he doesn't have any intention of taking care of himself at all. But I think if there was, you know, more availability for somebody to get to health care, or health care coming to them – that would help.

Individual key stakeholder 8 noted the lack of a wound care clinic as an unmet health care service need for homeless persons on Maui. She commented that if homeless persons had a place to stay after hospital discharge, they could get spot-checks of their wounds to make sure that they were healing on an outpatient basis. At one point, IKS 8 said she did a "spot" survey at the hospital and found 20 homeless persons in the hospital with a diagnosis of cellulitis, occupying almost 10 % of the hospital beds. For more commentary, see Appendix V, Commentary on Unmet Wound and Skin Care Needs of Homeless Persons by Individual Key Stakeholders.

Unmet wound and skin care needs of homeless persons per group stakeholders. The hospital social workers, as group stakeholders (GS), commented that discharges are complicated for homeless persons with wounds. The social workers are unable to arrange for a patient to be discharged to Family Life Center with a wound vacuum because the wound vacuum requires electricity to operate. Clients are required to leave the shelter during the day. So the person with a wound vacuum would not have an electricity source during the day to operate the machine. If patients need intravenous antibiotics and are unable to make it to the hospital daily, they are kept in the hospital for treatment that, had they had transportation and a place to stay, they could have received on an outpatient basis. That is very expensive for the hospital.

Other unmet needs and other medical unmet needs.

Other unmet needs and other medical unmet needs of individual homeless persons. Other unmet health care needs and other unmet medical needs were needs outside of the categories of the semi-structured questions of the interview. Other unmet health care and other unmet medical needs was the category with the highest frequency of IHP sources. Here the two categories of other unmet needs and other medical unmet needs are combined because of their considerable overlap. For a display of these, see Table 4.24 *Other Unmet Needs and Other Unmet Medical Needs of Individual Homeless Persons*.

Table 4.24. *Other Unmet Needs and Other Unmet Medical Needs of Individual Homeless Persons* (IHPs) (n=32)

Other and Other Medical Unmet Needs	**IHPs**	**Number**	**Total**
Unmet housing or shelter needs	IHPs 1-32	32	32
• Safe campground okay	IHP 1, 9, 11, 13, 29	5	
Unmet need for restful sleep	IHP 11, 14, 17, 27, 28, 32	6	6
Unmet need for hygiene	IHP 2, 9, 12, 14	4	4
Unmet need for privacy	IHP 13	1	1
Unmet need for durable medical equipment	IHP 15, 18	2	2
Unmet need for caregiver	IHP 20	1	1
Unmet need for chiropractic care	IHP 29	1	1
Unmet need for naturopathic medicine	IHP 29	1	1
Unmet need for medical marijuana license	IHP 29	1	1
Unmet need for imaging - CT scan or x-ray	IHP 30, 31	2	2
Unmet need for gynecologic or genitourinary care	IHP 5, 15, 19	3	3
Unmet need for asthma care	IHP 4, 5, 18, 20	4	4
Unmet need for diabetes management	IHP 19, 20, 22	3	3
Unmet need for physical exam to assess for diabetes, kidney problems, liver problems	IHP 11	1	1
Fatigue	IHP 14	1	1
Unmet need for high blood pressure treatment	IHP 16	1	1
Others not specified	IHP 24	1	1

Note. Some IHPs appear in more than one category

All 32 IHPs mentioned their needs for housing or consistent shelter or a safe camping ground. Five IHPs would welcome continued camping in a stable place where they were allowed to stay. Individual homeless person nine was accepting of being "houseless" and spoke philosophically:

> IHP 9: So it's a sense of security. Like I feel you can carry your home where you are. And wherever you go is where you belong. And where you want to feel safe. So it becomes an inner journey. And. And it is just a journey. A little Buddhism, a little Christ. [Laughs] it'll help.
>
> *CPZ: Helps get you through.*
>
> IHP 9: I think so.

She imagined what a safe and secure living situation might be for her in this excerpt:

> IHP 9: I would like to sit on a piece of land, even if a tent or a small home, or cottage or whatever, and grow food. And a lot of people want that. A lot of women, a lot of people I

know want that. We could be happy on a piece of property [emphasis]. Like if someone would let us put a tent on a property without a house.

CPZ: Just a place where you could put your tent and not get chased out.

IHP 9: Yeah. Where you could come and go without being worried. You can make awesome food. And establish a real community or just get real interconnected with nature - simple [emphasis on simple]. We don't have money. We can't expect to have a car and T.V. and all this stuff. You know. So it could be very, very simple. But we need the peace, and the fresh air, and the water. You know. And a lot of women they would like to grow, they would weave, they would sew, you know, they would play music. And to have a space where you could really bring your creative self. And not have conformed expectations of what life is supposed to be.

Most other IHPs wanted the safety of actual housing. Six IHPs spoke of being chronically sleep-deprived. They were unable to get restful sleep due to insects, the locations they chose for sleep, and wakefulness due to wariness of the risk of other persons stealing their possessions. They also voiced concern about others assaulting them, and the disruption of being awakened, and told to move on.

Individual homeless person 27 spoke about the need for rest in order to heal. He said he is in his 50s now and has been living outside since he was a teenager. He felt it was getting too difficult for him to tolerate the stress of being homeless, unlike when he was younger. He felt that he was deteriorating physically and would die unless he found a home:

IHP 27: Just that because, when you get housing you can sleep [emphasis] with a clear mind with nobody sneaking up around you.

CPZ: Uh huh.

IHP 27: Cuz even the psychologist said, "If you sleep outside, you guys never do sleep. You guys think you do sleeping, but half your mind stay wide awake because you worried about people crawling on you." Yeah.

CPZ: You're worried about your safety.

IHP 27: Yeah. Besides the insects and everything else. So, you never do sleep. They say homeless people never sleep. They think they sleep, but they no sleep. Yeah because their mind up. One third of their mind stay up in case somebody crawl on 'em.

CPZ: Uh huh.

IHP 27: That's what makes it hard. Because you put one homeless person on a bed and give him three days in that room, that person gonna be snoring with the door locked. That's sleeping.

CPZ: Recovering.

IHP 27: That's sleeping.

CPZ: Getting a deep sleep.

IHP 27: The body can heal that way.

Four IHPs spoke of the need for better hygiene facilities. Individual homeless person 9 wished for hot showers, and bathrooms that stay open for 24 hours. Individual homeless person 13 spoke of how challenging it is to assure moments of privacy when you are living outside.

Health care that is an out-of-pocket expense was difficult to obtain such as chiropractic care, a twenty-four hour caregiver, naturopathic treatments and medical marijuana. Durable medical equipment items such as a walker, leg braces, and a nebulizer for asthma treatment were challenging to get insurance to pay for. Radiographic imaging that two IHPs mentioned that they wanted but was not deemed medically necessary was not covered by insurance and not affordable. Individual homeless person 30 spoke about needing CT scans done of his head and neck for old workplace injuries he wanted to get a monetary settlement for. Individual homeless person 31 wanted his whole body x-rayed so he could study his bones and better understand his family history. Individual homeless person 12 said he had a punctured ear drum but wasn't planning to seek health care services.

Three IHPs had gynecologic or genitourinary problems for which they needed treatment. IHP 10 felt she needed the services of a "good woman doctor" because she had not had a check-up in a long time. She was concerned she had a yeast infection and a stress ulcer. In addition, IHP 16 said she had avoided women's health care because she was "kind of shy down there" after being molested as a child. Although she is in her fifties, she has never had a mammogram and has had only one Pap smear in her life.

Four IHPs had poorly managed asthma. Individual homeless person 17 stated she has asthma and finds getting rest very difficult at the shelter because of the kids running around screaming and shouting there. Individual homeless person 5 commented that he has had chronic urinary tract infections with multiple emergency department visits. When the DNP student spoke with him, he was attempting to get an appointment with a urologist, and waiting for a call back on a phone he

had borrowed. He also had asthma, and reported an instance when after losing his inhaler, he had an asthma attack. He said that he called the ambulance when his face turned purple and he could not breathe. The paramedics gave him an inhaler to use and he felt better after using it, thereby not requiring a trip to the emergency department. He said if he personally had an inhaler at the time of the asthma attack, that he would have been fine and would not have needed to call the ambulance.

Individual homeless person 7 said he had knee problems and back problems from playing football. He also reported having sustained brain damage from multiple causes including playing football, alcohol use, methamphetamine use, physical assaults and a work place exposure to toxic paint fumes. He said that he had muscle and nerve injuries, and that his muscles twitched all day long. Individual homeless person 15 said she needs a neurologist's care for neuropathic leg problems and for a seizure disorder.

Three IHPs had poor diabetes management while they were homeless. Individual homeless person 16 had a high blood pressure recorded which she had not followed up about with a health care provider. Individual homeless person 14 had chronic fatigue but he had not visited a health care provider to have the symptom evaluated. Individual homeless person 11 wondered about why he had a swollen foot and thought he should be checked for diabetes, kidney problems, or liver problems.

Individual homeless person 19 had a bladder infection and a persistent parasitic skin infection that caused her itching and discomfort for years. Individual homeless person 21 said he suffered from migraines, blood in his urine, and a fatty liver. Individual homeless person 24 said that he had health problems and realized that he was playing a time game -- hoping that his health problems would not become worse because he was without insurance. He did not elaborate on the specific health problems that he had. For more commentary, see Appendix W, Other Unmet Needs and Other Unmet Medical Needs per Individual Homeless Persons.

Other unmet needs and other unmet medical needs of homeless persons per individual key stakeholders. Due to the overlap of the categories of other unmet needs and other unmet medical needs per individual key stakeholders, they are reported together in Table 4.25. For themes on these categories, see Table 4.25 *Other Unmet Needs and Other Unmet Medical Needs of Homeless Persons per Individual Key Stakeholders*.

Table 4.25. *Other Unmet Needs and Other Unmet Medical Needs of Homeless Persons per Individual Key Stakeholders* (IKSs) (n=12)

Other and Other Medical Unmet Needs	**IKSs**	**Number**	**Total**
State of homelessness interferes with being able to get care	IKS 6, 12	2	2
Unmet need for housing	IKS 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12	11	11
• Need for shelter where they can continue to recuperate after hospital discharge	IKS 2, 4, 6, 7, 8, 10,11	7	
• Supportive housing	IKS 1, 9, 10	3	
• Congregate housing	IKS 10	1	
• Affordable housing units	IKS 2, 6	2	
• Cubicles	IKS 3	1	
• Sober living housing	IKS 6	1	
Unmet need for hygiene centers with showers	IKS 1, 10	2	2
• Located at feeding centers	IKS 10	1	
Unmet need for help to heal their response to experiences in their lives	IKS 6	1	1
Unmet need for compassionate care without judgment	IKS 1, 2, 6, 7	4	4
Unmet need for tough love	IKS 3	1	1
Unmet need for motivation	IKS 4	1	1
Unmet need for education about self-care	IKS 2, 3	2	2
Unmet need for easy way to replace lost or stolen identification	IKS 2	1	1
Unmet need for place to receive mail	IKS 6	1	1
Unmet need for call center for making and receiving phone calls	IKS 6	1	1
Unmet need for care for medical problems people are hesitant to talk about: HIV, AIDS, tuberculosis, hepatitis C	IKS 2	1	1
Unmet need for health care providers who will take them as patients	IKS 3, 4, 5, 7, 8, 12	6	6
• Homeless persons have a stigma	IKS 3	1	
• Health care providers in West Maui needed	IKS 12	1	
• Specialty care – orthopedics, urology	IKS 5	1	
• Easier entry to MIKOHC	IKS 1, 6, 7	3	
• Counseling group	IKS 4	1	
• Women's health care	IKS 6 ,7	2	
○ Contraceptive services	IKS 6	1	
• Comprehensive care	IKS 10	1	
Unmet need for health outreach	IKS 1, 2, 8, 10, 12	5	5
• Outreach visits at feeding centers	IKS 10	1	

Table 4.25. (Continued) *Other Unmet Needs*

Unmet need for outpatient clinic to help people before they need hospitalization	IKS 9, 12	2	2
Unmet need for walk-in clinic	IKS 1, 4, 6, 8, 9, 12	6	6
• Wound clinic	IKS 8, 12	2	
• Mental health clinic	IKS 9, 12	2	
• Pain management clinic	IKS 8	1	
Unmet need for emergency dental services	IKS 5	1	1
Unmet need for detox facility	IKS 9	1	1
Unmet need for follow-up care	IKS 5, 8, 9, 10, 12	5	5

Note. Some IKSs appear in more than one category

Eleven of the 12 IKSs spoke about housing as a way to reduce unmet medical needs of homeless persons on Maui. Individual key stakeholder 10 offered his thoughts about the need for congregate housing which would concentrate homeless persons in one area, making it feasible to provide support services that they need to survive. He felt scattering homeless persons in isolated housing without support services would result in their death -- "You gonna find 'em dead". Individual key stakeholder 6 validated IHP 10's perspective about the need for supportive services to help keep people housed. He said:

> Even if you've got the house, you need to have the supportive services along with the housing. So that the people can continue to keep the housing. And that ultimately will make them healthier. You know, whether it's physically or mentally. It can do both.

Six IKS participants commented on the need for health care providers who would accept homeless persons, and IKS 7 spoke of the need for a safety net clinic that will actually accept them as patients. For additional commentary by IKSs, See Appendix X, Commentary of Individual Key Stakeholders on Other Unmet Needs and Other Unmet Medical Needs of Homeless Persons.

Other unmet needs and other unmet medical needs of homeless persons per group stakeholder hospital social workers. In their group response, GS focused on the unmet needs of homeless persons related to their discharge from the hospital. See Table 4.26 *Other Unmet Needs and Other Unmet Medical Needs of Homeless Persons per Group Stakeholder Hospital Social Workers.*

Table 4.26. *Other Unmet Needs and Other Unmet Medical Needs of Homeless Persons per Group Stakeholder Hospital Social Workers* (GS)

Other and Other Medical Unmet Needs	GS	Number	Total
Unmet need for housing or shelter where they can continue to recuperate after hospital discharge	1	1	1
Unmet need for easy way to replace lost or stolen identification	1	1	1
Unmet need for replacement of durable medical equipment	1	1	1
Unmet need for basic living supplies	1	1	1
Unmet need for representative payees	1	1	1

Note. Group stakeholders (GS) gave one response for the entire group

The GS commented that homeless persons discharged from the hospital need housing or at least a shelter where they can stay overnight, and also remain during the day. Some homeless persons need oxygen machines, or electrical equipment (e.g., wound vacuums) such as wound vacuums, so they cannot be out on the street during the day. They have to be able to plug equipment into electricity. The GS also commented that the homeless need a shelter facility where they can receive care such as intravenous antibiotics and wound dressing changes. Lack of such services may prolong their hospital length of stay or result in readmissions shortly after being discharged.

Another issue that was noted was that homeless persons cannot leave the hospital prior to discharge to go to the Department of Motor Vehicles to apply for identification that has been lost. Per the GS, they need another way to readily replace their identification and their social security cards when these are lost or stolen. Without appropriate identification, it is difficult for homeless persons to get services, pick-up medications from pharmacies, and board airplane flights.

Per the GS, some homeless persons live in their wheelchairs on the street. When they are hospitalized, items may be left behind, broken, lost or stolen. These items are difficult to repeatedly through existing insurance.

Per the GS, homeless persons need basic living items when they are discharged like clean clothes, shoes, a blanket and toiletries. They need a mailing address to receive benefits. They may need a representative payee when discharged who is an agent authorized to receive their social security benefits, manage their funds, and sign them up for housing waitlists. It is often

difficult to secure a representative payee for homeless persons. According to the Social Security Administration, a representative payee may be either a person or an organization. The U.S. Social Security Administration appoints a payee to receive the Social Security or SSI benefits for anyone who cannot manage or direct the management of his, or her, own benefits. A payee's main duties are to use the benefits to pay for the current and future needs of the beneficiary, and properly save any benefits not needed to meet current needs. A payee must also keep records of expenses. When the administration requests a report, a payee must provide an accounting to them of how he or she used or saved the benefits (U.S. Social Security Administration, 2016).

Unmet need for prescription medication.

Unmet need for prescription medication per individual homeless persons. Twenty-two of 32 IHPs commented on needs for prescription medications, with 17 commenting on their unmet needs. Themes of what IHPs said about unmet needs for prescription medication are represented in Table 4.27 *Unmet Needs for Prescription Medications per Individual Homeless Persons*.

Table 4.27. *Unmet Needs for Prescription Medications per Individual Homeless Persons* (IHPs) (n=22)

Unmet need for prescription medication	**IHPs**	**Number**	**Total**
Unmet need for prescription medications that he or she needs and does not have	IHP 4, 5, 6, 7, 10, 14, 15, 16, 18, 19, 20, 26, 27, 28, 29, 30, 31	17	17
Reasons for unmet prescription medication needs:		17	17
• Difficulty getting prescription medication because of lost insurance, or lack of insurance	IHP 4, 6, 7, 10, 14, 16, 31	7	
• Medications were lost or stolen	IHP 4, 5, 20, 27	4	
• Cannot afford prescription medications	IHP 18, 24	2	
○ No generic version of medication available	IHP 18	1	
• No access to provider for prescription medications	IHP 5, 19	2	
• Refused prescription pain medications at clinic due to perception of inappropriate use	IHP 29, 30	2	
• Gets prescription medications from ED	IHP 15, 26	2	
• Pays out-of-pocket for prescription medications	IHP 6, 14	2	
○ Buys antibiotics on the street	IHP 14	1	
• Problems with storing prescription medications	IHP 20, 27	2	
○ No refrigeration for insulin	IHP 20	1	
• Cannot afford transportation to prescriber	IHP 26	1	
• Decided to discontinue taking prescription psych medications	IHP 28	1	
No unmet need related to prescription medications	IHP 11, 17, 22, 32	4	4

Note. Some IHPs appear in more than one category

Some of the challenges of managing a chronic disease like asthma, and getting and using prescription medications, while being homeless are apparent in the account IHP 18 gave of her experience. In this excerpt from the interview with IHP 18, she described being overwhelmed by the expense of medications she needed to control her asthma and not being able to get the doctor to listen to her:

> IHP 18: For my Advair. For my disk. Yeah. I was just in there the other day. So. Yeah. And even I tripped out on it. I was like "Really?" And they're like "Yeah. It's like $300. Your health care insurance pays for half of it, and you have to come up with another 150

bucks. [Later in the interview she said this]

IHP 18: I've been trying to figure that out - a way around having to pay 150 bucks every time I need my Advair.

CPZ: …Yeah. You may have to tell them "Hey. I need an inexpensive drug."…

IHP 18: I don't know. I'm about ready to go up there and be like. I can't get it. I need you to listen to me please.

CPZ: They're not listening.

See Appendix Y Commentary on Unmet Needs for Prescription Medications per Individual Homeless Persons for more excerpts from her interview, and also for commentary from other IHPs.

Unmet needs of homeless persons for prescription medications per individual key stakeholders. Themes expressed by IKSs are displayed in Table 4.28 *Unmet Needs of Homeless Persons for Prescription Medications per Individual Key Stakeholders*. Reasons for unmet needs for prescription medications are identified. There is emphasis on behavior problems, and changes in behavior IKSs felt homeless persons should make.

Table 4.28. *Unmet Needs of Homeless Persons for Prescription Medications per Individual Key Stakeholders* (IKSs) (n=10)

Unmet Needs for Prescription Medications	**IKSs**	**Number**	**Total**
Homeless persons have unmet prescription medication needs	IKS 1, 2, 4, 5, 6, 7, 8, 9, 10, 12	10	10
Reasons for unmet prescription medication needs of homeless persons	IKS 2, 6, 9, 10, 12	5	5
• No money for prescription fill or refill	IKS 2, 6, 10	3	3
• No Identification to pick-up prescription	IKS 6, 12	2	2
• Lack of providers to write prescriptions	IKS 12	1	1
• No insurance	IKS 6, 9	2	2
• Inappropriate medication prescription	IKS 6	1	1
• Lost or stolen medications	IKS 6	1	1
• Do not seek treatment	IKS 1, 7	2	2
Homeless persons' behavior change needed: compliance with prescription medication treatment regimen	IKS 4, 5, 7, 9, 10, 12	6	6
• Compliance with antibiotic regimen	IKS 4	1	
• Compliance with psych medications	IKS 4, 5, 7, 9, 10, 12	6	
Problems related to management of medication treatment regimens:	IKS 3, 5, 6, 8	4	4
• Stolen or lost medications	IKS 6	1	
• Abuse of prescription medications	IKS 6	1	
• Sale of prescription medications	IKS 6	1	
• Getting prescriptions for medications and refills at ED rather than primary care	IKS 5, 6, 8	3	
• Seeking drugs of abuse in ED	IKS 3, 8	2	
Resources for prescriptions for some medications are available at hospital discharge through case managers	IKS 8	2	2

Note. Some IKSs appear in more than one category

Challenges that homeless persons encounter in taking prescription medications are well described by IKS 6. Here is an excerpt from the interview with him:

> IKS 6: A lot of times even if they do go to the clinic and they get seen by a doctor, and they get given a prescription, then how is their prescription going to get paid for? So then the client doesn't go and get the prescription. They don't start taking the medicine so they can't get any better. Or when they go to get the prescription, sometimes places require an I.D. for whatever type of medication it might be, and the individuals won't have any identification. They didn't pick up the I.D. in the first place yet alone have any money for the uh…medication…

See Appendix Z, Commentary of Individual Key Stakeholders on Unmet Needs of Homeless Persons for Prescription Medications for more specifics from IKS 6, and for commentary by other IKSs.

Unmet needs of homeless persons for prescription medication per group stakeholders. Hospital social workers (GS) are unable to help hospitalized homeless persons replace their lost, or stolen identification. It is necessary to go to the Department of Motor Vehicles to replace identification. A particular barrier is that when homeless persons are hospitalized and have lost their identification card, they cannot go to the Department of Motor Vehicles to apply for a new identification card. This results in limited or delayed services when they are discharged from the hospital because it is difficult for social workers to arrange other services like transportation, or prescription medications, or other social services for them.

Unmet needs for pain management.

Unmet needs for pain management per individual homeless persons. Themes for unmet needs for pain management from interviews with IHPs are displayed in Table 4.29 *Unmet Needs for Pain Management per Individual Homeless Persons*. Eleven IHPs commented on this.

Table 4.29. *Unmet Needs for Pain Management per Individual Homeless Persons* (IHPs) (n=11)

Unmet Needs for Pain Management	**IHPs**	**Number**	**Total**
Unmet Need for Pain Management	IHP 6, 7, 8, 10, 14, 15, 18, 19, 21, 29, 30	11	11
• Self-medicates with inadequate relief	IHP 7, 8, 10, 14, 18, 19, 21, 29, 30	9	
• Orthopedic pain	IHP 7, 18, 19, 29, 30	5	
• Pain due to infection	IHP 10, 14, 29	3	
• Oral or dental pain	IHP 8, 18, 29	3	
• Headaches	IHP 21, 29	2	
• Psychic pain with self-harm	IHP 6, 15	2	
• Self-management includes use of alcohol, marijuana, methamphetamine or opioids	IHP 6, 7, 29, 30	4	
IHP was refused opioid pain relievers at the clinic due to clinician's perspective the medications would be used inappropriately	IHP 29, 30	2	2

Note. Some IHPs appear in more than one category

Some IHPs were self-medicating for pain relief for problems that could have been relieved by appropriate medical treatment, for example dental problems, and wound and skin infections. For more IHPs commentaries, see Appendix AA, Commentary on Unmet Pain Management Needs per Individual Homeless Persons. Appendix AA follows Appendix Z.

Unmet needs of homeless persons for pain management per individual key stakeholders. Seven IKSs addressed unmet need for pain management. For a display of themes they spoke of, see Table 4.30 *Unmet Needs of Homeless Persons for Pain Management per Individual Key Stakeholders*.

Table 4.30. *Unmet Needs of Homeless Persons for Pain Management per Individual Key Stakeholders* (IKSs) (n=8)

Unmet Needs for Pain Management	IKSs	Number	Total
Unmet need for pain management services	IKS 1, 3, 5, 6, 8, 10, 11, 12	8	8
Pain management clinic	IKS 8	1	1
Providers who will accept homeless persons for chronic pain management	IKS 3, 5, 6, 8, 11, 12	6	6
• MIKOHC does not accept chronic pain patients	IKS 3, 8, 11	3	
• Some private pay doctors accept chronic pain patients	IKS 3	1	
• Persons come to ED looking for chronic pain medications	IKS 3, 5, 6, 8, 12	5	
• Shelter (Ka Hale A Ke Ola) does not accept homeless persons on prescription opiates	IKS 8	1	
Identification, which homeless persons may not have, is needed to fill schedule medication prescriptions	IKS 12	1	1
Pain may be what motivates homeless persons to get treatment for disease conditions	IKS 1, 10	2	2

Note. Some IKSs appear in more than one category

Because of the lack of providers willing to accept chronic pain patients, and the burden that demands for opioid analgesics places on the ED, IKS 8 suggested that a pain management clinic is needed on Maui. See Appendix AB, Commentary of Individual Key Stakeholders on Unmet Pain Management Needs of Homeless Persons, for more commentary. Appendix AB follows Appendix AA.

Unmet needs of homeless persons for pain management per group stakeholders. This was not addressed in the commentary; therefore, there is no table or appendix associated with it.

Unmet vision service needs.

Unmet vision service needs of individual homeless persons. Fourteen IHPs mentioned having vision needs that remained unmet at the time of their interviews. For a display of themes from IHPs, see Table 4.31 *Unmet Vision Services Needs of Individual Homeless Persons*.

Table 4.31. *Unmet Vision Services Needs of Individual Homeless Persons* (IHPs) (n=18)

Unmet Vision Service Needs	**IHPs**	**Number**	**Total**
Unmet vision service needs	IHP 1, 9, 10, 13, 15, 16, 17, 20, 22, 24, 26, 27, 28, 32	14	14
Needs glasses	IHP 1, 9, 13, 16, 17, 20, 24, 26, 27, 28, 32	11	11
• Needs them but will not wear them	IHP 1, 13	2	
• Needs prescription lenses	IHP 16, 17, 20, 28	4	
• Needs reading glasses	IHP 24	1	
• Glasses are broken	IHP 17	1	
• Glasses were stolen	IHP 13	1	
• Afraid he will lose them or break them	IHP 27	1	
• Uses glasses she found on the roadside	IHP 9	1	
Needs eye exam	IHP 10, 15, 22, 28	4	
• Afraid to go for exam because of how she might be treated	IHP 15	1	
• Unable to get an appointment	IHP 28	1	
• Had trauma to eye area from recent fall	IHP 10	1	
• Too busy with family for appointment	IHP 22	1	
No unmet vision service needs	IHP 7, 21, 29, 30	4	4

Note. Some IHPs appear in more than one category

Most of the unmet vision service needs IHPs described were for glasses. For more specific commentaries on this see Appendix AC Commentary of Individual Homeless Persons on Unmet Vision Service Needs.

Unmet vision service needs of homeless person per individual key stakeholders. Unmet vision service needs of individual homeless persons were noted by IKS 1 and IKS 10. Per IKS 10, the immediate feedback that vision correction gives a person makes it easy for the person to grasp the benefit of using the glasses and provides incentive for adhering to using them. Other treatments, like psych medications, may not provide such immediate feedback and incentive, and as a result, homeless persons may be less likely to adhere to them. He also noted that homeless persons commonly have difficulty with vision due to losing their glasses or breaking their glasses. There is no table, and no appendix associated with this section.

Unmet vision service needs of homeless person per group stakeholders. Group stakeholders did not comment on this unmet need. There is no table, and no appendix associated with this section.

Unmet nutritional needs.

Unmet nutritional needs of individual homeless persons. Six IHPs spoke of their unmet nutritional needs. Twenty IHPs commented on their nutritional needs. All IHPs had food available to them at the time of the interviews. Donated food items, or prepared meals from the Salvation Army or the Family Life Center, were available for IHPs. These agencies, and other agencies, provide food on a scheduled basis to persons in need. Some IHPs did talk about having food stamps, running out of food stamps prior to receiving the next allotment, or not having food stamps at all. See Table 4.32 *Unmet Nutritional Needs of Individual Homeless Persons* for a display of themes.

Table 4.32. *Unmet Nutritional Needs of Individual Homeless Persons* (IHPs) (n=20)

Unmet Nutritional Needs	**IHPs**	**Number**	**Total**
Unmet nutritional needs	IHP 1, 10, 11, 20, 27, 28	6	6
• Has inadequate funds to eat nutritious foods	IHP 1, 10, 11, 20	4	
• Gets hungry when food stamps run out	IHP 10, 20	2	
• Goes hungry	IHP 27, 28	2	
• Needs vitamins	IHP 1	1	
Does not have food stamps	IHP 9, 14, 21, 26	4	4
Has inadequate means of food storage	IHP 1, 11	2	2
Campsite was robbed and means of food preparation was stolen: knives and stove	IHP 18	1	1
Included B-12 deficiency as a way she has been victimized	IHP 19	1	1
Strategies for meeting nutritional needs	IHP 1, 2, 3, 13, 14, 17, 24, 30	8	8
• Tries to eat healthy foods	IHP 1, 13, 17, 24	4	
• Eats at feeding centers	IHP 2, 3, 14	3	
• Eats leftover food at harbor from Lahaina tour boats	IHP 30	1	
• Grinds nuts for protein because he has no teeth and cannot chew nuts	IHP 24	1	
Would like to have a garden to grow own food	IHP 9, 29	2	2
No lack of food	IHP 3, 4, 5	3	3

Note. Some IHPs appear in more than one category

All IHPs, with the exception of IHP 12, appeared vulnerable for nutritional needs due to their reliance on donated food, feeding centers, or being on the federal food stamp program. For

more commentary on IHPs' unmet nutritional needs see Appendix AD, Commentary of Individual Homeless Persons on Unmet Nutritional Needs.

Unmet nutritional needs of homeless persons per individual key stakeholders.

Seven IKSs commented on unmet nutritional needs. See Table 4.33 *Unmet Nutritional Needs of Homeless Persons per Individual Key Stakeholders.*

Table 4.33. *Unmet Nutritional Needs of Homeless Persons per Individual Key Stakeholders* (IKSs) (n=7)

Unmet Nutritional Needs	**IKSs**	**Number**	**Total**
Unmet nutritional needs	IKS 3, 4, 6, 9, 10	5	5
• Illness due to eating spoiled food	IKS 10	1	
• Need for food and shelter is a reason people seek hospital admission or drug and alcohol treatment	IKS 3, 4, 9	3	
• Lack of motivation for change puts them at risk	IKS 4	1	
• Hand-outs are not enough to stabilize people	IKS 6	1	
Homeless persons are resourceful	IKS 4, 11, 12	3	3
• Homeless persons know where to get a meal	IKS 4	1	
• Homeless persons do not go hungry in the Wailuku area	IKS 11	1	
• Stop feeding homeless persons and they will go somewhere else	IKS 12	1	
Feeding could be one of many support services in congregate housing	IKS 10	1	1

Note. Some IKSs appear in more than one category

Comments of IKSs referred to both the unmet nutritional needs of homeless persons, and the ways in which their needs are already met. For more specific commentary, see Appendix AE, Commentary of Individual Key Stakeholders on Unmet Nutritional Needs of Homeless Persons.

Unmet nutritional needs of homeless persons per group stakeholders. There is no table for group stakeholders on unmet nutritional needs of homeless persons. This was not addressed in their commentary.

Unmet needs for surgical services.

Unmet need for surgical services per individual homeless persons. Only IHP 24 mentioned an unmet surgical need. He said that he needed a hernia repair. He was uninsured at the time of the interview and was not seeking treatment.

Unmet need of homeless persons for surgical services per individual key stakeholders. According to IKS 5, uninsured homeless persons who come to the emergency department may have difficulty getting orthopedic care. If a person comes to the ED with a fracture, is treated and then referred to an orthopedic doctor for follow-up, the orthopedic doctor is not bound to see the person under the COBRA-EMTALA Law. The doctor may require payment for services prior to seeing the person. If the person is uninsured, and does not have cash to spend, the person may go without orthopedic follow-up. He reported that many of the homeless people get frustrated, give up, and just let the bone heal on its own.

Unmet needs of homeless persons for surgical services per group stakeholders. There is no table for group stakeholders on unmet surgical needs of homeless persons. This was not addressed in their commentary.

Unmet health care needs of homeless children.

Unmet health care needs of homeless children per homeless persons. No children were interviewed for this study. Adult IHPs were asked about the health care needs of homeless children they had observed. Themes of what the IHPs said are displayed in Table 4.34 *Unmet Health Care Needs of Homeless Children per Individual Homeless Persons.*

Table 4.34. *Unmet Health Care Needs of Homeless Children per Individual Homeless Persons* (IHPs) (n=27)

Unmet health care needs of homeless children	**IHPs**	**Number**	**Total**
Has seen homeless children with unmet health care service needs	IHP 8, 14, 18, 22, 24	5	5
• Dental care	IHP 8	1	
• Nutrition: at feeding center at end of month	IHP 14	1	
• Contraceptive care	IHP 22	1	
• Wound care: insect bites	IHP 22	1	
• Needed vaccines not covered by Quest	IHP 18	1	
• Hygiene, clean clothes	IHP 24	1	
Has minor children living with someone else	IHP 3, 4, 7, 10, 17, 18, 23, 26	8	8
• IHP has lost custody of children	IHP 4, 10, 23	3	
• Unclear if IHP has lost custody of children	IHP 3, 7, 17, 18, 26	5	
Has minor siblings who are homeless	IHP 8	1	1
IHP was homeless as a child	IHP 6, 7, 27	3	3
Has not seen or rarely sees homeless children	IHP 2, 11, 12, 13, 30, 31, 32	7	7
Other reports of homeless children	IHP 6, 21, 22, 28	4	4
• Babysits grandchild at campsite	IHP 21	1	
• Sees homeless children at Kanaha Park well-cared for by parents	IHP 6	1	
• Sees homeless children sleeping in truck beds with parents	IHP 28	1	
• Has grandchildren at Kanaha	IHP 22	1	
IHP has children (minor or adult)	IHP 3, 4, 7, 8, 9, 10, 17, 18, 19, 20, 21, 22, 23, 25, 26	15	15
• IHP has grandchildren	IHP 20, 21, 22, 25	4	

Note. Some IHPs appear in more than one category

Five IHPs remarked on unmet health care service needs of homeless children. More than that number (seven) said they rarely see or don't see homeless children. Eight of 32 IHPs said that they had children (under 18 years of age) living with someone else. For more specific commentary see Appendix AF, Commentary on Unmet Health Care Service Needs of Homeless Children by Individual Homeless Persons.

Unmet health care service needs of homeless children per individual key stakeholders. None of the IKSs interviewed for this study worked primarily with children. For a display of themes, see Table 4.35 *Unmet Health Care Service Needs of Homeless Children per Individual Stakeholders.*

Table 4.35. *Unmet Health Care Service Needs of Homeless Children per Individual Stakeholders* (IKSs) (n=6)

Unmet health care service needs of homeless children	**IKSs**	**Number**	**Total**
Observed homeless children with unmet health care needs	IKS 2, 3, 5, 6, 10, 12	6	6
Children and parents may be separated so that they need help with reconnection, or a change to new safe foster setting	IKS 2, 6, 10, 12	4	4
• Campsite eviction	IKS 2	1	
• Child protective services (CPS)	IKS 10	1	
• Runaway children	IKS 6, 12	2	
Children may be kept out of sight	IKS 12	1	1
Parental drug use may result in homelessness for children	IKS 12	1	1
Unmet health care service needs	IKS 3, 5, 12	3	3
• Dental care needs	IKS 5	1	
• Psychiatric care: hospital adolescent psych unit is closed	IKS 3	1	
• Protection from and treatment for abuse	IKS 12	1	
Children do not stand-out prominently as a group with unmet health care service needs	IKS 5	1	1

Note. Some IKSs appear in more than one category

Six IKSs observed homeless children with unmet health care service needs. Some of the needs they observed were for dental care, protection from abuse, and psychiatric treatment (specifically in terms of adolescents with mental health issues). One IKS, (IKS 5) stated that homeless children did not stand out as prominently, as a group, when considering unmet health care needs of homeless persons. In addition, IKSs mentioned that the separation of parents and

children may be viewed as a social services need and also as a health care service need because separation from the parents is likely to impact the health of the children. For specific commentary see Appendix AG, Commentary on Unmet Health Care Service Needs of Homeless Children per Individual Key Stakeholders.

Unmet health care service needs of homeless children per group stakeholders. There is no table for group stakeholders on unmet need for health care services of homeless children. This was not addressed in their commentary.

Unmet health care service needs of homeless pregnant women.

Unmet health care service needs of homeless pregnant women per individual homeless persons. Twenty IHPs said they had not noticed pregnant homeless women with unmet health care service needs, with nine other IHPs mentioning the unmet needs of this particular group of homeless individuals. For a display of themes, see Table 4.36 *Unmet Health Care Service Needs of Pregnant Homeless Women per Individual Homeless Persons.*

Table 4.36. *Unmet Health Care Service Needs of Pregnant Homeless Women per Individual Homeless Persons* (IHPs) (n=29)

Unmet health care service needs of pregnant homeless women	**IHPs**	**Number**	**Total**
Unmet health care service needs of pregnant homeless women	IHP 3, 4, 9, 15, 18, 24, 26, 28, 31	9	9
• Mental health services or counseling for relationship problems	IHP 3, 4, 9	3	
• Substance abuse treatment	IHP 26, 28, 31	3	
○ Sees pregnant women doing drugs	IHP 28	1	
○ Sees pregnant women drinking alcohol	IHP 31	1	
○ IHP is pregnant and uses drugs and drinks alcohol	IHP 26	1	
• Need money for prenatal vitamins	IHP 18	1	
• Need transportation to medical appointments	IHP 26	1	
• Avoid health care due to stigma of homelessness	IHP 15	1	
• Need to accept available services	IHP 24, 26	2	
○ Pregnant and did not accept available housing because of restrictions on alcohol and drug use	IHP 26	1	
Has not noticed pregnant homeless women with unmet health care service needs	IHP 1, 2, 5, 6, 7, 8, 10, 11, 12, 13, 14, 16, 17, 20, 21, 22, 23, 25, 26, 30	20	20
• Sees pregnant women but does not know if they get services	IHP 14, 30	2	
• Knows pregnant women who get health care services	IHP 8, 12,	2	
• Has not seen any recently	IHP 20	1	
Was pregnant and homeless previously	IHP 4	1	1
Pregnant women get more protection than men get	IHP 6	1	1

Note. Some IHPs appear in more than one category

Individual homeless persons noted needs of pregnant women for substance abuse treatment, mental health and counseling services. Most IHPs said they had not really noticed needs of pregnant homeless women. For more specific commentary see Appendix AH, Commentary on Unmet Health Care Service Needs of Pregnant Homeless Women by Individual Homeless Persons.

Unmet health care service needs of homeless pregnant women per individual key stakeholders. Individual key stakeholders spoke about exceptional cases of pregnant homeless women who had unmet health care service needs, rather than about large numbers of pregnant homeless women with unmet health care service needs. For a display of themes from their interviews, see Table 4.37 *Unmet Health Care Service Needs of Pregnant Homeless Women per Individual Key Stakeholders*.

Table 4.37. *Unmet Health Care Service Needs of Pregnant Homeless Women per Individual Key Stakeholders* (IKSs) (n=5)

Unmet health care service needs of pregnant homeless women	**IKSs**	**Number**	**Total**
Unmet health care service needs of pregnant homeless women	IKS 2, 6, 10, 12	4	4
• Mental health services and counseling	IKS 2, 6	2	
• Substance abuse treatment	IKS 2, 6	2	
• May choose not to get services	IKS 10	1	
Pregnant homeless women IKSs knew of	IKS 2, 6, 12	3	
• Woman still on the street in late pregnancy	IKS 2	1	
• Drug addicted woman who gave birth and was back on the street without her baby	IKS 6	1	
• Woman employed but living at a campsite	IKS 6	1	
• Homeless woman on street with newborn	IKS 12	1	
Does not see many homeless pregnant women in ED	IKS 5	1	
Has female outreach worker for pregnant homeless women	IKS 6	1	

Note. Some IKSs appear in more than one category

Some IKSs mentioned that pregnant homeless women with mental illness and drug addiction often refuse services offered to them, endangering themselves and their babies. For more specific commentary see Appendix AI, Commentary on Unmet Health Care Service Needs of Pregnant Homeless Women by Individual Key Stakeholders.

Unmet health care service needs of pregnant women homeless women per group stakeholders. There is no table for group stakeholder comments on unmet health care service needs of pregnant homeless women. This was not addressed in their commentary.

Unmet needs for health care services observed in other homeless persons per individual homeless persons. Observed unmet needs for health care services of homeless children and pregnant homeless women were addressed in previous categories. For a display of the unmet health care service needs of other homeless persons, please refer to Table 4.38 *Unmet Health Care Service Needs Observed in Other Persons per Individual Homeless Persons.*

Table 4.38. *Unmet Health Care Service Needs Observed in Other Persons per Individual Homeless Persons* (IHPs) (n=12)

Unmet Health Care Service Needs Observed in Others	**IHPs**	**Number**	**Total**
Observed unmet health care needs in other non-pregnant homeless adults	IHP 1, 6, 7, 11, 12, 13, 15, 18, 24, 27, 28, 32	12	12
Wound care needs	IHP 1, 27, 32	3	3
• Education about self-care and staph prevention	IHP 27	1	
• Shoes and foot protection	IHP 1	1	
• MRSA treatment	IHP 32	1	
Better hygiene	IHP 6, 7, 24	3	3
Substance abuse treatment	IHP 7, 12, 28	3	3
Judgment free health care services	IHP 6, 15	2	2
Prevention of homelessness because street life leads to death	IHP 6	1	1
Dental care	IHP 18	1	1
Restful sleep	IHP 11, 27	2	2
Assurance of confidentiality about homelessness status	IHP 11	1	1
Privacy for quiet reflection	IHP 13	1	1
Garden plots for growing own food	IHP 9, 29	2	2

Note. Some IHPs appear in more than one category

The themes mentioned in this category are similar to themes IHPs addressed in discussion of their own needs. For more specific commentary see Appendix AJ**,** Commentary of Individual Homeless Persons on Unmet Health Care Service Needs of Other Persons.

No unmet health care service needs.

No unmet health care service needs per individual homeless persons. Three IHPs initially said they had no unmet health care service needs, but in the course of the interview, they did mention unmet health care service needs they had. For a display of themes see Table 4.39 *No Unmet Health Care Service Needs per Individual Homeless Persons*.

Table 4.39. *No Unmet Health Care Service Needs per Individual Homeless Persons* (IHPs) (n=3)

No Unmet Health Care Service Needs	**IHP**	**Number**	**Total**
IHPs who perceived no unmet health care service needs	IHP 9, 11, 25	3	3
IHP perceived no unmet health care service needs	IHP 9	1	1
• No health care provider service in years	IHP 9	1	
• No dental care service in 20 years other than one extraction	IHP 9	1	
• Health need for hygiene facilities o Hot showers o 24 hour bathroom access	IHP 9	1	
• Security need o Place she would not be chased out of	IHP 9	1	
IHP perceived no unmet health care service needs	IHP 11	1	1
• No health care provider service in 20 years except for incident of spider bite and tooth extraction	IHP 11	1	
• Wonders why his foot is swollen and would like medical exam	IHP 11	1	
• Health need for restful sleep due to sleep deprivation due to homelessness	IHP 11	1	
• Health need for refrigeration or cooler for food but has no place to keep it	IHP 11	1	
• Avoids health care service perhaps related to experience of judgmental care	IHP 11	1	
IHP perceived no unmet health care service needs	IHP 25 IHP 25	1 1	1
• Complains of broken teeth and need for dental services			

Note. Some IHPs appear in more than one category

Individual homeless person 9 spoke of the need she had for hot showers, twenty-four hour bathroom access, and a place to stay where she would not be chased out. She said she had not seen a health care provider in years. That meant she had not gotten preventive services like immunizations, womens' health services such as Papanicolaou tests and mammograms, or screening for hypertension, diabetes and colon cancer. She said she had a tooth extracted about 18 months prior to the interview but, other than that, she had not had dental care in 20 years.

Individual homeless person 11 said he had no health care in 20 years other than treatment for spider bites and a tooth extraction. Like IHP 9, he had not had preventive care or screening. He was concerned about his swollen foot and wondered if he was developing diabetes or kidney problems.

Individual homeless person 25 had taken care of his primary care and mental health care service needs. However, he did state that he had broken teeth and needed dental care services.

No unmet health care service needs of homeless persons per individual key stakeholders. No IKSs had the opinion that homeless persons have no unmet health care service needs. Individual key stakeholder 3 expressed that she felt homeless persons get incredible service at the hospital, and that the deficit in services is in outpatient services.

Analysis of Barriers to Health Care Services Access

Perception that improvement of available health care services will worsen the problem of homelessness on Maui.

Perception that improvement of available health care services will worsen the problem of homelessness on Maui per individual homeless persons. No IHPs expressed the opinion that improving health care services would worsen the problem of homelessness on Maui. Individual homeless person 1 did comment that he had "graduated L.A.", meaning that he had learned to survive homelessness in Los Angeles, and had passed that difficult test. He thought Los Angeles was a tougher place to be homeless than Maui. Individual homeless person 2 said he had arrived on the island eight days prior to the interview. He said:

> IHP 2: I haven't had to work. I'm actually not in need of much. I have food and I have shelter [referring to his campsite]… This place is a place they are always providing. Food is not something you have to save money for. Having the Salvation Army and the church down the road takes a huge burden off. They are always giving away some kind of food.

You come and eat breakfast and they got all kinds of stuff you can take home. That's awesome. Yeah. Lifesaver.

Perception that improvement of available health care services will worsen the problem of homelessness on Maui per individual key stakeholders. Some IKSs expressed the view that improving health care services for homeless persons on Maui would worsen the problem of homelessness. For a display of themes, see Table 4.40, *Perception that Improvement of Available Health Care Services on Maui for Homeless Persons Would Worsen Problem of Homelessness per Individual Key Stakeholders*.

Table 4.40. *Perception that Improvement of Available Health Care Services on Maui, for Homeless Persons, Would Worsen Problem of Homelessness per Individual Key Stakeholders (IKSs) (n= 5)*

Improvements Would Worsen Problem	**IKSs**	**Number**	**Total**
Improvements Would Worsen Problem	IKS 3, 6, 7, 10, 12 and unrecorded comments	5	5
Improvements in health care services would likely attract more homeless persons to Maui, increasing the homeless population and problems	IKS 3, 6, 7, 10, 12, and unrecorded comments	5	5
• Makes it too easy for homeless people, unfair to middle class	IKS 3	1	
• Housing with support services is needed but could attract more homeless persons to Maui	IKS 6	1	
• Homeless persons should be required to do work to get more services	IKS 3 and another unrecorded comment	2	
• Problem with improving services is attracting more homeless people to Maui – "eight hundred pound gorilla" in room no one is talking about.	Unrecorded comment	1	
• Maui is attractive enough already to homeless persons. Improved services would make it even more attractive	IKS 7	1	
• Homeless population increased when public bus transportation became available	IKS 12	1	
• Feeding homeless persons will attract more homeless persons	IKS 12	1	
• Improving health care for the homeless will attract more homeless persons	IKS 12	1	
There is a dilemma between providing humane services and being a magnet for the homeless. If services are cut off, people will just die off.	Unrecorded comment	1	1
It may not be possible to improve health care services without attracting more homeless persons to Maui	IKS 7, 10, 12	3	3
Elected officials use legal liability as an excuse not to make improvements in services	IKS 10	1	1
Improving health care services for the homeless is expensive	IKS 7, 10	2	2
• Health outreach, and housing first are "Cadillac" services	IKS 7	1	
• Improvements for homeless persons take resources from other less visible people in need who are not living out in the open, in the public eye, e.g. elderly at home	IKS 10	1	

Table 4.40 (Continued) *Perception*

Strategies for improving health care services while simultaneously preventing migration of homeless persons to Maui	0	0	0

Note. Some IKSs appear in more than one category

Individual key stakeholder 12 verbalized his concerns about this succinctly when he said:

> IKS 12: Now, if you build it they will come. So you're going to bring more. Not only can you live on Maui, they have all this stuff. [Emphasis]… It's a double-edged sword, it really is.
>
> *CPZ: So it's kind of a problem from wanting to provide humane treatment and solve problems, as well as not add to them…*
>
> IKS 12: But once people find out that not only can you live on an island, not have to have a job, and get fed, and have great health care, you send a bad message
>
> *CPZ: Yeah.*
>
> IKS 12: that it's okay to not be accountable for what you do.

For additional commentary from IKSs, see Appendix AK, Commentary by Individual Key Stakeholders on the Perception that Improving Health Care Services on Maui for Homeless Persons Will Worsen Homelessness Problems.

Lack of health care facilities.

Lack of health care facilities that accept homeless persons per individual homeless persons. Individual homeless persons had little to say with regard to lack of health care service facilities being a barrier for getting services. For themes, see Table 4.41 *Lack of Health Care Facilities that Accept Homeless Persons per Individual Homeless Persons*.

Table 4.41. *Lack of Health Care Facilities that Accept Homeless Persons per Individual Homeless Persons* (IHPs) (n=4)

Lack of Health Care Facilities	**IHPs**	**Number**	**Total**
Lack of Health Care Facilities	IHP 10, 15, 29, 30	4	4
• that treat homeless persons with chronic pain diagnosis	IHP 10, 29, 30	3	
• that provide comprehensive services	IHP 15	1	
• that provide outreach dental care	IHP 15	1	

Note. Some IHPs appear in more than one category

Individual homeless person 10 had seen a private doctor previously who would no longer see her, because of fines she had not paid for appointments she had missed. She was unsure of where to get care for her burn wounds that appeared to be infected, as well as having chronic pain problems. Malama I Ke Ola Health Center does not accept patients who have a chronic pain diagnosis. Two other persons, IHP 29 and IHP 30, who had requested controlled medications were refused care at MIKOHC due to the suspicion that they were misusing the prescription pain medications, and/or selling them. Individual homeless person 15 had moved from the island of Hawaii to Maui and had difficulty finding a primary care provider and specialty services. For more specific commentary, see Appendix AL, Commentary by Individual Homeless Persons on Lack of Facilities that Accept Homeless Persons.

Lack of health care service facilities that accept homeless persons per individual key stakeholders and group stakeholders. All IKSs and GS had comments on the lack of health care service facilities for homeless persons on Maui being a barrier to health care service access. For a display of themes, see Table 4.42 *Lack of Health Care Service Facilities that Will Accept Homeless Persons per Individual Key Stakeholders and Group Stakeholders*.

Table 4.42. *Lack of Health Care Service Facilities that Will Accept Homeless Persons per Individual Key Stakeholders* (IKSs) and *Group Stakeholders* (GS) (n=13)

Lack of Health Care Service Facilities	**IKSs**	**Number**	**Total**
Lack of primary care facilities that will accept homeless persons	IKS 1, 3, 4, 5, 6, 7, 8, 11, 12	9	9
• Red tape at safety net facility MIKOHC prevents homeless person access	IKS 7	1	
• Lack of primary care services in South and West Maui that will accept homeless persons	IKS 12	1	
• Difficult to find primary care services that will accept homeless persons	IKS 8, 12	2	
• Delays in getting appointments may result in homeless persons giving up	IKS 1, 4, 6, 12	4	
Lack of walk-in clinics that will see homeless persons	IKS 1, 6, 8, 9, 12	5	5
• No mental health walk-in clinic	IKS 9	1	
• No wound care clinic	IKS 8, 12	2	
Lack of pain management clinic	IKS 8	1	1
Lack of detox and substance abuse treatment	IKS 3, 6, 9, 12	4	4
• Lack of outpatient substance abuse treatment	IKS 12	1	
Lack of primary care facilities with services designed to treat homeless persons needs	IKS 2, 12	2	2
Lack of health outreach for the homeless	IKS 1, 6, 7, 8, 11, 12	6	6
Lack of facility to accept homeless patients after hospital discharge	IKS 5, 6, 7, 8, 9, GS	6	6
Lack of housing with support services	IKS 6, 7, 8, 9, 10	5	5
• Lack of sober living housing	IKS 6	1	
• Lack of congregate housing with support services	IKS 10	1	

Note. Some IKSs appear in more than one category

Individual key stakeholder 7 identified the lack of a health care safety net that is supposed to be there to assist homeless persons without care so their health will not worsen and require care in the ED or hospital. Federally qualified health centers (FQHC), funded by the Department of Health and Human Services, have a mission to provide comprehensive outpatient services to a medically-underserved area, or a medically-underserved population (U.S. Department of Health and Human Services, 2016). Malama I Ke Ola is a FQHC. Here is an excerpt from the interview with IKS 7:

IKS 7: Always… when the case managers and I do that, we always run into that red tape

issue. Instead of kind of like opening the door and saying like [He imagined what an ideal response from MIKOHC staff might be when they are being given information on a patient being discharged from the hospital.]: "Ah! Thank you guys for taking care of that dude

CPZ: Yeah.

IKS 7: and we'll follow-up on that cellulitis, and we'll do his dressing changes over here three times a week."

CPZ: Uh huh. It's not there.

IKS 7: Not there at all. And I kind of thought that was one of our safety nets if you will, is what I kind of thought they were. And they haven't been that at all...so. They'd probably disagree, but that's been my experience.

CPZ: Yeah.

IKS 7: So I'm a little bit...I'm a little bit worried that's one of my problems with unmet health care needs are what was to me our safety net just isn't there.

For more commentary, see Appendix AM, Commentary by Individual Key Stakeholders and Group Stakeholders on Lack of Health Care Facilities that Accept Homeless Persons.

Lack of health care providers who accept homeless persons.

Lack of health care providers who will accept homeless persons per individual homeless persons. Six IHPs commented on lack of health care providers who accept homeless persons as a barrier to receiving services. For themes from their comments, see Table 4.43 *Lack of Health Care Providers who Accept Homeless Persons per Individual Homeless Persons.*

Table 4.43. *Lack of Health Care Providers Who Accept Homeless Persons per Individual Homeless Persons* (IHPs) (n= 6)

Lack of Health Care Providers	IHPs	Number	Total
Unable to get primary care provider	IHP 5, 10, 15, 19, 29, 30	6	6
• Chronic pain diagnosis	IHP 10, 29, 30	3	
Unable to get specialty care	IHP 5, 15	2	2

Note. Some IHPs appear in more than one category

Six IHPs expressed frustration with being unable to find a provider for health care services. Most IHPs were more concerned with other barriers like no identification, no insurance,

or no money. Some were not concerned about their lack of a primary care provider. They said they would just go to the ED if they needed service. For more commentary, see Appendix AN Commentary of Individual Homeless Persons on Lack of a Health Care Provider Who Will Accept Homeless Persons.

Lack of health care providers who will accept homeless persons as patients per individual key stakeholders. Eleven of 12 IKSs addressed lack of health care providers who will take homeless persons as patients as a barrier to homeless persons receiving services. Group stakeholders did not comment on this. For a display of themes, see Table 4.44 *Lack of Health Care Providers Who Will Accept Homeless Persons as Patients per Individual Key Stakeholders*.

Table 4.44. *Lack of Health Care Providers Who Will Accept Homeless Persons as Patients per Individual Key Stakeholders* (IKSs) (n=11)

Lack of Health Care Providers Who Will Take Homeless Persons as Patients	**IKSs**	**Number**	**Total**
Lack of number of health care providers	IKS 3, 4, 5, 6, 7, 8, 12	7	7
• Not enough doctors on Maui	IKS 3, 4, 5, 6, 7, 8	6	
• No staffing for clinic	IKS 12	1	
Bias against homeless persons	IKS 2, 3, 12	3	3
Dumping patients	IKS 1	1	1
Low insurance reimbursement	IKS 8	1	1
Liability concerns discourages voluntarism	IKS 5	1	1
Congregate housing would increase efficiency of care delivery	IKS 10	1	1

Note. Some IKSs appear in more than one category

Seven of the IKSs commented that there were insufficient number of health care providers on Maui to provide services that are needed for those residing here. Individual key stakeholder 12 related the closing of a clinic in West Maui due to the lack of staff available to work there. Other factors contributing to a lack of providers who are willing to accept homeless persons as patients included the financial burden on a practice of having a large percentage of patients who have Medicaid insurance, with low reimbursement rates, or patients who have no insurance and are unable to pay a fee for services. Providers may hesitate to do volunteer service because of liability insurance costs. Distaste and frustration with dealing with behaviors of the population may bias some providers against accepting homeless persons as patients. Home visits to homeless persons concentrated in congregate housing would enable a provider to see more patients in one visit, and improve the efficiency of care delivery per IKS 10. For more specific

commentary see Appendix AO, Commentary on a Lack of Health Care Providers Who Will Accept Homeless Persons as Patients per Individual Key Stakeholders.

Lack of follow-up and support systems.

Lack of follow-up and support systems per individual homeless persons. Individual homeless persons provided many examples of their own lack of follow-up to obtain services, and their lack of support systems which are barriers to receiving health care services. Three IHPs described support systems they had with other homeless persons. For a display of themes, see Table 4.45 *Lack of Follow-up and Support Systems per Individual Homeless Persons*.

Table 4.45. *Lack of Follow-up and Support Systems per Individual Homeless Persons* (IHPs) (n=31)

Lack of Follow-Up and Support Services	**IHPs**	**Number**	**Total**
IHP lack of follow-up	IHP 4, 7, 10, 11, 13, 14, 16, 17, 20, 21, 22, 23, 24, 26, 28	15	15
• Get health insurance	IHP 4, 21	1	
• Go to appointments	IHP 4, 10, 23	3	
• Replace identification	IHP 7, 24	2	
• Get shelter or housing	IHP 17, 20, 24, 26	4	
• Take care of health needs	IHP 4, 10, 11,13,14, 16, 22, 23, 28	9	
• Get veteran's services	IHP 11, 14	2	
• Get transportation assistance	IHP 20	1	
Health care provider lack of follow-up • Request for specialist appointment	IHP 5	1	1
IHP lack of support system	IHP 1, 2, 3, 4, 5, 6, 7, 10, 16, 17, 18, 19, 20, 25, 26, 28, 29, 31	18	18
• New to being on Maui	IHP 2, 28, 31	3	
• Chooses to stay alone	IHP 1, 5, 19, 25, 29	5	
• Told by family to leave home or has disputes with family or associations	IHP 3, 4, 6, 7, 10, 17, 20	7	
• Friend left the island now she is alone	IHP 16	1	
• Boyfriend encourages alcohol and drug abuse	IHP 26	1	
• Separated from family when campsite was swept	IHP 18	1	
IHP has support system with other homeless persons	IHP 8, 11, 22, 23, 24	5	5
IHP has support from friends or family with housing	IHP 8, 21, 22, 25, 32	5	5
IHP has support from Salvation Army or Family Life Center	IHP 1-11, 13-32	31	31

Note. Some IHPs appear in more than one category

Fifteen IHPs gave examples, in the course of their interviews, of how they did not follow-up with health care services. Eighteen IHPs expressed a lack of support from either family or friends. Interpersonal conflict was noted by seven IHPs to have contributed to their being homeless. Five IHPs spoke about a support system they have with other homeless persons. For more specific commentaries by IHPs, see Appendix AP, Commentary by Individual Homeless Persons on Lack of Follow-Up and Lack of Support Systems.

Lack of follow-up services and support services for homeless persons per individual key stakeholders and group stakeholders. Follow-up is the continuation of treatment, following an initial treatment, which supports stabilization, recuperation and health maintenance. Support services aid a person to follow up, and promote optimal functioning. All 12 IKSs had comments about lack of follow-up and lack of support services that are barriers to homeless person receiving health care services. Individual key stakeholders also made many comments about efforts to insure follow-up, and discussed what support services were available. For a display of themes see Table 4.46 *Lack of Follow-Up and Support Services for Homeless Persons per Individual Key Stakeholders and Group Stakeholders*.

Table 4.46. *Lack of Follow-Up and Support Services for Homeless Persons per Individual Key Stakeholders* (IKSs) *and Group Stakeholders* (GS) (n=13)

Lack of Follow-Up and Support Services	**IKSs and GS**	**Number**	**Total**
Lack of follow-up and / or support services undermines homeless persons' treatment	IKS 1-12, GS	12	12
Conditions that lead to lack of follow-up	IKS 1-12	12	12
• Communication problems e.g. no phone contact	IKS 5, 6, 8	3	
• Lack of insurance, or lack of insurance that is accepted by provider	IKS 1, 2, 3, 6, 8, 9	6	
• Lack of identification	IKS 2, 6	2	
• Lack of transportation	IKS 2, 6, 8, 9, 11	5	
• No mailing address	IKS 6, 8	2	
• Missed appointments	IKS 8, 9, 11	3	
• Intoxication	IKS 4	1	
• Friends and associations	IKS 10	1	
• Lack of personal support system	IKS 3, 12	2	
• Follow-up not a priority	IKS 4	1	
• Hopelessness	IKS 2	1	
• Rule averse	IKS 9	1	
• Mental illness	IKS 7	1	
• Anti-social behaviors	IKS 10, 12	2	
• Lack of money	IKS 5, 6	2	
• Perception of getting the "runaround"	IKS 6	1	
Lack of support services for homeless persons	IKS 1, 3, 4, 5, 6, 7, 8, 9, 10, 12, GS	11	11
• ED cannot provide array of social services needed by homeless persons	IKS 7	1	
• Lack of health outreach	IKS 1, 7, 8, 12	4	
• Lack of intensive case management	IKS 3, 9	2	
• Lack of shelters that allow follow-up	IKS 8, GS	2	
• Lack of providers who will accept them as patients	IKS 3, 7, 8	3	
• Lack of close therapeutic relationship with provider	IKS 9	1	
• No home health services	IKS 8, GS	2	
• Lack of supportive housing	IKS 6, 7, 9, 10	4	
• Lack of specialists who accept them	IKS 4, 5	2	

Note. Some IKSs appear in more than one category

Per IKS 9, follow-up care is one of the biggest unmet health care service needs of homeless persons. Per IKS 10, it is how the person is monitored, not what drug the person is put on that matters most. For more commentary, see Appendix AQ Lack of Follow-up and Support Services per Individual Key Stakeholders and Group Stakeholders.

Lack of requirements for access to health care services.

Lack of requirements for access to health care services per individual homeless persons. Many IHPs lacked some of the basic requirements for getting health care services in a place other than the ED, or from EMS, which creates a barrier to accessing primary care services. Some of those normal requirements are identification, health insurance, and money; phone communication, transportation, and a mailing address; and keeping appointments. See Table 4.47 *Lack of Requirements for Access to Health Care Services per Individual Homeless Persons*.

Table 4.47. *Lack of Requirements for Access to Health Care Services per Individual Homeless Persons* (IHPs) (n=32)

Lack of Requirements for Access	**IHPs**	**Number**	**Total**
No identification	IHP 1, 2, 5, 7, 8, 14, 16, 24, 32	9	9
• Identification was stolen	IHP 2, 14, 16, 32	4	
Health insurance	IHP 1-32	32	32
• No health insurance accepted in Hawaii	IHP 1, 2, 4, 7, 8, 9, 12, 13, 14, 16, 19, 21, 24, 31	14	
○ Out-of-state insurance	IHP 19, 31	2	
• Has health insurance accepted in Hawaii	IHP 3, 5, 6, 10, 11, 15, 17, 18, 20, 22, 23, 25, 26, 27, 28, 29, 30, 32	18	
Not enough money for health care services	IHP 1, 2, 3, 7, 8, 10, 16, 17, 18, 20, 24, 26, 31, 32	14	14
Phone status	IHP 1-32	32	32
• No phone of own	IHP 1, 3, 5, 6, 7, 10, 13, 14, 20, 21, 24, 26, 27, 30, 31, 32	16	
○ Phone was stolen	IHP 14, 20, 32	3	
○ Uses another person's phone	IHP 3, 5, 14, 21, 30	5	
• Has own phone	IHP 2, 4, 8, 9, 15, 16, 17, 18, 22, 23, 25, 28, 29	13	
• Unknown phone status	IHP 11, 12, 19	3	
Transportation	IHP 1-32	32	32
• Walk	IHP 3, 4, 6, 9, 13, 15, 16, 17, 18, 19, 28, 29, 31	13	
• Take the bus	IHP 1, 5, 7, 10, 12, 14, 15, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32	20	
• Bicycle	IHP 10, 11, 24, 29	4	
• Catch ride with others	IHP 12, 17, 18, 21	4	
• Use family vehicle	IHP 8	1	
• Hitchhike	IHP 1	1	
• Vehicle unregistered or unrepaired	IHP 10, 20, 26	3	
No mailing address	IHP 14, 16, 24	3	3
Difficulty making or keeping appointments	IHP 4, 5, 6, 7, 10, 15, 17, 18, 20, 22, 23, 24, 26, 27, 30, 31, 32	17	17

Note. Some IHPs appear in more than one category

During the interviews, IHPs were not routinely asked whether they had a mailing address. Three IHPs identified that as a problem. There may have been more than three IHPs for which that was a barrier to basic requirements for health care access outside of the ED or EMS. For more commentary see Appendix AR, Commentary from Individual Homeless Persons on Lack of Requirements for Access to Health Care Services.

Lack of requirements of homeless persons for access to services per individual key stakeholders and group stakeholders. Individual key stakeholders also addressed how homeless persons may lack some of the basic requirements for getting health care services somewhere other than the ED, or EMS, which creates a barrier to accessing primary care services. For a display of themes see Table 4.48 *Homeless Persons' Lack of Requirements for Access to Health Care Services per Individual Key Stakeholders and Group Stakeholders*.

Table 4.48. *Homeless Persons' Lack of Requirements for Access to Health Care Services per Individual Key Stakeholders* (IKSs) *and Group Stakeholders* (GS) (n=13)

Lack of Requirements for Access	**IKSs**	**Number**	**Total**
No identification (ID)	IKS 2, 6, 11, 12, GS	5	5
• One of the biggest barriers	IKS 2	1	
• May be refused medical treatment	IKS 2, 11	2	
• Unable to apply for services	IKS 2, GS	2	
• Unable to pick-up prescriptions	IKS 2, 6, 12, GS	4	
• Unable to board airplane	12, GS	2	
• Salvation Army assists with replacement	IKS 6	1	
No insurance	IKS 1, 2, 5, 6, 7, 8, 9, 11, 12	9	9
• Need advocate to help with paperwork	IKS 1, 11	2	
• Reason people who need treatment don't seek treatment	IKS 2	1	
• Primary care will not see patients without insurance unless they pay cash up front	IKS 5, 12	2	
• Specialists will not see patients without insurance unless they pay cash up front	IKS 5	1	
• Without insurance, need proof of income for sliding scale fee at MIKOHC	IKS 7, 11	2	
• Problem with affording prescriptions	IKS 6, 9	2	
• Hospital staff assist with application for insurance during acute care stay	IKS 8	1	
• May lose insurance after hospital discharge if they have not followed up with paperwork mailed to them	IKS 8	1	
• After dental emergency in ED, no outpatient dentist may see them	IKS 5	1	
Not enough money for health care services	IKS 4, 5, 6, 11, GS	5	5
• No money for fee for ID replacement	IKS 6	1	
• No money to fill prescriptions	IKS 6	1	
• For uninsured, there is a sliding scale fee at MIKOHC	IKS 11	1	
• Uninsured need cash to follow-up with orthopedic doctor after ED	IKS 5	1	
• Some psychiatrists will treat anyone on a cash basis, but very expensive	IKS 4	1	
• No bus fare to go to follow-up appointments	GS	1	

Table 4.48. (Continued) *Lack of Requirements*			
No phone creates follow-up problem	IKS 4, 5, 6, 8, 10, 11	6	6
• ED cannot notify them of lab and culture results, and change in required treatment	IKS 4, 5	2	
• Missed appointments	IKS 6	1	
• Cannot use Crisis Line	IKS 4	1	
• MIKOHC cannot contact referred patients, discharged from hospital	IKS 8	1	
Transportation problems	IKS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	12	12
• Huge issue	IKS 7, 8, 10, GS	4	
• May not seek health care because of transportation problem	IKS 2	1	
• Complicates follow-up if they live at distant campsite	IKS 5, 9	2	
• Police and paramedics may give bus fare to homeless persons	IKS 12	1	
• Bus driver may refuse transport depending on way person looks or smells	IKS 12	1	
• Salvation Army assists with transport to health care	IKS 1	1	
• Maui Economic Opportunity can be scheduled to pick-up for doctor visits	IKS 8	1	
• Outreach would help people get services where they are	IKS 6	1	
• Transportation assistance is inappropriately enabling	IKS 3	1	
• Homeless persons are resourceful in meeting transportation needs	IKS 4, 8	2	
• Need intensive case management to transport persons to appointments to ensure follow-up	IKS 9	1	
• Bus stops at front door of MIKOHC	IKS 11	1	
No mailing address	IKS 6, 8	2	2
• Necessary to receive benefits, get insurance cards	IKS 6	1	
• Need government issued ID to get mail at Family Life Center	IKS 6	1	
• May result in loss of insurance arranged during acute care hospitalization	IKS 8	1	

Table 4.48. (Continued) *Lack of Requirements*			
Difficulty making or keeping appointments	IKS 4, 6, 7, 8, 9, 10, 11, 12	8	8
• Homeless state makes it difficult to make an appointment and show-up for it	IKS 7	1	
• Walk-in clinic would fill some of the need the ED fills	IKS 4	1	
• Nurse case managers at hospital set-up outpatient appointments but homeless persons often do not show-up	IKS 8	1	
• Need intensive case management to get them to their appointments	IKS 9	1	
• Difficulty getting organized to make and keep appointments	IKS 10	1	
• Hours of service can be a problem	IKS 6	1	
• May have to wait 2 to 3 weeks for appointment when they need same day treatment	IKS 6	1	
• May get restless and impatient if they have to wait	IKS 11	1	
• Need walk-in clinic services	IKS 4, 6, 9, 12	4	
• Need free clinic services where money is not required	IKS 6	1	

Note. Some IKSs appear in more than one category

For commentary from IKSs and GS, see Appendix AS Homeless Persons Lack of Basic Requirements for Health Care Services per Individual Key Stakeholders and Group Stakeholders.

Knowledge, experience, attitudes, and behaviors of homeless persons that are a barrier to accessing health care services.

Knowledge, experience, attitudes, and behaviors of homeless persons that are a barrier to accessing health care services per individual homeless persons. Twenty-eight IHPs spoke about knowledge, experiences, attitudes or behaviors as barriers to accessing health care services. For a display of themes see Table 4.49 *Knowledge, Experience, Attitude, and Behaviors that are a Barrier per Individual Homeless Persons*.

Table 4.49. *Knowledge, Experience, Attitudes, and Behaviors that are a Barrier per Individual Homeless Persons* (IHPs) (n=28)

Knowledge, Experience, Attitudes, and Behaviors	**IHPs**	**Number**	**Total**
Lack of knowledge of available resources as barrier	IHP 6, 8, 14, 20, 22, 28	6	6
• New to island	IHP 28	1	
• Chronic disease management education for diabetes	IHP 20, 22	2	
• Hui No Ke Ola Pono services for native Hawaiians	IHP 22	1	
• MIKOHC	IHP 6, 14	2	
• Housing program for veterans	IHP 14	1	
• ID replacement assistance	IHP 8	1	
• Information about insurance benefits is difficult to get	IHP 18	1	
Experiences as barrier	IHP 2, 6, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 23, 27, 28, 30, 31	18	18
• Negative health care experiences discourage requests for health care services	IHP 6, 9, 11, 12, 15, 18, 20, 28	8	
• Fear of what might happen with health care experience	IHP 2, 11, 13, 15, 16, 19, 20, 23, 27, 28, 30	11	
• Cumbersome access procedures	IHP 15, 19, 28	3	
• Communication problems with providers	IHP 18, 20, 29	3	
• Felt stigmatized during health care experience	IHP 6, 12, 14, 15, 20, 28, 31	7	
• Positive expectations about care	IHP 11, 17, 24, 27	4	4
Attitude as a barrier	IHP 2, 4, 7, 9, 10, 15, 18, 19, 20, 22, 23, 24, 26, 28, 29, 30, 31, 32	18	18
• Lack of accountability for behavior	IHP 19, 29, 30	3	
• Rule averse	IHP 2, 4, 9, 20, 29	5	
• Does not care anymore	IHP 4, 5, 6, 10, 15, 18, 20, 28	8	
• Has competing priorities	IHP 4, 7, 22, 23, 24, 26, 27, 28, 31, 32	10	
Behavior as a barrier	IHP 30 + Table 4.45	16	16
• Chooses not to adhere to treatment	IHP 20, 28	2	
• Sells prescription drugs	IHP 30	1	
• Lack of follow-up	See Table 4.45	15	

Note. Some IHPs appear in more than one category

There were pieces of information that IHPs did not have about health care services. Overall, the weight of their previous experiences, the attitudes they held, and their behaviors were more frequently barriers to accessing health care services than lack of knowledge. For additional commentary from IHPs, see Appendix AT Commentary on Knowledge, Experiences, Attitudes and Behaviors as Barriers to Access to Health Care Services per Individual Homeless Persons.

Knowledge, experience, attitudes, and behaviors of homeless persons that are a barrier to accessing health care services per individual key stakeholders. Individual key stakeholders had an abundance of comments on these topics. For a display of themes, see Table 4.50 *Knowledge, Experience, Attitude and Behaviors of Homeless Persons that are a Barrier to Accessing Health Care Services per Individual Key Stakeholders*.

Table 4.50 *Knowledge, Experience, Attitudes and Behaviors of Homeless Persons that are a Barrier to Accessing Health Care Services per Individual Key Stakeholders* (IKSs) (n=12)

Knowledge, Experience, Attitude and Behaviors	**IKSs**	**Number**	**Total**
Lack of knowledge of available resources as a barrier	IKS 1, 2, 3, 4, 6, 11, 12	7	7
• Lifestyle makes homeless persons not want to seek out services	IKS 4	1	
• Need assistance with paperwork	IKS 1, 6, 11	3	
• Need education about self-care	IKS 2, 3, 12	3	
• Need education about when to go to ED	IKS 4	1	
• May know about resources but need incentive to use them	IKS 4	1	
Know well how to take advantage of resources	IKS 4	1	1
Experiences as a barrier	IKS 1, 2, 3, 6, 7, 12	6	6
• Bias of health care professionals discourages seeking health care	IKS 1, 2, 6	3	
• Health care professionals need to get past bias	IKS 7	1	
• Cumbersome requirements and runaround discourage access seeking	IKS 6, 12	2	
• Possible racial discrimination	IKS 3	1	
• Fear of legal complications	IKS 12	1	
Attitude as a barrier	IKS 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	11	11
• Sense of entitlement alienates health professionals	IKS 3, 5, 12	3	
• Rule averse	IKS 3, 4, 6, 8, 11, 12	6	
• Health care is not priority	IKS 4, 7, 10	3	
• Sense of hopelessness, do not care anymore	IKS 2, 6, 9	3	
• Hesitance to disclose chronic disease	IKS 2	1	
• Lack sense of purpose and self-reliance	IKS 3	1	
Behaviors as a barrier	IKS 1-12	12	12
• Discordant and disruptive behaviors in health care environment	IKS 10, 12	2	
• May be refused service by providers other than ED and EMS, if intoxicated	IKS 2	1	
• So intoxicated, do not care for themselves	IKS 4, 6	2	

Table 4.50. (Continued) *Knowledge*			
Behaviors as a barrier continued			
• Do not seek care in timely manner results in complications	IKS 1, 4	2	
• Lack of compliance with treatment plan	IKS 4, 5	2	
• Poor hygiene	IKS 2, 4, 12	3	
• Ten to 40% of population cause most of the problems	IKS 10, 12	2	
• Lack of follow-up and poor support systems as in Table 4.46	IKS 1-12	12	
Liability concerns of providers	IKS 5, 8	2	2

Note. Some IKSs appear in more than one category

For particular commentary see Appendix AU, Knowledge, Experience, Attitudes and Behaviors of Homeless Persons that are a Barrier to Accessing Health Care Services per Individual Key Stakeholders.

Analysis of Ideas for Solutions

Ideas for solutions.

Ideas for solutions per individual homeless persons. Often, IHPs were caught up in the stress of their own homelessness. They had some ideas about what would improve their own situations, and a few ideas about broader solutions for homeless persons in general. For a display of themes, see Table 4.51 *Ideas for Solution per Individual Homeless Persons.*

Table 4.51. *Ideas for Solutions per Individual Homeless Persons* (IHPs) (n=32)

Ideas for Solutions	**IHPs**	**Number**	**Total**
Ideas for solutions	IHP 1-32	32	32
Meet unmet health care needs	IHP 1, 6, 7, 8, 10, 14, 15, 16, 18, 19, 20, 24, 26, 27, 28, 30, 32	17	17
• Get identification	IHP 7, 16	2	
• Get health insurance	IHP 7, 8, 16	3	
• Get job	IHP 7, 16, 21	3	
• Money	IHP 1	1	
• Family support	IHP 6	1	
• Medical outreach services	IHP 7, 12, 15, 26	4	
• Wound care outreach	IHP 7	1	
• Dental care for homeless	IHP 15, 18, 19	3	
• Comprehensive health care services for homeless persons in one place	IHP 15, 19	2	
• Transportation assistance	IHP 10, 14, 18, 26, 27, 32	6	
• Nonjudgmental health care professionals	IHP 6, 15, 28	3	
• Health care professionals who clearly explain what available services are and required steps	IHP 28	1	
• More doctors, less homeless persons	IHP 30	1	
• Friend who can talk with him about his situation	IHP 24	1	
• Marijuana dispensary	IHP 29	1	
• Naturopathic care covered by insurance	IHP 29	1	
• Housing	IHP 12, 18, 20, 27	4	
Avoid inappropriate ED use	IHP 8, 14, 18, 27, 32	5	5
• Learning about other places to get health care	IHP 14	1	
• Transportation means to other location	IHP 14	1	
• Get health insurance	IHP 8	1	
• Treat wounds early before there are complications	IHP 27	1	
• Register at MIKOHC	IHP 32	1	
• Get asthma inhalers to prevent severe attack	IHP 18	1	
Reduce hospital length of stay	No comments		

Table 4.51. (Continued) Ideas			
Place to stay after discharge from the hospital	IHP 8, 11, 13, 14, 16, 17, 18, 21, 22, 23, 24, 26, 27, 28, 29, 30, 31, 32	18	18
• Stay with family	IHP 8, 17, 21, 22	4	
• Stay with friends	IHP 13	1	
• Family Life Center	IHP 16, 18, 26	3	
• Return to camping or street	IHP 8, 11, 28, 30	4	
• No place	IHP 14, 23, 24, 27, 29, 31, 32	7	
Get housing	IHP 1, 2, 3, 4, 5, 6, 7 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 22, 23, 24, 25, 26, 27, 29, 30, 32	26	
• Identification	IHP 2, 5, 8, 32	4	
• Money	IHP 3, 14, 22, 25, 30, 31, 32	7	
• Job	IHP 2, 3, 7, 8, 10, 11, 16, 21, 28, 32	10	
• Nothing would help	IHP 5	1	
• Stop drinking alcohol, or find shelter without rules	IHP 4, 26	2	
• Shelters that allow pets	IHP 10	1	
• Prefer camping, doesn't want to live in projects	IHP 1	1	
• Permission to put up tent on piece of land	IHP 9, 29	2	
• Okay with living outside	IHP 24	1	
• Not interested in housing	IHP 13	1	
• Wait-listed for Steadfast Housing	IHP 6, 15	2	
• Wait-listed for housing	IHP 23, 27	2	
• Working with case manager	IHP 18	1	
• Find place that will accept HUD voucher	IHP 17	1	
• Work with HUDVASH	IHP 14	1	
Other ideas for solutions	IHP 9, 10, 11, 12	4	
• Public bath house for hygiene	IHP 9, 10, 12	3	
• Allow sleeping in parks	IHP 11	1	
• Give away free phones	IHP 10	1	

Note. Some IHPs appear in more than one category

For particular commentary, see Appendix AV Ideas for Solutions per Individual Homeless Persons.

Ideas for solutions per individual key stakeholders and group stakeholders. All IKSs and GS had ideas for solutions to closing the gap in health care services for homeless persons on Maui. For a display of themes, see Table 4.52 *Ideas for Solutions per Individual Key Stakeholders and Group Stakeholders.*

Table 4.52. *Ideas for Solutions per Individual Key Stakeholders* (IKSs) *and Group Stakeholders* (GS) (n= 13)

Ideas for Solutions	**IKSs and GS**	**Number**	**Total**
Ideas for solutions	IKS 1-12 and GS	13	13
Meet unmet health care needs	IKS 1-12, GS	13	13
• Open up MIKOHC so they will take anyone	IKS 7	1	
• Community Mental Health Facility that will accept them	IKS 9	1	
• Walk-in clinic	IKS 1, 3, 4, 6, 7, 8, 9, 12	8	
○ Walk-in wound care clinic	IKS 3, 8, 12	3	
○ Walk-in mental health clinic	IKS 9, 12	2	
○ Free clinic services	IKS 6	1	
• Pain management clinic	IKS 8	1	
• Outpatient detox	IKS 8	1	
• Health outreach	IKS 1, 5, 6, 7, 8, 10, GS	7	
○ Wound care outreach	IKS 1, 6, 7, 8, GS	5	
○ Outreach at congregate housing	IKS 10	1	
○ Go out and see people, they are not going to come to you	IKS 9	1	
	IKS 10	1	
• Intensive outpatient mental health case management	IKS 9	1	
• Frequent follow-up with patients	IKS 9, 10	2	
• Redirect persons to primary care rather than ED when possible	IKS 4	1	
• Primary care clinics in Lahaina and Kihei that will accept homeless persons	IKS 12	1	
• More doctors willing to accept homeless persons as patients	IKS 3, 8, 12	3	
• Comprehensive health center with services tailored to homeless persons	IKS 12	1	
• More substance abuse treatment programs	IKS 4, 6, 8, 9, 12	5	
• Nonjudgmental care from health professionals	IKS 1, 2, 7	3	
• Call center	IKS 6	1	
• Place to get mail	IKS 6	1	
• Assistance with paperwork	IKS 6	1	
• Heal old wounds, uncover motivation	IKS 6	1	
• Preregister persons at MIKOHC before they are really sick	IKS 1, 11	2	
• State and County funding and problem solving	IKS 5, 9	2	
• DMV to issue basic state ID for homeless	GS	1	
Utilize under-utilized state buildings for clinic	IKS 12	1	

Table 4.52. (Continued) *Ideas*		
Avoid inappropriate ED use	IKS 2-10, 12	10
• Walk-in clinic for homeless	IKS 4, 6, 9, 12	4
○ See patients without ID	IKS 6	1
○ Walk-in mental health services	IKS 9, 12	2
○ Walk-in wound care services	IKS 3, 8, 12	3
• Health outreach to homeless	IKS 5, 7, 8, 12	4
• Pain management clinic	IKS 8	1
• Community Mental health to take more patients	IKS 9	1
• Comprehensive primary care in West Maui	IKS 12	1
• Strong outpatient mental health case management	IKS 9	1
• Better hygiene	IKS 4, 10, 12	3
• Redirect patients to primary care	IKS 4	1
• Get persons health insurance	IKS 2	1
• Place persons in housing first or congregate housing with support	IKS 7, 10	2
• Juvenile detention center	IKS 3	1
• Drunk tank	IKS 3	1
• Repeal COBRA EMTALA law	IKS 3	1
Reduce length of hospital stay	IKS 2, 4, 5, 6, 7, 8, 9	7
• Homeless persons knowing when it is appropriate to come in for treatment	IKS 4	1
• Appropriate facility that will accept them when they are discharged from hospital	IKS 2, 5, 6, 7, 8, 9	6
• Just have to discharge them regardless of whether there is a facility	IKS 3	1
Place to go at hospital discharge	IKS 1, 3, 6, 7, 8, 9, GS	7
• Campsite and tent may be gone if they have been away	IKS 1	1
• Family Life Center is not a “dumping ground”, but an overnight shelter only	IKS 6	1
• Need supportive group of people to assist the person	IKS 1	1
• More medical respite in the community	IKS 3	1
• If there was health outreach, health outreach could do follow-up care	IKS 7, GS	2
• If there was a dormitory style setting where persons could have dressings changed and get oral antibiotics	IKS 7	1
• A clean place for homeless persons to stay, and a day clinic where they could receive follow-up care	IKS 8	1
• Nurse case managers can set-up appointments and transportation	IKS 8	1
• Housing with support services	IKS 9	1

Table 4.52 (Continued) *Ideas*		
• Some persons can be assisted to return to their families off-island, if their families or a facility will take them	IKS 8	1
• Salvation Army should set-up a new shelter	IKS 8	1
• Several beds at Family Life Center where persons who cannot go out, could stay during the day and receive follow-up	GS	1
• Mobile unit set-up at shelter to provide intravenous antibiotics and wound care	GS	1
Get housing	IKS 1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12	11
• Developers and landlords that choose what is right over what is profitable	IKS 1	1
• Get land donation and volunteer contractors	IKS 11	1
• More affordable housing	IKS 2, 5	2
• More jobs to be able to afford housing	IKS 2	1
• Finding location for housing is a problem	IKS 5, 12	2
○ People may not want to live where the housing is	IKS 5	1
○ Residents and business people do not want housing near them	IKS 12	1
• More public housing with support services, not just shelters	IKS 6, 9	1
• Congregate housing with support services	IKS 10	1
• Housing could attract more homeless persons to Maui which is not desired outcome	IKS 7, 12	2
• Uncover homeless persons motivation to encourage them to get housed	IKS 6	1
• Work program with housing in a farm setting	IKS 3	1

Note. Some IKSs appear in more than one category

For particular commentary, see Appendix AW Ideas for Solutions from Individual Key Stakeholders and Group Stakeholders.

Summary of Results

Analysis of sources of health care. Eighteen of 32 IHPs had health insurance that was accepted in the State of Hawaii. Fourteen IHPs did not have health insurance that was accepted in the State of Hawaii. Twenty-eight of 32 IHPs reported using the ED for health care services. All 32 IHPs were aware that the ED was an option for health care services. The most commonly identified reasons IHPs gave for seeking health care services at the ED were staph infections (n = 8) and injuries (n = 6). Many preferred using the ED for services. This preference is reflected in a statement made by IHP 3 when he was asked about where he sought health care services. He said, "I just go ER. You get seen and they know what is wrong with you."

All 12 IKSs commented on homeless persons use of the ED. Prominent themes they mentioned were that homeless persons inappropriate use of the ED for services was overwhelming the ED (n = 6), homeless persons often delayed seeking services and then went to the ED when they were really sick with complications (n = 6), other people sent homeless persons to the ED because they did not know what else to do with them (n = 5), and that homeless persons go to the ED instead of going to primary care services (n = 5).

Twelve IHPs stated they had used the services of the federally qualified health center Malama I Ke Ola Health Center (MIKOHC) at some time. Two of those were banned from returning to MIKOHC for services due to suspicion of misuse/resale of controlled prescription pain reliever medication. The remaining 20 IHPs said they did not use MIKOHC for health care services for a variety of reasons. Six IHPs reported receiving services at Maui Medical Group. No IHPs were receiving their health care services at Kaiser Permanente, or at the Veterans' Administration Clinic while they were homeless.

Eleven IKSs commented on use of MIKOHC for health care services by homeless persons. Themes of their comments include MIKOHC has a cumbersome admission process (n = 4), MIKOHC is overwhelmed with the numbers of patients they serve (n = 3), and patients with a diagnosis of chronic pain are not accepted (n = 2). According to IKS 7, MIKOHC is not functioning as a safety net for primary care services for the most vulnerable of homeless persons.

Only four IHPs commented on their use of emergency medical services (EMS) for health care services. Six of 12 IKSs commented on homeless persons' use of EMS. Common reasons given by IKSs for ambulance transport were altered mental status with apparent intoxication with the same person or persons frequently transported, having no other means of transportation to the

ED, infected wounds, suicidal ideation, pneumonia, and chest pain. The emergency ambulance may be tied up treating and transporting a homeless person who has problems that could have been addressed in a primary care setting, and then be unavailable to persons having true medical emergencies (n = 2). Per IKS 12, "We've had people actually die because there was no ambulance to cover while we took care of a homeless minor event." He also stated that frequent EMS users are a small subset of homeless persons. Two IKSs said that homeless persons may experience bias when they are treated by EMS (n = 2).

Twenty-one of 32 IHPs commented on their own self-care strategies which included ways to prevent wound infection (n = 9), insure good hygiene (n = 4), maintain good nutrition (n = 4), manage pain (n = 3), exercise (n = 3), be self-reliant (n = 3), and take medication (n = 3). Eleven IKSs commented on homeless persons' self-care strategies with most of the themes emphasizing inattention to self-care. Six IKSs said that substance abuse and mental illness interfered with homeless persons' self-care. Three IKSs said that homeless persons' inattention to personal hygiene created health complications for them. Two IKSs commented that homeless persons are resourceful in meeting their needs.

Twenty-six IHPs said they had no source of dental care services. Twenty-two IHPs were unable to get primary care services, or specialty services. Four IHPs chose not to get health care services. Two IKSs commented that there is a hesitation on the part of providers to provide care to the homeless population, that there is a lack of primary care services that will take them as patients (n = 4), and that primary care services for homeless patients are unavailable in some geographic areas of the island (n = 1). Other deficits in services IKSs noted were lack of shelters where homeless persons can receive follow-up care after hospital discharge (n = 2), insufficient detox and substance abuse treatment services (n = 2), no wound care clinic (n = 1), no pain management clinic (n = 1), no walk-in mental health clinic (n = 1), and no intensive outpatient mental health case management (n = 1).

A**nalysis of unmet health care service needs**

There is some agreement and there are some discrepancies between IHPs and IKSs perceptions of what unmet health care needs for homeless persons on Maui are. All participants identified unmet health care needs for homeless persons. The IHPs, IKSs, and GS were in agreement on three of the top five unmet health care needs: for wound and skin care, prescription medication, and other health matters and unmet medical need. Dental care service needs and

vision care needs were identified in the top five by IHPs, but not emphasized by IKSs. Mental health or counseling, and substance abuse treatment were identified in the top five by IKSs, but not emphasized by IHPs.

Twenty-four IHPs had ongoing unmet dental care needs. Their interviews were full of references to long standing dental care problems and lack of services other than extraction. Only four IKSs discussed dental care as an unmet need. Their comments related to the lack of available services for adults on Maui other than extraction, unless persons had dental care insurance.

Only four of the IHPs felt they had a need for substance abuse treatment and only two of those four said that they were willing to enter into treatment. Those two willing to go into treatment had no health insurance. Most IHPs denied the need for substance abuse treatment (n = 22). Fourteen IHPs said they were using alcohol or drugs. Eight IHPs had substance abuse treatment previously. Seven IHPs said they did not drink alcohol and eight IHPs said they did not do drugs.

All 12 IKSs identified substance abuse treatment as an unmet need of homeless persons. Prominent themes were substance abuse leads to homelessness and poor health (n = 8), homelessness can lead to substance abuse (n = 4), many homeless persons have combined problems of substance abuse disorders and mental illness (n = 9), and homeless persons' substance abuse creates multiple problems (n = 9). Some of the problems IKSs identified as created by homeless persons' substance abuse were complications of medical problems (n = 5), poor compliance with medical treatment plans (n = 5), barriers to getting into shelters (n = 3), and repulsion of health care professionals (n = 4). Eight IKSs said there was a need for more substance abuse treatment services on Maui.

Only six of the IHPs said they were in need of mental health or counseling services that were not available to them. Nine IHPs said they were receiving mental health or counseling services. Seven persons reported an extensive psychiatric history. Three reported being abuse victims. Eight IHPs self-descriptions were consistent with obvious mental health issues (e.g., depression, unresolved grief, wish to harm self, overwhelming personal stressors and having stopped their medications for schizophrenia and bipolar disorder). Fifteen IHPs said they were not interested in mental health or counseling services.

All 12 IKSs identified mental health and counseling services as an unmet need of homeless persons on Maui. The state of homelessness is a stressor on mental health (n = 4). Homeless persons often have behavioral problems that are difficult to treat that include poor social skills and poor anger management skills (n = 1). Six IKSs thought there were inadequate mental health or counseling services on Maui. They discussed a variety of inadequacies including no adolescent psychiatric unit at the hospital (n = 2), the need for a community mental health service that will actually take new patients (n = 1), lack of walk-in mental health clinic facilities so that patients are not stabilized, but instead end up being treated in the ED (n = 1), intensive outpatient case management (n = 1), and long term housing with support services (n = 1). They identified follow-up as being particularly problematic (n = 4) as there may be no phone contact for the persons, the homeless person may miss appointments, and have no transportation. Seven IKSs mentioned traits of homeless persons with mental health problems that make them difficult to treat including having given up hope of recovery (n = 1), being off their medications and destabilized (n = 4), and poor compliance with treatment (n = 1). They also included friends and associates that complicate homeless persons' treatment (n = 1), substance abuse problems that need care before progress can be made (n = 2), and a sense of entitlement to services (n = 2). Also identified was manipulation of the health care system with threats of suicide (n = 2).

Many IHPs described wound and skin care needs they had at the time of the interview (n = 17), ED visits or hospitalization for infected wounds they had while being homeless (n = 5), ED visits or hospitalization for wounds from assaults they sustained while being homeless (n = 6), or wounds they had seen other homeless persons have (n = 6). According to IHP 7, wound care is the number one unmet need of homeless persons. Four IHPs described the challenges of keeping a wound clean while being homeless. Nine IHPs were very concerned about the risk of staph infections. One IHP (IHP 27) said he did not realize staph was so serious until he knew someone who lost his leg to staph infection. He said repeatedly in a shocked tone during the interview, "They took his leg."

All 12 IKSs commented on unmet wound and skin care needs of homeless persons. One IKS (IKS 6) estimated that 70% of the homeless persons he worked with had staph infections. Ten IKSs thought that homeless persons often neglected their own wounds and two described homeless persons that had maggot infested wounds. Two IKSs thought that homeless persons' experiences of being stigmatized by health care providers caused them to delay getting timely

care for their wounds. Three IKSs thought homeless persons needed more focused coaching and instruction in wound care. Four IKSs thought that poor hygiene interfered with homeless persons' wound healing. Five IKSs identified needs for further wound care services including walk-in clinic services where homeless persons wounds could be treated (n = 2), a wound care clinic (n = 2), and a clean place for homeless persons to stay after hospital discharge where they could continue to recuperate from their wounds (n = 2). Lack of an appropriate place for homeless persons to stay when they are discharged from the hospital can result in revolving door readmissions to the hospital (n = 2). Homeless persons' wound and skin complications impact others with the cost of their prolonged acute care hospital stays (n = 2), and homeless persons may not be concerned about those costs (n = 1). Wound and skin care problems of homeless persons would be better addressed in primary care than with EMS services (n = 1). Misuse of the emergency ambulance for patients with problems that would be better addressed in primary care can result in a delayed response to true medical emergencies, and loss of life for others in the community (n = 1).

Other unmet health and or unmet needs for medical care are needs identified that may not have been part of the semi-structured interview format but were mentioned during the interview. All 32 IHPs had other unmet health or unmet needs for medical care. Housing or shelter was a need common to all. Five persons would have been satisfied with a safe stable campground setting. Restful sleep (n = 6), hygiene facilities (n = 3), durable medical equipment (n = 2) were some of the other needs mentioned. Asthma management (n = 4), diabetes management (n = 3), treatment for high blood pressure (n = 1) were among the other medical needs mentioned.

All 12 IKSs and GS had comments on other unmet needs and unmet needs for medical care. Unmet needs for housing included safe shelters where homeless persons could go after hospital discharge and continue to recuperate (n = 7 and GS), housing with support services (n = 3), affordable housing (n = 2), sober living housing (n = 1). IKSs also mentioned hygiene centers with showers (n = 2), a call center (n = 1), a place to receive mail (n = 1), and an easier way to replace identification (GS). The need to receive compassionate care from health care providers without judgment (n = 4) and to get help to heal their responses to experiences in their lives (n = 1), the need for help in uncovering their motivation (n = 1), care for medical problems people may hesitate to talk about like HIV, tuberculosis and hepatitis C (n = 1). Per IKSs, homeless persons have a need for health care providers who will accept them as patients (n = 6), easier

entry into MIKOHC (n = 3), and for health outreach services (n = 5). Per IKSs, homeless persons also have a need for walk-in clinic services (n = 6), a walk-in wound care clinic (n = 2), a walk-in mental health clinic (n = 2), and a pain management clinic (n = 1). They have a need for follow-up care (n = 5) and additional detox services (n = 1). Group stakeholders also mentioned the need for replacement of durable medical equipment and basic supplies of living, like clothing and toiletries.

Seventeen IHPs commented on unmet needs for prescription medications. A variety of reasons for problems with getting prescription medications were given. They included lost insurance or lack of insurance (n = 7), lost or stolen medications (n = 4), lack of money to purchase medications (n = 2), no access to a provider to get prescriptions (n = 2), and problems with storing medications (n = 2).

Ten IKSs commented on unmet prescription medications needs of homeless persons. The IKSs mentioned reasons similar to the reasons given by the IHPs. In addition, they mentioned as reasons homeless persons not seeking treatment (n = 2), lack of compliance with psych medications (n = 6) and lack of compliance with antibiotic regimens (n = 1). Four IKSs mentioned difficulty with managing prescription medications including abuse / resale of prescription medications (n = 1), seeking drugs of abuse in the ED (n = 2), and using the ED as a place to get prescription refills rather than using primary care services (n = 3).

Eleven IHPs commented on unmet needs for pain management. Nine said they self-medicated with inadequate relief. Pain they described was due to orthopedic problems, infections, dental pain, headaches, or psychic pain with self-harm. Four persons self-managed pain with alcohol, marijuana, methamphetamines, or opioids. Six IKSs commented on homeless persons unmet needs for pain management and on the need for providers who will accept homeless persons with a diagnosis of chronic pain. Identification, which homeless persons may have lost or had stolen, is needed to fill schedule medication prescriptions (n = 1).

Fourteen IHPs reported unmet needs for vision services. Eleven IHPs needed glasses. Four felt they needed an eye exam. Two IKSs commented on needs for vision services due to losing or breaking glasses.

Six IHPs spoke of having unmet nutritional needs. They included inadequate funds to eat nutritious foods (n = 4), going hungry (n = 2), going hungry when food stamps run out (n = 2), and needing vitamins (n = 1). Four did not get food stamps. Two reported inadequate means to

store food that resulted in spoiled food and extra expenses. Eight had strategies for meeting their nutritional needs which included trying to select healthy food choices (n = 4), eating at feeding centers (n = 3), eating food left over by tour boat operators at the harbor (n = 1), and compensating for having no teeth or dentures by grinding nuts to eat in order to have a protein source (n = 1). Two wanted access to a garden to grow food. Three reported they had no lack of food.

Five IKSs spoke about homeless persons unmet nutritional needs. They said homeless persons have illnesses due to eating spoiled food (n = 1), and needing food and shelter may inspire them to seek hospital admission, especially during bad weather (n = 3). IKSs also commented on homeless persons' resourcefulness and said that homeless persons usually know where to get a meal (n = 1), and that if people would stop feeding homeless persons they would go away (n = 1). One IKS said, "…if you stop feeding something that's wild, it needs to go somewhere else. But once they find that they can get fed, they usually stay."

Unmet need for surgical services was mentioned by only one IHP who said it was for a problem that was of little concern to him. One IKS spoke about the difficulty homeless persons, who have been treated in the ED, have in getting follow-up orthopedic care for fractures. If they have no insurance, or no money for cash payment prior to being seen, they often just have to let the bone heal on its own because specialists, with practices outside the hospital, are not bound to treat persons under the COBRA-EMTALA Law.

No persons under 18 years of age were interviewed for this study. Five IHPs said they had seen homeless children with unmet health care needs which included dental care needs (n = 1), inadequate food availability (n = 1), contraceptive needs (n = 1), wound care (n = 1), vaccines not covered by insurance (n = 1), and hygiene and clean clothes (n = 1). Eight IHPs had minor children living with someone else. Three of them had lost custody of their children. For the other five IHPs, it was unclear to the DNP student whether they had lost custody of their minor children. Fifteen IHPs had children of their own, and four had grandchildren. Seven IHPs said they have not seen, or they rarely see homeless children.

Six IKSs commented on children with unmet health care needs. Children and parents may get separated when families are evicted from a campsite (n = 1), or by intervention from Child Protective Services (n = 1). They may need help reconnecting with family members or adjusting to a safe foster setting, and the stress of separation. Parental drug use may result in homelessness

for the children (n = 1). Other needs that were mentioned were dental care (n = 1), adolescent inpatient psychiatric treatment (n = 1), and protection from abuse (n = 1).

Nine IHPs noticed unmet health care service needs of pregnant homeless women. The needs they noticed were for mental health or counseling help with dysfunctional relationships (n = 3), substance abuse treatment as they were observed to continue to use substances of abuse during their pregnancies (n = 3), money for prenatal vitamins (n = 1), and transportation to medical appointments (n = 1). One IHP (IHP 15) thought that pregnant homeless women avoid services because of the stigma of homelessness. Two other persons said they had noticed pregnant homeless women who did not accept available services, like shelter or housing, because they would not accept restrictions on their alcohol and drug use. Twenty IHPs said that they had not noticed pregnant women who had unmet health care service needs. Two IHPs knew pregnant homeless women who were getting health care services.

Three IKSs spoke about extreme cases of homeless pregnant women who had unmet health care service needs that they knew of, rather than about large numbers of pregnant homeless women with unmet needs. They mentioned a pregnant homeless woman who was on the street late into her pregnancy (n = 1), a drug-addicted pregnant homeless woman who was living on the street, gave birth at the hospital, and then was back on the street without her baby (n = 1), a pregnant homeless woman who was employed and living at a campsite, whose partner had left her, and appeared to be taking care of herself (n = 1), and a homeless woman on the street with a newborn (n = 1). One IKS said he had the assistance of a female outreach worker for talking with pregnant homeless women. Children who are at risk and living homeless can be taken into custody by Child Protective Services, but according to one IKS, a pregnant homeless woman cannot be forced into housing for the sake of her unborn child. Some IKSs mentioned that pregnant homeless women with mental illness and drug addiction often refuse services, endangering themselves and their unborn babies.

Twelve IHPs spoke about unmet health care service needs that they noticed in other non-pregnant, adult homeless persons. The themes of the needs they observed were similar to what IHPs mentioned as their own needs. They include wound care needs (n = 3), judgment free health care services (n = 2), better hygiene (n = 3), substance abuse treatment services for other people (n = 3), and garden plots for growing food (n = 2). Three IHPs said they had no unmet health care service needs, but during their interviews, they did identify unmet needs.

Analysis of barriers to health care services access

No IHPs expressed the opinion that improving health care services for homeless persons would worsen problems of homelessness on Maui. One IHP (IHP 2) who had recently arrived on Maui said, “This is the place to be. If you're going to be in this kind of situation [homeless], right here in Kahului, Maui.” He was appreciative of how available food assistance was, and the attitudes of those providing service.

Five IKS expressed the view that improving health care services on Maui would worsen the problem of homelessness by attracting more homeless persons to Maui. Some of the opinions were that Maui is attractive enough already to homeless persons without making it more attractive, by improving services (n = 1), improving services would make it too easy for homeless persons and is therefore unfair to the middle class (n = 1), and housing with support services is needed but could attract more homeless persons to Maui (n = 1). Other opinions were homeless persons should be required to do work to get services (n = 2), the homeless population on Maui increased when public bus service became available (n = 1), feeding homeless persons will attract more homeless persons (n = 1), and improving health care for the homeless will attract more homeless persons (n = 1). Outside the recorded portion of the interview, one interviewee noted that there is a dilemma between providing humane services and being a magnet for more homeless persons, and that if services are cut, people will just die off.

Two IKSs commented that improving health care services for the homeless is very expensive. Health outreach and housing first were identified as expensive programs (n = 1). Resources devoted to homeless programs reduce subsidies to other programs for needy people who are less in the public eye, e.g. the frail elderly living at home (n = 1). No IKSs or GS spoke of strategies for improving health care services while simultaneously preventing migration of homeless persons to Maui.

Four IHPs commented on the lack of health care service facilities on Maui that will treat homeless persons. They noted a lack of facilities for homeless persons who have a chronic pain diagnosis (n = 1), facilities with comprehensive services (n = 1), and outreach dental care (n = 1).

Twelve IKSs and the GS commented on lack of health care facilities that serve homeless persons. Nine IKSs commented on the lack of primary care facilities that serve homeless persons. Their comments included cumbersome registration requirements at MIKOHC (n = 1), lack of primary care services that will accept homeless persons in South and West Maui (n = 1),

and delays in getting appointments that may result in homeless persons giving up (n = 4). There are a lack of walk-in clinics that will see homeless persons (n = 5). There is no walk-in mental health clinic (n = 1), no walk-in wound care clinic (n = 2), and no pain management clinic (n = 1). There is a lack of detox and substance abuse treatment facilities (n = 4), and no outpatient substance abuse treatment for homeless persons (n = 1). There is a lack of primary care facilities with services tailored to treat homeless persons (n = 2). There are outreach services for homeless persons, but there is a lack of health outreach for the homeless (n = 6). There is a lack of facilities to accept homeless persons when they are discharged from acute hospital care (n = 6). There is a lack of housing with support services (n = 5) including a lack of sober living housing for persons who homeless persons who have completed substance abuse treatment programs (n = 1).

Six IHPs commented on the lack of health care providers who will accept homeless persons as patients for primary care (n = 6), when they have a chronic pain diagnosis (n = 3), and for specialty services like urology (n = 2). Eleven IKSs commented on the lack of providers who will accept homeless persons as patients. Six IKSs said there are not enough doctors on Maui, and one said there was no staffing for a clinic. Three IKSs identified bias against homeless persons as a contributing factor. They also identified low insurance reimbursement from Hawaii Medicaid (n = 1), and liability concerns that discourage voluntarism (n = 1). One IKS said that congregate housing would increase the efficiency of care delivery to homeless persons because they would be clustered in one location, and that, in order to serve them, you have to go out to them - they are not going to come to you.

Lack of follow-up and support systems are barriers to access to health care services. Thirty-one IHPs commented on this. Fifteen IHPs gave examples of how they did not follow-up to receive services. Their examples included not following up to get health insurance (n = 2), get identification replaced (n = 2), and go to appointments (n = 3). They also spoke of not following-up to get shelter or housing (n = 4), take care of their health needs (n = 9), and get veterans' services (n = 2). Eighteen IHPs described having a weak personal support system. Some of the reasons they gave for weak personal support systems were being new to Maui (n = 3), choosing to stay alone (n = 5), and family disputes (n = 7). Five IHPs described having a personal support system with other homeless persons. Four described having support from friends, or family who had housing. Thirty-one IHPs had support from either Salvation Army or Family Life Center.

All twelve IKSs and the GS commented on homeless persons' lack of follow-up and lack of support systems. They identified a number of conditions that led to lack of follow-up, some of which are included here. Conditions included lack of insurance (n = 6), lack of transportation (n = 5), and communication problems such as no phone (n = 3). In addition, they identified lack of identification (n = 2), no mailing address (n = 2), and lack of money (n = 2). Ten IKS and the GS identified lack of support services for homeless persons including lack of health outreach (n = 4), lack of intensive case management (n = 2), and lack of shelters that allow follow-up health care (n = 2).

Basic requirements for accessing health care services outside the ED, or from a service other than EMS include identification, health insurance or a cash payment prior to services, phone communication, transportation, a mailing address, and keeping appointments. Nine IHPs reported having no identification and four of those said their identification had been stolen. Fourteen IHPs did not have health insurance that was accepted in Hawaii. Fourteen IHPs said they did not have enough money to get health care services. Sixteen IHPs did not have a phone of their own. Three of the IHPs without a phone had their phones stolen. Five IHPs were able to use another person's phone if they had to make a call. For their means of transportation, 20 IHPs said they took the bus, 13 IHPs said they walked, and four IHPs travelled by bicycle. Four IHPs caught rides with others, three IHPs had a vehicle that could not be driven because it was unregistered or needed repairs, and one IHP got a ride in a family vehicle. Three IHPs said they had no mailing address, although IHPs were not routinely asked whether they had a mailing address during the interviews. Seventeen IHPs said they had difficulty making or keeping appointments.

All IKSs and the GS commented on homeless persons' lack of basic requirements for access to health care services. Four IKSs and the GS remarked on problems associated with no identification which included that it may be one of the biggest barriers to health care access (n = 1), homeless persons may be refused primary care services without it, even at MIKOHC (n = 2), and they are unable to apply for services (n = 2). Without identification, they are unable to pick-up prescriptions (n = 4), or board a commercial airplane flight (n = 2). Salvation Army assists homeless persons with identification replacement (n = 1).

Nine IKSs identified lack of health insurance as a barrier. Homeless persons need an advocate to help them with insurance application paperwork (n = 2), and that help is available at

Salvation Army, Family Life Center, MIKOHC, and from hospital staff during an acute care hospitalization. Lack of health insurance is one reason people who need treatment, don't seek it (n = 1). Primary care (n = 2) and specialists (n = 1) will not see patients without health insurance unless they pay cash first. Without insurance, patients need specific proof of income paperwork to be eligible for the MIKOHC sliding scale fee schedule (n = 2). Lack of insurance can make prescription medications unaffordable (n = 2). Homeless persons may lose health insurance that they signed up for during their acute care hospital stay, if they do not follow-up with paperwork sent to their mailing address. Without dental coverage, they may not be able to see a dentist for a dental emergency (n = 1).

Four IKSs and the GS identified lack of money as a barrier to accessing health care services. Reasons given that it is a barrier included no money for identification replacement (n = 1), no money to fill prescriptions (n = 1), and for the uninsured, no money to pay sliding scale fees at MIKOHC (n = 1). Reasons also included no money to pay for specialists' services (n = 2), and no bus fare for follow-up appointments (n = 1).

Six IKSs identified ways that having no phone creates barriers to health care access. The ED cannot notify the person of lab results that may require a change in treatment (n = 2), persons may miss appointments (n = 1), and the Crisis Line for mental health assistance requires a phone (n = 1). Without a phone, persons referred to MIKOHC after hospital discharge cannot be contacted by MIKOHC for follow-up (n = 1).

All 12 IKSs and the GS identified transportation problems as a barrier to health care service access. It was identified as a huge issue (n = 4). The public bus stops in front of MIKOHC's front door (n = 1). Having no mailing address may result in loss of health insurance arranged during acute care hospitalization (n = 1). A mailing address is necessary to receive benefits (n = 1), and a government identification is necessary to receive mail at Family Life Center (n = 1).

Six IHPs lacked information about health care resources. Eighteen IHPs had experiences that were a barrier to receiving health care services. They included past negative health care experiences that discouraged them from seeking services (n = 8), feelings of being stigmatized during health care experiences (n = 7), and fear of what might happen during the experience (n = 11). They also included cumbersome access procedures (n = 3), and communication problems with providers (n = 3). Four IHPs had positive expectations about care they would receive.

Attitude was a barrier for 18 IHPs. Attitude barriers included lack of accountability for their behaviors (n = 3), being rule averse (n = 5), not caring anymore (n = 8), and having competing priorities (n = 10). Behaviors of IHPs were also a barrier and included nonadherence to treatment (n = 2), sale of prescription medications (n = 1), and lack of follow-up as previously mentioned (n = 15).

Individual key stakeholders had an abundance of comments on knowledge, experiences, attitudes and behaviors of homeless persons that were barriers to receiving health care. Homeless persons need assistance with paperwork (n = 3), education about how to do self-care especially for wound care (n = 3), and education about when it is appropriate to seek care at the ED (n = 1). One IKS commented that homeless persons may know about the resources but may need to be given incentives to motivate them to use them (n = 1).

Three IKSs said that biases of health care professionals can discourage homeless persons from seeking care when they need it. One IKS suggested health care professionals need to get past the fact that people are drinking alcohol and taking drugs, and see them as ill with an addictive disorder. Cumbersome registration procedures and the perception of getting the runaround discourage care seeking (n = 2). Some homeless persons may face racial discrimination against Caucasians from local service providers (n = 1). Illegal immigrants may be afraid to seek services for fear of being deported (n = 1).

Eleven IKSs identified attitudes of homeless persons as barriers to care. Three IKSs said that homeless persons' attitudes of entitlement irritated health care professionals. Six IKSs found rule adverse attitudes to be a barrier, e.g. by interfering with adherence to treatment plans. Three IKSs stated that health care is not a priority for homeless persons so it may get neglected. Three IKSs identified a sense of hopelessness, or an attitude of not caring anymore, as a barrier. And one identified a lack of sense of purpose or self-reliance.

Behaviors that were identified as barriers to receiving services included behaviors that were discordant, or disruptive (n = 2). IKS 12 gave an example of advice he gave homeless persons seeking health care, "And I tell every single one that's sick: 'Be nice… Go in there and be nice… Act like you want to be helped… Don't yell and scream, and people will probably be nice to you.'" Homeless persons may be refused services from sources other than ED or EMS if they appear to be intoxicated (n = 1). Other behavior problems IKSs identified are that some homeless persons may be so intoxicated that they do not care for themselves (n = 2), they have

poor hygiene (n = 3), and they do not seek care in a timely manner (n = 2). In addition, IKSs included that homeless persons may have a lack of compliance with treatment plans (n = 2), 10% to 40% of the homeless population causes most of the problems (n = 2), and lack of follow-up and poor support systems as previously described (n = 12).

Analysis of ideas for solutions

Often IHPs seemed absorbed by the stressors of their own homelessness. They suggested ideas for solutions to meet their own needs such as replacing identification documents (n = 2), applying for health insurance (n = 3), getting employment (n = 3), and support from family and friends (n = 2). Health care service changes they suggested included health outreach with wound care (n = 4), transportation assistance (n = 6), and comprehensive health care services in one place (n = 2). They also suggested nonjudgmental care from health care professionals (n = 6), more doctors and fewer homeless persons (n = 1), and health care professionals who clearly explain what services are available and the steps required to get the services (n = 3).

Five IHPs thought of ideas to help them avoid inappropriate ED use which included learning about other places to get health care services (n = 1), registering at MIKOHC (n = 1), and getting health insurance (n = 1). They also mentioned treating their wounds early before they have complications (n = 1), and getting asthma inhalers to prevent severe attacks (n = 1).

Individual homeless persons had no comments on how they might reduce their hospital lengths of stay if they were hospitalized. Eighteen IHPs commented on places to stay after hospital discharge. Seven IHPs thought they would have no place to go and four other IHPs thought they would have to return to camping or the living on the street. Four IHPs thought they could stay with family. One IHP thought he could stay with friends. Three IHPs thought they would stay at Family Life Center.

Twenty-six IHPs commented on ideas for getting housing. The most frequently mentioned ideas were get a job (n = 10), have money (n = 7), and get identification (n = 4). One IHP said he was very interested in getting housing, but there was nothing ever that would help him get housing. Two IHPs suggested that if they were able to stop drinking alcohol, they would be able to get shelter. Other ideas were for having shelters that allow pets (n = 1), and working with a case manager (n = 1). Also mentioned were finding housing that will accept a HUD voucher (n = 1) and work with Housing and Urban Development Veterans' Administration Support Housing program (HUD-VASH) (n = 1). Four persons were wait-listed for housing.

Other ideas for solutions IHPs mentioned were public bath houses for hygiene (n = 3), permitting homeless persons to sleep in parks without getting chased out (n = 1), and making free phones available (n = 1).

All twelve IKSs and the GS had ideas for solutions to close the gap in health care services for homeless persons on Maui. One IKS suggested opening up MIKOHC, so MIKOHC would take anyone. Another IKS suggested having a Community Mental Health Center that would accept homeless persons. Eight IKSs suggested walk-in clinic services with wound care (n = 3), mental health services (n = 2), and a free clinic service that would see patients without identification so all patients might be seen (n = 1). Other suggestions were a pain management clinic (n = 1) and outpatient detox (n = 1). Health outreach was suggested by six IKSs and the GS to include wound care outreach (n = 5), and outreach to congregate housing (n = 1). Intensive outpatient mental health case management (n = 1) and frequent follow-up with patients (n = 2). Additional ideas were to redirect patients from the ED to primary care when possible (n = 1), and to get more doctors willing to accept homeless persons as patients (n = 3), especially in South Maui and West Maui (n = 1). A health center with comprehensive services, tailored to the homeless population (n = 1), more substance abuse treatment centers (n = 3), and nonjudgmental care from health care professionals (n = 3) were suggested. Other ideas from IKSs included a call center where homeless persons could make calls, and receive calls and messages (n = 1), a mail center (n = 1), and a simplified and expedited process at the Department of Motor Vehicles for getting a state identification (n = 1). Additional ideas were pre-registration at MIKOHC before homeless persons are really sick (n = 2), utilization of an under-utilized state building for a walk-in clinic (n = 1), and State and County funding and problem solving (n = 1).

Ideas to avoid inappropriate ED use from IKSs and GS included many of the ideas in the previous paragraph. In addition they mentioned promoting better hygiene (n = 3), getting persons health insurance (n = 1), and placing persons in Housing First facilities or congregate housing with support services (n = 2). Other ideas mentioned were a juvenile detention center (n = 1), a drunk tank (n = 1), and repeal of the COBRA- EMTALA law (n = 1).

Seven IKSs had ideas to reduce the acute care hospital length of stay. Six IKSs suggested that an appropriate facility to discharge homeless persons to would reduce acute care hospital lengths of stay. One person suggested that stays would be shortened if homeless persons knew when it was appropriate for them to come to the hospital. One IKS suggested discharging

homeless persons from the hospital regardless of whether there is a facility available to take them.

Six IKSs and the GS offered ideas about where homeless persons might go after hospital discharge. One IKS mentioned that the campsite and the tent the person had might be gone if the person is away from it for a few days at the hospital, and that persons need a support group for assistance when they are discharged. The GS suggested that Family Life Center expand their services and set up beds where homeless persons could stay inside during the day, because homeless patients are difficult to place when they are discharged from the hospital. They would be able to use their oxygen or their equipment that requires an electrical outlet. One IKS emphasized that Family Life Center is not a "dumping ground", but rather an overnight shelter and does not provide medical care. Another IKS suggested that Salvation Army should set-up another shelter. Other IKSs suggested more medical respite sites in the community (n = 1), a dormitory style setting where persons could have wound dressings changed and get oral antibiotic medication (n = 1), and a clean place to stay where they could receive follow-up care at a day clinic (n = 1). Hospital nurse case managers can set-up the appointments and transportation to a day clinic (n = 1). Some persons can be assisted by nurse case managers to return to their families who are off-island, if the families or a facility will take them (n = 1). One IKS and the GS also suggested health outreach as a means for providing follow-up care (n = 2).

Eleven IKSs commented on ideas for housing. One IKS suggested that it is sometimes necessary to elicit homeless persons' motivation for getting housed to support them in making the effort (n = 1). Two ideas they had were having developers and landlords that choose what is right over what is profitable (n = 1) and getting land donation from the County of Maui and the help of volunteer contractors to build the housing (n = 1). Other ideas that had more to do with what is needed included more affordable housing units (n = 2), more jobs so that persons are able to afford housing, and more public housing and congregate housing with support services, not just shelters (n = 2). Finding locations for housing is a problem because people may not want to live where the housing is constructed (n = 1), and residents and business people may not want the housing located near them (n = 1). Another IKS commented that a drawback of housing with support services is that it could attract more homeless persons to move to Maui. One IKS suggested offering a work program with housing in a farm setting.

Conclusion

Seventy–five per cent of the IHPs were unsheltered, 19% were sheltered only at an overnight shelter, and only the remaining 6% had longer term shelter. The results of the needs assessment show that 56% of the IHPs reported having health insurance that may be accepted in Hawaii, although in fact, there may be few or no providers willing to accept it. Sixty-nine percent of IHPs said they had no access to primary care services. Eighty-eight per cent of IHPs said they had used the ED for services while only 38% said they had ever used the FQHC MIKOHC for services. All the IKSs had comments on problem use of the ED by homeless persons, and many commented on difficulties homeless persons have in getting services at MIKOHC.

Individual homeless persons and IKSs have some areas of agreement and some discrepancies in their perceptions of homeless persons' unmet health care service needs. A large number of sources in all groups agreed that wound care, prescription medications and other needs were unmet. Unmet needs for dental care services and for vision care services were named by a large number of IHPs but not by a large number of IKSs and GS. Unmet needs for substance abuse treatment and mental health or counseling services were named by all IKSs, but not often by IHPs.

Some IKSs expressed concern that improving services would worsen the problem of homelessness. Other barriers many IHPs face are a lack of basic requirements for accessing health care services such as identification, insurance, money, communication, transportation and keeping appointments. In addition lack of follow-up and lack of a support system were often barriers. A lack of facilities and of providers that will treat homeless persons was identified by IKSs. Primary care, specialty care, substance abuse treatment, mental health and medical respite services are lacking. Care from service providers that is trauma-informed is needed. Attitudes, behaviors and poor skills that function as barriers were identified. Ideas for solutions include walk-in clinics with mental health and wound care services, health outreach, opening up access at MIKOHC, and enabling services.

Chapter 5. Discussion

Introduction

Chapter 5 addresses the interpretation of the study results from Phase 1 of the DNP Project, specifically, what the gaps in health care services for homeless persons on Maui are, and beginning ideas for how services might be improved to close those identified gaps. Phase 2 will include planning of interventions based on the results of the needs assessment and Phase 3 will consist of piloting and implementing interventions and evaluating the outcomes of these. In Chapter 5, there is also an explanation given of how the DNP Project meets the AACN Essentials criteria, a plan for dissemination of the Project, and a summary.

Interpretation of findings

The perception that improvements would worsen the problem of homelessness is a barrier to making improvements. Such views could result in opposition, or lukewarm support only, for efforts to make improvements. Such views need to be taken into account and addressed, if improvements are to be made.

A search of the databases PubMed Medline, the Cochrane Reviews, CINAHL, and also Google Scholar and Google with keyword combinations of homeless persons, migration, population dynamics, health services, improvements, decision-making, Maui and Hawaii yielded no research studies that addressed the question of whether improvement of health care services was related to an increase in the homeless population in the United States, or in Hawaii, or on Maui.

Queries were submitted by email and phone to the National Health Care for the Homeless Council (NHCHC). During a telephone conversation, the technical assistant at NHCHC said she was not aware of any such studies but would explore the question further and follow-up with the DNP student (L. Hopper, personal communication, September 16, 2016). A similar email query was also sent to the Boston Health Care for the Homeless Program.

A search of Yahoo and Google search engines with the question “Why did you move to Maui?” or “Why would you move to Maui?” did yield a number of websites that encouraged moving to Maui, or to Hawaii and gave advice about how to do it. One in particular, gave 50 reasons to move to Hawaii. None of the reasons given had to do with health care services, or social services for the homeless (Living in Hawaii, September 2016). It appears that there are a number of other more compelling reasons why someone might choose to move to Maui besides

health care service availability. At this time, there does not appear to be any evidence that improvement of health care services for homeless persons on Maui would attract more homeless persons to Maui. The lack of evidence to support that concern can be shared with service providers who are worried about it when attempting to engage their support for improvements.

Source of health care services

Strategies for opening up access to primary care services. One of the major gaps in health care services for homeless persons on Maui is lack of access to primary care services. Basic requirements for health care service other than in the ED and EMS include an individual's personal identification, health insurance or sufficient cash, phone communication, transportation, a mailing address and keeping appointments. All 32 IHPs had problems with some or all of these basic requirements which create a barrier to accessing primary care services. The requirements for registration at MIKOHC effectively create a barrier to keep out homeless persons who lack such basic requirements.

Patients seen at MIKOHC must have identification. Per the MIKOHC website (MIKOHC, 2016), a patient is eligible for fee discounts if specific verifiable documentation of low income level is given. The minimum discounted fee for a visit is $25. Visits are by appointment. Walk-in clinic service is not available.

According to the U.S. Department of Health and Human Services website:

> No patient will be denied health care services due to an individual's inability to pay for such services by the health center, assuring that any fees or payments required by the center for such services will be reduced or waived. (Section 330(k)(3)(G) of the PHS Act, 42 CFR 51c.303(f), and 42 CFR 51c.303(u)) (HRSA, 2016)

With regard to homeless service programs, the website says:

> Health Care for the Homeless grantees recognize the complex needs of homeless persons and strive to provide a coordinated, comprehensive approach to health care including substance abuse and mental health services (HRSA, 2016).

Individual key stakeholder 7 recommended opening up service at MIKOHC so that anyone could receive treatment there. That improvement would not be likely to increase the number of homeless persons attracted to Maui, but would increase the number of unsheltered homeless persons seeking services at MIKOHC. Three ways for MIKOHC to close the gap in access to primary care services would be acceptance of a temporary personal identification

document, modification of policies on required documentation of income status, and adjustment of the sliding scale fee.

Per the technical assistant at the National Health Care for the Homeless Council (NHCHC) (L. Hopper, personal conversation September 16, 2016), some FQHCs will treat patients who do not have government identification. She gave an example of how that might be done. She said that a staff member takes the patient's picture, prints a card with the picture on it, and has the person sign it. Then the person takes the card, and the health center keeps one card on record as that person's identification for health center use only, until the person gets a government identification. In that way, lack of identification does not become a barrier to the person without government identification who seeks health care services at a FQHC.

The technical assistant at NHCHC (L. Hopper, personal conversation September 16, 2016) also had ideas about how to prevent lack of documentation from being a barrier to homeless persons receiving health care services at a FQHC. She said that some FQHCs have a homeless person sign a statement that he or she is homeless, or get a signed letter from the shelter where he or she is staying, verifying their stay at the shelter.

The Boston Health Care for the Homeless Program (BHCHP) has been in operation since 1985. Their sliding fee discount program (SFDP) asserts the following:

> No aspect of the SFDP, including BHCHP's fees themselves, the procedures for assessing patient eligibility, or the procedures for collecting payments, will create barriers to health care services. All services within BHCHP's approved scope of project for which BHCHP charges patients are offered on the SFSD and are available to patients regardless of their ability to pay (BHCHP, 2016)

The deepest discount at BHCHP is a fee for services of $0. If MIKOHC adopted a similar sliding fee discount policy, it could eliminate having no money as a barrier to homeless persons on Maui receiving primary care services. Another possibility for MIKOHC would be to use grant funding or charitable donations to close the gap between the person's lack of funds and the fee requested. In addition, the BHCHP policy on documentation of income prevents documentation from being a barrier to receiving health care services. An excerpt from the BHCHP policy follows:

> BHCHP will assist patients in completing an income verification form and will collect any available income verification documentation from patients. Whenever possible, completion of the verification form and collection of income verification documentation will occur prior to BHCHP's rendering health care services to the patient, or as soon thereafter as is

> reasonable, but always prior to the application of the discount. Nonetheless, under no circumstances will health care services be withheld or denied on account of delay of the eligibility documentation process (BHCHP, 2016).

If MIKOHC adopted a similar policy on documentation, no patient would have to be turned away for lack of documentation of income. Assistance is already available at MIKOHC, Salvation Army and Family Life Center for signing up for health insurance if persons are uninsured.

At the time of the interview with IKS 12, MIKOHC satellite services in Lahaina were unavailable. Individual key stakeholder 12 felt that lack of such services was diverting emergency ambulances to the care of homeless persons with primary care problems who might have been more appropriately treated in a clinic setting. He said he knew of cases in which persons having medical emergencies had actually died because the ambulance was tied up transporting a homeless person to the ED who could have been treated, instead, at a primary care clinic, had there been a service to take the person. As of September 2016, services have resumed at the satellite clinic per the MIKOHC website and per a clerical person at the clinic (MIKOHC clerical staff, personal communication September 15, 2016).

Two IHPs thought that having comprehensive health care services for the homeless in one place would help them to better meet their health care service needs. Eight IKSs thought that walk-in clinic services, where persons could arrive and be seen without an appointment, are needed for homeless persons on Maui. IKS 4 thought that walk-in clinic services would satisfy a need of homeless persons that the ED is currently is burdened with. In addition to that, IKSs suggested walk-in wound care services, and walk-in mental health services would help care for patients and stabilize patients before they destabilized and had to go to the ED.

Suggestions such as these can be offered to the Chief Medical Officer and Administrators of MIKOHC in a collaborative meeting with hospital staff, concerned health care professionals and MIKOHC. Such a meeting would also be an opportunity to find out what further assistance or funding MIKOHC would need to make changes. If additional work is being suggested for staff, help should be offered in working out how it is to be sustained. If additional costs will be incurred, ideas for how to finance them should be offered. A joint collaborative committee to improve direction of homeless patients with primary care problems to MIKOHC, and with emergency problems to the ED, and improve follow-up of patients after hospital discharge should be initiated. The DNP student would promote the formation of this joint collaborative committee during Phase 2 or Phase 3 of the DNP Project.

Strategies to reduce inappropriate ED visits. A 2011 report from the United States Government Accountability Office identifies three strategies health centers and emergency departments have used collaboratively that may reduce emergency department use that would be relevant for Maui (USGAO, 2011). The DNP student reported on these during a directed study. Employing these strategies would be dependent on opening up MIKOHC so that any patient could be cared for there. One strategy is emergency department diversion of patients. This strategy would focus on educating homeless emergency department patients about appropriate use of the emergency department, informing them about services available at the health center, and arranging appointments or referrals to the health center. Patients who may be targeted are those who use the emergency department inappropriately for non-urgent problems, have no usual health care provider, are uninsured or who have Medicaid, or are frequent users of the emergency department.

To be effective this strategy requires good communication and collaboration between the hospital and the health center and open access to homeless persons at the health center, so it would be contingent on reducing barriers at MIKOHC. Other diversion strategies that have been used include stationing health center community health workers at the hospital emergency department to link eligible patients to the health center, although most likely this would be too costly an intervention for Maui; using charitable contributions from corporations to pay for the patient's first health center visit and prescription; and connecting the patients to case managers at their first health center visit. Other approaches are health center and hospital staff meeting on a monthly basis to discuss targeted patients and care plan improvement; health center case managers conducting outreach at hospital emergency rooms; case managers following-up with patients after they leave the emergency department to make sure they receive needed services. This is difficult but could be done by improving the means of follow-up with enabling services.

Care coordination is a second approach used by health center case managers to prevent avoidable emergency department visits (USGAO, 2011). This approach focuses on teaching patients to seek care first at the health center and preventing disease related emergencies. A third strategy is that health centers make their services accessible to patients and raise community awareness of the services they offer. Examples of this include expanded health center hours and locations to make them a convenient alternative to emergency department visits; making available same day or walk-in appointments; and arranging transportation to health center

locations. The public bus stops at MIKOHC, so bus passes are an appropriate way to assist patients with transportation. One problem identified with these strategies is that health centers do not benefit from any cost savings to emergency departments. Another problem is that some health center officials have reported difficulty in changing the habits of substance abusers and homeless persons who frequent the emergency department. These sample strategies of collaboration between hospitals and health centers would be potentially useful suggestions for Maui facilities. (Petith-Zbiciak, 2015)

If it does not appear to be possible to open up MIKOHC so it takes care of any patient requesting services, other possibilities should be considered in order to meet health care service needs of homeless persons. It may be possible to develop a satellite service from another FQHC that would offer services to the homeless.

Other strategies to assure basic requirements to access health care services. Another gap is lack of other basic requirements for getting health care services. Homeless persons often lack a phone, lack a mailing address, have problems with transportation, and have difficulty keeping appointments. Family Life Center assists homeless persons staying at the shelter with these needs.

A facility that served additional clients would be helpful. A way to close this gap would be for Salvation Army Maui to reopen a Safe Haven in a new location in Central Maui. Services could include a call center where homeless persons could make and receive calls, and receive messages. Such a service would reduce some of the difficulties of keeping appointments. It would make follow-up from health care providers possible. A mailing address service could improve persons' ability to replace identification and receive benefits. Persons with health center appointments could be assisted with bus passes, or with transportation by staff. The DNP student will discuss this with the Salvation Army Board of Directors during Phase 2 of the DNP Project.

Unmet Health Care Needs

Housing. Many IHPs and IKSs commented on the adverse impact of the unstable homeless lifestyle on their health. The Maui Homeless Alliance has identified getting housing for homeless persons as the organization's top priority (Maui Homeless Alliance Priority Setting Meeting, September 7, 2016). The DNP student will continue to support the Maui Homeless Alliance in legislative and funding endeavors to achieve this goal and encourage others to do so also.

Wound and skin care. Wound and skin care needs were in the top five unmet needs identified by IHPs, IKSs, and GS. Ideas for solutions included health outreach that includes wound care, wound care services at a walk-in clinic with education about self-care and available supplies for wound care, public hygiene facilities, and medical respite following hospital discharge. These are all services that would help to close the gap in care that homeless persons experience with wounds and skin care.

In March of 2013, the DNP student arranged for Dr. Valerie Foree of Waikiki Health Center to come to Maui and give a presentation on the Waikiki Care-A-Van that provides multidisciplinary health outreach to homeless persons on Oahu. The staff at MIKOHC were unavailable to attend. Prior to that Dr. Jay Faris, who was the Medical Director of MIKOHC at the time, emailed that it would be an internal decision whether MIKOHC had the staff and resources for outreach. He wrote that they would determine if it was part of their mission to have an outreach service similar to Waikiki Health Center (Dr. Jay Faris, email communication January 6, 2014).

Health Outreach Partners (HOP) developed the National Outreach Guidelines for Underserved Populations: Executive Summary (2012) which states:

> HOP advocates for community health models that include structured outreach programs as part of the overall health delivery system. These programs should be well-integrated into the health center structure and closely aligned with administrative and clinical priorities. A strong outreach program offer the best opportunity for the most vulnerable populations to be connected to and engaged with true medical homes.

Health outreach disconnected from a health center with comprehensive services is not consistent with guidelines, or with optimal services. During a directed study on sustainability, the DNP student noted that Kemble (2000) described her experience with a charity care program in rural Massachusetts called Health Links that recruited local physicians to provide charity care to uninsured patients. The program preceded the establishment of a FQHC in the area to provide primary care services to the underserved patients. Kemble concluded that charity care and volunteerism that is organized by gatekeeping agencies has limited usefulness in meeting the medical needs of poor and underserved communities, and may actually result in costly, fragmented substandard care. This leads me to believe that it would be a strategic mistake to try to compensate for lack of primary care services to homeless persons on Maui with volunteer

outreach services. A volunteer health outreach service disconnected from the health center may be of limited benefit. (Petith-Zbiciak, 2015)

Malama I Ke Ola Health Center, according to their website, has job openings for a number of staff positions including the Chief Medical Officer (MIKOHC, 2016). During Phase 2 and Phase 3 of the DNP Project it may still be possible to develop interest in an outreach program with MIKOHC. If an outreach program based at MIKOHC is not feasible, and if access to health care services at MIKOHC becomes more open, a volunteer health outreach program with a streamlined referral process to link patients into the health center would likely still be beneficial.

Other unmet health needs. Other unmet health and medical needs were in the top five unmet needs identified by IHPs, IKSs, and GS. Two other unmet health needs named by IHPs were for restful sleep and hygiene facilities. Hygiene facilities were also identified by IKSs. A public hygiene facility with hot showers and rest rooms would be helpful to those with wound problems also. Family Life Center has shower services for homeless persons staying there and for some others during the day who may not be staying there (Maude Cumming, personal communication September 7, 2016). Additional public hygiene facilities offered by the County, or by another agency such as Salvation Army would help to meet this need. During Phase 2 and Phase 3 interest in developing public hygiene facilities and additional shelter space should be explored.

Prescription medications. Unmet needs for prescription medications were in the top five unmet needs identified by IHPs, IKSs and GS. Reasons for unmet needs for prescription medications included lack of insurance, lack of money to fill prescription, lack of identification; and reasons related to the unstable homeless lifestyle including lost, or stolen medications. Remedies for this unmet need continue to be assisting homeless persons to get insurance, and replace lost or stolen identification. One IHP the DNP student spoke with had arranged for Salvation Army Lahaina to store most of his medication so that he carried only a few tablets of his antibiotic with him at a time. That way he was less likely to lose the entire container of medication, or have it stolen. He restocked a few tablets at a time when he visited Salvation Army Lahaina.

Another complaint of IKSs was that homeless persons did not adhere to their medication regimens. At the same time, homeless persons complained of health care providers not listening

to the concerns they had about medications, and not getting clear instructions. In addition to helping persons get insured, replacing lost or stolen identification documents, storing[MS2] persons' medications to secure against theft, damage and loss, and careful attention to communications about prescription medications on the part of both health care providers and patients would meet some unmet needs. This is a topic where patient coaching about how to manage a health care visit could be helpful.

Dental care. Unmet needs for dental care was one of the top five most frequently identified unmet needs of IHPs. Current outreach services offer dental care items such as toothbrushes and toothpaste. In additions, there are a number of dental care cubicles at MIKOHC. Services available are exams, fillings, extractions and dental hygiene. The minimal charge listed for a dental visit is $30. How to increase access to these services to meet homeless persons' unmet needs for dental care services is a topic for discussion during Phase 2 of the DNP Project. Self-care for prevention of dental problems and for maintaining oral health are important education topics to share with homeless persons.

Vision services. Unmet needs for vision services was one of the top most frequently mentioned unmet health care service needs of IHPs. Fourteen IHPs mentioned an unmet need for vision care services. Eleven identified needing glasses as an unmet need. Project Vision, a recreational vehicle equipped to provide retinal screenings will be providing screenings at variable locations on Maui beginning September of 2016 for a period of six months. The providers refer persons to their own eye care professionals for other services (Project Vision, 2016). Further discussion of how to meet this need would be appropriate during Phase 2.

Mental health or counseling service. A need for walk-in mental health services was identified to help persons before they destabilize and have to be seen in the ED. Currently Mental Health Kokua sees patients by appointment (staff member, personal conversation, May 18, 2016). How to make walk-in mental health services available on Maui is a topic for discussion during Phase 2. One aspect to further explore is whether it is possible to expand mental health services at the Community Mental Health Center in Wailuku and what would be necessary to allow that to happen.

Follow-up was identified as particularly difficult to achieve with homeless persons with mental health needs. Implementing a centralized call center, and establishing mailing address services mentioned previously under the heading [MS3]*Other strategies to assure basic*

requirements to access health care services, might be helpful in facilitating follow-up. Intensive case management and the need for congregate housing and housing with support services was also emphasized..

Substance abuse treatment. A need for additional substance abuse treatment services on Maui was identified. A question for Phase 2 of the DNP Project is how might it be possible to expand substance abuse treatment options on Maui e.g., on an outpatient basis. Salvation Army has substance abuse treatment services on Oahu but not yet on Maui and could be asked about expanding services to Maui.

Health outreach. One of the functions of outreach is to improve access to care. In order for that to occur, it is necessary to have a health care facility to refer persons to that will enroll them as patients to follow-up on their primary care needs (Health Outreach Partners, 2012). The alternative is just to continue sending homeless persons with primary care needs to the ED. Health outreach could be done in collaboration with existing outreach services, or at feeding centers as a volunteer activity until a FQHC initiates multidisciplinary outreach services. Planning for health outreach will occur during Phase 2 of the DNP Project.

Walk-in clinic. A need for walk-in clinic services was identified. This was mentioned previously when wound care and when mental health or counseling service needs were discussed. A range of possibilities would be same day appointments when possible for walk-in patients, walk-in and wait for an opening services, and one-day-a-week, regularly-scheduled walk-in clinic services; walk-in service always available for patients who are already registered, or registration and walk-in service available for new patients. If there is a willingness to implement walk-in services at MIKOHC, other health care professionals in the community could support this by offering assistance that staff decided was necessary to implement walk-in services, e.g., raising additional funding. One IKS (IKS 4) thought that a walk-in clinic would lighten the burden on the ED of homeless persons who were seeking services. He said, “If you have issues, you can come on in. Basically the same thing we do.”

Medical respite following hospital discharge. The Salvation Army previously operated a small shelter but closed it. A shelter could be opened again which would meet such a need as medical respite. Discussions about this can take place during Phase 2 of the DNP Project.

Public hygiene facilities. Improving homeless persons' hygiene is a health issue that was identified. Public hygiene facilities that included hot showers, and restrooms are needed. This was addressed previously under the unmet health needs heading.

Barriers to accessing health care services.

Stigma and judgmental attitude from care providers. Training in trauma-informed care and the culture of homelessness would help those who see themselves as being helping health care professionals, in order to not cause further trauma for these vulnerable homeless patients (Proffitt, 2010). Plans for presenting this approach can be done during Phase 2 of the DNP Project.

Attitudes and behaviors of homeless persons that interfere with accessing health care services. Coaching homeless persons on attitudes and behaviors consistent with accessing health care services may be helpful in getting them health care services. It would be helpful to involve outreach workers and outreach case managers in this coaching. Planning for this could take place during Phase 2 of the DNP Project.

Strengths and limitations of the project

A strength of the project is that it elicits information on what the gaps in health care services for homeless persons on Maui are from people on Maui rather than assuming that the unmet needs are what researchers have found them to be in other geographic areas. Another strength is that the sample of IHPs were mostly unsheltered and, therefore, represent some of the most vulnerable of homeless persons.

Thirty-one of the 32 IHPs were soliciting services from Salvation Army or Family Life Center at the time of the interviews. A limitation of the study may be that some homeless persons some service providers identified as being the most problematic (e.g., those with repeated ED admissions for intoxication) may have been a different subset of homeless persons than the ones the DNP student interviewed. That difference may account to a small extent for a difference in perspective between IHPs and IKSs on unmet health care service needs of homeless persons.

AACN Essentials

Ideas of how this DNP Project is consistent with essentials described in the AACN Essentials for Doctoral Education in Advanced Practice Nursing (2006) are displayed in Table 5.1 and described below.

Table 5.1. *Essentials of Doctoral Education for Advanced Nursing Practice: Implications/ Recommendations of DNP Project*

Essential I: **Scientific Underpinnings of Practice**	
Essential I Elements	DNP Project Demonstrates Essential I
• Integrate nursing science with knowledge from other areas: ethics, biophysical, psychosocial, analytic, and organizational	• Ethics – IRB exempt status, Psychosocial – culture of homelessness, Analytic-qualitative analysis, Organizational – sustainability
• Use science-based theories and concepts in health care delivery for phenomena, alleviation, evaluation of outcomes	• Review research related to homelessness and homeless persons' health status to prepare study for quality improvement
• Develop and evaluate new practice approaches based on nursing theories and theories from other disciplines	• Identify gaps in current health care services to design strategies to close the gaps
Essential II: **Organizational and Systems Leadership for Quality Improvement and Systems Thinking for QI and Economics**	
Essential II Elements	DNP Project Demonstrates Essential II
• Develop and evaluate care delivery for current and future needs	• Elicit input on unmet needs from multiple sources – homeless persons, service providers to design improved services
• Ensure accountability for quality of health care and patient safety for populations	• Improve quality of care by identifying ways to improve access to care
• Develop strategies for managing ethical dilemmas	• Study was beneficent and honored persons' autonomy
Essential III: **Clinical Scholarship and Analytical Methods for Evidence-Based Practice /Translation Science**	
Essential III Elements	DNP Project Demonstrates Essential III
• Appraise existing literature and evidence for best evidence for practice	• Literature synthesis for DNP Project
• Design and implement processes to evaluate outcomes of practice	• Logic models for Phase 2 and Phase 3
• Design, direct, and evaluate quality improvement methodologies	• Developed semi-structured interviews and the process of interviews
• Apply relevant findings to improve practice	• Interpret results and interest others in care delivery changes
• Use information technology	• Used NVivo for Windows for data management, identified means to use electronic health record Practice Fusion on an outreach project
• Function as a research practice consultant	• Will share study results with health care professionals for care delivery modification
• Disseminate findings from evidence-based practice and research to improve healthcare outcomes	• Plan to improve primary care access, outreach services, medical respite and quality of interaction between homeless persons and health care providers to better meet persons' needs

Table 5.1 (Continued) *AACN Essentials*

Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care	
Essential IV Elements	DNP Project Demonstrates Essential IV
• Design, select use and evaluate information technology programs	• Selected and implemented NVivo software, selected Practice Fusion electronic health record for possible outreach project
• Analyze and communicate critical elements necessary	• Reviewed requirements from Health IT.gov
• Extract data from practice information systems	• Coded persons' responses in interviews in NVivo software and conducted queries to identify themes about sources of health care etc.
• Provide leadership in evaluation and resolution of ethical and legal issues with use of information technology	• Identified ways to make an electronic health record used in outreach HIPAA compliant
• Evaluate consumer health information sources	• Level information to literacy and needs of consumer
Essential V: Health Care Policy for Advocacy in Health Care	
Essential V Elements	DNP Project Demonstrates Essential V
• Critically analyze health policy from multiple perspectives	
• Demonstrate leadership in policy development	• Consider the impact of laws meant to criminalize homelessness and homeless persons' constitutional rights. Consider the impact of Medicaid expansion on health care to the poor
• Influence policymakers through active participation	• Propose policy changes to increase access to care for homeless persons given FQHC program requirements and unmet patient's needs
• Educate others about policy	• Submit testimony to the legislature on bills
• Advocate for the nursing profession within the policy community	• Advocate for policies that make health care services available to the unsheltered homeless
• Develop, evaluate and provide leadership for healthcare financing, regulation and delivery	
• Advocate for social justice, equity, and ethical policies within all healthcare arenas	
Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes	
Essential VI Elements	DNP Project Demonstrates Essential VI
• Effective communication and collaborative skills in the development and implementation of practice models, peer review, practice guidelines, health policy, standards of care, and/or other scholarly products	• Collaborated with nursing, social work, physicians, outreach workers, case managers, homeless persons and others to identify unmet health care needs, barriers to access and ideas for solutions

Table 5.1. (Continued) *AACN Essentials*

• Lead interprofessional teams in analysis of complex practice and organizational issues • Employ consultative and leadership skills with intraprofessional and interprofesional teams to create change in health care delivery	
Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health	
Essential VII Elements	DNP Project Demonstrates Essential VII
• Analyze data related to individual, aggregate and population health • Synthesize concepts, including psychosocial dimensions and cultural diversity to address health promotion and disease prevention, improve health status /access patterns, and address gaps in care for individuals, aggregates and populations • Evaluate delivery care models and strategies using concepts related to community, cultural and socioeconomic dimensions of health	• The interview data from the Project was coded, themes were identified, results were interpreted and conclusions drawn. • A presentation on the culture of homelessness for primary care health care providers was developed • How homeless persons health care service needs are being addressed was evaluated in light of research recommendations for care of the homeless, national HRSA policy standards for FQHC. • Strategies for improving services are being developed
Essential VIII: Advanced Nursing Practice	
Essential VIII Elements	DNP Project Demonstrates Essential VIII
• Conduct a comprehensive and systematic assessment of health and illness parameters • Design implement and evaluate therapeutic interventions • Develop and sustain therapeutic relationships with patients and other professionals • Demonstrate advanced levels of clinical judgment in evidence-based care • Guide mentor and support other nurses • Educate and guide individuals and groups through transitions • Use conceptual and analytic skill in evaluating links among practice, organizational, population, fiscal and policy issues	• Renewed American Nurse Credentialing Center (ANCC) Family Nurse Practitioner certification 7/2016
Incorporation of Specialty Focused Competencies	
Essential Elements	DNP Project Demonstrates Specialty Focused Competencies
• APN	• Continuous certification by ANCC since 2001 as Family Nurse Practitioner

For Essential I: Scientific Underpinnings for Practice, the coursework of the DNP Program was foundational for guiding the development and implementation of the DNP Project. The coursework of the Nursing 669 Introduction to Evidence-Base Practice course and Nursing 761 Translational Science course were particularly helpful in this regard. The interdisciplinary emphasis of the coursework was also extremely helpful (e.g., completing courses in law, informatics, and political science).

For Essential II: Organizational and Systems Leadership for Quality Improvement and Economics, the Nursing 774 Leadership and Management in Nursing course and Nursing 768 Advanced Clinical Economics and Finances served to prepare students for leading a project and for considering financial sustainability of a program over time. The DNP Project was very much about care delivery and current and future needs. One of the ethical dilemmas observed was that some health care providers were concerned that improving services might make the problem of homelessness worse for the rest of the population, but at the same time they wanted to better meet homeless persons' needs. The concern seems to be founded more on opinion than evidence, and it provides another question that can be evaluated in a study.

For Essential III: Evidence-Based Practice/Translation Science the course work from the Nursing 669 and Nursing 761 courses provided preparation for integrating the elements of this Essential. The studies in translational science will be useful when informing health care professionals about the study results, especially when it comes to planning how to reduce barriers to primary care and promote trauma-informed care and sensitivity to the culture of homelessness, without inciting great resistance.

For Essential IV: Information Systems/Technology, the Information and Computer Sciences course ICS 614 was helpful. During the project, the DNP student recorded interviews on a digital recorder as mp3 files, uploaded them to NVivo software, transcribed them, coded them with the software in order to identify themes, and conducted queries on the coded items. Free electronic health record software, called Practice Fusion, for volunteer health outreach was located and evaluated for use.

For Essential V: Health Care Policy and Ethics the courses Political Science POLS 670 Introduction to Public Policy and Public Health 623 Social Science and Public Health were helpful. The DNP Project advocates for policies that make health care services more equitable. The DNP Project lays a foundation for a systematic, patient-acceptable process for homeless

persons on Maui to receive health care services. A study of ethics related to research with human subjects was necessary in order to get Institutional Review Board exempt status approval for the needs assessment.

For Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes, collaboration was a prominent feature of the DNP Project. For this Project, the DNP student collaborated with academic advisers, an external adviser, faculty peers at University of Hawaii Maui College, physicians, hospital and community nurses, nursing students, social workers, outreach workers, case managers, and homeless persons. For the development of the needs assessment, the DNP student elicited the assistance of experts at the National Health Care for the Homeless Council.

For Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health, the courses Nursing 699 Program Evaluation and Nursing Doctorate Online NUDO 6059 Cultural Competence in Advanced Practice from the University of Colorado were relevant. For the DNP Project, data related to individual, aggregate and population health were analyzed. Data such as the Point in Time Count and the Homeless Service Utilization Report were considered. Data from the homeless population nationally was reviewed e.g., for prevalent health problems. Data from Maui homeless persons were collected and analyzed. The study was about identifying gaps in care and developing strategies to improve health care and close the identified gaps. Current delivery care processes were identified and changes proposed.

For Essential VIII: Advanced Practice Nursing. The DNP student has been certified by the American Nurse Credentialing Center as a family nurse practitioner (FNP) since 2001. In July of 2016, the DNP student renewed FNP certification. The courses taken in this Program, including Nurs 776, improved my understanding of clinical skills needed in caring for the homeless and my ability to provide leadership in changes needed in the delivery of care. The coursework, including Nurs 776, improved my ability to identify a clinical problem, analyze evidence about it in the literature, study it systematically in collaboration with others, analyze the results, and create improved health care services for the homeless.

Plans for Dissemination.

After the DNP Project Defense, the DNP student will share the findings and the interpretation of the findings with nursing faculty colleagues at University of Hawaii Maui College. One colleague in particular is likely to be interested in promoting trauma-informed care and sensitivity to the culture of homelessness, and collaborating with the DNP student focusing

on these issues. Several service providers have also asked for the results of the needs assessment, so the DNP student will share the results with them.

The DNP student plans to consult with ED staff about interest in collaborating with MIKOHC for directing patients to the appropriate source of care, and opening up MIKOHC. The DNP student will seek support from other health care professionals and service providers in presenting ideas for service modification to reduce barriers to MIKOHC.

The DNP student will make the information from the Project available to the State Department of Health and the Department of Health and Human Services. The Vice Chancellor of Academic Affairs at University of Hawaii Maui College has asked the DNP student to publish an article in the Maui News related to the results. The DNP student has been invited to do a presentation about health care for the homeless to the Tri-Isle State Health Planning and Development Agency. The DNP student will offer to present the findings to the Maui Homeless Alliance. The DNP student has also been invited to join the Board of Directors of the Salvation Army Maui and plans to propose additional services that the Salvation Army Maui might offer as mentioned previously. The DNP student plans to write an article to submit to the Hawaii Journal of Medicine and Public Health on this project.

Summary

Housing is good medicine and making housing available to homeless persons would reduce many health stressors homeless persons on Maui have. Beyond the obvious need for housing, this study identified gaps in health care services for homeless persons on Maui, especially those who are unsheltered.

Strategies for closing the gaps in health care services for homeless persons on Maui include opening up access to primary care services for the most vulnerable, including the unsheltered homeless population. This vulnerable group may not have identification, insurance, documentation of income, or money; therefore, tailoring primary care services to meet the particular needs of homeless persons is essential. Services that have been identified by stakeholders who engaged in sharing their perspectives on homeless persons living in Maui include wound and skin care, mental health or counseling, outpatient substance abuse treatment, and same day appointments or walk-in service; public hygiene facilities with hot showers and restrooms; and providing enabling services such as a call center, a mail service center, and transportation assistance to medical appointments.

Additional remedies to further assess include collaboration between the emergency department and MIKOHC to encourage patients to seek care at the appropriate health care site given their health care need (e.g., community clinic versus an emergency department), health outreach with streamlined referral to MIKOHC, and medical respite facilities so homeless persons discharged from the hospital have a safe place to continue recuperation. In addition, service providers require coaching in trauma-informed care and the culture of homelessness, and homeless persons require coaching in behaviors required for receiving health care services.

Appendix A: Survey Forms

Appendix A-1

Semi-Structured Survey Conversation with Individual Knowledgeable Stakeholder

Number ___

1. **May I have your permission to interview you on the topic of closing the gap in health care services for the homeless on Maui?**
2. **What do you think are the unmet health care needs of homeless persons on Maui?**

a. Medical
b. Surgical
c. Prescription medication
d. Vision service, e.g. eyeglasses
e. Dental
f. Mental health / counseling
g. Substance abuse treatment
h. Wound and skin care
i. Other

3. **What barriers do you think homeless persons on Maui face in accessing health care services on Maui?**

a. Appointment times
b. Communication – no phone
c. Transportation
d. No insurance
e. No money for co-pay
f. Attitudes of those providing service
g. "Don't care anymore"
h. Competing priorities (e.g. food, alcohol, drugs, or work)
i. Fears
j. Other

4. **What interventions would help homeless persons on Maui to meet their health care needs?**

5. **What interventions would reduce unnecessary emergency department visits for homeless persons on Maui?**

6. **What interventions would reduce the unnecessary length of stay for acute care hospitalization for homeless persons on Maui?**

7. **What would help homeless persons on Maui get housing?**

Appendix A-2

Semi-Structured Survey Conversation with Group of Knowledgeable Stakeholders

Number____

1. **May I have your permission to interview you on the topic of closing the gap in health care services for the homeless on Maui?**
2. **What do you think are the unmet health care needs of homeless persons on Maui?**

a. Medical

b. Surgical

c. Prescription medication

d. Vision service, e.g. eyeglasses

e. Dental

f. Mental health / counseling

g. Substance abuse treatment

h. Wound and skin care

i. Other

3. What barriers do you think homeless persons on Maui face in accessing health care services on Maui?

a. Appointment times

b. Communication – no phone

c. Transportation

d. No insurance

e. No money for co-pay

f. Attitudes of those providing service

g. “Don’t care anymore”

h. Competing priorities(e.g. food, alcohol, drugs or work)

i. Fears

j. Other

4. What interventions would help homeless persons on Maui to meet their health care needs?

5. **What interventions would reduce unnecessary emergency department visits for homeless persons on Maui?**

6. **What interventions would reduce the unnecessary length of stay for acute care hospitalization for homeless persons on Maui?**

7. **What would help homeless persons on Maui get housing?**

Appendix A-3

Semi-Structured Survey Conversation with Individual Persons **Number____**

1. **Where do you stay?** **Verbal permission for Survey ___**

Incentive_____

_____

Homeless? Yes No Length of time homeless? _____

a. Sheltered
    i. Rental
    ii. Shelter
    iii. Temporarily with friends or relatives
b. Unsheltered
    i. Vehicle
    ii. Park
    iii. Abandoned building
    iv. Beach
    v. Bushes
    vi. Sidewalk
    vii. Street
    viii. Other _____

2. Do you have health insurance?

a. Yes
b. No

3. **Where do you go when you need to see a health care provider?**

a. Malama I Ke Ola Health Center

b. V.A. Clinic

c. Kaiser

d. Maui Medical Group

e. MMMC Emergency Department

f. Other

4. **What, if any, unmet health care needs do you have?**

a. Medical

b. Surgical

c. Prescription medication

d. Vision service, e.g. eyeglasses

e. Dental

f. Mental health / counselling

g. Substance abuse treatment

h. Wound and skin care

i. Other

5. What, if any, barriers do you find in meeting your needs for health care services?

a. Appointment times

b. Communication – no phone

c. Transportation

d. No insurance

e. No money for co-pay

f. Attitudes of those providing service

g. Fears

h. "Don't care anymore"

i. Competing priorities

j. Other

6. What would help you meet your needs for health care services?

7. **If you use the emergency department for health services, what would help you get health services at locations other than the emergency department?**

8. **If you get admitted to the hospital as a patient, what would help you to have a place to stay when you are discharged?**

9. **What would help you get housing?**

Appendix B: Phase 2 and Phase 3

Appendix B-1

Phase 2

Phase 2 begins following the student's graduation from the DNP Program. The goal for Phase 2 is to develop a plan to meet homeless persons unmet health care service needs. See

Use of findings

How will the needs assessment be used

The program findings will be used to inform key stakeholders, stakeholder groups including, the Maui Compassion Collaborative, the Maui Homeless Alliance, and the DNP Committee, and to plan interventions during Phase 2. If for example, one of the common health care needs is wound care, outreach health members will plan and implement services to address this health issue. If the unmet need identified is substance abuse treatment, service to address this health issue will be developed. If the barrier to accessing care turns out to be transportation, health outreach may be able to provide bus passes, at least for those who are disabled, and work on transportation solutions. If it is reported that barrier to accessing care is appointment times, health outreach volunteers can open discussion with health care service providers about adjusting appointment times.

Plans to assure results are used by stakeholders

Health outreach volunteers will be partnering with existing outreach services, e.g. Salvation Army Outreach. Those workers and volunteers will be informed of the results and the modification of services. Malama I Ke Ola Health Center will be informed of the results. Inreach activities will be conducted for Malama I Ke Ola Health Center and for staff at Maui Memorial Medical Center, if the administrators and staff are receptive to it.

Table B.1. Phase 2 Project Evaluation Medium Term Outcome

PHASE 2 GOAL: **Develop a Plan to meet homeless persons unmet health care service needs**					
Short Term Outcomes	**SMART Objectives**	**Evaluation data**			**Timeframe 2015**
		Measure	**Baseline**	**Target**	**Data Source**
OUTCOME 2 Plan for implementation of inreach and outreach interventions	OBJECTIVE 1 The DNP graduate produces a plan for post-graduation implementation of inreach and outreach interventions in collaboration with other groups and professionals in the community.	Plan that includes what, when, where how, specifics for implementation	Ideas for intervention based on literature synthesis and pre-survey projections	Participants identified. Particular interventions identified. Documentation and licensure addressed. Funding and resources addressed Schedule outlined	Literature synthesis Needs assessment report Expert opinion

Appendix B-2 Phase 3

Table B.2. Phase 3 Goal: Improve how well health care service needs for homeless persons on Maui are met Output 2						
Short Term Outcomes	**SMART Objectives**	**Evaluation data**				**Timeframe**
		Measure	**Baseline**	**Target**	**Data Source**	
OUTPUT 2 Homeless needs after outreach and inreach services initiated show 25% of homeless persons on Maui with primary care access by April 2016.	PROCESS OBJECTIVE 1 The DNP student during Phase 3, compares results of pre and post mixed methods survey of a purposive sample of 30 homeless persons on Maui to assess their met and unmet health care service needs; perceived barriers to obtaining health care services; and ideas about interventions that would help them meet their health care service needs.	Mixed-methods Face-to-face survey of unmet needs, barriers, ideas for solutions	Pre-intervention survey 2015	25% of persons report access to primary care services	Mixed methods face-to-face surveys	Phase 3 April 2016
	PROCESS OBJECTIVE 2 The DNP student during Phase 3 compares results of pre and post mixed methods survey of a purposive sample of 5 knowledgeable stakeholders about Maui homeless persons' unmet health care service needs; barriers to obtaining health care services; and their ideas about interventions that would help homeless persons on Maui meet their health care service needs.	Qualitative face-to-face survey of view of homeless persons unmet needs, barriers, ideas for solutions	Pre-intervention survey 2015	25% of persons report access to primary care services	Qualitative face-to-face surveys	Phase 3 April 2016
	PROCESS OBJECTIVE 3 The DNP student during Phase 3 compares results of pre and post mixed methods survey of a purposive sample 2 groups of key stakeholders involved in the care of homeless persons on Maui about homeless persons' on Maui met and unmet health care service needs; barriers to obtaining health care services; and their ideas about interventions that would help homeless persons on Maui meet their health care service needs.	Qualitative face-to-face group survey of view of homeless persons unmet needs, barriers, ideas for solutions	Pre-intervention survey 2015	25% of persons report access to primary care services	Qualitative face-to-face group surveys	Phase 3 April 2016

Table B.3. PHASE 3 GOALS: Improve how well health care service needs for homeless persons on Maui are met Output 3						
Short Term Outcomes	**SMART Objectives**	**Evaluation data**				**Timeframe**
		Measure	**Baseline**	**Target**	**Data Source**	
OUTPUT 3 Homeless needs after outreach and inreach services initiated show a decrease of one of unmet health care needs for homeless persons on Maui by April 2016.	OBJECTIVE 1 The DNP student, during Phase 3, compares results of pre and post mixed methods survey of a purposive sample of 30 homeless persons on Maui to assess their met and unmet health care service needs; perceived barriers to obtaining health care services; and ideas about interventions that would help them meet their health care service needs.	Mixed-methods Face-to-face survey of unmet needs, barriers, ideas for solutions	Pre-intervention survey 2015	Decrease by one of unmet healthcare needs	Mixed methods face-to-face surveys	April 2016
	OBJECTIVE 2 The DNP student during Phase 3, compares results of pre and post mixed methods survey of a purposive sample of 5 knowledgeable stakeholders about Maui homeless persons' unmet health care service needs; barriers to obtaining health care services; and their ideas about interventions that would help homeless persons on Maui meet their health care service needs.	Qualitative face-to-face survey of view of homeless persons unmet needs, barriers, ideas for solutions	Pre-intervention survey 2015	Decrease by one of unmet healthcare needs	Qualitative face-to-face surveys	April 2016
	OBJECTIVE 3 The DNP student during Phase 3 compares results of pre and post mixed methods survey of a purposive sample 2 groups of key stakeholders involved in the care of homeless persons on Maui about homeless persons' on Maui met and unmet health care service needs; barriers to obtaining health care services; and their ideas about interventions that would help homeless persons on Maui meet their health care service needs.	Qualitative face-to-face group survey of view of homeless persons unmet needs, barriers, ideas for solutions	Pre-intervention survey 2015	Decrease by one of unmet healthcare needs	Qualitative face-to-face group surveys	April 2016

How to determine whether the purpose of the evaluation was accomplished in Phase 3

Phase 1 pre-intervention results will be compared to Phase 3 post-intervention results, and patient satisfaction results will be reported. This DNP Project is a *low-probability technology program*. According to McDavid et al (2013), social programs are considered low-probability programs in which rival hypotheses for outcomes make it difficult to establish causal linkages. Targets for the post-intervention results compared to the pre-intervention results are a decrease in one or more unmet health care needs, a decrease in one or more barriers to accessing health care services. The purpose of the evaluation is to ascertain the effectiveness of tailored interventions. Causal linkages will not be established. The evaluation will indicate that the program is effective if results are obtained on what interventions are associated with decreased unmet health needs, and improved access to primary care, and what other interventions might be initiated.

Comments on the steps and procedures

The patient satisfaction survey is being developed. The patient satisfaction survey will be used to collect data after each intervention, and be used for a continuous improvement process in order to adjust approaches and interventions during Phase 3.

Pilot the evidence-based practice change in Phase 3

Consistent with the Iowa Model of Evidence-Based Practice to Promote Quality Care (Titler et al, 2001), a practice change is trialed or piloted before it is implemented broadly in a quality improvement project. This quality improvement project expands on previous University of Hawaii Maui College Nursing Program projects for the homeless. This DNP Project is affiliated with University of Hawaii Maui College Nursing Program and Health Center. The practice change is formation of a multidisciplinary volunteer health outreach team which provides services to homeless persons on Maui. The pilot interventions will be based on evidence from the literature, as well as results of surveys described in the previous section, local expertise and fitted to the Maui setting.

Volunteers include nurse practitioners, clinical nurse specialists, nurses, nursing students, psychologists, and social workers. Volunteers will be organized as Maui Health Outreach under the auspices of the University of Hawaii Maui College Campus Health Center. Maui Health Outreach volunteers will develop a mission and vision statement. Participating volunteers will be credentialed, and carry their own liability insurance. Volunteers will train together with materials

such as Health Care for the Homeless 101 (NHCHC, 2013) and Trauma-Informed Care (NHCHC, 2010), and develop standard operating procedures and protocols. Volunteers will partner with and augment existing outreach services of organizations active in the community where a memorandum of understanding is in place with University of Hawaii Maui College such as Salvation Army. See figure 1 below for a photo of the A Cup of Cold Water outreach service. During the pilot process, a nurse practitioner, Valerie Foree DNP from Waikiki Health's Care-A-Van service may be available to mentor on an intermittent basis (V. Foree personal communication March 21, 2014). Other opportunities for volunteers to function in a background support capacity for fund-raising, supply procurement, office help, and liaisons will be available.

Patients will sign consent forms for treatment prior to being served. Interventions will include assisting homeless persons who do not have health insurance to sign-up for health insurance, connecting individuals in the community to helpful resources such as shower locations, feeding locations, shelters, mental health and substance abuse treatment services. Health care interventions include basic screening, and assessments, therapeutic communication, and patient education in the motivational interviewing style. Treatment includes wound care, and treatment of other skin disorders; treatment of upper respiratory tract infections; and other basic primary care treatments that can be provided in the field. Vitamins, over the counter medications, and basic wound care supplies can be offered. Prescription services will be available at a later date. Medical records will be maintained on patients treated. Patients will be referred to primary care services, or other services as needed for further follow-up. An electronic referral for the patient will be sent to the service the patient is referred to.

During the 2016 pilot, there will be approximately four Maui Health Outreach events other dates. Later, during implementation, health outreach will be offered on a weekly basis.

Funding for the pilot and the implementation is not yet secure. Funding will be necessary for supplies and equipment, and office materials. Supplies and equipment will be assembled in a compact and easily transported configuration. At least two funding sources are interested in supporting this DNP Project: the Ho'omoana Foundation (L. Darcy personal communication, January 3, 2014) and the Maui Nurses' Scholarship Foundation (N. Johnson multiple personal communications during 2013, and 2014).

In addition, inreach overtures will be made to health care facilities and providers who treat homeless patients to facilitate the smooth entry, provision of care to homeless patients, and

smooth discharge from appointments, and stays. Networking by email and face-to-face, and group meetings at an approximate every other month frequency with the Maui Compassionate Collaborative or the Maui Homeless Alliance will continue with topics and discussions to move this DNP Project forward, and other interventions for the homeless on Maui such as the relocation and expansion of the Salvation Army's Safe Haven Program.

Figure B.1 Volunteers at A Cup of Cold Water October 2013. Photo courtesy Maui Weekly available at http://www.mauiweekly.com/page/content.detail/id/531965/A-Cup-of-Cold-Water.html?nav=11

Procedures: Implement the Evidence Based Practice Change

Introduction

In the previous section, entitled Pilot the Evidence-Based Practice Change, the trial formation of a multidisciplinary volunteer health outreach team to provide services to homeless persons on Maui for Phase 3 of Closing the Gap in Health Care Services for Homeless Persons on Maui, was discussed. Volunteers include nurse practitioners (two to three), clinical nurse specialists (one to two), nurses, nursing students, psychologists (one to two), and social workers (one to two) under the auspices of the University of Hawaii Maui College Health Center, and other background support persons. Maui Health Outreach volunteers will partner with existing outreach services such as Salvation Army Maui with a memorandum of understanding in place that are currently operating without a health care component.

Social marketing

Rogers (2003) has defined *social marketing* as the application of commercial marketing strategies to the diffusion of nonprofit products and services. For this DNP Project, social marketing will include the communication processes to spark participation of volunteers, of homeless persons, of providers of care, and of donors. Rogers (2003) alludes to *audience segmentation* as a strategy which tailors messages to such subgroups.

Formative research (Rogers, 2003) is conducted to understand the perspective of the subgroup more clearly, in order to craft a message that will appeal to the subgroup and be impactful. This DNP Project is a quality improvement project, not a research project. The data collection done in spring of 2015 with semi-structured survey interviews with open-ended questions will enrich understanding of the homeless person's perspective and the provider's perspective. That enriched understanding will facilitate creation of effective messages that encourage homeless persons' participation, and health care providers' openness to homeless persons.

The innovation is positioned relative to the intended audience's cultural meanings so to emphasize certain desired aspects (Rogers, 2003). Most likely messages for homeless persons will have meanings about how they will benefit; for health care providers, how homeless persons can be directed to comply with their regulations, to cause less disruption, and expense; for volunteers and donors, the good they will do to relieve suffering.

The price of the innovation should be kept low to encourage adoption (Rogers, 2003). For homeless persons, there will not be a cost. For volunteers, the cost will be time, and perhaps money for supplies and equipment not otherwise funded. For donors, the price will be reduced because volunteers will partner with existing outreach services. Health care providers might incur a cost if asked to modify services.

Attributes of the innovation

Rogers (2003) identified attributes of an innovation that influence the rate of adoption of that innovation by users. They are *relative advantage, compatibility, complexity, trialability, and observability.*

Relative advantage which is the degree to which an innovation is perceived as better than what it supersedes, which in this case, is care as usual, or lack of care as usual. Relative advantage affects the rate of adoption of the innovation (Rogers, 2003). From homeless persons'

perspective, health outreach volunteers should be a plus. That perception, of course, will be colored by the way services are presented. Some persons in the community, perceive offering additional services to homeless persons as attracting homeless persons to Maui, so do not view expanded services as a plus (anonymous person, personal communication, January 2014)

Compatibility is the degree to which an innovation is perceived as consistent with existing values, practices, history, and needs of users (Rogers, 2003). This innovation is compatible with faith-based groups who are committed by compassion to helping the less fortunate. Whether it is compatible with homeless persons' needs, likely depends on whether it is trauma-informed care (Proffitt, 2010). Trauma-informed care recognizes that many homeless persons are trauma survivors. Trauma survivors may have a sense of estrangement from others, feelings of powerlessness or helplessness, loss of trust in interpersonal interactions, treatment settings, or specific environments, and feelings of shame, guilt, and stigma. Trauma-informed care is highly compatible with homeless persons. Trauma-informed care provides a physically and emotionally safe environment; and an atmosphere of trustworthiness with clear instructions, keeping promises, and appropriate boundaries. Homeless persons are offered choices, invited to collaborate on health decision-making, and empowered to do for themselves. All Maui Health Outreach volunteers will concur with providing trauma-informed care to homeless persons. Volunteers will read trauma-informed care information, and practice trauma-informed simulations as a team. Another way to increase compatibility is to increase convenience. Volunteers will offer convenient care at locations where homeless persons gather, at times when they gather. Services offered will be shaped with the results of the interview surveys with homeless persons, key stakeholder individuals, and groups of key stakeholders.

Trialability refers to the degree to which an innovation may be piloted on a limited basis, and then revised in response to the results of the pilot (Rogers, 2003). Because this is a quality improvement project, not a research project, it is possible to make adjustments to interventions throughout the project for the purpose of improvement. Health outreach volunteer efforts will be piloted in fall of 2015 on four occasions.

Observability is the degree to which results of an innovation are visible to others (Rogers, 2003). Health outreach volunteers can increase their observability by wearing attire with a logo – such as a tee shirt. Providing care at places and times where homeless persons commonly gather will allow homeless persons to observe other homeless persons receiving care. Reports back to

health care providers, and donors including pictures will increase observability. Reports will be made back to health care providers and donors after each outreach event during the pilot and then regularly during spring of 2016. Sharing stories and pictures of recipients is limited by compliance with the Health Information Portability and Accountability Act (HIPAA) (U.S. Department of Health and Human Services, 2014).

Permission procedure

During Phase 1 pre-intervention interview surveys with homeless persons, individual key stakeholders, and groups of key stakeholders, participants will be asked for permission to interview them with a survey and take notes. The permission is a courtesy rather than a legal consent, as this is not a research project. Data collected is de-identified and aggregated. During post-intervention surveys with homeless persons, there is no assumption made that the same individuals who participated in the pre-intervention interview survey are being resurveyed. Data will be de-identified and aggregated.

During the pilot, and during the implementation, written consent for treatment, such as wound care, will be obtained from homeless persons prior to treatment. It is important to notice that this consent is consistent with provision of health care services, and not a consent for inclusion in a research project. According to Goldman and Schafer (2012), informed consent is a person's autonomous authorization to a health care provider to undertake diagnostic or therapeutic procedures for himself or herself. The essential requirements for informed consent are mental capacity to consent, disclosure by the provider, understanding on the part of the recipient and, voluntariness. Adults are usually considered to be legally competent to make health care decisions. Practically this is evidenced by whether the person can understand the information disclosed, appreciate how the information applies to his or her own situation, and use logical and consistent thought processes to make a decision. Crucial information must be disclosed. The person's consent must be voluntary without manipulation or coercion. Persons have a right to refuse treatment.

Data collection plan

The semi-structured interview survey process for 30 homeless persons, five individual key stakeholders, and two groups of stakeholders was previously described. Survey forms for each group are included in the Appendix. Interviews will be face-to-face. Notes will be taken by the surveyor. No recording or photographing of the interviewees will be done. These interviews

take place during Phase 1 and contribute to shaping interventions. They will also take place in Phase 3 after the intervention to gather data on the possible effects of the intervention. In addition a brief patient satisfaction survey will be done after individual health care encounters.

Programs that deliver human services are considered low-probability for establishing causal linkages between interventions and effects due to the number of external variables (McDavid et al, 2013). Results of Phase 3 post-intervention surveys may identify a trend or suggest a relationship, but are unlikely to prove a causal connection between the outcome and the intervention. The targets for the post-intervention data analysis would be a decrease in one or more of the unmet health care needs identified in the pre-intervention survey; and a decrease in one or more of the barriers to health care services identified in the pre-intervention survey. The target for the patient satisfaction survey is satisfied patients. Results will be used on an ongoing basis for intervention modification. The target of the bookkeeping data collection is a balance of receipts and expenditures. The target of the intervention records is a measure of the volume and type of service provided, and the repeat encounters. See Table 3.7, Data Collection Table.

Innovation implementation during Phase 3

Health outreach volunteers will maintain their own credentials, their own liability and malpractice insurance, and function within the scope of practice of their own licensure. The volunteers will initially be a small group, supplemented at times by nursing students under the supervision of a nursing faculty member. Non-undergraduate student volunteers will collaborate to develop standard procedure guidelines for outreach activities. Volunteer team members will train together with regard to trauma-informed care, and health care services to the homeless, including simulated scenarios. Team members will meet following pilot activities to review the activities and make modifications as needed. Grant applications for funding will be written. Planned interventions will be modified as needed with the needs assessment results.

In January 2016, volunteer health outreach activities will become more frequent and occur on a weekly basis. Volunteers will provide their own transportation to the location of the outreach. Health outreach teams will usually consist of three to four volunteers at a time, including a nurse practitioner and/or a clinical nurse specialist. Some activities may require additional volunteers. Some outreach activities will be done in collaboration with Salvation Army, and Salvation Army Outreach. Other possible outreach sites are with A Cup of Cold Water, the Family Life Resource Center shelter, and feeding locations. Interventions will include

offers of assistance to sign-up for health care insurance to those who are uninsured, referral to services, health screening and evaluation of individual complaints, therapeutic communication, education in the motivational interviewing style. Also wound care education and treatment, give away of over the counter supplies such as vitamins, ointments and creams, and nonprescription analgesics would be available with the presence of a nurse practitioner. Referral would be made to existing primary care services such as Malama I Ke Ola Health Center. Records on the patient encounter would be kept securely.

At the same time, inreach efforts will continue with health care providers. The DNP graduate will continue engagement with the Maui Compassion Collaborative, and the Maui Homeless Alliance, continue support of Safe Haven relocation and expansion at the Salvation Army, and initiatives for housing for the homeless.

Health Records and HIPAA

Generating health records during interventions when outreach services are piloted Phase 2 and implemented during Phase 3, is a separate process from interviewing homeless persons as part of a needs assessment in Phase 1. Cavacuiti and Svoboda (2008) surveyed 28 homeless outreach agencies throughout North America. Nine of them used electronic medical records for homeless outreach. They found that users appreciated the advantage offered when different sites and providers could access patients' information, and found the capacity to aggregate data such as numbers of clients served, services provided and outcomes were helpful for planning, evaluation, and advocacy purposes. One barrier to introducing the use of electronic health records (EHR) in homeless outreach programs is cost.

Open Source software is software that can be freely used, changed, and shared and is distributed under licenses (Open Source Initiative, 2014). A study by Goldwater et al (2013) of the use of open source EHR among federal safety net providers for the underserved found that open source EHR provided advantages for those with limited resources. Barriers they found for use of open source EHRs were technical expertise, misperceptions that it was without cost, and misperceptions that it did not meet federal meaningful use requirements. An open source EHR that provides technical assistance, reduces costs, and meets federal requirements is available at http://www.practicefusion.com.

During Phase 3, individual health records will be kept according to the plan below. A back-up plan for generating and maintaining health records is also described. Outreach services

will be offered without charge. At this time, no federal funds or insurance reimbursements will be sought, so it is not necessary to collect identifiers like social security numbers or insurance numbers.

Practice Fusion is an open source EHR developed for ambulatory care, designed to be user friendly. It is free for use, and is certified by the Office of the National Coordinator (ONC) for Health Information Technology (Health IT, 2014). Practice Fusion is available at http://www.practicefusion.com. Tutorials, a help function, and live chat are available to assist users. Once a user agrees to license terms, it is possible to set-up an EHR. Although the website gives the impression a physician is required in the practice, physician oversight is not required for use of the Practice Fusion EHR (personal communication with accounts manager, June 11, 2014). An accounts manager is available for set-up assistance when the project is within two weeks of documenting on actual patients. There is no charge for using the software. Pop up ads are the funding source for the software. Charting templates can be customized. Referral and chart sharing functions are available. The software supports tablet use. Data is stored in the cloud. The EHR is capable of generating various reports with collected data. Costs to the user include laptop and tablet hardware and internet connectivity. Time to train is also a resource to be considered.

The DNP graduate will agree to the license terms. The DNP graduate has an iPad with internet service. Charting information saved as PDFs will be downloaded to a laptop that is locked in a cabinet in the DNP graduate's office when not in use. A laptop or tablet used during outreach will be secured by cable to a larger object to prevent loss by theft. Notification of patients of privacy rights, and consents for treatment and transfer of electronic information will be paper format. The originals will be kept locked in a cabinet in the DNP graduate's office. Originals can be scanned and uploaded. Referrals using the EHR can be faxed to health care providers under HIPAA regulations. An agreement with providers about the referral mechanism would be made prior to implementation.

A back-up system for health records will be a hybrid of paper and electronic records. Paper charting can be done during outreach, and later scanned onto a flash drive, and then loaded into a laptop. The laptop, with records and consents scanned in, can be taken on outreach. Blank paper forms will be taken on outreach for documentation. That combination will make records available in a light, portable, and compact design. Charting templates from health care providers

to the underserved are available free of charge on the website of the National Health Care for the Homeless Council (NHCHC, 2014).

Health care providers who are covered entities, which would include nurse practitioners, nurses, and any other members of health outreach volunteers, must make provisions to protect the privacy and security of their patients protected health information (PHI) under the Health Information Portability and Accountability Act (HIPAA) (HHS, 2014). Health outreach volunteers will all complete HIPAA training. Trainings are available on the HIPAA website (HHS, 2014). PHI is defined as individually identifiable health information held or transmitted by a covered entity or its business associate in any media, oral paper, or electronic form (HHS, 2014). Privacy in the outreach setting can be maintained by talking with patients physically distanced from others to prevent others from overhearing the interaction (personal communication with Dr. Valerie Foree, October 2014). Safeguards for PHI on mobile devices are recommended by the Health IT website (Health IT, 2014). Using a password or other authentication. Access to both the laptop and iPad are password protected. Access to EHRs on Practice Fusion requires authorization by the administrator which will be the DNP graduate, and is password protected. Encryption protects PHI stored and sent from mobile devices. Practice Fusion is certified by ONC and has met the required standards for encryption (Health IT, 2014). Remote disabling allows locking or erasing data stored on a mobile device if a device is lost or stolen. Installed security software protects against malicious software, spyware, and viruses. Mobile devices will have security software installed and kept up to date. Mobile devices can be protected by maintaining control of them which would include keeping them locked, or in hand, and not loaning them. PHI should be deleted before discarding or recycling the mobile device.

According to Hawaii Revised Statute §622-58:

> Medical records may be computerized…The health care provider shall retain medical records in the original or reproduced form for a minimum of seven years after the last data entry except in the case of minors…Basic information from the records of a physician or surgeon shall include the patient's name and birthdate, a list of dated diagnoses and intrusive treatments, and a record of all drugs prescribed or given…The health care provider, or health care provider's successor, shall be liable for the preservation of basic information from the medical record for twenty-five years after the last entry, except in the case of minors…(State of Hawaii HRS, accessed 2014)

The definition of health care provider referred to in §671-1 does not include nurse practitioners (State of Hawaii HRS, accessed 2014). The most cautious interpretation of this statute would be to imagine that it does apply to nurse practitioners. In order to comply with this statute health records will be kept in computerized form for the required length of time. Should health outreach volunteers cease to operate, health records can be stored in computerized form on a flash drive at the University of Hawaii Maui College Health Center.

Appendix C

Commentary from Individual Homeless Persons on the Use of Self-Care

Individual homeless person 1 said he makes sure to hydrate himself to avoid the problems he had previously with dehydration and kidney injury. Individual homeless person 2 said he does what he can, on his own, because of the cost of health care services. Individual homeless person 7 said he manages his chronic pain by taking Tylenol, ibuprofen and drinking beer. He said he pays attention to keeping clean, getting a shower and rinsing out his clothes. What he said about hygiene was quoted in the text associated with this appendix.

Individual homeless person 9 has faith and treats herself with herbs, nature and self-purification. Here is some conversation between IHP 9 and the DNP student:

> IHP 9: That's one thing with people without right mental conditions, they're not able to go into the woods say, and get away, because they're afraid.
>
> *CPZ: Uh huh.*
>
> IHP 9: So those are the people you see more that are going to be workers. You know. People like me, you know, I go into the woods and you don't see me much. But I'll come out… because they're going to give me some free things over here. [Laughs]
>
> *CPZ: You come out for different needs. But you feel safe in the woods.*
>
> IHP 9: I personally do, because I have a strong faith …"Even unto the end of the earth, or the world." It's quoted in different ways. Different [indecipherable] So that's one of my things so you're not afraid. And when I used to go into the woods because society drove me a little crazy cuz there's a lot of mean [emphasis] things in society.
>
> *CPZ: Mean things. Safer to be away from people, sometimes.*
>
> IHP 9: Yeah. So it was like walking into the arms of my Mother [emphasis] when you go into Nature. So we can bring the Mother back into our conversation. You know we do come from a father and a mother.
>
> *CPZ: Yeah.*
>
> IHP 9: So I have a Mother right here. All the time. So I'm not afraid. [Laughs] And I have a Father, right there. [Laughs and gestures grandly to the surroundings and the sky]. I'm like yeah. I'm all backed up. [Laughs]
>
> *CPZ: Yeah.*

Individual homeless person 11 said that he puts off seeking health care until he is

really sick, because he doesn't want to appear needy. Individual homeless person 13 said he never really gets sick because he gets plenty of exercise. He walks 20 to 25 miles per day. He eats fruits, vegetables, meat and not too many sweets. The DNP student and IHP 13 had this dialogue:

IHP 13: Considering that I've been outside now for going on four years, you learn little tricks of the trade as it were.

CPZ: Okay. You have tricks of the trade. Can you say more about that?

IHP 13: Mustard is great for staph.

CPZ: The mustard you would put on a hot dog?

IHP 13: Hmm huh. Particularly yellow mustard. But any mustard will do.

Individual homeless person 14 said he bought his medications, including antibiotics, on the street. He said he had a computer and when he was able to connect to the internet, he went to the website drugs.com to identify the pills he had, so he knew what he was taking. Individual homeless person 15 treated a wound on her leg, due to a poorly fitted leg brace, with Neosporin. She was careful to keep it clean. Individual homeless person 17 said she was diabetic so she kept something sweet in her bag to eat just in case she felt like she had a low blood sugar. She was attempting to lose weight by increasing her exercise by walking with a friend. Individual homeless person 12 said he did not go to health care providers but took care of himself even if he had broken bones.

Individual homeless person 24 had all his teeth pulled because they were rotting and hurting him. Being toothless limited what he was able to eat. He compensated by cutting his food into small pieces, and grinding nuts, so he did not miss out on that protein source. Individual homeless person 25 said he showered at a friend's house. Individual homeless person 27 said he showered at Salvation Army Lahaina. He said "You gotta shower. Bacteria gone spread". Individual homeless person 29 said he went through an alcoholic phase due to rinsing his mouth with vodka because of the painful infections in his teeth. He said he self-medicated for headaches and musculoskeletal pain with aspirin, ibuprofen, glucosamine and marijuana, and treated his lethargy with caffeine tablets.

Appendix D

Commentary from Individual Key Stakeholders on Homeless Persons' Use of Self-Care

Six IKSs commented on the connection between substance abuse, mental illness and lack of self-care. According to IKS 4:

> IKS 4: Oh yeah. I mean, if you were able to get the substance abuse under control, you would get a lot of things taken care of. Um ... Someone who is clean and sober is much more likely to take care of his personal medical needs than someone who is intoxicated and lies in their incontinence for days …

According to IKS 6:

> I have a client that has been homeless in Kihei for 20 some odd years, in the same spot. He has severe MRSA. And he often ends up in the hospital septic, because he drinks. That's all he does is drink and smoke cigarettes. He lives off of beer and cigarettes. And, you know, he doesn't even take care...he can't even reach the spots to take care of himself.

According to IKS 7:

> IKS 7: And of course, a lot of them, very unfortunately, because they're diseased, choose not to have any care for that. And then of course their schizophrenia leads them away from you and I, and they're out there wandering on the streets and they have all of the usual skin and soft tissue infections, and then everything else because they don't have any medications and don't choose to take any medications for their schizophrenia or for their mental illness. And then there's a huge population with substance abuse problems, predominantly alcohol, which you know again because their disease of addiction is active, and they're not seeking any help for it, uh ... that in itself is a problem because they get thrown in jail all the time for it, and, and [emphasis] it's a problem because they don't pay attention to any of the other medical problems, particularly skin and soft tissue. So we end up admitting them endlessly to the hospital because of skin and soft tissue infections. And their primary problem is their alcohol which keeps them on the street.

Individual key stakeholder 1 said that he sees homeless persons not attending to their wounds in a timely manner and feels it is often due to an unwillingness to go in to a provider to be taken care of due to the provider attitudes they anticipate encountering. Individual key stakeholders 2 and IKS 3 felt that homeless persons needed more education about how to

properly care for their wounds. Individual key stakeholder 4 has noticed that many of the unmet health needs are related to a lack of hygiene, and complications when homeless persons go into the ocean with open sores. He said that homeless persons are resourceful, and health care providers limit them by trying to do everything for them. Individual key stakeholder 5 noticed noncompliance with instructions and self-care deficit, for example, when a homeless person with instructions to clean a wound daily, returned with a one-week-old dressing on his wound.

Homeless persons are resourceful using their social networks to meet their transportation needs according to IKS 8. According to IKS 10, homeless persons' associations with other homeless persons interfere with their self-care:

> IKS 10: and a lot of these people with their associations, are preyed upon. If we're friends and you have money, you gonna spend it on yourself, your medications? "Oh yeah, yeah. No. We're going out". [He imitated the thought process of someone who preys on a homeless person with resources]
>
> *CPZ: Have a beer.*
>
> IKS 10: and get some gasoline, and drive around.
>
> *CPZ: Drive around* [Laughs]
>
> IKS 10: Because medication is a personal thing, and try to convince Your associations, "Oh no I need this medication". [He imagined homeless person's assertion.] "Oh no. You're being selfish." [He imagined role of associate]

Appendix E

Comments from Individual Homeless Persons on Use and Nonuse of Malama I Ke Ola Health Center

Individual homeless person 4 stated that she usually goes to MIKOHC in Wailuku. When he had spider bites once in the past, IHP 11 went to MIKOHC in Lahaina, but otherwise he has not gone to a physician for about 20 years. Individual homeless person 18 said she goes to MIKOHC and is treated there for asthma. Individual homeless person 21 said sometimes he goes there, and also spoke of going to Maui Medical Group, and the ED. Individual homeless person 23 said she goes to MIKOHC. Individual homeless person 25 stated his doctor is there at MIKOHC. Individual homeless person 26 said she normally goes to the ED for care. Since the time that her pregnancy was diagnosed at the ED, she started going to MIKOHC for prenatal care. Individual homeless person 27 went to MIKOHC for tooth extractions. Individual homeless person 30 went to MIKOHC for pain management, and was told to sign an admission that he sold his prescription pain medications, so he cannot obtain prescriptions there again. Individual homeless person 31 said MIKOHC is attempting to get his mental health records from the mainland.

Individual homeless person 5 said he is not allowed at MIKOHC because he does not have an identification card. Individual homeless person 6 thought that the services were only for girls and so has not sought services there. Individual homeless person 10 does not go there. Her former private doctor will no longer see her due to the fact that she missed her appointments, and did not pay the required penalty fee. Her former private doctor referred her to MIKOHC but she has not been there yet, and likely cannot be treated there because she has a chronic pain diagnosis. Individual homeless person 14 had never heard of MIKOHC. Individual homeless person 15 wanted a “permanent doctor” but had not been to MIKOHC. Individual homeless person 17 reported she was told she could not get services at MIKOHC because she had health insurance. Individual homeless person 19 reported she could not get services there because her health insurance was from California. She was given an application and told when she got her insurance cleared in another month, she could make an appointment. Individual homeless person 28 had not been there but was interested in it. He wrote down the phone number for MIKOHC when it was offered. Individual homeless person 29 was turned away and was threatened with the police when he requested opioid analgesics at MIKOHC in Lahaina. Individual homeless

person 30 was accused of selling prescription opioid analgesics to his associates who drove him to the clinic. Individual homeless persons 1, 2, 3, 7, 9, 12, 13, 16, 20, 22, and 32 denied receiving services at MIKOHC.

Appendix F

Comments of Individual Key Stakeholders on Homeless Persons' Use of Malama I Ke Ola Health Center

According to IKS 1, individuals being seen for the first time at MIKOHC must register on one day, before they can make an appointment to be seen on another day. Individual key stakeholder 1 had a client he offered to take to MIKOHC or ED for an injured hand. The client was told he probably would not be seen that same day at MIKOHC, so he opted to go to the ED instead of MIKOHC, even though IKS 1 encouraged him to get started at MIKOHC so he could have a primary care physician. Individual key stakeholder 3 stated that MIKOHC won't give opiates for pain. Individual key stakeholder 5 said that it is hard to get patients in there. Individual stakeholder 6 described sending patients to MIKOHC. He said that commonly people have to wait several weeks for an appointment because MIKOHC always seems overwhelmed by patients. He hadn't heard of people not being able to get in because of insurance problems.

Individual key stakeholder 7 said that it was his experience that it hasn't been very easy to get people into MIKOHC. He is quoted in the text related to this appendix. Individual key stakeholder 8 spoke of the difficulties she encounters getting patients who are being discharged from the hospital to follow-up at MIKOHC. The case managers make the arrangements. They identify the primary care provider, make the appointment and fax the application. Often times, there is no way to reach the homeless person. The person doesn't have a cell phone, or the phone number doesn't work. About half of the time, IKS 8 estimated, the homeless patients do not keep their follow-up appointments at MIKOHC after they are discharged from the hospital. Individual key stakeholder 9 was unfamiliar with MIKOHC.

Individual key stakeholder 10 did not discuss MIKOHC. Individual key stakeholder 11 mentioned that homeless persons like to spend the night in the parking lot at MIKOHC. He sees their belongings there in the parking lot in the morning. He said MIKOHC has doctors who will see HIV patients. They may treat people without identification if they recognize who the person is. It is done on a case-by-case, basis. He emphasized that MIKOHC does not like to turn people away because it may be the last available stop on the island for them to receive primary care services. He is quoted in the text that is related to this appendix. Individual key stakeholder 11 said having a walk-in clinic is an idea under discussion at MIKOHC because there are patients that do not commit to their appointments; the rate of people not appearing for their appointments

was approximately 10%; and the staff was well aware of the type of patients who come through MIKOHC, and the struggles that patients have. He said that the members' service staff sit patients down, and go over the application process with them. They have a sliding scale fee for those who are uninsured that is based on their income. People can be seen the same day they register, if there is an appointment time open.

According to IKS 12, the satellite clinic for MIKOHC in West Maui closed and homeless patients with or without Quest have no access to health care services other than emergency medical services. Their lack of access to health care services is impacting emergency medical services and the community. The ambulance is often tied up with non-emergent homeless persons' cases, and sometimes unavailable for true medical emergencies.

Appendix G

Comments of Individual Homeless Persons on Use of Emergency Medical Services

Individual homeless person 5 lost his inhaler that he used to treat his asthma, and found himself turning purple and unable to breathe. He called the ambulance. The paramedics gave him another inhaler. He got better. Paramedics did not transport him to the ED. Individual homeless person 18 had an asthma attack in response to the vog [volcanic emissions] and used the ambulance to get to the ED. Her insurance was not activated at the time and she had to pay out-of-pocket for the ambulance service. Individual homeless person 20's girlfriend called the ambulance when IHP 20 looked ashen, and had an altered mental status. At the time, she was newly diagnosed with diabetes, and was told that her blood sugar was 800. She was diagnosed with asthma at that same time. Individual homeless person 11 commented that the waits in the ED are so long, he feels it is better to just call the ambulance because then you are taken directly into the patient care area.

Appendix H

Comments of Individual Key Stakeholders on Homeless Persons' Use of Emergency Medical Services

Individual key stakeholder 1 complained that ambulance crews dropped a patient, who appeared to be drunk, off at a park when there was no place for him at the hospital. He knew of three such occurrences, he said. He also described a wheelchair bound patient, who did not have a wheel chair and could not stand, who was dropped off by the ambulance at the destination of his choice. Individual key stakeholder 2 described a person who was covered with flies, and open wounds that the ambulance did not transport because the ED refused to treat the person. Individual key stakeholder 6 commented that when EMS crews hear the same address over, and over again, it sometimes takes them a little longer to arrive at the address.

Individual key stakeholder 3 reported that many people who are just drunk are brought into the emergency room to sober up because the paramedics are obligated to transport them. She described knowing of one person who had 300 ED visits in six years.

Individual key stakeholder four said:

> IKS 4: You know like in our world, we have a patient, there's a few of them, who are brought in because they're found down…And I get it. Someone drives by, someone is down. And uh… medics are called, and they bring 'em in. "Why did you bring 'em in?" [He recalled asking.] "Because they're intoxicated and can't walk." And again, it's like okay, so you are using our resources. And you know, nothing against the medics. They're in that bind too … And so now, we have to deal with them … It's great if they just sleep it off and walk out. But it's not okay if they're just obnoxious and incontinent, and just being a whole pain, and want everything. They want us to take care of everything for them. It's like, those types of situations. I get it. I understand people are concerned. But at some point. I mean how many times are you going to take care of someone whose only complaint is intoxication. You know, and if they're coming from Lahaina [Laughs]. Really your tying up the medics for an intoxicated person we're going to discharge, and they are going to do the same thing tomorrow?

Individual key stakeholder 12 described being unavailable for patients with life-threatening problems while transporting homeless persons with extremity infections or pneumonias who have no health care providers who will treat them, and no other transportation

to the ED. He estimated that such transports occur, on the average, about four times in a 24 hour period. He has noticed that homeless persons have learned that a statement of intent to commit suicide, a complaint of chest pain, or inability to move results in a decision to transport to the ED. He expressed that more health care services in West Maui and South Maui for homeless persons would alleviate the burden on the ED. The following dialogue occurred between IKS 12 and the DNP student:

CPZ : So what do you think the unmet health care service needs of homeless persons on Maui are?

IKS 12: So for us currently, on my side of the island where I work, we don't have anything really for the uninsured homeless.

CPZ: There's no primary care, there's no community clinic over there?

IKS 12: It's been closed recently and

CPZ: That's news to me. Hmmm.

IKS 12: They'll end up going to the emergency room more than likely um...

CPZ: Because the providers over there won't take them.

IKS 12: They won't take them.

CPZ: And that would impact you.

IKS 12: Yes. So what happens is that when there's no health care service for them, paramedic units are pulled out of the area for upwards to an hour and a half to take someone, you know, with maybe a foot infection, to the hospital.

CPZ: Oh.

IKS 12: And not uncommon that we'll be leaving with someone like that with a minor injury that could have been helped at a clinic. And then someone won't be breathing, and that person's care is delayed because a unit's coming from another area.

CPZ: So you've had specific episodes where

IKS 12: We've had people actually die because there was no ambulance there to cover while we took care of a homeless minor event.

IKS 12: But you know we can't leave them, because they're ill and

CPZ: They have no other transportation.

IKS 12: They don't have cars. They don't have the ability... And when you mention the bus, most of them will say. "Well, I have Quest. Or I have something." We say a bus

would be a great venue for you. So we always try to do the right things for them, but some of them will just dig their heels in and say "I want an ambulance. I want to be taken somewhere." And so, in essence what it does is it pulls the whole rescuer provider out of the district.

CPZ: Yeah.

IKS 12: I've literally looked at patients, the people that I'm taking care of, and I'll "Someone will die while we're gone because you're bringing us in because you have an infected foot."

CPZ: Oh.

IKS 12: And it happens, and we should probably start documenting so we can see the frequency but it does happen.

CPZ: You know that would be a great argument to present about why the community clinic would have to reopen services over there. To be able to document "Okay, this happened when we were out of the area."

IKS 12: Yeah.

CPZ: on a case.

IKS 12: Everything's on computer now, so we can actually do that. Cuz I can look at how many times we were called on transfers. The bummer is just trying things like the Banyan Tree, or even the homeless shelter there behind Shaw Street, and how many times we go there now that their clinic isn't there. Because we've already seen an increase. Of you know of the people come in they got a cough.

CPZ: Uh huh.

IKS 12: "I think I'm getting pneumonia." [imitating person's complaint] I talked to a guy the other day, probably early pneumonia.

CPZ: Yeah.

IKS 12: Didn't really need the ambulance. But the clinic was closed and we ended up taking him.

CPZ: He needed treatment. Yeah. Wow.

IKS 12: So it does...I think we feel the impact more than anybody. Because most people don't know what's going on. They see the homeless on the side of the road. They see them everywhere, but they don't realize how sick these people really are, both mentally

and physically from not being medicated for normal ailments like blood pressure and diabetes, to not being able to do simple care of a wound.

CPZ: Uh huh.

IKS 12: So we would say, I'd say in Lahaina, I'd have to pull up our stats but I would...sometimes we'll go as many as four times a shift to take

CPZ: Four times a shift

IKS 12: There are some of them that are abusers, they're obviously abusers, and they shouldn't be put under a big bubble of homeless. But there's some that will take that person in a wheel chair living under the Banyan Tree, will take them three times, four times a week by ambulance out of the district.

CPZ: You're kidding – the same person?

IKS 12: The same guy. We know all of our homeless generally by name because they call so much …

CPZ: That's four times a 24 hour shift?

IKS 12: Yeah. And we can do up to that in a Lahaina shift – take four homeless people with minor needs,

CPZ: Wow.

IKS 12: and really all they need to do is some of them will say "I'm going to kill myself." [Imitating homeless person] And that's enough that we have to act, take them. One of them complained of chest pain. And I'm looking at him and say "You don't have chest pain do you?" [His question to homeless person] "No, the other guy said if I said I had chest pain, you'd have to take me." [Imitating homeless person's response]

CPZ: Oh no.

IKS 12: But we're talking about maybe a small amount of people, like a dozen people, that routinely do this. And most of them, they have substance issues. Psych and substance issues.

CPZ: Yeah.

IKS 12: So we do have shelters and a place to put these people

CPZ: Yeah.

IKS 12: But they won't obey the rules and they won't stay sober, so Nobody wants them. So they're the guys we see again, and again, and again. So it isn't the full homeless

population. But there's a whole bunch of them that we see. And the word that people say is that other social services, other services, communities are sending us [Emphasis] their people. Cuz I interview people.

CPZ: What do you mean?

Then he spoke about individual homeless persons that had come from other geographic areas. He mentioned the increases in numbers of homeless persons he was seeing compared to the numbers of persons he saw years ago. He continued:

IKS 12: We'll physically know them by name because they'll go in the hospital, the hospital will clean them up, send them back out. Two days later, they'll be back in again.

CPZ: Uh huh.

IKS 12: It's just this kind of this revolving door that doesn't get fixed. It's not our health care though. [Emphasis] In some ways, I don't think some of these people are not dealing with their – they got substance abuse stuff and

CPZ: Yeah. Big substance abuse

IKS 12: That's their big one. But you can drive down Alamaha [Alamaha Street in Kahului] and see camps [Emphasis] of people.

CPZ: Uh huh.

IKS 12: You can drive...In Lahaina, we pushed them out of the bushes and now they're droving, they're moving them out of town so they're pushing them more towards Ukumehame. There's many, many people living in the bushes over there.

CPZ: Oh at Ukumehame.

IKS 12: And you can see it, because when you come in in the morning, they're walking back to town, because "Now I won't get beat up because I'm far enough out of town, that people won't find me." [Imagines homeless person's thought process] So then they start walking in. So you see them walking on the side of the road because they're walking in for services, or whatever they do, can get.

CPZ: Uh huh.

IKS 12: But in Kihei, it's huge. [Emphasis] And they're kind of everywhere. It's pretty big.

CPZ: Do you think you're seeing a lot of people that have problems that could be addressed in primary care?

IKS 12: Yeah. Cuz a lot of it is unmet psych needs – whether they need psych meds to control their bipolar, whatever they be.

CPZ: Yeah.

IKS 12: And then obviously there's no system where they can come back in and be checked "How ya doing?" And so more of that psych services on the West Side. Cuz even if you decide you want to kill yourself, there's nothing out there – there's no counselors, there's no somebody whose going to come and deal with you. And because of the fear that if they do kill themselves, we look pretty bad for not jumping at it.

CPZ: Right

IKS 12: We have to take anybody in that

CPZ: That has like...says that they want to, and they have a method in mind, and they're at risk.

IKS 12: And most of them know what to say, because then they're going to get in and get dealt with. I was just taking care of someone the other day, and she said "Because I have Quest, can you just give me an Ace wrap, or something to wrap my arm up." [Imitating what homeless person requested from him.]

CPZ: Uh huh.

IKS 12: They just need like simple things that a clinic would have.

CPZ: So... Hmmm... Let's see so the ambulance... your role is being uh compromised, and your attention is being diverted to people in need, that really should have their needs addressed somewhere else.

IKS 12: Yeah …And then again we have to limit...you know some of these guys are coming in, and they don't have real problems. They want pain meds.

CPZ: Yeah.

IKS 12: They want something. Some of those guys fall through the cracks because they're abusing that system that was there

CPZ: Yeah.

IKS 12: and they recognized it so they say "No." I mean...we're so much to the point where like a lot of people that want to work my district they go "I hate dealing with your homeless."

CPZ: Yeah.

IKS 12: That they would rather work up in Kula where they don't see it at all.

CPZ: It's a much bigger issue for your district. If they're close to the hospital, then it's a short run. It's always been like that. Okay, pick 'em up, drop 'em off, you're done. You're back available in a few minutes.

IKS 12: At Medic 1 [Ambulance unit stationed in central Maui], some of the medics will go "Jump in. You too. You want to come? Jump in. Because we're here. How many want to go now?" [Both Laugh] And they put 'em in and go.

CPZ: Really?

IKS 12: Because they know "We're going to be back a few hours later for that guy, and that guy." I mean if you drive...I don't know if you drove around. But if you drive around by Safeway, and you drive down by Alamaha

CPZ: Yeah.

IKS 12: There's just bunches of people living in the canals, and living in those areas… Yeah. Because I do see the ones that literally are just kind of lost in the shuffle. Most of the ones that EMS are complaining about are the drug addicted and psych that there psych stuff hasn't been balanced.

CPZ: Yeah. Yeah. That have untreated mental health and substance abuse issues…

IKS 12: And I say: "Why don't you ... I'm gonna put a bandage on that

CPZ: Uh huh

IKS 12: and get on a bus and you'll be at Maui Memorial. We give 'em [a ticket] and tell them how to get there.

CPZ: And does that work sometimes?

IKS 12: Ehhh... For some of them. But most of them, the word's around that lay around, say you can't move, say you can't get on a bus, and you'll get a free ambulance air conditioned ride.

CPZ: Uh huh.

IKS 12: So... In the EMS field, there's a lot of resentment for that and they're more apt to leave sick people. The guys will come and go "Oh, it's a homeless person. Leave him." [Imitating the response of the EMS crew] and I Go "Guys, you can't do that. These are super sick people."

CPZ: Yeah.

IKS 12: "that aren't being medicated. And if anybody in the community needs a ride, a lot of these people do."

CPZ: Yeah. They have no family members to cover them.

IKS 12: They don't have anything. And no one is going to put them in their car. And the cab is almost 100 bucks from the West Side.

CPZ: Is it? Oh.

IKS 12: Yeah. It's ridiculous. And the hospital, gave tokens for awhile, but the hospital doesn't want them either. I mean they really don't. There's a four hour backlog at the ER at any given day. They just sit forever.

CPZ: Uh huh.

IKS 12: So if they had a little more services on the West Side, and even on the South side, it would stop the burden in the emergency room. Cuz all these guys, I'll call the emergency room and say "I'm bringing a homeless guy with a cut on his foot that looks infected." They'll say: "Put him in triage." …

CPZ: Uh huh. So he goes through the lobby. He doesn't go through the back.

IKS 12: Now we're at the point, we don't even take them into the Emergency Room, we drop them at the lobby.

CPZ: Hmmm huh

IKS 12: It's funny, I got a call: "There's an unresponsive person in library park." [Imitating call from emergency dispatch] And I wanted to tell dispatch "There's probably six unresponsive persons in Library Park"

CPZ: "Which one do you want us to see?" [Imagining his possible response]

IKS 12: Just tap them all. "Are you the one?" [Imagining what he would say] [Both Laugh]

IKS 12: But in the day and age of cell phone, and you're visiting looking at the beautiful ocean, and you go "Oh my gosh. There's something wrong with that guy. What's wrong with that guy?" [Imitating a visitor's thought process] He's just homeless.

CPZ: Yeah.

IKS 12: He's sick and he's drunk and he's laying there.

CPZ: Yeah.

IKS 12: And that's kind of how it is.

CPZ: Well you know, how often would you say you have people that are unresponsive and appear to be intoxicated with alcohol, that you wind up transporting?

IKS 12: Oh, at least once a day.

CPZ: Once a day?

IKS 12: Oh yeah. It's a bet.

CPZ: So people wake up in the ER, and usually they probably get released over there, are they glad they got transported?

IKS 12: Most of them, I mean some of them are hoping they can get cleaned up a little bit, and they can get something to eat, and maybe some more drugs, some painkillers, or whatever their need is.

CPZ: And then go back to the West Side?

IKS 12: Well I try to explain to them, "You are going to sit for four hours, and then they're going to put you out on the street. So where do you want to be? Do you want to stay in your community or do you want to be on the street now wondering how I'm getting back to Lahaina?" [What he might ask]

CPZ: Yeah.

IKS 12: So if there was an option where they could go get fixed in Lahaina, because they really don't need to come to town, but if they had better options that we could fix them and get them right back. Unfortunately right back to where? Under their tree. [Laughs]

CPZ: Yeah. Yeah…

IKS 12: We have actually – obviously someone could challenge it – but we, I've have literally myself, on at least four occasions left with somebody who was just a little intoxicated, had a cut foot.

CPZ: Yeah.

IKS 12: And someone's gone into cardiac arrest, and we've waited for Kihei to come in. Or we have a rapid response vehicle now so when we're all out

CPZ: At Maalaea

IKS 12: it starts heading over. But it's not ... and every medic you talk to has had those

cases where they're just hitting themselves in the head going "We are taking you in because you have an infected foot, or you can't pee."

CPZ: Yeah.

IKS 12: Yeah. [Sigh] In fact, I got recently...the guy was had insomnia, he couldn't sleep and was demanding to be taken in and "You can't leave me here", and he was living at the shelter. And he said "I can't sleep and I can't do this anymore."

CPZ: Uh huh.

IKS 12: And I transported with an emergency vehicle someone with insomnia because he was just making a big scene. I said "You can't do this." He said: "I want an ambulance. And I will get an ambulance."…

CPZ: They want to go in.

IKS 12: They want to get off the street for just a moment to get cleaned up, to get drugs, to get whatever

CPZ: Uh huh.

IKS 12: To get whatever their motive is.

CPZ: So people want to be transported.

IKS 12: Yeah.

CPZ: Yeah. Uh huh. Okay. And prescription meds you said like people run out of psych meds.

IKS 12: Yeah. They can't get their meds. And without an ID, you can't get any control stuff.

CPZ: You can't get anything really.

IKS 12: Someone steals their ID and their backpack because they're on the street.

CPZ: Yeah.

IKS 12: And I just had a guy that way. He just got a bypass. Like a single bypass four weeks ago. And he's living on the street.

CPZ: Yeah.

IKS 12: And he uh he can't pick up his meds because he doesn't have an ID.

CPZ: He just had a bypass surgery, and he's living on the street?

IKS 12: Yeah. I've never seen a homeless bypass. But he came from Vegas, and I guess he had some insurance, and he was homeless.

And he had chest pain. We took him in there. They put him in our cath lab. They uh...No they actually cracked his chest and bypassed him. And he's back on the street. And within two weeks we get him for chest pain. But what I realized was when I came up to him and said, "So what makes your chest pain better?" [Imitating his question to homeless person]. And he goes "Dilaudid", and all right. So there we go. But he can't, he hurts. I think he just hurts from post-surgery and all kinds of stuff.

CPZ: Yeah.

IKS 12: And he can't pick up controlled substances because he doesn't have an ID. So the hospital lets him go but he can't fulfill his thing.

CPZ: Yeah.

IKS 12: So he calls us he's in pain, and we don't treat him for cardiac. We just basically take him in and let the hospital turn him around. [Both laugh] It's kind of hard because we can't let a post CABG ... We can't say "No. You don't need us." I mean we'll always have to take someone with chest pain.

CPZ: Right and the risk. I mean I've seen patients post CABG that have had sternal infections, and its pretty wicked.

IKS 12: Yeah.

CPZ: And then wound and skin care, we kind of talked about that.

IKS 12: That's huge…Most of them will take their buddy by the hand, and go "Come on. Let's go." But it has to be something that's there and will see 'em. But we send them and if they can't get in or for some reason, they can't see them, they just give up. They know they can take the easy route. Just call 911.

CPZ: Yeah.

IKS 12: And then we'll do it.

Appendix I

Individual Homeless Persons' Self-Reported Reasons for Emergency Department Use

Individual homeless person 1 went to the ED in Los Angeles when he was homeless and his kidneys nearly "shut down" from dehydration. He had no identification and no insurance at the time of the interview. He said that if he really needed to see a health care provider, he would just go to the ED. When he was in Guam and had a head injury secondary to an assault with a crow bar, IHP 2 went to the ED. When he had rib pain after an assault, IHP 6 went to the ED. Individual homeless person 21 was treated in ED for severe flank pain, blood in his urine and hernia pain. Previous to that, IHP 21 was treated in the ED for a severe head injury secondary to an assault, and he required emergency air transfer to Oahu for neurosurgical treatment.

Individual homeless person 3 has been seen at ED for chest pain and was quoted in the text associated with this appendix. He was more confident in the care he got in the ED than elsewhere. When her asthma gets really bad, IHP 4 said she goes to the ED. She lost her inhaler and didn't know where to get another one. Individual homeless person 18 has been treated in the ED for asthma. Individual homeless person 17 has been treated at the ED for asthma and centipede stings.

Individual homeless person 7 went to the ED for a fractured clavicle, and was quoted in the text associated with this appendix. Individual homeless person 11 brought a friend to the ED who had bad, untreated leg wounds from a fall. Individual homeless person 30 has been treated in the ED for lacerations.

Individual homeless person 10 had been treated in the ED for staph. Individual homeless person 14 had no insurance or identification. He was planning to go to the ED for treatment of his hand that was swollen after injury. He suspected it was infected with staph. He was treated at the ED previously for staph infection of leg wounds. He is quoted in the text related to this appendix.

Individual homeless person 25 took his friend to the ED for a staph infection of his leg. Individual homeless person 27 reported going to the ED for severe staph infections and showed the DNP student scars from wounds that had been debrided. Individual homeless person 29 went to the ED for staph wounds of his legs and was hospitalized for two weeks. Individual homeless person 31 and IHP 32 were treated in the ED for staph.

Individual homeless person five went to the ED six times in eight months, sometimes for

unresolved urinary tract infections. Individual homeless person 15 didn't like going to the ED because she thought it was just a "patch-up" job. She had been trying to find a "permanent doctor" but had been unable to find one. She had been treated at the ED for neuropathy of her leg, a bladder infection, and refills of prescriptions for her mental illness. When she was new to Maui, IHP 19 found that no health care providers would accept her California insurance. She was treated at the ED for a urinary tract infection. When she fainted, IHP 16 was treated at the ED. Her identification had been stolen and she had no insurance.

Individual homeless person 20 had diabetes and had been treated in the ED for hyperglycemia when her blood sugar was greater than 800, and for asthma. She was also treated there at other times for abdominal pain. Individual homeless person 22 said she takes her husband to the ED for diabetes complications. When she runs out of psychiatric medications, IHP 26 said she goes to the ED. Individual homeless person 8 had used the ED. She said if she needs services she would have to go to the ED and just pay, because she has no insurance. Individual homeless person 24 had no insurance and no identification, and would just go the ED if he needed services.

Individual homeless person 9 stated that she does not use the ED but heals herself with fresh air, nature and herbs. Even if he has broken bones, IHP 12 stated that he just takes care of himself. Individual homeless person 13 said he doesn't use the ED. He said he has "tricks of the trade" for taking care of himself including putting yellow mustard on his wounds to prevent staph infection. Individual homeless person 28 stated he tries to avoid EDs and hospitals because: "It's like my grandma used to tell me you never go to the hospital and get good news, you always gonna get bad news."

Appendix J

Individual Key Stakeholders' Comments on Homeless Persons' Use of the Emergency Department

Twelve of the 12 IKSs commented on homeless persons' use of the ED. Individual key stakeholder 1 talked about the difficulty in getting people to actually go in to the ED when he felt they needed care:

> IKS 1: We talk to the guys and talk to the guys until we're blue in the face about going to emergency, going to see a doctor. There's just a hesitancy with them to actually go up the hill there… [Then IKS 1 referred to what an IHP said to him.] He talked about a couple of other patients in there at the same time [referring to the ED] with their situations. And they didn't seem to be, in his estimation, they didn't seem to be cared for at the level they needed to be cared for either. So a lot of times we hear stories like that and that then keeps them from "Well I'm not going to go up because I'm going to go up and sit around for a couple of hours, and they're not going to do anything any way".

He also spoke about the hesitancy of some of the homeless persons to go to the ED because they have been in there so many times, they are well known and labelled.

Individual key stakeholder 2 suggested that spending time in places like the ED, where IHPs access health care, would make apparent what the needs of homeless persons are. He felt bias and prejudice against homeless persons were the problems preventing people from getting services. Individual key stakeholder 3 commented that:

> IKS 3: I believe a lot of the homeless people have relationships with their cellulitis, because we see a lot of cellulitis … There's no incentive to get better. Because it's a dysfunctional relationship, but it's a relationship that gets them everything they want … You come in here. Your leg. You get treated. You get benzos. You get narcotics. You get fed. You get IVs. You get taken care of. You go upstairs. You get whatever you want. You get bathed. You have a T.V. You get antibiotics. You stay a month … I think this E.R. I think people get very, very good care. If anything, they get excessive care.

Individual key stakeholder 4 said that there are days when the ED is so busy that the staff really cannot take the time to just talk with someone who just needs someone who will listen. Homeless persons sometimes wait too long before they come in to get treated. He is quoted in the text related to this appendix. He also talked about homeless persons using the ED as a

primary care clinic, and imitated asking a person about choosing the ED for care rather than primary care. He said: "I think they see us as their primary. So that's why they don't go. You go to what works. You go to where your needs are … [met]."

Individual key stakeholder 5 talked about reminding patients that they are only treated for emergencies at the ED, and they need to follow-up with primary care for further treatment. He said many times people don't have a primary care physician and then they are referred to Malama I Ke Ola Health Center, but it is difficult to get them in there for services.

Individual key stakeholder 6 said that a lot of homeless people do not have insurance, and do not know how to get it. They only know the ED as their primary care provider. Even if they do have a primary care physician, it is difficult to get an appointment. It may take two to three weeks to get an appointment when the person needs to be seen on the same day. He said that hospital staff get frustrated because homeless people make the ED their primary care provider, because that is who can see them on the same day that they feel in need. He felt there is a lack of same day services on Maui.

Individual key stakeholder 7 spoke about the high incidence of skin and soft tissue infections in homeless persons. He said: "And getting care for those is crucial because basically we end up having to admit them to the hospital all the time because they haven't received any kind of significant outpatient care." He pointed out that homeless persons are not getting routine medical care for chronic disease problems. He said:

> IKS 7: They don't have any routine medical care for their hypertension or of course their COPD, or any of that so of course they come into the emergency room with exacerbation of their underlying lung disease, with exacerbation of their hypertension, they come in because they have a stroke, or because they have a heart attack, because they haven't received any care for any of those. Period … So there's obviously a number of homeless people that are very hard to service because they have schizophrenia, or some significant psychiatric diagnosis … And of course, a lot of them, very unfortunately, because they're diseased choose not to have any care for that. And then of course their schizophrenia leads them away from you and I, and they're out their wandering on the streets and they have all of the usual skin and soft tissue infections, and then everything else because they don't have any medications and then there's a huge population with substance abuse problems, predominantly alcohol, which you know again because their disease of

addiction is active and they're not seeking any help for it, uh … that in itself is a problem because they get thrown in jail all the time for it, and, and [emphasis] it's a problem because they don't pay attention to any of the other medical problems, particularly skin and soft tissue. So we end up admitting them endlessly to the hospital because of skin and soft tissue infections. And their primary problem is their alcohol which keeps them on the street.

Individual key stakeholder 7 commented on how there is only one ED on the island and it is tremendously busy. He explained ED services are often not what is really needed by homeless persons:

IKS 7: All of our homeless acutely show up in that emergency room for their medical care … No way … are they going to get significant medical care in there. And they are definitely not going to get access to any social services. Because we're so darned busy, we don't have time to do anything. So it's either you get put in the hospital or you don't get put in the hospital. But you're not going to get … you know … you may get your acute problem of your sore throat looked at or you may get your leg abscess looked at, but you're not going to get anything else. So wouldn't it be nice to have an outpatient kind of community clinic again?

Individual key stakeholder 8 talked about homeless persons inappropriately using the ED as a pain clinic. Individual key stakeholder 9 mentioned that case managers, who are phoned for assistance, may tell mental health patients who are having problems to go to the ED. He said:

IKS 9: And the answer when somebody is homeless and acts different, or strange, or appears sick in anyway, most of, many times it's just they're lying down on the sidewalk, or they're sleeping on private property. The police come and bring these people to the emergency department, and then drop them off and leave.

He described the route of homeless persons with mental illness from the airport to the hospital:

IKS 9: I mean we're taking these people in, many of these homeless people, some of them are chronic, and they bounce in and out. But many of them are people who have arrived on the island, within the past several weeks, and already, they're in the emergency department. Because many times, they're off their medicines, they come…there's nowhere for them to get their medicines even refilled. You arrive on this island, how are you gonna…you have no insurance. How are you going

to get an appointment?

Individual key stakeholder 10 felt that you cannot tell homeless people not to go to the ED, because half of the time that is what they need – their wounds are so infected that they get admitted. He expressed that better hygiene would prevent some wound infections.

Individual key stakeholder 11 responded to a question about what happens to a homeless person who comes to the safety net clinic with no identification. He said the person may be seen, or may be sent to the ED to be treated there instead, for a primary care problem. The decision of whether or not to treat the person is made by the physician at MIKOHC on a case, by case, basis.

Individual key stakeholder 12 commented that the satellite MIKOHC community clinic in West Maui has been shut down so that homeless persons will end up going to the ED instead of going there for care. There is no one who will take them as patients in West Maui. He said:

> IKS 12: So what happens is that when there's no health care service for them, paramedic units are pulled out of the area for upwards to an hour and a half to take someone, you know, with maybe a foot infection, to the hospital…And not uncommon that we'll be leaving with someone like that with a minor injury that could have been helped at a clinic. And then someone won't be breathing, and that person's care is delayed because a unit's coming from another area. We've had people actually die because there was no ambulance there to cover while we took care of a homeless minor event. But you know we can't leave them, because they're ill …

Appendix K

Comments from Individual Homeless Persons on Use of Other Sources of Health Care Services

Six IHPs said they receive health care services at Maui Medical Group. They are IHP 17 and IHP 20 who both had asthma and diabetes; IHP 21 who has survived skull fracture and intracranial hemorrhage secondary to assault, and had a liver disorder; and IHP 22 who had diabetes, and whose husband had diabetes and chronic kidney disease. Also seen at Maui Medical group were IHP 23 who was a young mother who had lost custody of her children, and IHP 27 who was recovering from necrotizing fasciitis and received wound monitoring there.

Two IHPs formerly saw a private physician but are unable to get services there any longer. Individual homeless person 10 was one of those. She failed to make her appointments, was fined a fee which she hadn't paid, and could no longer see that physician. Individual homeless person 16 saw a private physician before she was unemployed and homeless. The physician had since retired from practice. Individual homeless person 5 was attempting to get an appointment with a urologist, but without success.

Five IHPs received health care services in the past while incarcerated. They are IHP 14, IHP 21, IHP 25, IHP 29 and IHP 30. Individual homeless person 14 said he was a veteran but has not received services from the Veterans Administration Clinic. He said he did not have paper documentation of his service record. Individual homeless person 11 also said he was a veteran but does not receive services from the Veterans Administration Clinic. None of the IHPs received services, at the time of interview, from Kaiser Permanente. In the past, prior to losing her job, IHP 32 did receive services from Kaiser Permanente. Individual homeless person 28 initially said he received services from Kaiser, and then he corrected himself. He said he received services from MIKOHC.

Three IHPs received help from Mental Health Kokua (MHK). They are IHP 15 who said she had post-traumatic stress disorder, depression, bipolar disorder, and borderline personality disorder; IHP 18 who had depression, separation anxiety, and was out of her psychiatric medications; and IHP 30 who was self-medicating with methamphetamine, marijuana and alcohol. Individual homeless person four received services from MHK previously, and then experienced a lapse in her insurance coverage. At the time of the interview, she was trying to get re-instated at MHK to get treatment for depression. She had lost custody of her son.

Individual homeless person 25 received services from Wailuku Mental Health. Three IHPs saw a psychiatrist or psychologist. Individual homeless person 6 reported frequent suicidal ideation, took multiple medications and saw two different providers. Individual homeless person 23 stated she sees a therapist. Individual homeless persons 26 and IHP 27 saw a psychiatrist, or a psychologist. Individual homeless person 10 had lost custody of her daughter and sometimes talked to her daughter's psychiatrist, but had been unable to get an appointment anymore with that psychiatrist at the time of the interview.

Appendix L

Comments from Individual Key Stakeholders on Use of Other Sources of Health Care Services

Individual key stakeholder 3 commented that there is a lack of doctors who treat patients for chronic pain. She said that a few physicians will prescribe opioid pain medications for those who will pay privately for the service and the medications. Aloha House accepts a small number of patients for substance abuse treatment. Individual key stakeholder 4 described referring persons to the Crisis Line who request a psychiatrist. He said he recommends that people contact their insurance company to find out what providers will accept their insurance. He mentioned that Mental Health Kokua has a psychiatrist and an APRN with prescriptive authority. The Molokini Unit has a "partial program" for patients who have been discharged from the hospital, but might still benefit from additional services. Wailuku Mental Health does not take dual diagnosis patients with a substance abuse problem. Veterans who were dishonorably discharged cannot receive services at the Veteran Administration Clinic. Individual key stakeholder 8 mentioned a new clinic, Mango Clinic, with offices in Wailuku and in Kihei, that will accept Quest patients.

Appendix M

Commentary from Individual Homeless Persons on Having No Source of Health Care Services

Individual homeless person 6 said he got services "nowhere" even though he also described seeing a psychiatrist, and going to the ED for services. Individual homeless person 10 had burns on her hands that appeared infected, and she was not registered at MIKOHC. She was unable to receive services any longer from the private doctor she had seen previously. She did not know where to go for care. Individual homeless person 11 said he had only been to a physician for health care once in 20 years. Individual homeless person 13 said he just doesn't see health care providers. Individual homeless person 15 said she could not find a health care provider who would accept her Ohana health insurance. Individual homeless person 16 had not seen a doctor in years, and was not sure where to go. She became concerned when another shelter resident checked her blood pressure the night before the interview and got a reading that was high. Individual homeless person 28 said he was new to the island, and so does not know where he would go for health care services. He has not been taking his medications as usual for psychiatric problems.

Most IHPs remarked on not having a source of dental care. See comments in the section on unmet health care service needs with regard to dental care for more information about what IHPs said.

Appendix N

Commentary by Individual Key Stakeholders and Group Stakeholders on Homeless Persons Having No Source of Health Care Services

Individual key stakeholder 6 said that homeless persons often do not know how to get health insurance, and do not know any source of health care services other than the emergency department.

Individual key stakeholder 8 mentioned that there are not enough shelters that will allow homeless persons to receive health care services and follow-up. There is no wound care clinic for the homeless on Maui. Such a clinic could help prevent cellulitis. It could also help persons who do get cellulitis, to recover from it. She also mentioned that there is no pain management service. The group stakeholders (GS) who are hospital social workers conveyed the following:

> GS: Housing is always an issue, however with Family Life Center [FLC], they [homeless persons] can only be there at night and out during the day. This is very hard on the homeless who are elderly and need oxygen machines, electrical equipment, wound vacs [wound vacuum machines] etc. FLC does not allow for this type of equipment and patients can't go out, if they do not have a place to plug in [to electricity].

Individual key stakeholder 9 said that persons are sometimes desperate to get into the shelter of the hospital. They realize that suicidal ideation can get them an admission, and actually do something to hurt themselves so they can get admitted. These patients need a meal, dry clothing, and to warm-up. There is no walk-in mental health clinic to treat them before they become destabilized. There are no intensive outpatient mental health case management services. Individual key stakeholder 10 observed that many people helping the homeless are afraid to expand into medical care, and say that they [services helping the homeless] are busy enough just feeding them. Individual key stakeholder 12 remarked that many homeless persons in West Maui have told him they went to the clinics there, and no one would see them.

Appendix O

Commentary on Unmet Dental Care Needs from Individual Homeless Persons

Individual homeless person 3 and IHP 14 wanted to have their teeth cleaned. Individual homeless person 7 wanted dental care. He had not seen a dentist since he was a child. Individual homeless person 12 was avid about cleaning his teeth but had not had dental care. He wanted to see a dentist. Individual homeless person 19 could not get dental services here, and could not get them in California either. Individual homeless person 18 could not get dental care about the time of the interview. She and her husband, and her children all needed it. Individual homeless person 13 had no dental care in four years. He said he had no need for dental services but he had teeth that appeared in obviously very poor condition to the DNP student. Individual homeless person 9 had not had any dental care for 20 years except for an extraction last year. Individual homeless person 22 needed dental care and did not know how to get it. She needed a denture for missing upper teeth. Individual homeless person 8 said she, and her brother and her sister, always have dental pain. She lived in a campsite without running water. They got their water from five gallon jugs they "lugged". They tried to keep up with brushing their teeth, but they found that it was hard to do without having running water. Individual homeless person 23 had sore teeth and was afraid to go to the dentist.

Individual homeless person 16 had a broken molar. Individual homeless person 25 had broken teeth. Individual homeless person 1 had broken teeth. He said his molars were gone due to grinding his teeth, and he wanted to keep what teeth he had left. Individual homeless person 21 wanted dental care because he had a lot of cavities, and the last time he was treated was three years before the interview when he was incarcerated. Individual homeless person 26 had cavities. Individual homeless person 30 had cavities and oral infections. Individual homeless person 27 has had a number of abscessed teeth extracted. Individual homeless person 28 said he needed braces. Individual homeless person 29 said he drank vodka to cleanse wounds in his mouth and went through an "alcoholic phase". He had also had headaches because of dental problems. Individual homeless person 20 pulled out her front tooth the day before the interview because it was loose and hanging. She said that now she has what she called "garage mouth", meaning the front was open like a garage with no car parked in it. She was concerned about her appearance. Individual homeless person 31 had missing teeth and wanted a denture, and to have his smile brightened. Individual homeless person 17 said she felt ashamed walking around with no teeth

and would like to get dentures. Individual homeless person 11 had an extraction two years ago. Individual homeless person 24 had no teeth. They had all been extracted. He said he had to cut his food into small pieces and grind the nuts he eats because he can’t chew them.

Appendix P

Commentary on Unmet Dental Care Needs of Homeless Persons by Individual Key Stakeholders

Individual key stakeholder 5 commented that providing dental care for ED patients is difficult, because there are no emergency dental services on Maui. Patients can be given antibiotics in the ED and referred to a dentist. If they don't have insurance with dental care coverage, there is often no dentist to see them. Individual key stakeholder 12 commented that all the homeless persons he sees are "awful" in terms of dental condition. Individual key stakeholder 10 and the DNP student had this conversation:

IKS 10: Yeah. Dental is a mess.

CPZ: For everyone.

IKS 10: For everyone.

CPZ: Yeah.

IKS 10: And uh…just remember. It's for everyone. So we are not going to try to … (sighs) well … yeah. Just a mess. There's no [indecipherable] providers. The copayments are so high.

CPZ: Yeah

IKS 10: Even if there was insurance. Obamacare is supposed to cover

CPZ: It doesn't.

IKS 10: Yeah. Well there's a huge copayment. Right? And so, there's a bunch of people, even insured, the copayment they have to pay is so high, it's like a different priority.

CPZ: Okay.

IKS 10: Unless it's pain. If it's pain, then they'll come in for pain.

CPZ: Uh huh.

IKS 10: And then they'll have to have it pulled. Cuz that's all we give, right, for adult.

CPZ: Extraction

IKS 10: Extraction. We don't do…uh…yeah.

Appendix Q

Commentary on Unmet Substance Abuse Treatment Needs by Individual Homeless Persons

Individual homeless person 4 shared that she was homeless and living on the street, and had lost custody of her two year old son. Even so, she was not really ready to abandon her substance abuse. She had her son's picture on her cell phone. She talked about it during the interview with the DNP student:

CPZ: And seeing your son on your phone every morning reminds you.

IHP 4: Reminds me of it. I'm just too stubborn to wake up just yet. I don't know why.

CPZ: Something is pulling you back into the party life.

IHP 4: I try not to but it's hard being out on the streets.

CPZ: I'm sure it is. I'm sure it's really tough.

IHP 4: Everything around you. Drinking. Drinking was my major thing.

CPZ: Your major thing. That's still a concern you're not quite sure you are ready to let go of yet.

IHP 4: Yeah

CPZ: Do you ever go to the groups like A.A.?

IHP 4: No. I only turned to alcohol because when I turned 18 my Mom passed away.

CPZ: Oh.

IHP 4: And it was just hard for me because she was like my best friend.

CPZ: You miss her.

IHP 4: I miss her a lot.

CPZ: What would your Mom want for you?

IHP 4: I know she would want the best for me.

Individual homeless person 7 talked about his return to substance abuse after being treated at Aloha House, and his wish to give treatment another try:

IHP 7: Yeah I did Aloha House. They never help. Just made it worse.

CPZ: Never help?

IHP 7: Never help. Oh yeah. They just made it worse.

CPZ: Really?

IHP 7: Just talk about drugs. Talk about drugs.

CPZ: Got you thinking about it.

IHP 7: Yeah. God, that doesn't work. [Laugh]

CPZ: So would some other kind of program be better?

IHP 7: Well I was thinking of soon just going up to maybe Aloha House. But I don't have medical or the money.

Individual homeless person 10 was drinking from an open beer container during the interview. She stated that she only drinks two days a year and does not need any kind of substance abuse treatment. Individual homeless person 16 said alcoholism runs in her family. She was depressed after she lost her job and was drinking heavily, then she lost her home. She said she would be interested in treatment services or counseling.

Individual homeless person 26 said she recently found out she was pregnant, was living in the park, and said she just had to get her partying controlled because she was told she could be given a place to live by a religious group if she committed to sobriety. Here is a segment of the interview with IHP 26:

CPZ: You mentioned that you really want to stop drinking and drugging and then if you do that you see ways to get housing. But there's something that's keeping you from stopping and I'm wondering if you know...

IHP 26: [Points to her boyfriend next to her]

CPZ: It's him? That's the daddy? Okay well. So it's good that you're going to the meetings.

IHP 26: He comes.

CPZ: He comes too. So you're both thinking it over. You're both working on it.

IHP 26: Yeah.

Individual homeless person 28 described his older brother who was also homeless on Maui and had a problem with alcohol. Individual homeless person 30 doesn't want substance abuse treatment because substances are the way he manages his pain. Individual homeless person 31 is seeking help through reading the Bible to quit cigarettes, marijuana and alcohol. Individual homeless person 12 reported seeing a lot of people aging fast, and dying young from alcohol and drug abuse. Individual homeless person three and IHP 11 spoke about the support homeless persons give each other when they were asked about their needs for substance abuse treatment:

CPZ: How about for alcohol or drug treatment?

IHP 11: That should probably...That would be beneficial around here, but I'm okay. I don't drink that much.

CPZ: Okay. But you see other people have that need.

IHP 11: Oh yeah. We counsel them. Try to counsel them too.

CPZ: You watch out for the other guys.

IHP 11: Yeah. We all do. We kind of look out for each other. We counsel them "Hey, you had way too much last night dude. Had to go pick-up all your stuff, your bicycle was sitting there by the sidewalk." It happens.

CPZ: So you're kind of watching out informally for each other.

IHP 11: Yeah.

CPZ: It's a little community.

IHP 11: Yeah. It's a little community here. But don't get along because of it. And if they're into stuff you're not into – crazy or loud. [indecipherable] You'll find different people. You'll see older people hanging out in this pavilion. You get into fights in the other two pavilions. They are different crowd, a younger crowd.

CPZ: It's like bars. Some bars are good for different people. Some are for the bawdy only.

IHP 11: Right. [indecipherable] Yeah.

Appendix R

Commentary on Unmet Substance Abuse Treatment Needs by Individual Key Stakeholders

Many IKSs commented on how substance abuse can lead to homelessness and poor health, and also how homelessness can lead to substance abuse. Comments from IKS 7 were included in the section accompanying Table 4.19. In addition, IKS 10 commented:

> IKS 10: One of the hardest things to treat is skid row alcoholics – hard core alcoholics, homeless alcoholics. Now there are a bunch of guys homeless because they're alcoholics… There's guys that really got into alcohol after being homeless because they hang out with friends. [friends who are alcoholics]

About the connection between substance abuse and mental illness, IKS 12 said:

> IKS12: Cuz I think with all these people if you could get their substance abuse controlled, they'll follow the rest of it. They'll get their drugs back on [IKS 12 referred to psych medications]. They'll get their wound care. But I think they're just by noon, they're wasted, and it's another day of insanity for them …

With regard for the need for additional substance abuse treatment services on Maui, IKS 9 said this in dialogue with the DNP student:

> IKS 9: We're not a detox facility [referring to the hospital], so we end up having to detox them because there's nowhere else for them to go. All right...um...and then, after that, they're back out on the street, and then they're drinking again because there's no...The alternative then is to send them to Oahu
>
> *CPZ: Yeah.*
>
> IKS 9: But there are waiting lists for all programs. So in the homeless, drugs and alcohol is big time. Also, as well, involvement of Maui Police Department. Big time. [Emphasis] … And the answer when somebody is homeless and acts different, or strange, or appears sick in any way, most of, many times it's just they're lying down on the sidewalk, or they're sleeping on private property.
>
> *CPZ: Yeah.*
>
> IKS 9: The police come and bring these people to the emergency department, and then drop them off and leave.
>
> *CPZ: So it sounds like services that you see that are unmet are for more follow-up care,*

and then for detox.

IKS 9: Follow-up care, detox. Uh... Let's say that those are...you know the initials, they're either brought in by ambulance, or they're brought in by the police. They're left in the emergency department, and if they meet the criteria, then we help them. The problem is, if they don't get into the hospital, then they're just right back out on the street. And these people will come into the emergency department every single day [emphasis] until they have something ... you know they'll be complaining of soreness, or joint pain, or whatever, until they usually discover upon the idea that suicidal ideation brings hospitalization. And then if it doesn't, then the person may even do something, to hurt themselves.

CPZ: Just to get into this shelter.

IKS 9: Just to get in. Right.

CPZ: For showering, bed, food, care.

IKS 9: Because they have nowhere else to go.

CPZ: Uh huh.

IKS 9: Uh huh. If the weather is lousy outside...

CPZ: Do you have more patients then?

IKS 9: Yes absolutely. They're coming in. They need a meal. They need dry clothing, and to warm-up.

Individual key stakeholder 4 noted a lack of substance abuse treatment programs and said:

IKS 4: Oh yeah. I mean, if you were able to get the substance abuse under control, you would get a lot of things taken care of. Um … Someone who is clean and sober is much more likely to take care of his personal medical needs than someone who is intoxicated and lies in their incontinence for days.

Treating homeless persons with substance abuse problems creates a strain on the health care system. According to IKS 3, Aloha House only contracts with the hospital for two treatment beds. She shared the following with the DNP student:

IKS 3: And we have a lot of frequent flyers…I mean a lot of frequent flyers, lots. They come here. They're drunk. We sober them up. We make them feel better. [Laugh]

CPZ: Send them out.

IKS 3: They go back out. [whisper next sentence] They come back in.

[Normal voice volume] I mean we had one guy. He still comes in here. Let's see how long have I been here? … Probably close to 300 E.R. visits.

According to IKS 3, homeless persons with substance abuse disorders, abuse the health care system with drug-seeking behaviors. She said homeless people cut off from prescription medications that they are addicted to, go into withdrawal and come to the ED attempting to get pain relief medications.

Many IKSs commented on ways that substance abuse creates further health complications for homeless persons. According to IKS 2, the three biggest unmet needs for health care service for homeless persons are substance abuse treatment, mental health services and wound care. He described persons with mental illness and substance abuse just giving up hope. Individual key stakeholder one mentioned a person he knew of who has a seizure disorder that is made worse by alcohol. He said the person seizes frequently so the ambulance is called for him and he is taken to the ED where he is well known, and labelled. He perceived him as hesitant to get care at the ED for other problems when he needs it because of the reputation he has in the ED. Individual key stakeholder four expressed frustration with homeless persons' failed substance abuse treatment. He said:

IKS 4: I mean you can look at that a lot of different ways. A lot of what we see is people who really don't, don't really want… have a strong desire to change their substance abuse, you know. But if it gets them a warm bed for a couple of nights – "Yeah. Sure, I'll go to detox." … Is the desire to change there? No. So there needs to be a lot of education [emphasis] in that area. Along with the mentally ill. You know what I mean, a lot of the times, they're hand in hand.

Individual key stakeholder 4 also spoke about the difficulty of getting alcoholic patients to comply with a treatment plan. He found that people often demanded that they be provided with an immediate solution, and then were also selective about what they were, and were not, willing to do. Individual key stakeholder 12 commented: "because most of the guys living in the Banyan Tree [a large tree in Lahaina], they could sleep in a shelter. They're just drunk and the shelter doesn't allow them…". [does not allow them in the shelter drunk]

Individual key stakeholder 6 rated wound care, substance abuse treatment needs and mental health service needs as the top three unmet health care needs for homeless persons on Maui. He noted that the treatment at Aloha House is 30 days. After 30 days the person may be

back again on the street, homeless with no place to go and self-medicating, which is a formula for relapse. Sober living accommodations are not available. According to IKS 9, disobeying any rules at Aloha House results in immediate discharge, and then there is no follow-up with the person. The only alternative to that residential treatment program is referral to services on Oahu. The hospital on Maui is not really a detox facility but may provide that at times because, other than Aloha House, there is nowhere else for people to go on Maui. According to IKS 11, MIKOHC does not have an outpatient alcohol or drug abuse treatment program. Smoking cessation programs are available.

Appendix S

Commentary on Unmet Mental Health and Counseling Service Needs by Individual Homeless Persons

Seven IHPs self-reported an extensive history of mental health concerns. IHP 4 was a patient at Mental Health Kokua previously but lost her insurance for a period of time. She was trying to resume services there to treat her major depression. She was still grieving over the death of her mother who died when IHP 4 was a teen. She had lost custody of her son while being homeless and drinking alcohol heavily. She had difficulty following through to make her appointments with Mental Health Kokua.

IHP 6 spoke to the DNP student at length about mental health concerns:

CPZ: You know you're talking about dying. Do you feel like you're in danger of dying right now?

IHP 6: No. No, I'm not. I just was suicidal. About everything. I love that. I love pain. I love harming myself.

CPZ: You do? That's from…

IHP 6: [points to area on arm that is scarred] That, that's minor. This is from one broken bottle glass right here.

CPZ: So you love harming yourself.

IHP 6: Yes cause I don't want anyone to harm others. I don't want nobody feeling my pain. You know what I mean. So if I did this to you, that would be an assault.

CPZ: Yeah [At this point, I am getting uncomfortable. There are other people in the environment e.g. the leaf blowers. Rather than moving to a more quiet, private area, I stayed where people were circulating around and keeping an eye on us, and put up with the noise.]

IHP 6: That would be a big fine for me. If I do it to myself, I don't get fines. I don't get charged. I don't get accused, that I did that to somebody.

CPZ: So you only have two choices. One is to hurt somebody else, and one is to hurt yourself. That's all the choices.

IHP 6: No. One is just to hurt myself. One is to hurt myself and one… I do not hurt nobody else.

CPZ: Yeah.

IHP 6: I choose not to hurt nobody else. Cuz I don't want them feeling my pain.

CPZ: What about… are there other choices to get rid of your pain?

IHP 6: No. If you on the street like me 17 years, you learn how to be humble, how to respect, how to be a good friend when you need to be, a good listener. I just took that all in. And I would tell people, they would ask me, "Why would you do this?". Cuz I don't want to do that to you. And then you press charges. You say "Oh, he assaulted me. He cut me." Now I cut you with a deadly weapon. That's a big charge. That's 30 years in jail.

CPZ: That's right. Would you ever like to talk to somebody about this?

IHP 6: [Noise, looking through backpack for medication] I have the new guy. [Humming]

CPZ: Oh. So you have some medication.

IHP 6: Yeah I take lithium – for bipolar. That's for mood swings. I take trazadone my nightmare. I take … [states name of medication] for episodes…

CPZ: Helps you not smoke.

IHP 6: Well yeah. I got an appointment on the 9th. You know. And I talk to him. [He shows me a card].

CPZ: Yeah.

IHP 6: And I see Dr. [Gives name of doctor].

CPZ: Does that help, taking the medicines?

IHP 6: Yeah. This is just for mood swings. Say if I had one really bad day today,

CPZ: Make you feel better.

IHP 6: I'm not always wrong.

CPZ: You can relax.

IHP 6: I'm not the bad guy. I can [indecipherable] myself. I can calm down. I can relax.

CPZ: You can calm down.

IHP 6: Yeah.

CPZ: So, it sounds like you feel like you're getting your needs met for counseling and mental health services?

IHP 6: No.

CPZ; What else would help you?

IHP 6: Oh my little sister. I have a little sister. The only reason I say that cuz my younger sister, she was there when I was going through my mental illness. She would know when I had my episodes. She would know when I am flipping out. And, she was always there. She would be my supporter. And, you know, when I came out of the hospital, she told me, she told me. [Leaf blower sound decreased].

CPZ: That's better now. Not so noisy. Huh?

IHP 6: Yes.

CPZ: The noise is a stress.

IHP 6: She told me yesterday, when she dropped me off over here, "I want you to get to the shelter on your own. You can call me for help, assistance, you know. I will be there. But, I want you to do it yourself". So she put me back into the slum, in this place that I call slum.

Individual homeless person 15 reported being severely depressed, having borderline personality disorder, bipolar disorder and PTSD. She described being sexually abused as a child and taken from her parents' custody. She was trying to get psychological services through Mental Health Kokua. For IHP 18, separation anxiety and depression were a problem as well as difficulty getting her medications. Life long experience of victimization was IHP 19's complaint.

Individual homeless person 26 was very concerned that she had run out of her psych medication. She had not gotten an appointment with a psychiatrist. She said that she normally gets her prescription for psych medications through the emergency department. She picks up the prescription medication at Walgreens or Long's. She complained of not having any money for bus transportation to the emergency department, and also that her car was not in drivable condition. She said she has depression and bipolar disorder, and misses all her appointments due to lack of money for transportation.

Individual homeless person 28 is also schizophrenic and bipolar and does not like to take medication. He does hear voices and tries to distinguish if it is God, or his conscience talking to him. He shared this with the DNP student during the interview:

IHP 28: But it hasn't got to the point where it made me suicidal or violent toward anybody. So I don't feel the need to get it looked at.

CPZ: It was in the past, but now you got that managed.

IHP 28: Yes m'am.

Almost all of those interviewed appeared to be having mental health needs or crisis situations. Six were willing to have mental health or counseling services who were not receiving them at the time of the interview, and so had an unmet need. As an example, IHP 10 felt overwhelmed by the stressors in her life and said she had a rough week. Her dog was taken from her and put to sleep. Her car wouldn't start. She burned her hands and they appeared infected. She had a troubled relationship with her boyfriend. Sometimes she would see her daughter's therapist, but her daughter's therapist had not been available to her recently. Her daughter had been taken from her and was in foster care. She was one of the six interviewed who were not receiving mental health services at the time of the interview but would have accepted them if they were available.

Individual homeless person 2 had this conversation with the DNP student:

IHP 2: It would be nice to have someone to talk to.

CPZ: Talk about concerns you have?

IHP 2: To talk about anything. I guess that's a psychological thing.

CPZ: In general about your life?

IHP 2: You mean what would I like to talk about? Well, like yesterday, a security guard came up to me and I thought he was going to kick me out. He just sat down and he started talking. And half way through, I realized like wow, I really appreciated, at that time, just having someone to just talk to. I felt a lot more confident – having expressed everything that happened to me. I don't know. He didn't have much advice to offer. But that was a powerful thing. It was strong.

CPZ: To have someone to just listen. How about the staff here …

IHP 2: I don't come here very often. It's probably my third time coming. They are pretty OK. But I don't really go to them and talk about anything. They're always busy. I guess they are here. I'm sure they wouldn't turn me away.

Individual homeless person 16 was interviewed at a shelter. When asked about mental health service needs, she quipped that she would let me know after another week of staying at the shelter. She got teary eyed when alluding to the experience of being sexually abused as a child, and related that, to her choice for years not to seek services for her woman's health needs.

Individual homeless person 19 spoke at length about being victimized for 20 years, beginning with victimization by her family, and followed by victimization in every setting she

had been in since. She had not had any friends or social contacts for a long time. She hoped someday to have a friend she could have a cup of coffee with and talk to about how beautiful her daughter was.

Other IHPs who were interviewed were not interested in mental health or counseling services. Individual homeless person 9 viewed individuals who retreat to living in the woods as persons who are mentally healthy, and that those who live in society and are workers as not mentally healthy because they're afraid to go live in the woods. She herself didn't feel she needed mental health services.

Individual homeless person 13 did not feel he needed services. He likened his poor distance vision to the loss of vision by the New Testament Biblical Saul who lost his vision when struck down by the Lord, and then regained his sight and became Paul, missionary of Christ. He feels he will regain his vision also.

Individual homeless person 17 denied mental health service needs, but said that she was advised to get services and did not get them. Individual homeless person 20 described sometimes feeling so depressed that she just does not take her insulin for her diabetes, or her medication for hypertension or for high cholesterol. She said: "I do go into stages where I get so depressed I don't want to live or nothing. Just take what I get. I sleep in my car all day, and not do anything." She mentioned that she has never sought help from Mental Health Kokua because she felt: "They get into too much of your life." She has mentioned it to her doctor and he told her: "if I keep talking like that he has to call the police, if I really going to commit suicide [Laughs] I'm not laughing because I'm crazy. I laughing because I know the law, and I know." Then she said she did not plan to commit suicide but will probably just fade away. She wanted to find a little place to live where she can just grow her flowers. Individual homeless person 29 was uncertain if he needed counseling or mental health services.

Appendix T

Commentary on Unmet Mental Health and Counseling Service Needs of Homeless Persons by Individual Key Stakeholders

All 12 IKSs recognized that many homeless persons on Maui have problems with mental illness or counseling service needs. Mental health problems were rated as one of the top three health problems of homeless persons on Maui by IKS 1, IKS 2 and IKS 6. Being homeless is a stressor on mental health. In the interview dialogue, IKS 1 said:

> IKS 1: But you're right. People can't care for themselves, at the same level, if they're not housed. If they don't have shelter, and they have some injury, they're going to be consumed by where they're going to stay that night, how they're going to be safe, what food they're going to get, over how am I going to dress this week. And if they're coming from the hospital, they might be doing like 80% better, or even 100% better. But as soon as they get back in the weather, on the street, or on the beach, if they don't have the... [sigh] safety and the security of a roof over their head, then stress plays a huge role on our physical health.
>
> *CPZ: Yeah*
>
> IKS 1: So all of a sudden they are back in that stress that they were in before. And that's going to hinder them more, and they can get back into deterioration because they're in the stress of being houseless, unsheltered.

Five IKSs mentioned that homeless persons often have combined mental health and substance abuse problems. Per IKS 4, the Wailuku Mental Health Center does not accept patients for treatment who have alcohol use disorders. Six IKSs commented on the inadequacy of mental health and counseling services on Maui. There is currently no adolescent psych unit at the hospital per IKS 3 and IKS 4. Per IKS 4, people who come to the emergency department for psychiatric help and want someone to talk to may be given a phone number and referred to the Crisis Line. For homeless persons who have no phone, there is no follow-up from Crisis Line possible. At the emergency department, persons who want to be referred to a psychiatrist or a psychologist may be told to contact their insurance carrier, to find out what, if any providers will accept their insurance. He stated that there are a few psychiatrists on the island that will treat people on a cash basis, but that this is not particularly helpful to persons without money.

The DNP student and IKS 9 had this dialogue about mental health services for homeless persons on Maui:

CPZ: Yeah. So what would that look like for something that would help them before they have to be hospitalized?

IKS 9: Well, the biggest thing is that at least from our people, all right, Community Mental Health, the County's Community Mental Health needs to be taking these people in. They haven't taken a new patient in about two and a half years.

CPZ: Really?

IKS 9: Really.

CPZ: Now that's not Mental Health Kokua, right?

IKS 9: No. That's right here, down the hill from us.

CPZ: Oh. Okay. I don't even know much about it.

IKS 9: So they need walk-in at Community Mental Health.

CPZ: So they need walk-in, like a walk-in clinic for mental health.

IKS 9: They need services. Right. Instead of coming to an emergency department.

CPZ: Yeah.

IKS 9: I mean, most places, for example have a primary care. All right. And this is a County project. It needs to be that someone comes and can go to be seen and be screened before they need to go to the emergency room.

CPZ: You mentioned they haven't taken a new patient in two and a half years. Is there, are there service providers there?

IKS 9: There are service providers there. They are very limited.

CPZ: Yeah.

IKS 9: And so one of the best things they can do is fund their own community – the County's mental health system.

CPZ: Funded by...would that be funded by the County Council?

IKS 9: Well, it's gotta come through the County since it's their program. But most of these program come off state block grants.

CPZ: Yeah.

IKS 9: Okay, so it needs a state block grant to fund the Community Mental Health program.

CPZ: I don't even know anything about that program. I guess it's been kind of quiet for awhile.

IKS 9: Well, that's why it's so quiet. I mean, they have a chronic population that they're taking care of, but when you're talking about the homeless, many times...uh...here's another thing…

IKS 9: I mean we're taking these people in, many of these homeless people, Some of them are chronic, and they bounce in and out. But many of them are people who have arrived on the island, within the past several weeks, and already, they're in the emergency department. Because many times, they're off their medicines, they come...there's nowhere for them to get their medicines even refilled. You arrive on this island, how are you gonna...you have no insurance. How are you going to get an appointment?

CPZ: Uh huh. Yeah.

IKS 9: [Brief laugh] There needs to be some place.

CPZ: So a county walk-in clinic would cover them.

IKS 9: I think so. Get case management connected to that.

CPZ: Not Malama?

IKS 9: And all these other things.

CPZ: What about mental health at Malama? Would that substitute for that? The community clinic - Malama I Ke Ola?

IKS 9: Where -I don't know exactly where that is.

CPZ: That's in Wailuku. That's the federal safety net, the federally qualified clinic.

IKS 9: Ah...you know I hear about it once in a while but it doesn't seem to be where anybody takes the patient.

CPZ: Uh huh.

IKS 9: The patient is taken to the emergency department.

CPZ: Uh huh.

IKS 9: That seems to be the central point rather than, for example for mental health patients... a mental health clinic.

CPZ: Yeah.

IKS 9: You know.

CPZ: Would a drop-in clinic up here, where people could be diverted from the ED, would

that work or does it have to be at a different location do you think?

IKS 9: A drop-in clinic?

CPZ: You were talking about a drop-in mental health clinic.

IKS 9: Well...anything that you put together will be flooded. Because we have this tremendous population of people who are homeless

IKS 9: whether they're taking drugs, alcohol, have mental illnesses that are not being treated. If you have a place out there where they're getting services already, then chances are you will stop all the people who need to be, not all of them. but a huge percentage of the people who need to be admitted because you've caught them earlier.

CPZ: Uh huh. Yeah.

IKS 9: Before the problem results.

CPZ: Before the problem. Yeah. I totally see what you mean there.

IKS 9: We see a lot people who, for example are coming from the private clinic, from down the hill from us. All right. Like for example, Kaiser. We see a lot less Kaiser patients because they have services already.

CPZ: Their needs are addressed before they get so unstable they have to come to the ED.

IKS 9: They need intensive outpatient services or what's called an ICRS - intensive community rehabilitation services, or something, where you have a clinic that's connected to the county, whether the county wants to contract it out, it doesn't matter, but it's connected to them, and that they have a team of people who are following all these people. And if the patient has an appointment, I used to work for one of these, then a case worker goes out there picks up the patient, and makes sure they come to their appointment.

CPZ: Let's see, I guess all those things would reduce unnecessary ED visits: that close follow-up, and more detox, more county mental health, and would reduce length of stay here [reference to hospital] because there would be someone to transfer the patient out to.

IKS 9: That's right [emphasis]

CPZ: Any thoughts on

IKS 9: Many times we have to hold on to them until…Many times the problem we've had

gets to be how much you can get reimbursed ...you know...is it enough. Did this patient ever have any problems? I mean I think your group may be in this research the beginning of getting people together to start talking cuz whenever we actually find out about things, there's more than you think. But you don't seem to be able to get the patient in.

CPZ: Uh huh.

IKS 9: All right. And so whether it's not enough, you know the patient has a bad stigma, things like that...uh...especially when you're talking about chronic illness. It's not like okay, to get you out of the hospital, we'll send you to a shelter for, you know, a few days, and then it's not our problem again. It becomes our problem again because the patient's brought back to the emergency department because there's nowhere else to go, and then many times that patient is unable to go back to that location.

CPZ: Uh huh. Yeah.

IKS 9: And so, we need to start to develop many more sort of long term uh ... places ... uh

CPZ: Yeah.

IKS 9: You know.

CPZ: Not just transient shelters.

IKS 9: We're talking like houses, where they've been taken over but the people running them are professionals who deal with, for example mental health patients.

CPZ: Yeah. Support services integrated into the housing.

IKS 9: That that cooperation begins to develop between us whose discharging the patient that we know that this patient is not going to cause them that much trouble. Okay.

Seven IKSs commented on the difficulty of treating homeless persons with mental health or counseling needs. About this, IKS 10 had the following dialogue with the DNP student:

CPZ: So what do you think are the unmet health care service needs of homeless persons on Maui?

IKS 10: First of all, let me expand that spectrum a little bit. There are people who are homeless, and there are people who are about two minutes from becoming homeless.

CPZ: Uh huh.

IKS: So we know both aspects:

CPZ: Yeah

IKS 10: The homeless, and those who are trying so hard not to be homeless. So I'm going

to lump them all together.

CPZ: Yeah.

IKS 10: To me the hardest problem is actually behavioral issues – okay?

CPZ: Yeah.

IKS 10: A lot of these folks, it might not be outright psychosis

CPZ: Yeah

IKS 10: You know, delusions and all

CPZ: Yeah.

IKS 10: It might not be like that.

CPZ: Yeah.

IKS 10: It might just be horrible anti-social skills -okay?

CPZ: Yeah.

IKS 10: And so for the few that were homeless, are homeless, are soon going to be homeless, you know. These people don't have good anger-management skills - okay?

CPZ: Yeah.

IKS 10: And they ... you cannot really help them - medically or anything. They're just unstable. They get angry. They have poor rapport with people. Sometimes they're angry, sometimes they're just how do you say? - detached. But now, like I said, if they truly have a psychiatric diagnosis, they're fine. We can do whatever we have to do - medicate them. Some of these people are not truly psychiatrically ill. They just have personality defects.

CPZ: Uh huh.

IKS 10: So...behavioral problems. Yeah. How you gonna help 'em? In all aspects ... he just happens to be homeless. How are you gonna help him get a home, medical things, get an ID?

CPZ: Yeah.

IKS 10: Get food, anything… So, that's like problem number one. [Emphasis] And if you say, "well look here's my data, that's like only 10% of the people". First of all, it's not like 10% of the people. I think it's like 40%. And this, even if it were 10%

CPZ: Forty percent with poor social skills

IKS 10: Forty per cent that cause 90% of your problems. They're just unreliable - da, da,

da.

CPZ: Uh huh.

IKS 10: That's like just repeated, repeated, repeated. Okay. Now some of them have obligations... to their kids, I thought we removed all kids from the homeless situation. And some of them have obligations to their significant other.

CPZ: Yeah.

IKS 10: Ay Yay Yigh! And so when there's a peripherally prefunctional person trying to handle a dysfunctional person - well, they'll both be homeless. And a lot of times that person - I'm just going over a ton of 'em in my mind - they just can't help each other, because one of them has a restraining order against the other.

CPZ: Uh huh.

IKS 10: So you say, "Is that a behavioral problem?". I don't know what it is, but their associations are a mess…

CPZ: And then mental health and counselling?

IKS 10: And remember, the behavioral health, this must be like 10% of all behavioral issues is aggression, anti-social behavior, just [makes a grunting noise]. But if they happen to have a true diagnosis - you know schizophrenia, bipolar. The follow-up - where's that follow-up? It's zero. [Emphasis] How can you follow anybody who is like so...how you gonna control these guys who don't make their appointments, you know, for mental health issues, psychiatric. "I guess we gotta put them in an institution." [Imitates someone commenting on the problem] Okay. We tried to have a clubhouse. They resurrected the clubhouse - like a true mental guys, who have to take medication, they come somewhere during the day. Now okay. They're using our center for now because there's this thing. The clubhouse wasn't funded. It was underfunded. We have struggled keeping that alive. But without this clubhouse, where they get together for food and come [indecipherable], they don't take their meds. [Emphasis]

CPZ: Uh huh.

IKS 10: They go do something violent and end up in the ER, and in jail. That's sad.

CPZ: So there's no clubhouse now. It's just [DNP student misunderstood]

IKS 10: No. No. No. We have one we're resurrecting it. The problem with this is their

compliance to take meds, and make the appointment. [Emphasis]

CPZ: Yeah. Compliance and appointments. Right.

IKS 10: Yes. No follow-up...

About services in West Maui, IKS 12 commented that there is no one in West Maui to treat homeless persons with mental health issues. People lose their identification or have it stolen and are unable to pick up their prescriptions for psych meds. He commented many of the people are one medication away from being functional.

Appendix U

Commentary on Unmet Wound and Skin Care Needs by Individual Homeless Persons

Seventeen of the 32 IHPs interviewed had some current wound and skin care needs. There is a quote from the interview with IHP 10 about this in the text section that corresponds to this appendix.

Individual homeless person 2 had a wound on his shoulder that he sustained while skate boarding. His skate board was his principle means of transportation. He was concerned that his wound would get infected so he kept it covered with a tee shirt to keep the flies off it. He wanted antibiotic ointment. He had difficulty washing his wound because of lack of places to shower.

Individual homeless person 11 had a wound on his leg from rebar that he sustained while working on a foundation. His foot was swollen and he was worried about how much staph there is in Hawaii. Individual homeless person 14 had a wound on his hand that he thought might be from a spider bite. His hand got very swollen. He self-treated with antibiotics he bought on the street. His hand looked better to him but it was still red, swollen, and he thought infected. Individual homeless person 15 had broken skin on her leg from an ill-fitted leg brace that rubbed on her skin. Individual homeless person 16 had multiple insect bites on her extremities. Individual homeless person 18 had a cyst on her foot she had for four years. Individual homeless person 19 had a sore on her foot that she had had for three years. In addition, she expressed worry that she was getting a recurrence of a parasitic skin infection she had had trouble with for many years. Individual homeless person 20 had diabetes and had healed wounds on her feet and legs she developed from scratching. She said she was attentive to them because of her diabetes. Individual homeless person 21 had survived head trauma from an assault with a baseball bat and a fall from a height. He had been in a coma for a month following the injury. He had neurosurgical treatment for the injury, and now had vision in only one eye, deformity to his skull and facial scarring. He said wires from the repair of his skull sometimes break through his skin. He complained of having peeling, pruritic lesions on the palms of his hands and the soles of his feet. He was not receptive to the suggestion to see a health care provider for a possible fungal infection. He said his father had the same problem and became an albino. Individual homeless person 22 had grandchildren camping at the park who had wound infections from insect bites that became infected. She had taken the grandchildren to a clinic for treatment. She was concerned because, staying in the park homeless and sleeping on the ground, the children

continued to get insect bites. Individual homeless person 27 has had MRSA infected wounds debrided at the hospital and was receiving follow-up wound care at a clinic. He was afraid of contracting more bacterial infections from living homeless outside. He said he wanted to get indoors.

Fifteen of 32 IHPs reported no current unmet wound and skin care needs. Those who had no current need, described hygiene and self-care measures they protect themselves with. Five IHPs reported past ED visits or hospitalizations for infected wounds while they were homeless. IHP 10 had been treated previously in the ED for staph infections. Individual homeless persons 14 and 32 said they were treated in the ED for staph infections and given antibiotics. IHP 27 and 29 were hospitalized, and had their wounds debrided. Individual homeless person 29 described his experience in this interview excerpt:

> IHP 29: At the time when I was sleeping in the field between Salvation Army and the Alano Club,
>
> *CPZ: Uh huh.*
>
> IHP 29: I started getting sores. I think it was from the dirty dirt, and the flies started getting into it.
>
> *CPZ: Flies.*
>
> IHP 29: And I got infected. And it was so bad that I couldn't even walk and I had to call for an ambulance.
>
> *CPZ: Yeah.*
>
> IHP 29: And I went to the emergency room.
>
> *CPZ: Uh huh.*
>
> IHP 29: Two weeks later, a $27,000 bill
>
> *CPZ: You had to be hospitalized for that.*
>
> IHP 29: Hmm huh. It was bad. And the ambulance was $800. It was a very expensive ride and the insurance didn't cover it. I had to make call, after call, and call. I kept returning the bill back to the insurance, and then finally they paid the ambulance and the medical. But I would have been a slave to debt because of that... economic.

Six IHPs described past visits to the ED or hospitalization for treatment of wounds secondary to an assault that occurred while they were homeless. Individual homeless person 2 was hit in the head with a crowbar on Guam. Individual homeless person 6 was punched in the

chest on the evening prior to the interview, thought he had sustained fractured ribs and went to the ED. Individual homeless person 7 said he had brain damage from football, partying and getting hit in the head. He said that people “act stupid”, and getting hit in the head is just something you end up dealing with “out here”. Before he went to prison and reformed, IHP 25 got into gang fights and went to the ED when he was injured. Individual homeless person 30 said he stayed in a graveyard at night, and has awakened to someone trying to cut the corners of his mouth. He said he has been treated in the ED for multiple lacerations.

Nine IHPs expressed concerns about how at risk they were for staph infections. Individual homeless person 27 said he had been living outside for 35 years on Maui, and now he is getting bacterial infections. He has had MRSA and he wants to get inside [housed]. Individual homeless person 14 said that if he hadn’t been able to buy antibiotics on the street, he would have gone to the ED, because of how concerned he is about staph infections. Here is an excerpt from the interview with IHP 14:

IHP 14: I would have made sure to get there one way or another.

CPZ: Yeah

IHP 14: Cause you know these kind of things, when they start eating a hole in your skin, it does not [emphasis] stop.

CPZ: It doesn't stop. It keeps going.

IHP 14: And I know that for a fact.

CPZ: You've experienced, and you've witnessed it, and studied it.

IHP 14: Well I've got holes in my left arm. Yeah. I used to ride the bicycle a lot, when I used to be able to get back into my property. And I'd cut and bruise myself. And as soon as I'd get a cut, it's like bam! All of a sudden infected. Just like that.

CPZ: Uh huh.

IHP 14: Amazing.

Four IHPs described the challenge of keeping wounds clean while being homeless. With regard to the challenges of keeping a wound clean, IHP 2 had this dialogue with the DNP student:

CPZ: So are you able to wash that out with soap and water?

IHP 2: [Laughs a little] Well, when I get a chance. When I get a chance to shower. That's probably the hardest thing to come by. Clean water. Drinking water. Showering water. We can get food, we got shelter. But water, that's the hardest thing to come by. I try to keep it clean.

CPZ: How about the showers over here, are they still working?

IHP 2: I'm afraid to use this shower, this one here - you know the hepatitis, staph infection, anything that could be spread so easily that would make my situation a lot worse. I've showered over here at the pool but you gotta be able to swim, and I can't swim because I have an open wound.

Even though the DNP student did not ask IHPs what they thought the number one unmet health care service need of homeless persons on Maui is, IHP 7 opined that it is wound care. This excerpt includes IHP 7's observations on that:

IHP 7: Wound care.

CPZ: For people living out in the bushes.

IHP 7: Wound care is the number one.

CPZ: Wound care.

IHP 7: Wound care is the number one. [emphasis] These guys take cuts. And they no shower.

CPZ: And there's a lot of flies.

IHP 7: Even if they do shower, still yet. You battling the elements, every day, all day long. It's not like you can lay down in one clean bed at night. They ain't laying down in a clean bed at night. Mostly laying on the floor. Which leads to infection - you have bugs, a lot of flies, dirty clothes.

Six IHPs spoke about the wound care needs that they have seen in other homeless persons. Individual homeless person 1 said he wears shoes all the time to protect his feet. He said he noticed homeless people on Maui have a lot of scars, and missing toes, from not wearing shoes or not having foot protection. Individual homeless person 7 noted that a lot of homeless people here have health insurance but don't utilize it when they need wound care. Here is an excerpt from the dialogue with IHP 7:

IHP 7: When they are injured, or they get stuff on them like that, it's basically dem [them] that don't go [emphasis]. You know. They just don't go. They know they have to go. They

just don't do it.

CPZ: Why do you think that is?

IHP 7: Lazy.

CPZ: Lazy.

IHP 7: Yeah. You know

CPZ: Uh huh.

IHP 7: But from my experience, that's what it mostly is. You know. They don't go. They don't care of their own selves.

CPZ: Uh huh.

IHP 7: Just because you homeless, doesn't mean you cannot take one shower. Or, you know, keep yourself in check.

CPZ: Rinse out your clothes. And stuff like that.

IHP 7: Yeah simple things like that. Even you get an injury, a staph. You just let it go. And they would not go...And they get medical [insurance].

CPZ: So you think it's lazy. They just won't go.

IHP 7: No. It's transportation. [suddenly changed his opinion]

Individual homeless person 11 described the difficult experience a friend of his had when he tried to get treatment for the wounds on his legs:

IHP 11: A buddy of mine here went to the emergency room. He had fallen and got cut really bad. We had to bandage it up here. And he went to the emergency room for four hours. The doctor didn't even look at it.

CPZ: Oh.

IHP 11: Didn't even change the bandage, didn't look at it, didn't unbandage it, didn't unwrap it to look to see if it was okay, if it was infected, just "have a good day". I'm not kidding. [emotion in voice]

CPZ: So

IHP 11: He waited four and a half hours to look at it. So the doctor

CPZ: How did he get from here to Wailuku?

IHP 11: The bus

CPZ: So he took the bus, and then waited four and a half hours, and then he took the bus back or

IHP 11: Yeah. He didn't see if needed stitches or antibiotics to make sure it didn't get infected

CPZ: Wow. Yeah.

IHP 11: "Have a good day" something. He waited four and half hours for someone to tell him that.

CPZ: Or a tetanus shot.

IHP 11: I understand big medical. [indecipherable] They don't have the finances to treat everybody… And I've never heard of a hospital getting in trouble for not doing that.

Individual homeless person 22 was concerned about her grandchildren who were also staying in the park because they were getting bitten by something, and it had been going on for weeks. She was told the culprit insects were sand fleas. She didn't think mosquitos were the problem but rather some bug on the ground. Individual homeless person 24 noticed that a lot of homeless people "out here" were not taking care of their hygiene.

Appendix V

Commentary on Unmet Wound and Skin Care Needs of Homeless Persons by Individual Key Stakeholders

The commentary from IKS 6 in the text associated with this appendix supports the perception that wound and skin problems are one of the most common health problems of homeless persons. Ten IKSs spoke about homeless persons not adequately attending to their own wound and skin care problems. In the following excerpt, IKS 1 relates the story of a homeless person who did not seek timely treatment and let his wounds go:

> IKS 1: One of our outreach workers, he saw this guy in one of the Kihei parks. And for weeks, he was trying to convince this guy to go in, and get checked out, and have his wounds, his lacerations looked at. And then finally, there was one trip he was making to Kihei. The guy was begging [emphasized] them to call 911, because at the point he was in so much pain, because he didn't take care of them right. He couldn't adequately take care of his wounds to the point where he was in such pain and they were in such an awful state with maggots in them, and everything, that he was willing at that point to call 911. Yeah.
>
> *CPZ: Uh huh*
>
> IKS 1: If he just went and he was cared for initially. It would never have got to that point.

He also spoke about frustrating attempts to get homeless persons with wounds to go to the ED or MIKOHC:

> IKS 1: We've tried to have bandaids and ointment. But that's great if it is just a normal cut or laceration. But if it's infected, there's more that needs to happen. We talk to the guys, and talk to the guys until we're blue in the face about going to emergency, going to see a doctor. There's just a hesitancy with them to actually go up the hill there.
>
> *CPZ: What do you think that hesitancy is?*
>
> IKS 1: Part of it is that - this isn't a blanket statement - but for some of them in the past they've gone and were unsatisfied with the visit - whether it was the length the time that it took in emerg to be looked at … [Then he described one homeless person's experience]
>
> IKS 1: So he just felt like he was ... that, they didn't take more time with him. They didn't say what the shooting pain was. They just gave him a wrap, wrapped it and told him to

ice it. He [the homeless person] talked about a couple of other patients in there at the same time with their situations. And they didn't seem to be, in his estimation, they didn't seem to be cared for at the level they needed to be cared for either. So a lot of times we hear stories like that and that then keeps them from "Well I'm not going to go up because, I'm going to go up and sit around for a couple of hours, and they're not going to do anything anyway".

During his interview, IKS 2 observed: “I think that's the biggest issue right there. Prejudice and preconceived notions about people. Bias about people because they're homeless.”

Five IKSs commented on substance abuse interfering with wound care treatment. In the following excerpt, IKS 4 addresses lack of hygiene and substance abuse as factors in wound complications:

C*PZ: Uh huh. Are there like certain medical needs that you’ve seen are really prominent among homeless people that aren’t being met?*

IKS 4: Well I think it’s…the needs are due to lack of hygiene a lot of the times. Just taking basic care of yourself. You get a cut, you get this, you get that … You know, you know…There’s no follow-up. Uh…Because of the substance abuse issues that the majority of them have, they don’t take care of things in a timely manner. It’s…they see that cut but they’re so intoxicated, or the need to continue to be intoxicated outweighs the need for medical care … Yeah. But even at the beach. Just getting under that.

CPZ: The beach shower. Yeah.

IKS 4: Yeah. A lot of them just walk around with board shorts and a tee shirt. There’s no reason. And if you have open sores and open wounds. There’s no reason for that. You know. Don’t go in the water if you have the open sores. Don’t go in the ocean if you have open sores. Basic.

Individual key stakeholder 12 relayed this story of substance abuse and wound complications:

CPZ: And then wound and skin care, we kind of talked about that.

IKS 12: That’s huge.

CPZ: That’s huge huh.

IKS 12: Yeah. Because so many of them have…I can show you a video clip of one of the guys I see all the time. I came out and was banging maggots out of his leg because his leg

was just alive with maggots and the other homeless were going well

CPZ: He was banging maggots? You were?

IKS 12: No they called us. And they said there was all maggots in his leg and this guy lays under the Banyan Tree and is in his wheelchair and is rotting. Because he doesn't have any way to take care of his wounds.

CPZ: Oh no.

IKS 12: And I took a video on my cell phone of maggots bubbling and doing their job in his wound and you know, I knocked most of them out and wrapped him up and I took him in. This guy, he called so much, he's now in hospice care. They finally got him into something.

CPZ: But yeah.

IKS 12: It literally had a huge wound,

CPZ: Oh my gosh.

IKS 12: The maggots were eating the dead flesh, and uh yeah. And this guy, unfortunately, when he's sober, he is wonderful. But he doesn't stay sober.

CPZ: He doesn't stay sober.

Individual key stakeholder 5 noticed that homeless persons' lack of compliance with the treatment regimen interferes with wound healing. He said: "You tell them you need to clean your wounds every day, do this and do that, and they're like ah… and they come in here with [a] one week old dressing". Individual key stakeholder 6 named wound care as the number one issue. He talked about how sometimes doctors misunderstand how difficult it is to care for a wound when you are homeless:

IKS 6: And then of course, the doctors are making the assumption, or encouraging the patient to take care of their ailment: maybe keep it clean, keep it bandaged regularly, or do things that are just not available. I don't know if available is the right word…But are just not …

CPZ: It's incompatible with living in the bushes.

IKS 6: It's incompatible with living in the bushes. So if you're living in the bushes, and you are trying to treat a staph infection, but there's bugs, and mosquitos, and dirt, and kiawe and, or you're even living out on the street some place and you're living in the gutter or living in some park where there are other staph germs that are all over the

grounds. And even um…you go to the beaches, while they might clean the table tops which I've talked to Parks and Recs about, they're not necessarily cleaning the benches. And then once they clean the benches, they're not treating the ground which is right below the benches where people are putting their feet and walking in these areas without any shoes on…I have a client that has been homeless in Kihei for 20 some odd years, in the same spot. He has severe MRSA. And he often ends up in the hospital septic, because he drinks. That's all he does is drink and smoke cigarettes. He lives off of beer and cigarettes. And, you know, he doesn't even take care…he can't even reach the spots to take care of himself…Staph is a really, really bad issue on Maui right now…

Individual key stakeholder 7 spoke about how many homeless persons are admitted to the hospital with skin and soft tissue infections because they have not had any significant outpatient care to nip the infection in the bud. Mental health and substance abuse problems contribute to neglect of skin and soft tissue problems. Individual key stakeholder 12 felt that most people don't realize how really sick many of the homeless persons are. He said:

IKS 12: Because most people don't know what's going on. They see the homeless on the side of the road. They see them everywhere, but they don't realize how sick these people really are, both mentally and physically from not being medicated for normal ailments like blood pressure and diabetes, to not being able to do simple care of a wound.

Three IKSs spoke about the need to encourage homeless persons to do better self-care of their wounds. Individual key stakeholder 3 suggested having outpatient clinics where people could be taught to do their own dressings.

Five IKSs commented on the lack of a variety of services related to wound care for the homeless persons. Both IKS 9 and IKS 12 affirmed that a walk-in clinic would allow persons to get their wounds treated before they developed complications that required hospitalization. Similarly, IKS 8 noted the lack of a wound care clinic. Putting himself in the place of a homeless person, IKS 7 imagined that he wouldn't know where to get services on Maui.

Both IKS 7 and IKS 8 commented that the lack of a clean, short term place for homeless persons to stay and continue to heal their wounds after hospital discharge results in prolonged hospital stays, hospital readmissions, and difficulty in placing persons who are otherwise not in need of acute care hospitalization. At the time of the interview, IKS 8 said, there were no home health agencies on Maui that would visit homeless persons for follow-up on their wound

treatment. There was also a paucity of health care providers that would accept them as outpatients. Individual key stake holder 8 had not been able to send discharged patients needing home health follow-up wound care to Ka Hale A Ke Ola Homeless Resource Center, if they needed opioid analgesics with wound care. Shelter regulations prohibit anyone from entering the shelter who tests positive for opioids 60 days prior, even if they received them as part of their prescribed treatment. She was very challenged by finding places to discharge people to that are safe and clean. She said that Kula Hospital and Hale Makua are hesitant to take homeless persons because they are concerned that once the skilled need has been cared for, there will be no place to discharge the patient to, and they will have the patient with no reimbursement for the person's extended stay.

Three IKSs commented on how homeless persons' wound and skin care complications impact others. The hospital has unreimbursed care for prolonged hospital length of stays. Individual key stakeholder three and IKS 6 felt that homeless persons are not concerned about the costs they incur for others by misusing health care services. Individual key stakeholder 12 described the impact of homeless persons unmet wound care needs, on other people in the community:

> IKS 12: Yes. So what happens is that when there's no health care service for them, paramedic units are pulled out of the area for upwards to an hour and a half to take someone, you know, with maybe a foot infection, to the hospital.
>
> *CPZ: Oh.*
>
> IKS 12: And not uncommon that we'll be leaving with someone like that with a minor injury that could have been helped at a clinic. And then someone won't be breathing, and that person's care is delayed because a unit's coming from another area.
>
> *CPZ: So you've had specific episodes where*
>
> IKS 12: We've had people actually die because there was no ambulance there to cover while we took care of a homeless minor event…

Appendix W

Other Unmet Needs and Other Unmet Medical Needs per Individual Homeless Persons

All IHPs had commentary on the need for housing, stable shelter or a safe camping situation to avoid the negative impacts of homelessness on their health. Individual homeless person 1 said “I graduated L.A.”. He felt that he had learned a lot about taking care of himself while homeless in Los Angeles. He said, that in Los Angeles, he drank a lot of caffeinated drinks to stay awake at night to watch out for himself. Then he got dehydrated, delirious and was hospitalized for a kidney injury. As a result, he became careful to hydrate himself. He felt Maui was an easier place to be homeless than Los Angeles. Being homeless, the food he has rots, gets stolen, or is eaten by bugs. A setting with refrigeration would allow him a nutritious diet. He also said he needs vitamins. Individual homeless person 3 said he is disabled with back pain. He thought housing would help him treat his back pain. Individual homeless person 4 said she is not ready to stop drinking alcohol and so cannot stay in the shelter because of the rules there. Living on the street, she has lost custody of her son and doesn’t manage her asthma. Individual homeless person 5 spoke about the extreme measures he takes to get privacy. He lived underground and described it in this excerpt:

CPZ: So it must be sort of interesting to be underground...

IHP 5: Oh yeah. Get away from people, it really is interesting.

CPZ: Get away from people.

IHP 5: Yeah.

CPZ: You feel safer that way?

IHP 5: Oh, yeah. Nobody's going to crawl in there with all those cockroaches, centipedes, brown spiders,

CPZ: Uh huh

IHP 5: scorpions.

CPZ: So it must be a little uncomfortable for you there...

IHP 5: Oh no.

CPZ: You like it.

IHP 5: I spray it with bug spray they all die before they get to bite me.

CPZ: Uh huh.

IHP 5: Yeah, I spray a line of bug spray when I first go in. And a line of bug spray when it turns about 100 feet later to another direction.

CPZ: Uh huh.

IHP 5: And, uh, yeah. Nobody goes down there. Ever, that I know of.

CPZ: So you got privacy there.

IHP 5: Yeah.

He also talked about problems with severe asthma and urological problems which could well have been exacerbated by his extreme measures to get privacy.

Individual homeless person 6 spoke about how homelessness impacts his and others self-esteem and makes him feel suicidal:

IHP 6: But right when someone mention you homeless, boom, they gonna pick on you. "Hey, get off the street. You don't look good on the streets. You don't look good laying down over there." Then all that high power of them, it's gonna make them low. Their esteem level, everything, is just gonna drop.

CPZ: How about when you go into the hospital or you see the doctor or counselor, do you have fears?

IHP 6: No. Only when I go to court and they try to [indecipherable].

Only court do that.

CPZ: How about "don't care anymore"?

IHP 6: When you don't care is when you suicidal … I try to take my life every chance I get.

CPZ: Well... I'm sorry to hear that.

IHP 6: Why?

CPZ: Because I would rather see people happy.

IHP 6: Oh no you can't...There's no... Oh you probably could catch a couple of homeless people happy, if they're on their fix. You know, their medication.

CPZ: Yeah.

IHP 6: You could see their happiness. But deep down inside, no, they're like crying, they're hurt. They're painful. They just put on a show to make everybody "All right. He's happy. Let him go." But deep inside he's really hurting.

CPZ: He's really hurting.

IHP 6: He's really tear down. He really want to give up. He's really "do not care anymore".

CPZ: Don't care anymore.

IHP 6: For me, I care. [emphasis] I understand there is life. And

CPZ: You like it here.

IHP 6: Oh yeah. I do. You know, I just saying, for others. Some people it's just the way that they feel. You know. Like, I could talk for everybody.

Individual homeless person 6 also thought family support and getting housing would help him. He was assaulted the previous night and was concerned his ribs were fractured. He was waitlisted for supportive housing.

Individual homeless person 7 also spoke about the dangers of homelessness –how common assaults are especially at night. Individual homeless person 8 does not have running water at her family's campsite. Because water is not easily available, she and her younger siblings do not brush their teeth regularly. She said they all have teeth with cavities. Individual homeless person 10 burned herself cooking on a campfire. She said her hands were too painful to use. Her burn wounds were showing signs of infection.

Individual homeless person 11 spoke about the problem of sleep deprivation and the need for sleep as a health issue. In his view, a safe place in the park to sleep would help people's health:

IHP 11: I would say, I would just complain about how they chase everybody out of the parks at night. What that does is it pushes your body to places that aren't easy to sleep in.

CPZ: Oh.

IHP 11: You know a lot of people go to the [indecipherable]. They're sitting up but they can't lay down on it.

CPZ: Uh huh.

IHP 11: And then they'll come back in the park during the day and just lay around and sleep during the day in front of all the tourists.

CPZ: They've been awake at night.

IHP 11: If they'd let us sleep in the park at night, they wouldn't have all these homeless people sleeping here during the day.

CPZ: Uh huh.

IHP 11: And it would be easier for people to get jobs because not so tired in the morning from trying to hide to find a place to sleep.

CPZ: Yeah.

IHP 11: People have to sleep in some…pretty…pretty uncomfortable places just to find a place to sleep at night.

CPZ: Yeah.

IHP 11: Yeah. By daytime, if they work, they're too tired [indecipherable].

CPZ: So kind of the other thing is a sleep deficit. Right?

IHP 11: Yeah. I'd say that. Deprivation.

CPZ: Sleep deprivation.

IHP 11: It's an issue. You see a lot of homeless people sleep during the day because they just can't sleep at night. Gotta hide from security, at the shopping centers. Gotta hide from the cops. Wherever they do sleep, sometimes it's on concrete, and it's not easy to sleep on concrete.

CPZ: No.

IHP 11: You know. It's hard to be up at night sleeping on the [indecipherable] and in the morning to be going looking for a job when you didn't sleep good. So they don't.

IHP 11: If they didn't run people out of the parks at night, maybe you could get a good night's sleep, have a better opportunity to get a job. It's hard to look for a job if you didn't sleep at all.

CPZ: It makes a lot of sense. It's hard to work, do physical labor, if you haven't slept.

IHP 11: Yeah. Yeah. I'd say that's one thing that's a barrier to people getting a job. They spend all their time just trying to find some place to sleep at night. I'm fortunate. I have a hammock. I can just string it up anywhere. You know.

CPZ: It's very portable.

IHP 11: Very portable. Very lightweight.

CPZ: As long as it doesn't rain.

IHP 11: Yeah. Rain. We don't get rain here very often. If it does, just string it up in the park's pavilion. [indecipherable]

Individual homeless person 12 opined that housing is the real issue. He would like to see public bathing facilities. He said without housing, homeless people "Go down, down, down".

Individual homeless person 13 remarked on how living outside, one loses privacy. Here is some of his conversation with the DNP student:

CPZ: Okay. Is there anything else you'd like to say about health care? We've been talking about something very cosmic, but is there anything else you want to say about health care?

IHP 13: I don't know if it pertains to health care but something I've thought about a lot since I've been out here. People who live out on the beach obviously have immediate concerns with medicine, clothes, if you need to see a doctor. Those kinds of things. And something that I've never heard people talk about is the lack of privacy. You're out on the beach, and there's nowhere where you can go and sit and truly be alone. With your own thoughts. Even if it's just for a couple of minutes. Kind of get away, sit down. And if I, I don't know, say for example if I move over here [pointing toward apartment building] and I live in a place and there's people living next to me and there's people up here, and down here, and there's walls and I don't hear anyone.

CPZ: Yeah.

IHP 13: I don't see anyone. I'm alone. I can have my own thoughts. But on the beach, as beautiful as this is, there's 50 people all around right here.

CPZ: Someone can walk in on you at any moment. Right?

IHP 13: Yeah. There is sometimes when it's nice to have a little space for few minutes.

CPZ: So have you figured out how to create that space for yourself?

IHP 13: I have.

CPZ: I won't ask you where because it wouldn't be private anymore.

IHP 13: No. No… I have a nice little space where I go that no one knows about.

CPZ: I don't want to know where it is. [Laughs]

IHP 13: It's just something I see in other people. It's great to be around other people and have friends. But it's something I sense in a lot of people. Say someone is just sitting at a table and reading a book, or listening to the radio, or just sitting here and watching the waves – and all of a sudden, people walk by and say "Yeah, that's my friend. I'm gonna stop and say 'hi'." You want to say "hi" to them but maybe right there at that one moment, you want to be private. You can never have that. There's no such thing as privacy living outside.

CPZ: How about people who live in tents? Do they get some privacy?

IHP 13: It can be created. I just think that most people don't think that it can. [Pause]

CPZ: But you're willing to forego that in order to stay outside. You could have it again if you moved into a house. But getting a house … it's not worth it.

IHP 13: Well I have a place where I can go and be private. If I want it even more so, I could go back to that life. I can't say that will never happen. I don't know. I don't know what's going to happen five minutes from now. But… where I'm at right now … No. I wouldn't get to talk to you to lovely people [Laugh].

[Paolo (nursing student) and CPZ laugh].

IHP 13: I'd be over here [Indicating the apartment building across the street] watching T.V. with my feet up on the table. Or whatever.

Individual homeless person 14 talked about feeling fatigued all the time while being homeless, the stress of it, and the difficulty of maintaining hygiene. He said: "I mean it's difficult. Hygiene is like…There's the pool. Thank God there's a pool. But there's only certain hours and you know. I haven't taken care of my teeth as much as I could have, I guess."

Individual homeless person 15 spoke about her mental health problems and how wounding the experience of being stigmatized as homeless has been for her. Individual homeless person 16 spoke about the danger of homelessness and how frightening it is. She had been staying in the park with a woman friend. When her friend left for the mainland, she said that all of a sudden there were not two sets of eyes on everything and her wallet was stolen. She was sleeping in the park and was awakened by what she said was a "couple different men groping me". At that point she went to the shelter.

Individual homeless person 17 has had chronic health problems of asthma and diabetes and was attempting to get into Ka Hale A Ke Ola Homeless Resource Center shelter and then to find housing. Her thirteen year old son was with his father and not with her. Individual homeless person 18's family has been split up as a result of homelessness. She and her husband and children were camping on the banks of a stream for six years. Her husbands' tools and other items were stolen. The campsite was cleared away by county workers. Her children were in the custody of relatives, she was upstairs at the shelter and her husband was separated from her, and staying downstairs at the shelter. They were looking for housing. She spoke of having a history of mental and physical health problems and having separation anxiety. Individual homeless

person 19 was housed in northern California but was not happy with her situation. She travelled to Kauai, couldn't get services there and then travelled to Maui. She was supposed to stay out of the sun while taking an antibiotic for a urinary tract infection and found that difficult to do without housing. She was sunburn. The overnight shelter is not open to homeless persons during the day. She was having pain in her legs from being on her feet walking all day. She also had diabetes.

Individual homeless person 20 had diabetes that she treated with insulin. She was living in an abandoned car. She said that she was afraid to be by herself, and felt she needed a 24 hour care giver to watch her in case she showed signs of hypoglycemia, hyperglycemia or severe asthma. Previously she had emergency hospitalization for those problems. She was depressed and having difficulty following a healthy diet for her diabetes while living in the abandoned car. She wanted to be safe in her own cottage.

Individual homeless person 21 had a campsite near a running stream. In order to get to his campsite he had to walk through the running stream so his hands, feet, and clothing frequently stayed wet. He had findings on the palms of his hands and soles of his feet consistent with fungal infection, which were likely exacerbated by so much wetness.

Individual homeless person 22 was concerned for her grandchildren staying in the park. They were sleeping on the ground and getting insect bites that repeatedly got infected. Individual homeless person 23 said she had lost her children to foster care. She had completed treatment for drug and alcohol use, was trying to regain custody of her children, and was wait-listed for housing.

Individual homeless person 26 said she was pregnant and had been offered housing through a church on the condition that she commit herself to not using drugs or alcohol. She said that she just was not sure she was ready for that, and so was still living at the park despite her pregnancy. She said she had three other children. They were not with her at the time of the interview. It was unclear if they had been removed from her custody and placed in foster care.

When asked about unmet health care needs, IHP 28 spoke about the difficulty of getting restful sleep while homeless:

> IHP 28: Mine is just rest. Being in an area where people are constantly up with the tourists and everything, it's hard to just sit down and sleep for an hour or two. So I look at it, I get the opportunity to lay my head down and sleep versus I take this. If I know

they got their lunch coming up at 11

CPZ: Uh huh.

IHP 28: and there's a place down there ain't got nobody, and I can sit down there and rest, I'm gonna do that first. So, my rest is my main priority.

CPZ: Night time for sleeping, you probably don't get good sleep.

IHP 28: Oh, no. Cuz I can't.

CPZ: You gotta keep one eye open.

IHP 28: I got all my personals in my backpack and everything, so, and Then I got my phone charge. And most places here don't let you charge your phone like that. It's lie your head down, close your eyes, rest for about 30 minutes, wake-up, make sure there ain't no security guard coming, make sure nobody's trying to steal your stuff, or just watching over you. Yeah. That's hazardous, man. So. And then being on the other side, it's a lot of ice users [methamphetamine users].

CPZ: On the other side.

IHP 28: Yes m'am.

CPZ: Not on this side.

IHP 28: Not on this side. But I know on the other side, there's a lot of meth users. I just came back over here a couple of days ago and with so many people doing meth, they're always up. And they're always looking to take your stuff.

CPZ: Oh. There always looking to grab your stuff.

IHP 28: Yeah. Always looking to take. Me – I'm still young. So I can afford to just stay up a couple of days, whatever the case may be, and I've seen people that just sit there and watch, and what they do is just wait 'til the people sleep

CPZ: Watch and wait until you go to sleep

IHP 28: Yeah. And then they'll go over there and pick through real lightly, like they're professionals, and then hurry up and take off. And I don't want to be a victim.

CPZ: No. No I don't blame you.

IHP 28: No. I don't want to be a victim. Even if for 30 minutes, you just lay down and lay your head for 30 minutes, I gotta get up.

CPZ: A lot of people get their ID stolen here. Was that an issue for you?

IHP 28: No. That wasn't an issue. It wasn't an issue. As far as somebody taking from me, I haven't had anybody do that. But because I see people doing it to other people, I try to be aware, and

CPZ: Watchful

IHP 28: Yeah. So it's hard to get rest at night

Individual homeless person 29 spoke about being hospitalized for two weeks for treatment of wound infections he developed on his legs after sleeping in the dirt. He said he's been "bulldozed" more than once – gone back to his encampment and everything he had was gone. Individual homeless person 30 is trying to find housing so he can avoid being robbed or assaulted. Once in a while, IHP 32 can sleep in a friend's backyard. She said that is really the only place she feels safe. She said:

IHP 32: I was so upset [Emphasis]. Yeah. And uh living outdoors, I've been ripped off so many times. So many times. [Emphasis]

CPZ: Uh huh

IHP 32: So many times. [Emphasis]

CPZ: Yeah.

IHP 32: Purses, backpacks, money. Uh, you turn your head for one minute, one minute, even in here, people will take your stuff.

CPZ: Uh huh. Even here. You have to keep it close.

IHP 32: Even here. Even here. You have to have your eyes on your stuff at all times. You leave your cell phone sitting out like that.

CPZ: It's gone.

IHP 32: They'll look "What's that bird?" [She imagined what someone might say.] Somebody took it. You know like that. All the time. Very, very vulnerable.

Appendix X

Commentary of Individual Key Stakeholders on Other Unmet Needs and Other Unmet Medical Needs of Homeless Persons

In addition to the comments about medical need for supportive housing cited in the text associated with this appendix, seven IKSs spoke about the need for shelter or medical respite where homeless persons can continue to recuperate after discharge from the hospital, and also for health outreach. The following is an excerpt of the interview with IKS 7:

CPZ: We need medical respite housing or something.

IKS 7: We do. That's exactly right. And so, you know it's so hard, Carol, because we have Lanai North [the name of a unit at the hospital] and stuff, but we have all these guys that are hanging around in the hospital on Maui North unfairly, predominantly on Maui North [hospital unit], not because they really need any further intravenous antibiotics, but they're there basically because they need wound care. And everybody knows they're going to go back to Kanaha Beach, and they're not going to take care of their wounds. And they're just going to get infected, and they'll be back in the emergency room in two or three days. And I don't know where our half way house is, so to speak. If they could go on an oral antibiotic, or we could give them a long acting seven [to] ten day intravenous antibiotic. We could do anything like that for the antibiotic. It's just we don't have anybody to take care of them. And of course, they're going to be drinking again too. Well wouldn't it be cool to have - I don't know - would it be an outreach again like our care-a-van roar out there and go "You know like you were just discharged from the hospital, we're following up. And yup you need your dressings changed each day, and we're going to be out here each day to change your dressing."

CPZ: Uh huh.

IKS 7: And of course it would be really cool to have

CPZ: a sheltered setting

IKS 7: a shelter. Where you literally had a dormitory type style, where you could take five or six guys, or whatever some six to 10 people post hospital stay. And go “Look. We're going to take care of your wounds here, give you some meals, and so forth.” I like that. That would be really cool.

Two IKSs spoke about the need for hygiene centers. Individual key stakeholder 10

recommended having showers at feeding centers rather than separate, and at a distance – e.g., expecting people to use beach park showers.

Four IKS spoke about the need for compassionate care without judgment from health care providers. Individual key stakeholder 6 said:

> IKS 6: You just need to take care of the patient. Make it happen. It doesn't matter what your opinion is what you think about the person. You just make it happen. And, you know, it's just how it is.

Individual key stakeholder 2 viewed this as essential to meeting homeless persons' needs for care. Here is an excerpt of the dialogue with him:

> *CPZ: What do you think would help homeless people on Maui get their health care needs met better?*
>
> IKS 2: I think it would be, the main thing is that service providers are willing to spend the time with people to learn what their needs are, and be willing to push [emphasis] to get those needs met.
>
> *CPZ: So you mean doctors and nurses when they come in...*
>
> IKS 2: So doctors and nurses... and not just turn someone away because they may be homeless, or unsheltered.
>
> *CPZ: Have dirty clothes.*
>
> IKS 2: Have dirty clothes or whatever.
>
> *CPZ: Yeah.*
>
> *CPZ: That's the main thing - not turning people away.*
>
> IKS 2: I think that's the biggest issue right there. Prejudice and preconceived notions about people. Bias about people because they're homeless.
>
> *CPZ: Umm. So it sounds like the biggest intervention to help people get their health care needs met really has to do with a change in understanding from the health care provider's point of view?*
>
> IKS 2: I think so.

The DNP student did not specifically ask any IHPs about having HIV, AIDS, hepatitis C or tuberculosis in an effort to avoid pushing on sensitive issues that might turn interviewees away. Interestingly, no IHPs self-disclosed having these problems. Individual key stakeholder two commented on how people may not be willing to share some information about themselves:

IKS 2: People are hesitant disclose some of those…some of those

CPZ: Concerned about trust issues.

IKS: Yeah. Yeah.

CPZ: Yeah. So, there may be something, and then they just won't tell anyone about it.

IKS 2: They won't want to talk about it. Sure. I've met some homeless clients, they have AIDS, or HIV, and don't want to talk about it. Some that have hep C, they don't want to talk about it.

CPZ: Yeah.

IKS 2: So if you don't know what those needs are, it's hard to address those needs.

Homeless persons are often marginalized from the rest of the community and need help reconnecting themselves into the community. Needs identified by IKSs include motivation stimulation, education about self-care, and easy ways to replace lost or stolen identification; a place to receive mail, and a call center for receiving messages and phone calls, and for making phone calls.

Six IKS recognized the need for health care providers who will accept homeless persons as patients despite the stigma they often have. Needs identified include providers in the geographic area of West Maui, easier entry into MIKOHC as the difficulty of getting services there may divert patients to the ED or discourage patients from persevering to get care, and women's health services including contraceptive care.

Here is an excerpt from the interview with IKS 7 in which he comments about accessing care at MIKOHC and the lack of a safety net clinic:

CPZ: And then what barriers do you think homeless persons on Maui face in accessing health care?

IKS 7: You know the biggest barrier is that a lot of them just don't want to have anything to do with us um and you know this is... oh that's under solutions ... you know...I don't want to really bad mouth the community clinic but my experience has been that it hasn't been real easy to get people into that clinic.

CPZ: That's my experience too. What can we do about that?

IKS 7: That depresses me because every time we try to refer somebody over there that clearly doesn't have any money or who is medi... I'm sorry Quest pending, or Medicaid pending and stuff, you know they seem to have a ton of red tape. [emphasis]

CPZ: Yeah.

IKS 7: You know you gotta jump through this hoop, you gotta give us this form, you gotta give us that form before they'll actually see somebody in their clinic.

CPZ: I'm hearing that from multiple sources.

IKS 7: I'm just like wait a minute. "Aren't you guys getting money from the State of Hawaii?" which I believe they are.

CPZ: And the federal government.

IKS 7: And I was going to say "Aren't you getting money from the federal government to help us?"

CPZ: Yeah

IKS 7: "You know with these people who really do need health services. So how come it's so difficult [emphasis], once we even have our hands on these people to get you to follow-up - you know once we've had them in the acute care setting in the hospital."

CPZ: Where's the key to unlock that?

IKS 7: I don't know the key to unlock that.

Always when … the case managers and I do that, we always run into that red tape issue. Instead of kind of like opening the door and saying like: "Ah! Thank you guys for taking care of that dude [imagining what a favorable response from the clinic he would like, would be]

CPZ: Yeah.

IKS 7: and we'll follow-up on that cellulitis, and we'll do his dressing changes over here three times a week."

CPZ: Uh huh. It's not there.

IKS 7: Not there at all. And I kind of thought that was one of our safety nets if you will, is what I kind of thought they were. And they haven't been that at all...so. They'd probably disagree but that's been my experience.

CPZ: Yeah.

IKS 7: So I'm a little bit...I'm a little bit worried that's one of my problems with unmet health care needs are what was to me our safety net just isn't there. The other thing that's really difficult is we have only one emergency room here on the island of Maui as you are well aware.

CPZ: Yeah.

IKS 7: It is a tremendously busy emergency room.

CPZ: Yeah.

IKS 7: All of our homeless acutely show up in that emergency room for their medical care.

CPZ: Yeah.

IKS 7: No way... are they going to get significant medical care in there. And they are definitely not going to get access to any social services.

Homeless persons sometimes need specialty care which they cannot access such as orthopedic follow-up after a fracture, treatment by a urologist, or emergency dental services. Individual key stakeholder 5 talked about the difficulty of getting follow-up orthopedic care for homeless persons after they have had a fracture. Orthopedists would not be bound by the COBRA / EMTALA Law to see patients, the way an emergency department physician would be. If patients don't have insurance, they would most likely have to pay cash prior to treatment for orthopedic care. Individual key stakeholder 7 pointed out that homeless persons on Maui commonly lack routine care for their chronic diseases like hypertension and COPD. He said that homeless women commonly have not had routine womens' care, contraceptive services or mammography. Individual key stakeholder 10 said that many homeless persons have gastrointestinal problems due to lack of refrigeration for their food, eating spoiled food, and discarded food from "dumpster diving". He said: "They get sick from eating. They consider that the norm". Individual key stakeholder 12 mentioned that pneumonia is a common health care problem and reason for seeking care for homeless persons on Maui.

Five IKSs commented on the need for health outreach to homeless persons, and two on the need for an outpatient clinic that will help to stabilize people and prevent complications before they need hospitalization. Six IKSs commented on the need for a walk-in clinic where homeless persons could get services without the need of an appointment. It would be like the ED, per IKS 4, in that if you need services you just go in. He said: "If you have issues, you can come on in. Basically the same thing we do." Individual key stakeholder nine said that homeless persons need a walk-in mental health clinic to take care of their needs before they have to be hospitalized. Per IKS 9, additional facilities for detoxification from drugs or alcohol are needed.

Five IKSs noted how lack of follow-up can undermine successful treatment. Individual

key stakeholder 10 felt that congregate housing would resolve some follow-up problems:

IKS 10: Classic. Lousy follow-up.

CPZ: Yeah. I've heard that repeatedly.

IKS 10: We see this with the poor, and certainly see it with the homeless.

CPZ: Yeah. Yeah.

IKS 10: No follow-up. Any medical condition, I can't follow the guy. How can you possibly intervene.

CPZ: Yeah.

IKS 10: So that's why we want to congregate housing, maybe like [names a person] might set-up. If you have 'em kind of grouped, I can send a nurse to go see everybody at once

CPZ: Yeah.

IKS 10: Or as much as we can at once

CPZ: Support services

IKS 10: At least I go out there and I see half of them. And then I go, I see the other half. Yeah. Support services. Okay. Now you realize, this lack of follow-up, is a result of weird behaviors, no infrastructure - they don't have transportation- or they're associating with a group that's not following up.

CPZ: And drugs and alcohol.

IKS 10: Yeah. Yeah.

Appendix Y

Commentary on Unmet Needs for Prescription Medications per Individual Homeless Persons

Some of the challenges of managing a chronic disease like asthma, and getting and using prescription medications while being homeless, are apparent in the experience of IHP 18. Here is an excerpt from the interview with her that took place at on overnight shelter:

CPZ: Oh. Do you have the medications you need - the inhalers?

IHP 18: I have an inhaler. Um... with five refills on and then I'm waiting for them to call me about my psych meds.

CPZ: Uh huh.

IHP 18: It's been about almost a week.

CPZ: You're out of your meds?

IHP 18: Oh.

CPZ: Okay. So...how are you going to get them refilled?

IHP 18: I have a case worker and my case worker's supposed to come pick me up on Monday.

CPZ: Okay. Then take you to like the doctor's appointment? Okay.

IHP 18: Yeah.

CPZ: Are you okay for now without them?

IHP 18: Yeah. I have separation anxiety issues. I have depression issues. So being in here helps. [Laughs, referring to overnight shelter location]

CPZ: It's a safe place.

IHP 18: Yeah.

CPZ: And there's lots of people around. People to talk to…So what if any unmet health care needs do you have? It sounds like getting some medications...

IHP 18: Getting medication...

CPZ: And you have the insurance now. And then how about money for copay? I think there's not too much copay usually with the Quest.

IHP 18: Uh. I pay about $10 every time I go to see a doctor and then I pay for half of my prescriptions so one of my inhalers costs about $300. They pay for half of that so I have to cover.

CPZ: How much?

IHP 18: Three hundred.

CPZ: Really?

IHP 18: For my Advair. For my disk. Yeah. I was just in there the other day. So. Yeah. And even I tripped out on it. I was like "Really?" And they're like "Yeah. It's like $300. Your health care insurance pays for half of it, and you have to come up with another 150 bucks.

CPZ: I'm surprised there's no generic...because

IHP 18: I even got a letter stating that my insurance does not cover Advair.

CPZ: So who prescribed it for you?

IHP 18: One of the doctors from the clinic.

CPZ: From Malama?

IHP 18: Yeah. I don't see one doctor. I have the whole ... yeah ... the whole group has the doctors. Which it makes it more hard because I don't have a set doctor to be at. Okay. This is my set doctor and this is what he said. And then I have to come in and I have to bring all my paper work again and explain to this doctor what this doctor said and ...

CPZ: Yeah. There should be like a generic that's cheaper than that. I'm surprised that they prescribed the Advair when it costs so much. Huh. That would be something to ask about …

IHP 18: Yeah I should ask them about that.

CPZ: Yeah. I think so.

IHP 18: I've been trying to figure that out - a way around having to pay 150 bucks every time I need my Advair.

CPZ: …Yeah. You may have to tell them "Hey. I need an inexpensive drug."…

IHP 18: I don't know. I'm about ready to go up there and be like. I can't get it. I need you to listen to me please.

CPZ: They're not listening.

IHP 18: No. Because I asked them for another nebulizer machine. Because my nebulizer machine that I had when I plugged it in - it went "shoo...". [she made the sound the nebulizer made when it stopped] And after four and a half years of having just that one,

I now need a new one to be replaced. Now and then I haven't gotten that yet.

CPZ: You know, in terms of barriers, it's like people not listening?

IHP 18: I would say... yeah. Because I sat there like how I'm sitting with you and I'm talking with them and I would be "Okay, like I need this. I need this, because this happened to this. And I need this because this. And I had this since I was 16 so, I know what I need. When I'm home here, and I've been taking holistic remedies to help with my asthma on top of the medications they've been giving me. Without the nebulizer machine it seems to be getting worse because the volcano is erupting on the other side. It's hazy every other day so. I'm just praying for they're not burning sugar cane any more.

CPZ: Yeah.

IHP 18: So, it still makes it hard.

CPZ: How about the attitudes of people who are providing the health care.

Are they okay?

IHP 18: I ran into some nice people who actually cared about their patients. And then I been on the other end where doctors are leaving, they got their tenure [word she used], they're about to retire and they just give off this I don't care attitude. Like "Okay. You need that, here. Go away." kinda thing. So.

Those who did not have insurance had difficulty filling prescriptions. Those who were able to get prescriptions had difficulty with related expenses and the complications of homelessness that interfere with taking prescription medications. Individual homeless person 4 was dropped from her health insurance plan, so no longer had access to prescription antidepressants to treat her major depression. She had an asthma attack, had lost her inhaler and didn't know how to replace it. She was treated in the ED for asthma. Individual homeless person 5 also lost his asthma inhaler. When he had an asthma attack, the ambulance paramedics gave him an inhaler. He said that if he would have had an inhaler prior to the attack, he would have been fine treating himself, and would not have needed to call the ambulance. Individual homeless person 6 said he also was dropped from his insurance and had to pay out-of-pocket the previous night to fill a prescription for lithium. Individual homeless person 7 does not have health insurance so he self-medicates for pain relief with over-the-counter medications and beer. Individual homeless person 14 does not have health insurance. He bought the prescription

medications he felt he needed on the street. He verified, for himself, what the medication was by looking it up on the internet on drugs.com. Individual homeless person 16 did not have health insurance, and suspected she had hypertension based on a blood pressure check another shelter resident did for her the night before the interview. She was concerned about how she could get prescription medication to treat hypertension without insurance, and without identification.

Individual homeless person 19 was concerned that she was having a recurrence of a parasitic infection. She was attempting to get her prescription medication refilled but has Medicaid insurance from California that was not accepted in Hawaii. Individual homeless person 20 had insurance coverage for her insulins. She could not refrigerate them because she lived in a parked car, and sometimes worried they might be ineffective due to exposure to heat. She said people do come by and ask her for her used syringes. She took antihypertensive medication and cholesterol-lowering agents, but did not want to take medications for her depression. Individual homeless person 24 had difficulty getting money to pay for prescriptions. Individual homeless person 26 had run out of her psych medication. She had no money for bus transportation to get to the Walmart pharmacy to pick-up refills.

Individual homeless person 27 felt he must be responsible for his prescription medications. He said he only walks around with two or three pills – not the whole bottle. He was concerned that if his backpack was stolen, someone else might take his medication. Individual homeless person 28 did not want to take his psych medication anymore. He felt he could manage the voices he heard without the medication. Individual homeless person 29 was refused a prescription for opioid analgesics from the clinic. He was offered a prescription for ibuprofen for chronic pain, and he refused that. He chose instead to self-medicate for chronic pain and narcolepsy with acetaminophen, aspirin and caffeine. Individual homeless person 30 caught a ride to a clinic and was waiting for a prescription for medication for pain management when the two men who gave him the ride went into the clinic and demanded drugs that were being prescribed for IHP 30. Individual homeless person 30 was told to sign a statement that he was attempting to sell prescription medication. He said he was banned from getting prescriptions at that clinic. He self-medicated for pain with over-the-counter medications and alcohol. Individual homeless person 31 felt he needed to get on the medication Adderall.

Appendix Z

Commentary of Individual Key Stakeholders on Unmet Needs of Homeless Persons for Prescription Medications

Individual key stakeholder 6 commented at length, and vividly, about the impact of the unstable homeless lifestyle on the process of taking prescription medications:

> IKS 6: A lot of times even if they do go to the clinic and they get seen by a doctor, and they get given a prescription, then how is their prescription going to get paid for? So then the client doesn't go and get the prescription. They don't start taking the medicine so they can't get any better. Or when they go to get the prescription, sometimes places require an I.D. for whatever type of medication it might be, and the individuals won't have any identification. They didn't pick up the I.D. in the first place yet alone have any money for the uh … medication … People that live out on the streets they often get robbed. They get robbed of their medications because people see that they have some sort of narcotic and they want to sell it and they grab it, or they do not even know whether or not it's a narcotic, they just steal somebody's medication in hopes that they can you know – sell it. A lot of times, the client has an addiction, maybe to alcohol and so because of that they become so inebriated, they can't remember where they put their medication or their articles that they were holding on to. Um…or they have no regular place to keep it. They have no locker. They have no place to stash it. Or even if it does get stashed, if it's in a place where it shouldn't be, it might get thrown away. It might get cleaned out. It might get removed for some reason … Security, yeah. A lot of times people will put stuff up in the trees and then, you know, it doesn't look good so it's cleaned out by whoever. It might be the owner of that property, it might be Parks and Rec. It might be DLNR. It might be…you know, it might be in a place where it's not supposed to be and it just looks rubbish and people want to clean up the place and it's gone … You know, for a while there it was pakalolo [term for marijuana], and alcohol. Well it's always been alcohol because alcohol is still legal. And you can still buy it. And even though, Maui has one of the strictest liquor laws, sometimes those cashiers are still selling them the liquor, you know. Or they're selling it to somebody else and that other person is giving it to that person. Um but as far as … then it was pakalolo and then it was crystal meth [methamphetamine]. It still is crystal meth but more so, it's become prescription drugs.

Um people, they sell 'em on the street for a good value per pill. They rob and steal people's medications. I believe a lot of people are getting prescribed the wrong medications or just freely prescribed medications that they don't really need. You know, I have a client right now that regularly takes oxy [oxycontin] and um he takes soma and [indecipherable], or something like that. And they're both for pain. And he regularly takes medications three times a day. And it says on his bottle "take three times a day" and it doesn't say "as needed for pain". It says "take three times a day". But this guy is always out of it because of his medication. He's like always…delirious or he's incontinent because his insides can't handle all the medications he's taken. And as soon as he runs out, he's Jonesing [withdrawing] immediately and just goes nuts, and sometimes calls the ambulance with an ailment to have the ambulance take him to the hospital, so he can get 10 more pills… I'm seeing this a lot. And, or people because they're already alcoholics and with their drinking wouldn't bother taking their medications. You know. It's just not controlled enough. And I can't administer them…

CPZ: So what you're seeing is more problems with people who have prescription drugs and not problems with getting the medication they need. Just having too much of something that causes them problems when they take it inappropriately.

IKS 6: Yes. Yes, I do see that. And then as far as getting them … um … it also can be an issue too because say for example, this guy, he doesn't have any money. So what he does is he calls the ambulance, and the ambulance picks him up and goes and takes him to the doctor, and then he sees the doctor and he gets prescribed these medicines and then he can go get his medicines. You know, whereas, he couldn't normally just go to the store and say: "Okay, I ran out of my medicine. Can you call my doctor, or call the doctor and just have him prescribe, another set of medication." That's how he ends up paying for his medication with wasting, you know, thousands of tax dollars in an ambulance taking him up to the hospital … but even as far as their medications are concerned, as far as purchasing the medications … a lot of times they are prescribed a medication but they have no money to get it. So they just don't take any medication – you know?

Per IKS 7, homeless persons with schizophrenia may be off their psych meds. Per IKS 9, homeless persons who have recently arrived on the island may have no provider to write

prescriptions for their psych medications. Here is an excerpt from the interview with IKS 9:

> IKS 9: I mean we're taking these people in [into the hospital], many of these homeless people, some of them are chronic, and they bounce in and out. But many of them are people who have arrived on the island, within the past several weeks, and already, they're in the emergency department. Because many times, they're off their medicines, they come...there's nowhere for them to get their medicines even refilled. You arrive on this island, how are you gonna...you have no insurance. How are you going to get an appointment?
>
> *CPZ: Uh huh. Yeah.*
>
> IKS 9: [Brief laugh] There needs to be some place
>
> *CPZ: So a county walk-in clinic would cover them.*
>
> IKS 9: I think so.

Individual key stakeholder 10 remarked on how the persons, that homeless persons associate with, may dissuade them from paying for their prescription medications. If they don't purchase their prescription medications, then the money can be used for other purposes, for example to buy beer to drink, and buy gasoline for the car, so they can drive around. He found that homeless persons are extreme, so that some are obsessed with taking medications, and others refuse to take any medications at all.

Individual key stakeholder 12 described a homeless person who had a coronary artery bypass graft surgery, who was several weeks postop, and was living on the street. His identification had been stolen so he was unable to get his prescription medications for pain. As a result, when he was in pain, he called the ambulance complaining of chest pain and the need for transportation to the hospital. He wanted to return to the mainland but was unable to do so without his identification, so he called the ambulance multiple times. He was transported to the hospital multiple times for pain medication.

Appendix AA

Commentary on Unmet Pain Management Needs per Individual Homeless Persons

Individual homeless person 6 said he felt so much psychic pain that sometimes he would hurt himself, for example by cutting himself with a broken bottle, to relieve the pain. At the time of the interview, he was taking psych medications and finding some relief with that treatment. Likewise, IHP 15 spoke about intentionally cutting herself when she was given an unflattering label by health care workers, and repeatedly addressed with that label.

Individual homeless person 7 had knee and back pain from old injuries. He had no health insurance. He used over-the-counter medications and beer to treat his pain. Individual homeless person 19 experienced pain in her legs, especially from being on her feet and walking around during the day when she was not allowed to be in the shelter. Individual homeless person 21 had painful bloody urination at times, and migraine headaches.

Individual homeless person 29 had severe headaches related to dental problems, and musculoskeletal pain due to old injuries that he sustained in a car accident. He tried to get hydrocodone at a clinic. When he demanded it, the doctor became indignant with him and refused to prescribe it, suspicious that he wanted to sell the hydrocodone. He self-treats with over-the-counter medication. Individual homeless person 30 said he had old injuries from a construction job and tried to get prescription pain medication from a clinic. When his companions grew impatient waiting for him in the car to get the medications, they entered the clinic and demanded the opiates. Clinic staff suspected IHP 30 of selling the opiates. He was banned from receiving prescriptions from the clinic. He said he used methamphetamine, marijuana and alcohol for pain management.

Appendix AB

Commentary of Individual Key Stakeholders on Unmet Pain Management Needs of Homeless Persons

Individual key stakeholder 3 described a lack of physicians on Maui who will treat homeless persons with chronic pain. She attributed the lack of chronic pain physicians in general to tightened regulatory controls. She mentioned that there are a few physicians on Maui who will prescribe opiates when they are paid privately, for example, paid a $200 fee. Drug seekers in the emergency department have been a big problem there. She observed that they get a prescription for only a small quantity of pills to mitigate withdrawal until, they can see their primary care provider. Patients who frequent the ED seeking drugs are tracked. Per IKS 5, some patients seek refills of chronic pain medications in the ED when the physician who prescribed it is unavailable, or off of the island.

Individual key stakeholder 6 described the misuse of the ambulance by some who seek medication refills. He gave an example of a patient who ran out of his chronic pain medication:

> And as soon as he runs out, he's Jonesing [withdrawing] immediately and just goes nuts, and sometimes calls the ambulance with an ailment to have the ambulance take him to the hospital, so he can get 10 more pills.

Individual key stakeholder 8 said that patients who are receiving, or have recently received, opioid analgesics as part of their treatment are not accepted for admission to the Ka Hale A Ke Ola Homeless Resource Center shelter. When patients come to the ED, they may just be given one or two pills, enough to hold them over until they can get to their primary care provider. Individual key stakeholder 3, IKS 8, and IKS 11 said MIKOHC refuses to take patients who have chronic pain control problems. Individual key stakeholder 8 suggested that a pain management clinic is urgently needed on Maui.

Individual key stakeholder 12 noted that one of the reasons homeless persons call the ambulance for a ride to the hospital is so they can get more pain control medication. He described one homeless person who had pain from a recent coronary artery bypass procedure who had had lost his identification, or had it stolen. The person could not pick up controlled medication from a pharmacy without identification. When he had complaints of chest pain he would just call the ambulance to take him to the ED, in order to be medicated there.

Pain may be what motivates patients who are hesitant to seek health care services to actually accept them per IKS 1, and IKS 10. In this interview excerpt, IKS 1 gives an example of a homeless person who accepted treatment as a result of pain:

> IKS 1: One of our outreach workers, he saw this guy in one of the Kihei parks. And for weeks, he was trying to convince this guy to go in, and get checked out, and have his wounds, his lacerations looked at. And then finally, there was one trip he was making to Kihei. The guy was begging [emphasized] them to call 911, because at the point he was in so much pain, because he didn't take care of them right. He couldn't adequately take care of his wounds to the point where he was in such pain and they were in such an awful state with maggots in them, and everything that he was willing at that point to call 911.

Appendix AC

Commentary of Individual Homeless Persons on Unmet Vision Service Needs

This appendix relates to Table 4.31. Needing glasses for vision correction was the most common unmet vision service need of IHPs. Both IHP 1 and IHP 13 said that even though they needed them, they wouldn't wear them if they had them. Here is an excerpt from the interview with IHP 13 in which he explained that choice:

CPZ: [pause] So do you have any unmet health care needs?

IHP 13: I need glasses.

CPZ: You need glasses. How's your vision then?

IHP 13: It's pretty bad actually. I'm supposed to wear glasses. But my glasses were stolen from me, about four months ago.

CPZ: Yeah.

IHP 13: Like, honestly, I'm looking for something that I should be able to see it with my glasses. Like that over there. That recycle bin that says "recycle". I know that says recycle, but looking at it, I can't tell you that it says "recycle".

CPZ: Okay. So you have a problem with your distance vision then.

IHP 13: I can't get a driver's license without glasses or contacts …

CPZ: Have you tried to get glasses replaced that were stolen?

IHP 13: Uh...Well the pair that I got before, was about two years ago and I got them from Walmart over here. I paid for them myself. I can go over there, and get replacements. They still have my prescription.

CPZ: Uh huh.

IHP 13: And my prescription that I got a couple of years ago is the same that it was 10 years ago.

CPZ: Uh huh.

IHP 13: So it's probably not changed. I can get a replacement they said for I think... $38.

CPZ: Oh.

IHP 13: I just ...I have the money to go get it. I just haven't wanted to. I feel like it's something that I have to go through. I have to be able to soften the edges. As it were.

CPZ: Can you tell me... I don't understand "soften the edges". What do you mean?

IHP 13: Well, let me ask you. You're wearing glasses, right? Do you

need them to read or to see?

CPZ: It's getting worse and worse. I need these to see up close and read. And I also need distance glasses. And then I also need sunglasses. So I always needs glasses. [Laughs]

IHP 13: Okay. When I have my vision when I can see like what normal people have, or they're supposed to have or what's considered proper, I tend to ...

IHP 13: I tend to see rough edges on things. It's more of a personal thing that uh...without my glasses...things become a little more round.

CPZ: You like the softened effect

IHP 13: A little bit... but eventually things are going to come back to where I need to see properly. It's nice for now. [Pause]

CPZ: So it's okay not to see what's out there... and just kind of have an idea of it... and you're working fine with that for now.

IHP 13: Hmmm huh. It also makes me concentrate on my other senses a little bit more.

CPZ: Okay so it focuses you on your other senses.

IHP 13: My hearing is very good. And believe it or not, I can actually see in the dark better now than when I had my glasses.

CPZ: So it sounds like there isn't really a barrier. It's just that you don't feel quite ready to see well again. What would help you meet your health care service needs?- because the only one you really mentioned was glasses.

IHP 13: Hmm huh

CPZ: So, what would that be - just readiness to see better?

IHP 13: Yeah. I would have to...Yeah. That's a good word. I would have to be ready for that…[Later in interview]

CPZ: Uh huh. So do you feel like you can practice your religion more completely when you're outside?

IHP 13: Hmm huh. Jesus himself was homeless his entire life.

CPZ: He was a wanderer. Huh?

IHP 13: Well that's not true [referring to his own statement]. He did sleep in a house a few times. But he slept outside. [Pause] He gave up his life.

CPZ: He did. He gave it up for us. To save us. That's pretty amazing. [Pause]

IHP 13: And that's that.

CPZ: So it sounds like Jesus is covering you. You don't have any health care needs right now except glasses that you are not quite ready for.

IHP 13: Yeah. It's kind of like the old Saul turning into Paul thing. Do you know what I'm talking about? Do you know that story?

CPZ: Yes I know that story.

IHP 13: He got blinded.

CPZ: Got knocked off his horse by a bolt of lightning, and he was blind.

IHP 13: He went blind.

CPZ: He was blind. So that's what it feels like to you.

IHP 13: It happened to me once for sure. It really felt like that.

CPZ: So you're in a transformational stage. And your vision is impaired. And when you come though the other side of it your vision will be good.

IHP 13: Exactly. [Pause]

Individual homeless person 27 is hesitant to get glasses while he remains homeless. He said he is concerned that he will lose them, or break them. He acknowledged that having poor vision puts him more at risk for accidents and injuries. Here is an excerpt from the interview with him:

CPZ: And then how about for vision services for eyeglasses?

IHP 27: I need. That I need.

CPZ: You need. Okay. Can you get that through Maui Medical Group?

IHP 27: Yeah.

CPZ: Will they refer you?

IHP 27: Yeah. But the thing on that I really hesitate on that because I either gonna lose them, or step on them out in the open. I don't have a secure place.

CPZ: Uh huh.

IHP 27: I thought I did. I didn't.

CPZ: If you use emergency department services, what would help you get health care services somewhere else besides the ER? It sounds like you went there when you had a wound infection.

IHP 27: A lot. ER.

CPZ: You go a lot. Over at Maui Memorial.

IHP 27: Yeah.

CPZ: What kind of reasons do you go there for. Is it all wounds?

IHP 27: It's all wounds.

CPZ: All wounds.

IHP 27: I cannot see good, so I accident prone. So all cuts and stuff.

CPZ: Uh huh.

IHP 27: And stitches. Serious kine. Get 'em all in the record.

CPZ: Uh huh.

IHP 27: You know what I mean. I no more nothing for hide. They looked at that, and they considered that, with my social security, all the times I was in there. See this cut - all the nerve damage.

CPZ: Uh huh.

IHP 27: Mean kine. Mean kine. Yeah.

CPZ: Uh huh. Okay.

IHP 27: But when heal, that's the thing. But never heal all the way.

CPZ: Yeah.

IHP 27: Sometimes I luck it's the chronic arthritis that coming. Aging.

CPZ: Yeah.

IHP 27: This time I aging now.

CPZ: So would taking care of your wounds as soon as you get them - would that help prevent you from having to go to the ER?

IHP 27: Yeah.

Individual homeless person 15 felt she needed an eye exam but was afraid to go in for an appointment as a result of her previous experiences with getting services. Here is an excerpt from her interview:

IHP 15: It's like eye doctors won't even see homeless people. I would like to get my eyes checked, because I know something is wrong with my eyes. But I don't go because we're treated differently by eye doctors. The word gets around, you know. People will tell you. Another homeless person will tell you "don't go to eye doctors because they won't treat you right".

Individual homeless person 28 reported frustration in trying to get an appointment for an

eye exam. Here is an excerpt from his interview:

CPZ: And you mentioned need for glasses. For what, reading or distance?

IHP 28: I have astigmatism in both my eyes. So my vision is very poor.

CPZ: Okay. Let's see. Have you tried to get services here for glasses?

IHP 28: I have but they gave me the run around.

CPZ: What do you mean they give you the run around?

IHP 28: They would tell me to go to this place and do this. And I'd go there, and they'd tell me to go to this place. And I'm not familiar with the island, so I just kind of gave up.

CPZ: Oh. Okay. So you didn't get clear directions about where you needed to go, or what you needed to do.

IHP 28: Yes m'am.

CPZ: It would have been helpful if somebody had explained things more clearly.

IHP 28: Yeah. It would be more clarify itself.

CPZ: Uh huh.

IHP 28: That would help a lot.

Four IHPs said they did not have any unmet vision service needs. One of them was IHP 21 who had lost the vision in his left eye due to an assault with a baseball bat. He learned to cope with his vision loss by using his right eye well. Here is an excerpt from the interview with him:

IHP 21: Well I have, I have only one eye vision. And to my baseball bat scar there to my forehead.

CPZ: You got hit with a baseball bat?

IHP 21: Yeah. I was in a coma for one month.

CPZ: Was that an assault?

IHP 21: Yeah.

CPZ: Wow.

IHP 21: They threw me off the second balcony up there.

CPZ: Oh my God.

IHP 21: Yeah back in '96.

CPZ: In west Maui?

IHP 21: Yeah. Down there by [names the location].

CPZ: Oh my gosh. I'm really sorry.

IHP 21: Yeah so my vision in my left, I mean I can see a little but, it's not really. It's been awhile though.

CPZ: Uh huh.

IHP 21: And I lost my memory for about a year and I got finally got it back again.

CPZ: And you were in a coma for how long?

IHP 21: About a month.

CPZ: Aye.

IHP 21: And I woke up and I was like that and it was sticking in my head.

CPZ: And then you had surgery on your head?

IHP 21: Yeah.

CPZ: Yeah.

IHP 21: I still have like a wire sometimes. Like doctor was saying sometimes it comes out and sometimes it don't. And then one time when I really did...came out about five years after.

CPZ: Uh huh.

IHP 21: It was like a dime when come out of my head. So I was kind of afraid.

CPZ: Uh huh.

IHP 21: So you know I

CPZ: You saw it.

IHP 21: Yeah. My head. And every time I feel it. Like some kind of a wire. You know.

CPZ: Uh huh.

IHP 21: So I when go to Honolulu to the Queens Hospital.

CPZ: Yeah.

IHP 21: And they check out for me and what they told me was next time it shows like that all you need to do is pull it out and it will come out. And he did it. And you don't have to go surgery when it's like this. And he put like a pliers thing

CPZ: So there was a wire that was sticking out from

IHP 21: From my surgery.

CPZ: Your skull was wired together

IHP 21: Cuz I had the blood internal on my brain. My brain was like almost full of blood.

CPZ: Yeah. Right.

IHP 21: And like I was saying, the doctor was saying that 95%, he can do the job.

CPZ: Uh huh.

IHP 21: But 5%, I don't know what's gonna happen, you know.

CPZ: Uh huh.

IHP 21: And he said out of 100, I can say will survive maybe about 95.

CPZ: Uh huh.

IHP 21: Cuz I was really concussion and everything.

CPZ: Yeah.

IHP 21: I guess really thankful that God really helped me.

CPZ: Yeah. It's amazing you survived that.

IHP 21: So. Now I get like a lazy eye.

CPZ: So your left eye is a problem now but your right eye is good.

IHP 21: Yeah.

CPZ: So do you have to follow-up with anybody regularly?

IHP 21: All they told me was that if I'm ready to go for surgery one more, they'll put one metal to make it little nicer. (His skull is deformed and he has large area of scarring on his forehead) But I not kidding myself, God already give me what I wanted.

CPZ: So

IHP 21: They said they have the stuff for me, to make it nicer, you know my forehead.

CPZ: To smooth it out.

IHP 21: Like I told you, I just thank God he gave me a life to live, you know.

CPZ: You're not so worried about that. You're just happy to be alive.

IHP 21: Exactly, yeah.

CPZ: Uh huh. Wow. Amazing. How long ago was that injury?

IHP 21: Back in '96.

CPZ: '96. Sorry, you mentioned that earlier. And then do you have to take prescription meds.

IHP 21: No.

CPZ: No. You don't have seizures.

IHP 21: I do have migraine headaches sometimes it comes back.

CPZ: Yeah. How about... do you have to wear glasses?

IHP 21: Well I'm all right with that cuz I can see real clear out of my right eye. At times as I say, it does affect me - but like I say, I just concentrate on my right eye and

CPZ: Uh huh. So you've learned to cope with it.

Appendix AD

Commentary of Individual Homeless Persons on Unmet Nutritional Needs

The contents of Appendix AD relate to Table 4.33 in the text. Six IHPs spoke about unmet nutritional needs they had. Individual homeless person 10 and IHP 20 said they get hungry when their food stamps run out. Individual homeless person 20 said she has diabetes and has difficulty affording the healthy foods she need to manage her diabetes. Here is an excerpt from the interview with her:

IHP 20: which...I need special food becomes I'm diabetic, yeah

CPZ: Yeah.

IHP 20: I been eating junk food, McDonald's and cheap ones I can afford.

CPZ: Yeah. You need vegetables and protein.

IHP 20: Yeah. The first few weeks of the month, I'm eating good, but the rest of the month I'm just scratching.

CPZ: Because of the food stamps

IHP 20: Yeah.

CPZ: So food is an issue then to manage your diabetes…

IHP 20: I need, I need a 24 hour caregiver. And so I hire my friends. And that's why I don't have enough money to pay for my storage and dakine [refers to another expense] because I hire my friends to help me. Because I'm afraid to be alone, because a few times I was alone and start shaking.

CPZ: Uh huh.

IHP 20: I couldn't see anything

CPZ: Yeah.

IHP 20: I ready to black out and they normally have phones. I don't have one. They can call emergency.

CPZ: So when you feel like that you need a sweet.

IHP 20: Sweet yeah.

CPZ: To raise your...and then to eat some food - good food.

IHP 20: And the good food part is questionary - cause like I say I get 175 food stamps, because of my, you know

CPZ: Uh huh.

IHP 20: And [indecipherable] You gotta have fresh vegetables is what you need

CPZ: Yeah.

IHP 20: Good, healthy stuff.

CPZ: So...let's see...if you had enough money to eat healthy and manage your diabetes better, it might keep you from going to the emergency department, and having so much trouble?

IHP 20: If I had an apartment or something

CPZ: If you had a house. Yeah.

IHP 20: I would even share with a female.

CPZ: Who is helping you find housing now, anybody?

IHP 20: No. They're to the point where I got to learn to help myself. I gotta do it myself. It's a cop out, but. I do go into stages where I get so depressed, I don't want to live or nothing. Just take what I get. I sleep in my car all day, and not do anything.

CPZ: Uh huh.

Individual homeless person 1 and IHP 11 also spoke of not being able to afford food that is healthful. Individual homeless person 1 said he needed vitamins, and was unable to afford them. Both IHP 1 and IHP 11 mentioned that food is more expensive without adequate refrigeration. Individual homeless person 1 said his food gets rotten, gets stolen, or gets eaten by bugs. Here is an excerpt of the interview with IHP 11:

IHP 11: Of the five years I've been here, I've spent three of those camping.

CPZ: Oh. It seems like you've got it figured out though.

IHP 11: It was easier with a vehicle.

CPZ: Yeah.

IHP 11: Cause I could carry more stuff. I had a cooler with ice. I had fruits and vegetables, meats and stuff to actually make food. One of the things that makes homelessness more difficult is that you can't carry food that goes bad.

CPZ: Like dairy products.

IHP 11: Like dairy or meats. Stuff will go bad. So it makes the cost of food much more. You're always forced to buy a premade meal as opposed to making a sandwich myself.

CPZ: Uh huh.

IHP 11: Because I'm buying the sandwich for five, and I could make it myself for two bucks.

CPZ: Yeah

IHP 11: So that increases the cost of living. The cost of living is the reason that most people are homeless in the first place.

CPZ: I think it has a lot to do with it.

IHP 11: Don't ever doubt it [emphasis].

CPZ: It's a hard kind of place.

IHP 11: People want to find a place. It doesn't take much to get that way financially for people to exist. If they don't have an option, they have to give up a place to live so they could ...

Individual homeless person 28 spoke about being hungry in the heat of Lahaina: “And the heat. And once the heat get to you and the lack of food. It kind of makes you either want to blackout, or it drains your energy real quick.”

Individual homeless person 18 was camping near a stream with her husband and children for six years. Her campsite was robbed. Among other things, her camp stove and kitchen knives were stolen. Her campsite was “swept”, and she moved to the shelter.

Eight IHPs mentioned strategies they use to meet their nutritional needs. Three IHPs mentioned eating at feeding centers, although all IHPs interviewed had donated food available to them at the time of the interview, and the DNP student witnessed many IHPs receiving the donated food, or meals. Individual homeless person 30 proudly spoke of his risky strategy to feed himself. He described getting leftover food, left at Lahaina harbor by tour boats operators.

Appendix AE

Commentary of Individual Key Stakeholders on Unmet Nutritional Needs of Homeless Persons

Comments of IKSs addressed unmet nutritional needs of homeless persons and also the way their nutritional needs are already being met. One of the needs is for safe food that is fresh and not spoiled. According to IKS 10, homeless persons become ill due to eating spoiled food. Here is an excerpt from the interview with IKS 10:

> IKS 10: The gastrointestinal, spoiled food. They don't have refrigeration, they're dumpster divers.
>
> *CPZ: Yeah. Oh*
>
> IKS 10: They're the last people complaining about this. All they want to do is eat.
>
> *CPZ: Yeah. Yeah.*
>
> IKS 10: If they get sick from eating, they consider that the norm.

According to IKS 3, IKS 4, and IKS 9 food and shelter, especially during bad weather, are reasons homeless persons seek acute care hospitalization, or residential treatment for substance abuse. Individual key stakeholder 3 remarked that some homeless persons have a relationship with their cellulitis, meaning that they benefit from the persistence of the cellulitis. Here is an excerpt from the interview with IKS 3:

> IKS 3: You come in here [hospital]. Your leg. You get treated. You get benzos. You get narcotics. You get fed. You get IVs. You get taken care of. You go upstairs. You get whatever you want. You get bathed. You have a T.V. You get antibiotics. You stay a month…

Individual key stakeholder 9 also commented on homeless persons' desperation in this excerpt from the interview with him:

> IKS 9: And these people will come into the emergency department every single day [emphasis] until they have something...you know they'll be complaining of soreness, or joint pain, or whatever, until they usually discover upon the idea that suicidal ideation brings hospitalization. And then if it doesn't, then the person may even do something, to hurt themselves.
>
> *CPZ: Just to get into this shelter [hospital]*.
>
> IKS 9: Just to get in. Right.

CPZ: For showering, bed, food, care.

IKS 9: Because they have nowhere else to go.

CPZ: Uh huh.

IKS 9: Uh huh. If the weather is lousy outside...

CPZ: Do you have more patients then?

IKS 9: Yes absolutely. They're coming in. They need a meal. They need dry clothing, and to warm-up and things like that.

Individual key stakeholder 4 commented on how resourceful and selective homeless persons can be in the following excerpt, from the interview with him:

IKS 4: And, you know, you kind of look at that - and then you go ... they seek what they feel that they need. It may not necessarily be that the services aren't out there. You get a homeless person in here, within 30 days of them reaching the island, they have their EBT card (Electronic Balance Transfer card for food stamp program participation].

They've already signed up for Quest insurance. You know so ... just because they're crazy, or they're substance abuse doesn't mean they're stupid.

CPZ: [Laugh]

IKS 4: They're well aware of their needs.

CPZ: U*h huh.*

IKS 4: You ask a person whose has just been here a few days "Where can I get a hot meal today?...". They're able to tell you. "Oh, go this place. Go that place. Don't be here on Sunday. Make sure you go to this place." That network is out there.

Individual key stakeholder 12 was concerned about how providing meals for people may encourage them to be dependent, and attract more homeless persons to Maui. Here is an excerpt from the interview with him:

IKS 12: I remember one time when we were in Kihei, this wasn't that long ago, but I scolded the Church, St. Theresa's "Shame on you for not teaching these people how to fish. You're just feeding them … And the lady was really calm and used some great verbal judo with me and said "You need to come and meet these people."

CPZ: Yeah

IKS 12: "Come and help us feed, and meet these people." [woman's reply to him] And so many of them are just one med away from being right… I think...and you've known it for

years, Maui wasn't a good place to be homeless, because there was no transportation.

CPZ: Right. And hitchhiking was illegal before.

IKS 12: And now, with transportation, it's opened it up.

CPZ: Oh, so you link those things.

IKS 12: I think transportation... I mean because basically, if you stop feeding something that's wild, it needs to go somewhere else. But once they find that they can get fed, they usually stay.

Appendix AF

Commentary on Unmet Health Care Service Needs of Homeless Children by Individual Homeless Persons

Concerns for homeless children's unmet health care service needs among IHPs were few in number in comparison with concerns for unmet needs for dental care, wound care, shelter or housing needs, and prescription medication that were mentioned previously. Individual homeless person 8 did have concerns about her siblings' dental care needs and cavities. She and her family lived without running water at their campsite and did not keep up with brushing their teeth regularly. Individual homeless person 14 said that he did not see many homeless children. Where he did see children was at St. Theresa's Church at the daily meal offered to the homeless, and anyone else who wants to eat. At the end of the month, he saw children there who may have been homeless, which is about the time many families run short of food stamps. Individual homeless person 22 was concerned about her grandchildren having unwanted teen pregnancies. She described how she tries to dissuade her grandchildren from being sexually active. She said they needed condoms. They also get insect bites that become infected. Individual homeless person 18 needed vaccines for her children that were not covered by Quest. Individual homeless person 24 said he saw children who appeared neglected, had dirty clothes and needed hygiene.

Three IHPs had lost custody of their children. Each of the three IHPs had substance abuse problems. Five other IHPs had minor children living with someone else. It was unclear whether the IHPs had lost custody of their children. Substance abuse appeared to be a problem for at least three of the five for which custody status was unclear.

Appendix AG

Commentary on Unmet Health Care Service Needs of Homeless Children per Individual Key Stakeholders

Homeless children may be separated from their parents. Individual key stakeholder 2 gave an example of how this can occur as part of the turbulent conditions of homelessness. Parents may be at work when a family is evicted from their campsite. Children, there without their parents, would be taken into custody. If families are offered shelter and parents refuse it, Child Protective Services may take the children into custody. In this excerpt from the interview with him, IKS 10 spoke about this:

> IKS 10: Pregnant women, we don't follow too much because we really try to pick them up [he referred to getting them housed]. But we just remove children. We are supposed to...they are supposed to have the highest priority
>
> *CPZ: Yeah.*
>
> IKS 10: The women and children. And in general they do [meaning they do take shelter or housing] unless they go against medical advice and say, "I want to live out here with my daughter" [imitates the words of a homeless mother]. I think you know which one we're talking about. But it's good here because we can have Child Protective Service.
>
> *CPZ: CPS*
>
> IKS 10: Yes. So the mother might say "We're going to live out here." "No you're not, for the sake of the child" [Official response to mother].

Runaway children also need reconnection to their families. Individual key stakeholder 6 spoke about seeing children 13 to 17 years of age who were “runaways for the day”. Individual key stakeholder 12 described an example of a young runaway, whose age he did not give, who got involved in substance abuse and experienced physical abuse and sexual assault:

> IKS 12: Because they do. They get robbed. They get raped. They get...everything happens to the homeless. I see these young kids. And I told this one kid "They're going to hurt you out there." And he was a young, soft kid. And I said, you're going to get hurt. And I watched him for a period of a few years, he had been raped. He had been brutalized. A big one where he was tied up to a tree and fu... yeah. It was awful.
>
> *CPZ: Oh no.*

IKS 12: And I told him, this is going to happen here. There's a bunch of angry, angry people living in the bush that will hurt you.

CPZ: Yeah.

IKS 12: And the poor kid did get really, really, really abused. I wished I could have channeled him better but he had a drug problem, and he kept going back to the drugs rather than

CPZ: Yeah.

IKS 12: So we try. I mean all of us have …

He also gave an example of how parental substance abuse can lead to homelessness for the children. A woman with three small children was living with her mother. The woman was a methamphetamine abuser who would not stop abusing methamphetamine. Her mother threw her out of the house with the three children. The woman and the three small children all moved into the bushes. Then the spot in the bushes, where they were sleeping, was cleared out by county workers.

Individual key stakeholder 5 described seeing whole families with dental care needs come into the ED who were homeless. There are no emergency dental services available in the ED. The closure of the adolescent psych unit at the hospital resulted in a loss of services to both homeless and non-homeless adolescents. Adolescents who need treatment in a psych unit must travel off-island in order to receive it.

Appendix AH

Commentary on Unmet Health Care Service Needs of Pregnant Homeless Women by Individual Homeless Persons

The need of pregnant homeless women for mental health services or counseling was suggested by IHP 3, IHP 4, and IHP 9. Individual homeless person 4 spoke from her own experience as she was pregnant in 2012, and living on the street during part of her pregnancy. Here is an excerpt from her interview:

CPZ: When you are around other people that are having trouble keeping a home, do you see any pregnant women, and what health care needs do you think they might have?

IHP 4: I haven't seen any pregnant women on the streets for so long. I was one of them at times.

CPZ: Oh. That happened to you? In the last two years?

IHP 4: 2012. I was pregnant living on the street. It was hard [emphasis]

CPZ: So what happened then? Did you have your child?

IHP 4: Yeah. I had my child 2013. I lost him to CPS. So my brother has legal guardianship right now.

CPZ: OK. So are you are trying to get your child back, or are you just going to let it go for now?

IHP 4: I'm trying to. I'm trying to. But I know he's in a better place right now. So I can get my things together.

CPZ: What kind of challenges did you have being pregnant and living on the street? That must have been quite tough.

IHP 4: I chose my baby's father over my family.

CPZ: Oh. They gave you an ultimatum.

IHP 4: Cause my family didn't like him. They didn't like him. But I'm no longer with him.

CPZ: He stepped out of the picture.

IHP 4: Yeah

CPZ: Did you have to deal with abuse too?

IHP 4: Emotional abuse.

CPZ: So how is it now. Are you free of that abuse?

IHP 4: No. I'm much happier now than I was before.

CPZ: Got rid of him.

IHP 4: Hmm huh

CPZ: How about do you have needs for contraceptive services until You get more settled?

IHP 4: I don't know.

CPZ: Did you stay out on the street the whole time you were pregnant?

IHP 4: No. Out there awhile and then asked my family if I could move back with them. I had my child and choose the wrong person. I go back to my baby's father.

CPZ: He was a bad influence.

IHP 4: I was so scared. And I didn't know how to tell him myself that I wanted to leave him. But because of his [indecipherable] and the past That he had was the reason why we lost our son. Cause he so abused his first baby's Mom and he's a domestic. Yes.

CPZ: He's a domestic violence guy. Doesn't sound like you miss him.

IHP 4: I don't.

CPZ: You got your own life now. Putting it back together.

IHP 4: Yeah I never. When I was with him, I couldn't go out and look for jobs or anything like that.

CPZ: He was very controlling.

IHP 4: He is controlling. And I never did have a smile walking around. I would always be looking at the down.

CPZ: How about the kids you see who are without homes, and just on the street. Any particular health care needs that you see them having?

IHP 4: No

CPZ: You must have been worried about your son.

IHP 4: I worry about my son, but I know he is in good hands right now.

CPZ: He's in good hands with your brother.

IHP 4: Yeah. And I was recently living with them, but I choose the wrong choices again. My brother just couldn't take it no more, and that's why I'm back out on the streets.

CPZ: You had a disagreement with him.

IHP 4: Yeah

Substance abuse treatment is another need for some pregnant homeless women. Both IHP

28 and IHP 31 spoke about seeing pregnant homeless women using drugs, or drinking alcohol. During the course of her interview, IHP 26 disclosed that she was pregnant and under the care of a doctor at MIKOHC. She said she had three living children already. A church group had offered her housing on the condition that she abstain from alcohol and drugs use. She said she was committed to stopping, but didn't quite have her "parties situated". When asked what was holding her back, she pointed to her boyfriend, the father of the baby.

Individual homeless person 24 mentioned seeing pregnant homeless women who were not accepting help that was offered. In this excerpt from her interview, IHP 15 commented on why she thought pregnant homeless women were not accepting services:

> *CPZ: And then, do you see pregnant women that have health care needs that aren't being met?*
>
> IHP 15: Yeah. A lot of pregnant women out here are homeless and they don't see doctors. Some of them just have their babies.
>
> *CPZ: For the same reason... the stigma thing* [She talked about the problem of stigmas prior to the start of the recording.]
>
> IHP 15: Yeah. Because they're homeless.

Individual homeless person 18 said she had known pregnant women who couldn't afford their prenatal vitamins. Individual homeless person 26 said she needed money for transportation to her medical appointments.

Appendix AI

Commentary on Unmet Health Care Service Needs of Pregnant Homeless Women by Individual Key Stakeholders

The unmet needs of pregnant homeless women that IKSs identified were mental health and counseling services, substance abuse treatment, and willingness on the part of the woman to receive services. Individual key stakeholder 2 thought of someone he knew of in this excerpt from his interview:

> IKS 2: I think with the pregnant women, a lot of what they need is counseling, in terms of what their health care options are, and how to make wise choices ... And, we do have, it is quite frequent, like I know a lady right now that's pregnant, and she's living on the streets, and she's in an advanced state of pregnancy, and soon to give birth.
>
> *CPZ: Ah... That's tough.*
>
> IKS 2: And really doesn't have any way to support the baby. Um. So, that's the kind of situation, where you need more community help, to work with someone like that. Because, in her case, she's vulnerable, and the child will be very vulnerable, out on the street.

Individual key stakeholder 6 recalled two pregnant homeless women with which he was familiar in this excerpt:

> *CPZ: Do you see pregnant women with problems, or children?*
>
> [indecipherable due to simultaneous timing with comments by IKS 6]
>
> IKS 6: Um...Yeah. We do see pregnant women. I don't say we see a lot of homeless pregnant women. But I do have encounters with them. One young lady, unfortunately, she just had her baby this last Friday. All of a sudden we saw her the next day, and she was just wandering around town like and she looked like she had no stomach.
>
> She goes "Oh yeah. I just gave birth last night." [His comment to the woman] "What are you doing here?"
>
> *CPZ: Where was the baby?*
>
> IKS 6: She said the baby was still at the hospital because it was only five pounds.
>
> *CPZ: Oh.*
>
> IKS 6: But it has a lot to do with her lifestyle. You know her homeless lifestyle, her drug addiction, her mental health issues. Um...and they're all combined.

CPZ: Yeah.

IKS 6: It's not just one. And you can't say that she has a drug addiction because of her mental health because I think she, my opinion, she had the mental health issue after her drug addiction. After she started using. Um... and of course you know just sleeping any kind of place - in the park, underneath a truck, behind a dumpster.

CPZ: I wonder if she'll get her baby back?

IKS 6: I'm not sure. It doesn't sound like she even cared whether she got the baby back or not, which is really sad… There's this other young lady - she's way out between Lahaina and central - Olowalu area, and she's actually working, which is good. She's a working girl. When I say "working girl" I mean she's actually working. She has a legitimate job.

CPZ: She's employed.

IKS 6: She's employed. That's a better way to phrase it [laughs]. And she's about six months, I'd say. I didn't have an opportunity to talk to her about whether or not she had any kind of health care but she hadn't been working for more than a year, so it's not likely that she has health care unless she's gone to Quest or something like that. She seemed quite the typical young lady that's used to her boyfriend taking care of things. And of course, he's no longer in the picture.

CPZ: Uh huh

IKS 6: And when she got pregnant, he no longer became a part of the picture...and uh, she looked in okay health. But she looked fatigued. And I can't imagine sleeping in a tent out in the elements and everything. It's not good for her pregnancy. I didn't really get a chance to talk to her too much because I sensed a, I sensed a...what do you call it uh...I sensed her distrust of me as a man.

CPZ: Oh.

IKS 6: And I involved a female outreach worker at that point.

CPZ: Uh huh.

IKS 6: which I'm really discerning about that. If I don't feel comfortable or I feel like there's an issue, I'll refer her to another person - which is the best way to do it because if a person has trauma like her, yeah, then I don't want to ...

CPZ: You need a certain amount of trust to be able to help them, and
if they can't trust you...yeah

IKS 6: And I'm certain that that outreach worker asked her about the pregnancy and the baby and whether she had any health care. I seriously doubt she did. She was relatively clean though which was good. As far as cleanliness or hygiene - her hygiene was good which surprised me considering... I know where she's staying. That kind of surprised me. But maybe where she works, she has, you know availability to stuff.

Individual key stakeholder 10 acknowledged how allowing for autonomy of the pregnant homeless woman might adversely affect the baby:

IKS 10: Pregnant women, we don't follow too much because we really try to pick them up [meaning get them housed]. But we just remove children. We are supposed to...they are supposed to have the highest priority

CPZ: Yeah.

IKS 10: The women and children. And in general they do unless they go against medical advice and say; "I want to live out here with my daughter." [he imagined what a homeless mother might say]. I think you know which one we're talking about. But it's good here because we can have Child Protective Service.

CPZ: CPS

IKS 10: Yes. So the mother might say "We're going to live out here." "No you're not, for the sake of the child." [official response to mother]. But pregnancy is spooky. If they are pregnant and this is the first child, they don't actually have a child,

CPZ: Yeah.

IKS 10: I don't know if CPS can say "For the sake of your unborn child, get off this site. Come with me." I don't think we can do that.

CPZ: Yeah. Their autonomy

IKS 10: Yeah. Which is spooky because that's maybe why a child is not born...is born with a defect.

CPZ: Yeah.

IKS 10: Because you know the fetal alcohol syndrome, and all that stuff like [Makes puffing sounds]. Mess. Okay.

In the following excerpt, IKS 12 recalled a homeless woman he saw who had a newborn baby.

CPZ: And how about, do you see pregnant women who are homeless who have unmet health care service needs? You do? What do you see there?

IKS 12: We do see the pregos walking around.

CPZ: Pregos? [both laugh]

IKS 12: They're walking. And then the one lady, it's really weird because she's homeless, she was pregnant and then we saw her pushing a baby. And it's like, how did they let that woman out of the hospital with a baby? So I think something fell through the cracks there. That was the first homeless brand new baby pushing around that I've ever seen.

CPZ: Uh huh.

IKS 12: Because I don't think that happens that often because they realize

CPZ: Uh huh

IKS 12: if you don't have a place to take this child, it's a high risk.

CPZ: Yeah. The child's at risk.

Appendix AJ

Commentary of Individual Homeless Persons on Unmet Health Care Service Needs of Other Persons.

Twelve IHPs had comments on unmet health care service needs they observed in other homeless adults, who were not pregnant. Individual homeless person 1 observed that he noticed a lot of homeless persons with scars and missing toes. He concluded they needed to wear shoes more often, and have better foot protection. Individual homeless person 32 was alarmed at how many skin infections she saw among homeless persons that looked like methicillin resistant staph aureus (MRSA). Individual homeless person 27 saw someone he knew lose a leg to a staph infection. That experience really impacted him. He repeated, with emphasis, “They took his leg” several times in the interview conversation. He felt that homeless persons needed more education about preventing staph infections and caring for them when they got them.

The poor hygiene many homeless persons have was mentioned by IHP 6, IHP 7, and IHP 24. Individual homeless person 6 and IHP 7 put it in the context of not caring anymore. Here is an excerpt from the interview with IHP 7:

> IHP 7: [Pause] I'm not too sure. I know. Most of the people, most of the homeless people I know has health insurance. And they really don't complain about it. When they are injured, or they get stuff on them like that, it's basically dem [his way of saying them] that don't go [emphasis]. You know. They just don't go. They know they have to go. They just don't do it.
>
> *CPZ: Why do you think that is?*
>
> IHP 7: Lazy.
>
> *CPZ: Lazy.*
>
> IHP 7: Yeah. You know.
>
> *CPZ: Uh huh.*
>
> IHP 7: But from my experience, that's what it mostly is. You know. They don't go. They don't care of their own selves.
>
> *CPZ: Uh huh.*
>
> IHP 7: Just because you homeless, doesn't mean you cannot take one shower. Or, you know, keep yourself in check.
>
> *CPZ: Rinse out your clothes. And stuff like that.*

IHP 7: Yeah simple things like that. Even you get an injury, a staph. You just let it go. And they would not go...And they get medical.

CPZ: So you think it's lazy. They just won't go.

IHP 7: No. It's transportation.

The need for substance abuse treatment was mentioned by IHP 7, IHP 12, and IHP 28. Individual homeless person 6 talked about dissuading people from becoming homeless. He said that street life with drug use, leads to death. He said that seven of his friends died on the street in the last year.

The need for judgment-free health care services was mentioned by IHP 6 and IHP 15. In this excerpt from his interview, IHP 6 explained that:

IHP 6: If you want to really know where the truly homeless thing,

CPZ: This study, about better health care

IHP 6: The study. You must live it.

CPZ: Well, I don't want to live it.

IHP 6: But if you live it. You can understand why [emphasis]. You can understand. Oh, I see why they don't want to talk. Cuz, they had a bad childhood. Maybe the father did something to them. That's why they don't want to talk.

CPZ: Yeah.

IHP 6: That's why they get high barriers.

CPZ: Yeah.

IHP 6: And, you know. Me, I don't bring up that. I make sure they get their barriers really low and they feel safe around me.

CPZ: Uh huh.

IHP 6: So they can speak up more.

CPZ: Yeah.

IHP 6: I don't want them feeling. Oh I no like that. And they be like right here, twiddling their thumbs. They don't even talk. Because they hurt inside.

CPZ: Because they hurt.

IHP 6: They don't want some good friend telling them...

CPZ: They don't want any more hurt.

IHP 6: Yeah

CPZ: They had enough hurt.

Individual homeless person 18 said her husband needed dental care. The need for restful sleep was identified by IHP 11 and IHP 27 as something that is so difficult to get when you have unsafe, and unstable sleeping situations. According to IHP 11, restful sleep would help more homeless persons be ready to work. Individual homeless person 11 also talked about the need for confidentiality. He thought that some homeless persons avoid health care settings because their pride is threatened by the questions they are asked. He said many don't want others to know they are homeless. Questions about who to contact in an emergency may be problematic for the homeless person. The person may be afraid that health care providers would contact a relative, who does not know that the person is homeless, and disclose that the person is homeless. Privacy for balance and quiet reflection is something that IHP 13 said he sees homeless persons are unable to get while living outside. Individual homeless person 9 and IHP 29 thought garden plots where persons could grow their own food would help them meet nutritional needs.

Appendix AK

Commentary by Individual Key Stakeholders on the Perception that Improving Health Care Services on Maui for Homeless Persons Will Worsen Homelessness Problems

Analysis of Sources of Care and of Unmet Health Care Service Needs shows that there is a gap between services homeless persons have, and what they need. Analysis of Barriers to Health Care Service Access exposes some reasons for this. The assumption that improving health care services for homeless persons attracts more homeless persons was accepted by some IKSs as an inevitable outcome. Creative, out-of-the-box ideas on how to provide humane services, without becoming a magnet for homeless persons, were not offered.

One person, when the recorder was off, expressed a survival-of-the fittest point of view. That person suggested that the problem of unmet health care service needs might be solved by cutting services, and letting people die off. Five IKSs and the unrecorded commentator thought that improving health care services would worsen the problem of homelessness.

Individual key stakeholder 3 commented that it is unfair to the working middle class to provide free health care services to the homeless. Here is an excerpt from her interview:

> IKS 3: But the way I see it, and the way it's going, is you either have a lot of money, or no money. And all the people in between are at loggerheads. I think those are the people that really suffer [gasping sound]. I think about it myself sometimes as I get older, and any money that I save, [emphasis] if I ever get sick, it will be taken from me. So it's better to have nothing and go on Quest, because you get everything. Or to have a lot of money cause you can buy whatever you need.
>
> *CPZ: Yeah.*
>
> IKS 3: But it's the middle class. And, the homeless people that we get in here, I think they get incredible service [emphasis]. There's nothing, nothing that they don't get. It's the outpatient services that are hard.

Individual key stakeholder 6 expressed how much housing with support services is needed on Maui but also acknowledged not wanting Maui to “turn into another Oahu”, that is turn into a place with the same out-of-control, ballooning homelessness problems present on the island of Oahu. He also remarked on how attractive Hawaii is to people who want to live off of others. Here is an excerpt from his interview:

> IKS 6: What's difficult in Hawaii is that it's so beautiful here. If you're going to be

homeless, you might as well be homeless here. And why pay the man if you're getting 721 a month or 733 a month for disability for something because all of a sudden you've got PTSD and bipolar, live off of 733 and then you travel from island to island and see the world, and that happens a lot over here, you know. A lot of transients. We say: "How did you buy your ticket?" "I got my monies." "Well, is that your monies or is that the entire society that helped contribute to your travelling the islands?".

CPZ: Yeah.

IKS 6: "You know. It's that waitress down the street. It's that owner of Longs, you know that person that works for the newspaper, that are paying their taxes, paying your 721 or your 733. It should be you, so you can house yourself, clean yourself, feed yourself, and you know and keep yourself not medicated with pakalolo [marijuana] and alcohol." [What he might say to someone] And, but unfortunately, even if they only get that amount, there's not a lot of places they can afford. So, if you get 733 or whatever, then you gotta look for places like 500 or less so you can still have at least $250 to do something with -maybe it's food, clothes, entertainment. If you don't have EBT [Electronic Balance Transfer card for the federal food stamp program] - if you have EBT then you're fortunate. But then EBT can only go for like five years or something from back when President Clinton signed that law so. You can only have it for so long. So you're sort of limited. And then if you can only find a place for 500, what if you've got a family, it can be difficult, because if you're just one single person, you might be able to find a room for 500. But then a lot of people can't live with other people. They have a hard time living with other people. I mean even myself. I live by myself. I prefer that, you know. A lot of people do prefer to live outside just like you talked about. I run into people all the time they have absolutely no intention of getting a house. They don't want to have anything to do with it. They have no problem being outside, and they don't care if the cops keep moving 'em from one place to another.

Individual key stakeholder 7 also acknowledged how attractive to the homeless Hawaii is:

IKS 7: Well money and getting rid of all of our prejudice too. [Ways to improve services] I certainly just like everybody else carry, "Oh gees. Why don't they help themselves?" But bottom line is, we need to get over the fact that people are drinking, and they require

help regardless of their disease of addiction.

CPZ: Yeah. Occasionally I run across thoughts of we don't want to make it too good here

IKS 7: Yeah

CPZ: Because we'll attract all those people in Honolulu here, and more people from the mainland.

IKS 7: And more people from the mainland, and so forth. Yes [Laughs] Seattle should really look at that experience. I'd be curious wouldn't you?

CPZ: If they've attracted more homeless people?

IKS 7: If they've attracted more homeless people and particularly more homeless, alcoholic people. Because they basically have these apartments now where you can go and live, and get food, and drink alcohol still. I'd be curious to see their numbers.

CPZ: Yeah. I don't know.

IKS 7: I'm not sure how they would get that data. But it would be interesting wouldn't it?

CPZ: Yeah.

IKS 7: To see if they'd become a more attractive homeless city. We're attractive enough Carol.

CPZ: I know. Because of the weather.

IKS 7: Exactly.

CPZ: Well those are the questions I had for you, are there any other things you have on your mind that related to this topic that you want to mention?

IKS 7: No. No. I can't think of anything else. Tough problem though. But man it's costing us a lot of money.

One person in an unrecorded comment expressed the view that attracting more homeless persons to live on Maui was the "eight hundred pound gorilla in the room" that no one was talking about as a consequence of improving health care services. The reference to the gorilla implied that attracting more homeless persons to Maui is a problem of great size, not easily contained, capable of creating uncontrollable damage, and a danger to all.

Individual key stakeholder 12 commented that he saw an association between the start of public bus transportation and the increase in homeless persons in West Maui. He also thought

that feeding people attracts more homeless persons, and was concerned that improvements in health care service would draw more homeless. Here is an excerpt from his interview:

> IKS 12: I remember one time when we were in Kihei, this wasn't that long ago but I scolded the Church, St. Theresa's "Shame on you for not teaching these people how to fish. You're just feeding them. They need to. We need to add more."
>
> [His comments to person feeding the homeless]
>
> *CPZ: Uh huh*
>
> IKS 12: And the lady was really calm and used some great verbal judo with me and said "You need to come and meet these people."
>
> *CPZ: Yeah*
>
> IKS 12: "Come and help us feed, and meet these people." [Woman's reply to him]… I think...and you've known it for years, Maui wasn't a good place to be homeless because there was no transportation.
>
> *CPZ: Right. And hitchhiking was illegal before.*
>
> IKS 12: And now, with transportation, it's opened it up.
>
> *CPZ: Oh, so you link those things.*
>
> IKS 12: I think transportation... I mean because basically, if you stop feeding something that's wild, it needs to go somewhere else. But once they find that they can get fed, they usually stay… And then what happened in Lahaina. The West Side didn't have a big homeless population, because there wasn't services. But as soon as now you can get to services and you can move around on the bus, they'll do it, and they'll get on the bus and move. So I think adding public transportation actually increased our problem.
>
> *CPZ: Well...what an interesting perspective.*
>
> IKS 12: Well it increased us. Because you wouldn't be homeless in Keanae. There's no way to get anywhere. You wouldn't survive. But if you can be homeless somewhere where you can get on a bus and go somewhere. So a little bit easier. So I think public transportation actually moved them around a little bit more.
>
> *CPZ: Uh huh.*
>
> IKS 12: Because I can stay over here and take the bus over here…There's actually a website, if you are a bum and want to travel, it helps you go wherever you want and the easiest route to do it. How you can get free services … But once people find out that not

only can you live on an island, not have to have a job and get fed and have great health care, you send a bad message

CPZ: Yeah.

IKS 12: that it's okay to not be accountable for what you do.

CPZ: Uh huh.

IKS 12: So obviously because we love people, and we want to care, and we're trying to take care of these people that are getting lost.

CPZ: Yeah.

IKS 12: But then the people who aren't lost and [are] manipulating, they grab on to that.

Individual key stakeholder 7 and IKS 10 expressed the view that improving health care services for the homeless would be very expensive. Individual key stakeholder 7 described health outreach programs and housing first programs as “Cadillac”, in other words an extravagant luxury-item, out of the financial reach of ordinary persons. Individual key stakeholder 10 observed that homeless persons are very visible because they are living out in the open, in the public eye. Funding improved health care services for that group would potentially take needed services from less visible groups, such as the frail elderly who live at home out of the public eye. Concerns about legal liability has been an excuse used by county officials to block programs for the homeless, per IKS 10.

Appendix AL

Commentary by Individual Homeless Persons on Lack of Health Care Service Facilities that Accept Homeless Persons

Individual homeless person 15 commented on the lack of health care services on Maui. She recalled services she knew of in Santa Cruz, California. She thought Maui should have similar services. Here is an excerpt from her interview:

IHP 15: Well I'll tell you what, in Santa Cruz California, they have a health care, it's called Health Care for the Homeless.

CPZ: Yeah.

IHP 15: And they have doctors from the community that come there three times a week. They address all their medical needs there. And if they don't have insurance, then they pay for it.

CPZ: Uh huh. They help you get insurance if you don't have it.

IHP 15: And they have a pharmacy right there. And Hawaii needs something just like the model of Santa Cruz, California - Health Care for the Homeless. They need something like that.

CPZ: So...

IHP 15: They need a place where the homeless can

CPZ: More comprehensive services for people that don't have homes.

IHP 15: Right. And they also have a mobile dental van.

Appendix AM

Commentary by Individual Key Stakeholders and Group Stakeholders on Lack of Health Care Facilities that Accept Homeless Persons

Nine IKSs identified a lack of primary care facilities that will accept homeless patients as a barrier to homeless persons receiving health care services. Some of the comments of IKS 7 were quoted in the text associated with this appendix. Here are some additional comments from the interview with IKS 7:

> IKS 7:..you know...I don't want to really bad mouth the community clinic but my experience has been that it hasn't been real easy to get people into that clinic.
>
> *CPZ: That's my experience too. What can we do about that?*
>
> IKS 7: That depresses me because every time we try to refer somebody over there, that clearly doesn't have any money or who is medi... I'm sorry Quest pending, or Medicaid pending and stuff, you know they seem to have a ton of red tape. [emphasis]
>
> *CPZ: Yeah.*
>
> IKS 7: You know you gotta jump through this hoop, you gotta give us this form, you gotta give us that form before they'll actually see somebody in their clinic.
>
> *CPZ: I'm hearing that from multiple sources.*
>
> IKS 7: I'm just like wait a minute. "Aren't you guys getting money from the State of Hawaii?" which I believe they are.
>
> *CPZ: And the federal government.*
>
> IKS 7: And I was going to say "Aren't you getting money from the federal government to help us?"
>
> *CPZ: Yeah*
>
> IKS 7: "You know with these people who really do need health services. So how come it's so difficult [emphasis], once we even have our hands on these people to get you to follow-up - you know once we've had them in the acute care setting in the hospital."
>
> *CPZ: Where's the key to unlock that?*
>
> IKS 7: I don't know the key to unlock that.

According to IKS 8 and IKS 12, it is difficult to find primary care services that will accept homeless persons as patients. According to IKS 12, there are basically no primary care services in South Maui, or West Maui, who will accept homeless persons. At the time of the

interview, IKS 12 said MIKOHC satellite services in West Maui had been shut down. Four IKSs commented that delays in getting appointments may result in homeless persons giving up seeking primary care services. Individual key stakeholder 1 gave an example of a homeless person, he was working with, who was unable to get an appointment the same day he registered at MIKOHC, who went to the ED instead. Individual key stakeholder 6 said that, commonly, homeless persons cannot get into MIKOHC when they are ill but must wait about two or three weeks, so that they may just go to the ED instead. Individual key stakeholder 12 recalled asking homeless persons with minor complaints why they called the ambulance instead of going to the clinic. He said they told him they waited, and waited, and just could not be seen at the clinic.

Five IKSs commented on the lack of walk-in clinics that will see homeless patients without an appointment. Individual key stakeholder 9 said that there is no walk-in clinic where homeless patients can be seen for mental health needs to stabilize them before they end up in the emergency department. He said he has never heard of patients going to MIKOHC for mental health treatment. See Appendix R for some additional commentary on the lack of mental health facilities that will accept homeless persons. Individual key stakeholder 8 and IKS 12 commented on the need for a wound care clinic to treat homeless persons in a timely fashion before they have to go to the ED with wound complications, and to follow-up with patients once they have received medical treatment. Per IKS 8, a pain management clinic is needed. Malama I Ke Ola Health Center does not take patients who have a diagnosis of chronic pain.

Four IKSs pointed out the lack of detox or substance abuse treatment facilities. Aloha house is the only residential substance abuse treatment center on Maui. The hospital is not a detox facility. Malama I Ke Ola does not provide alcohol and substance abuse treatment, other than tobacco cessation treatment. Per IKS 12, outpatient substance abuse treatment is not available. Per IKS 9, if a person cannot be treated at Aloha House, they can be wait-listed for services on Oahu.

There is a lack of primary care services that are designed to address the particular treatment needs of homeless persons. Here are comments IKS 2 made during the interview with him:

> IKS 2: I think it would be, the main thing is that service providers are willing to spend the time with people to learn what their needs are, and be willing to push [emphasis] to get those needs met.

CPZ: So you mean doctors and nurses when they come in...

IKS 2: So doctors and nurses... and not just turn someone away because they may be homeless, or unsheltered.

CPZ: Have dirty clothes.

IKS 2: Have dirty clothes or whatever.

Individual key stakeholder 12 commented on primary care services unwillingness to see homeless persons, and the need for a service especially for homeless persons. Here is an excerpt from the interview with IKS 12:

IKS 12: But even some of the docs that I've known for years, they don't want the homeless people slopping down on their couch, and scaring away these visitors that are paying most of their bills.

CPZ: Uh huh.

IKS 12: So yeah. They're not encouraged to do that.

CPZ: Yeah.

IKS 12: So you'd almost need something that was funded that you could say "Look, this is for you." [What he would say to a homeless person]

CPZ: This is for you. These are services directed at you. Wound care, dental, mental health, substance abuse.

IKS 12: "And even if you stink and you look wrong, we're going to take care of you." [What he might say, both laugh]

Six IKSs commented on the lack of health outreach services for the homeless. Individual key stakeholder 1 described health outreach services he has seen in other geographic areas in this excerpt:

IKS 1: I've worked in areas before, and cities before, where they have what is called "street nurses" and that's a nursing team of two generally who go out into... in our case it would be going out to the campsites or parks that are known, so sort of like the wound care idea, but a little more extended than just doing wound care, and seeing who is out there. And doing referrals ... doing referrals to whether its clinics, or to the ER, to wherever the proper place is, and what can be treated out there, being treated in the field, that way...

Five IKSs and the GS commented on the lack of facilities that will accept homeless persons after they are discharged from the hospital who still may need some services while they continue their recovery. There is a backlog of patients at the hospital because of the lack of facilities. Individual key stakeholder 5 said, that at any given time at the hospital, approximately one third of the patients may not really need acute care. They are awaiting placement in a facility, the family just doesn't want to take them home, or they are homeless. Individual key stakeholder 8 said that it is very difficult to find a place to discharge homeless persons to when they no longer need acute care hospitalization. If the person needs pulsatile lavage, a wound vacuum, intravenous antibiotics, or incision and drainage of the wound, they are kept as inpatients. If there is no clean place to discharge the person to, the person is kept at the hospital to avoid the "revolving door". The "revolving door" means the person would be discharged to homelessness, experience a reinfection of the wound, return to the ED, and be readmitted to the hospital. At one point, IKS 8 said she did a spot check of patients admitted to the hospital, and found 10% of the hospital beds were filled by homeless patients with a diagnosis of cellulitis. The GS addressed the difficulty of locating a place to discharge homeless persons to. Here is an excerpt from their note:

> [At] Family Life Center [FLC], they can only be there overnight, and out during the day. This is very hard on the homeless who are elderly and need oxygen machines, electrical equipment, wound vacs [vacuum] etc. FLC does not allow for this type of equipment, and patients can't go out if they don't have a place to plug in.

Family Life Center is an overnight shelter and unable to accept persons that need a daytime facility and continued care. Here is an excerpt of comments from IKS 6:

> IKS 6: There's no place to go. And so that's a huge issue here on this island. And it's really frustrating for myself and my agency because, you know, they call us all the time from the hospital, and they want to discharge somebody to our agency.
>
> *CPZ: And then what happens?*
>
> IKS 6: Well we don't accept that because that's just dumping them off onto somebody else.
>
> *CPZ: Yeah.*
>
> IKS 6: So a dumping ground is not acceptable. What needs to happen is we need more housing availability for people here in the island.

CPZ: Like respite housing.

IKS 6: Yeah. That could help. That could help. A lot of times, you know they'll say, "We discharged them because they were" - what is it - "they were ambulatory".

CPZ: Yeah.

IKS 6: And it's like "Well yeah. Because they gotta go to the bathroom." You know, they figure out how to get to the bathroom but, they're still not well enough to go [be discharged]. "I don't understand why you're letting them go."

Five IKSs commented on the lack of housing with support services. There is a lack of sober living housing for homeless persons who complete substance abuse treatment. If they are discharged back to homelessness, per IKS 6, they are likely to relapse into substance abuse. Per IKS 10, isolated housing where homeless persons are individually placed in separate locations without support services, is not an effective strategy. People would just die that way. He said they need support services in a congregate setting. Support services would include services like meals, medical visits, medications, help with hygiene, and help with needs like replacing lost or stolen identification.

Appendix AN

Commentary of Individual Homeless Persons on Lack of a Health Care Provider Who Will Accept Homeless Persons

Six IHPs expressed frustration with being unable to get a provider for health care services. Individual homeless person 5 said the clinic at the homeless shelter was always "booked". He said he couldn't get an appointment there to get his infection treated. As, a result of not being able to get an appointment, he went to the ED. Individual homeless person 15 was trying to get a "permanent" doctor, and was having difficulty with that. Individual homeless person 19 said she could not get an appointment at MIKOHC because she had the wrong health insurance, Medicaid insurance from California. She went to the ED to be treated for a urinary tract infection.

Both IHP 5 and IHP 15 said they needed specialty services, and were unable to get them. Individual homeless person five said he needed an appointment with a urologist for recurrent urinary tract infections. Individual homeless person 15 said she needed appointments with a psychologist, a neurologist, and a urologist.

As mentioned previously under unmet health care needs for prescription medication and for pain management, IHP 29 and IHP 30 were banned from MIKOHC. They were both under suspicion for inappropriate use of prescription pain medication, and of selling prescription pain medications on the street. They both lacked a source for primary care services. Individual homeless person 10 was no longer accepted by her previous doctor, and could not be treated at MIKOHC due to her chronic pain diagnosis.

Appendix AO

Commentary on a Lack of Health Care Providers Who Will Accept Homeless Persons as Patients per Individual Key Stakeholders

Seven IKSs commented that there is an insufficient number of doctors on Maui. Individual key stakeholder 3 mentioned that the population of the island has been increasing, and there are not enough providers to care for people. Individual key stakeholder 5 talked about the shortage of specialists on Maui. He said, that at the time of the interview, the only urologist on the island was a Kaiser doctor. He related that many of the doctors on Maui are older and retiring. Individual key stakeholder 4 mentioned the shortage of psychiatrists on Maui.

Bias was identified by IKS 2 as a reason for a lack of health care providers who will accept homeless persons as patients, resulting in barriers to homeless persons getting health care services. He said: “I think that's the biggest issue right there. Prejudice and preconceived notions about people. Bias about people because they're homeless.” Individual key stakeholder 12 thought providers may not want homeless persons as patients due to the impact they have on their office environment, and the prospect they will scare away paying patients.

Individual key stakeholder 8 pointed out that providers may have to limit the number of patients they have in their practice with Medicaid insurance in order to keep their practices financially viable, because of the low reimbursement for services Medicaid provides. Individual key stakeholder 5 commented that concerns about legal liability interfere with voluntarism. Providers may have liability insurance with rates that increase with the number of patients they see. If they are seeing patients on a volunteer basis or providing charity care, their costs increase without increasing their income to cover the increased costs.

Individual key stakeholder 10 commented that concentrating homeless persons in congregate housing with support services would make nursing and medical visits more efficient. More patients could be managed that way, with better follow-up care, than if patients were dispersed in isolated housing units.

Appendix AP

Commentary by Individual Homeless Persons on Lack of Follow-Up and Lack of Support Systems

During the course of his interview, IHP 24 explained the mindset of procrastination he has about following-up to get services. He shared that he thought other homeless people thought in a similar way about following-up. Here is an excerpt from the interview with IHP 24:

IHP 24: But you know, a lot of people, they have other issues so that kind of hinders their possibilities or the help that's there, that's wanting to help them.

CPZ: People have other issues - like what do you mean?

IHP 24: Well just daily issues. Well sometimes like I'll wake up and I'll need to go somewhere to fix something

CPZ: Yeah

IHP 24: Either financial or medical or whatever, and some mornings I'll just wake up and go "todays not the morning to do that".

CPZ: Today's not the day to do that.

IHP 24: And then it's put off for another time. And I see with a lot of people that they do the same, and then they don't get it.

CPZ: I guess the word I wrote down for that was competing priorities, does that make sense to you?

IHP 24: Yeah.

CPZ: So you see that sometimes with yourself, but you see it in others too. And if you wanted housing, what would help you get housing then?

IHP 24: Well, I guess if I really wanted housing, I would look into it and seek it out. Like I had... I was on the list for housing a few years ago and it's come up to where I'd probably have to wait in line.

CPZ: Yeah.

IHP 24: Well you know my time has come up but I lost all my paperwork and stuff and that kind of thing

CPZ: Oh.

IHP 24: And I just fell through the loops and

CPZ: So you kind of lost your spot.

IHP 24: I lost my spot. And you know I wasn't sad about it, because if I was really, really wanting it, needing it, I have the information and I could follow-up on it.

CPZ: Yeah.

IHP 24: But you know, I feel good, living out here on the street.

CPZ: Some people like living out on the street or living outside. It's just, how about when the weather's really bad, how do you cope with that?

IHP 24: I deal with it when it comes.

CPZ: When it comes.

IHP 24: I don't really prepare for it.

Eighteen IHPs lacked a support system. Some of the reasons they gave for that are displayed in Table 4.45. Five IHPs chose to stay alone. Individual homeless person 19 said she had been victimized, and had stayed alone for 20 years. She hoped someday to have a friend she could have a cup of coffee with, and who she could tell how beautiful her daughter was.

At least seven IHPs were told to leave home by family members, or they had disputes with family members or associations that led to their becoming homeless. Individual homeless person 4 said that her brother, who had custody of her child, took her into his house, and then threw her out for her "wrong choices". She talked about not being able to give up her "party life".

Five IHPs spoke about the support system they have with other homeless persons. Individual homeless person 8 regards herself as houseless, not homeless. Her family became homeless when her house burned down. Her family stayed together, and set-up an encampment on the land of their extended family members. Her identity and connections with others seemed intact.

Individual homeless person 24 spoke about the value of the friendship network he has with others. Here is an excerpt from his interview:

IHP 24: The only thing that would help me in those situations would be...uh...just a friend, you know just a friend, just to talk to me about the situation. Just a helping word here and there tends to push you a little bit.

CPZ: From that group of friends you have, you mean to encourage you if you have a health issue to get it treated?

IHP 24: Yeah. Usually, all people will tend to push you a little bit, help you with words like "It would be nice if you went. You could get that all cleared up, and you'll be 100% again instead of worrying about your health, and then worrying about daily life".

Appendix AQ

Lack of Follow-up and Support Services per Individual Key Stakeholders and Group Stakeholders.

According to IKS 10, if there is no follow-up on a patient, how can you possibly intervene to prevent complications, or improve the care the person gets? Monitoring with frequent follow-up, especially for the mentally ill homeless, is more important than what drug the person has prescribed for him or her. Because homeless persons frequently do not show up for appointments, congregate housing with support services would make the frequent follow-up possible.

According to IKS 9, follow-up care is one of the biggest unmet health care service needs of homeless persons he sees on Maui. Here is an excerpt from the interview with IKS 9:

> IKS 9: You know I'm working at a hospital right now and we finish what we need to do. We stabilize patients
>
> *CPZ: Yeah.*
>
> IKS 9: and then we send them...you know to get follow-up services - particularly, you know, I'm pretty holistic so I believe that care is not just getting their medicines or getting, you know being able to see a therapist, for example uh...but housing. You know, it's very hard when somebody is homeless and has no place to go to be able to remain stable. The stressors are just too much.
>
> *CPZ: Yeah. So you get people stabilized here, and then they go... if they're discharged and have no place to go then they destabilize again.*
>
> IKS 9: Yeah. They bounce back. A very large percentage of our patients are ... have multiple admissions … there needs to be something that is able to start helping these people before they have to be hospitalized.
>
> *CPZ: Uh huh.*
>
> IKS 9: Hospitalization is very expensive. All right. Whether they're taking drugs, alcohol, have mental illnesses that are not being treated. If you have a place out there where they're getting services already, then chances are you will stop all the people who need to be, not all of them, but a huge percentage of the people who need to be admitted because you've caught them earlier … They need intensive outpatient services or what's called an ICRS - intensive community rehabilitation services, or something, where you

have a clinic that's connected to the county, whether the county wants to contract it out, it doesn't matter, but it's connected to them, and that they have a team of people who are following all these people. And if the patient has an appointment, I used to work for one of these, then a case worker goes out there picks up the patient, and makes sure they come to their appointment…so, for example, I have a patient now who has just been readmitted. Couldn't do it as an outpatient to go into residential [treatment] for alcohol. All right. But if you're keeping a closer therapeutic connection with that patient, when that appointment...you know they don't break down before. And that when at last, it comes open, they're willing to go. [Emphasis]

CPZ: Uh huh.

IKS 9: But if you don't have that kind of alliance with the person, they, you know, they become hopeless, or they just don't care, or they forget about it.

CPZ: Uh huh.

IKS 9: I mean treatment is difficult. And so that I think is the most important piece of what people need is really that sort of case management piece that helps coordinate, sort of a total integrated care system.

Per IKS 8, homeless persons receive extensive services as hospital inpatients. For the nurse case managers, making discharge arrangements for them with what resources are available is complex and challenging. Here is an excerpt from the interview with IKS 8:

CPZ: How is it for you when you try to refer to Malama?

IKS 8: Right now...Malama is good but they are very, very impacted. They even told us that...when they go into the hospital, patients come In ... we are obligated to find them PCP [primary care provider] before they're discharged, because we want them to have a follow-up. Okay. So for homeless patients, we get the PCP over at Malama I Ke Ola [MIKOHC]

CPZ: Yeah.

IKS 8: But when they do the follow-up, we're hearing from the clinic that sometimes they don't show up. And there's no way to get a hold of them. Because we send the paperwork. We confirm the appointment, and we send them the application, but there's no way to get a hold of that person because either they don't have a cell - even though a lot of them do

CPZ: A lot of them do

IKS 8: A lot of them do. It might be the wrong number. We don't have a phone number. And when they call us, they're no longer here.

CPZ: Yeah.

IKS 8: So it's uh...it's hard. It's a mess.

CPZ: It's a mess. Do they

IKS 8: It's a mess.

CPZ: Do they get registered for Malama...because I know Malama has a process where they have to register first before they 'll actually take them.

IKS 8: We have a different process for the patients that come through the hospital...um...We have a system where we call the triage nurse, and we let them know the patient's going to be discharged. And we start the application process here. We fax [emphasis] them the H&P [history and physical report], and then when the doctors see the H&P, they confirm the appointment and we put it on their discharge orders.

CPZ: I see.

IKS 8: And this is usually done less than seven days and usually within 48 hours, of the discharge, if it's urgent.

CPZ: They get an appointment with a time.

IKS 8: Correct... Yeah. So, we make it a point for them to have.

CPZ: So you get everything lined up but they [the patients] drop the ball.

IKS 8: Sometimes.

CPZ: When they leave... what half the time, a third of the time.

IKS 8: Probably more than half the time.

CPZ: More than half the time, really?

IKS 8: Yes. Cuz the numbers that Malama shared with me was huge [emphasis].

CPZ: The numbers of people that they're seeing?

IKS 8: Not following up.

CPZ: Wow.

Later in the interview, IKS 8 explained how patients, who the case managers arranged Quest insurance for during their hospital stay, might lose the insurance after discharge:

IKS 8: But we apply for all homeless for Quest.

CPZ: And there's no problem

IKS 8: I mean for Medicaid and then they choose which provider they want.

CPZ: Okay. And then

IKS 8: It's the follow-up. If they don't do their own follow-up, they lose the insurance.

CPZ: They have to follow-up once you've initiated the application.

IKS 8: Correct.

CPZ: They have to fill out

IKS 8: They have to continue doing follow-up with their paperwork, outpatient

CPZ: Like on a monthly basis?

IKS 8: Whenever. Well say you apply with our Quest provider, which is in house, you apply, you can get it. But when you get discharged, additional information is going to be sent to you. "Do you want to continue? Do you want to..." So they have to respond.

CPZ: Oh. I see.

IKS 8: If they don't respond

CPZ: They lose it.

IKS 8: They lose it.

CPZ: Oh. I see.

IKS 8: “Make sure you have somewhere you can follow-up with your paperwork.” [What she might say to a patient being discharged]

CPZ: Yeah.

IKS 8: Because if you don't follow-up with your paperwork,

CPZ: You lose your insurance.

IKS 8: Yeah

Lack of a real mailing address would result in loss of Quest health insurance coverage after hospital discharge.

Appendix AR

Commentary from Individual Homeless Persons on Lack of Requirements for Access to Health Care Services

Nine IHPs said that they had no identification. Four of them said their identification was stolen. Individual homeless person two said he had been on Maui for eight days. He had a pouch with his money, identification, birth certificate, and social security card that magically disappeared. He described some of the impacts of that loss:

> IHP 2: It's hard to get a job. It's hard to do anything. I can't get food stamps. I can't do anything without my identification. I'll probably have to get a birth certificate mailed from my place of birth, and that will take three to four weeks. It'll be a long process.

Individual homeless person 16 was sleeping in the park when her wallet, which contained all her money and her identification, was stolen. Individual homeless person 32 also had her wallet stolen. Individual homeless person 8 lost her identification in a house fire, when her family home burned down. Individual homeless person 7 lost his identification in a domestic dispute. Here is an excerpt from the interview with him:

> IHP 7: My girlfriend took 'em out. She took all my documents and I never get 'em back. And she has two of my kids. Sometimes when you're at that point, you don't care.
>
> *CPZ: You just needed to get away. The documents were less important than getting away.*
>
> IHP 7: Huh?
>
> *CPZ: It was better to just get out of it, than to worry about the documents.*
>
> IHP 7: Yeah.

Individual homeless person 14 summed up what he felt like with no identification when he said: "Yeah. No I.D… No social security card. I'm a man without a country." He described what happened with the loss of his identification and the lack of a mailing address, and how easily things get lost "out here":

> IHP 14: Well I did send away and get my birth certificate. I do have that.
>
> *CPZ: But where did they mail it to?*
>
> IHP 14: Well I was working at a place, and they sent it to that working address.
>
> *CPZ: Oh I see.*
>
> IHP 14: My boss [indecipherable] it was a physical address. Um ... other than that I

haven't really had much of a chance to have any mail sent. I guess I could try that - get a piece of mail sent. Because you have to have a piece of mail and your birth certificate to get a social security card. And then you have to have that and whatever else you have, to get an I.D.

CPZ: Uh huh. So you know what the process is.

IHP 14: Well. It takes a long time because I've lost so much stuff. I had pieces of mail, that proved where I was. And now I don't have that anymore. So things get lost here. It just ... [indecipherable] the problem. Things get lost so easy out here. There's no way to hold on to them hardly.

CPZ: You'd have to carry it with you the whole time, and you can't even set it down.

IHP 14: Well it's almost impossible. I went to jail for a few months for something I didn't even do. They finally dropped the charges, but I was in there for three months, before they finally dropped charges.

CPZ: Yeah.

IHP 14: And they don't care. But by that time, everything that I had was gone, again. Everything that was important was gone. Phone. Court papers. The whole place I had was just ransacked. [The place he referred to was an abandoned vehicle, that he did not own, located in a gulch, on a property he did not have permission to stay on.]

CPZ: Yeah.

IHP 14: Gone.

CPZ: So someone had been in where you had things stashed.

IHP 14: Oh yeah. Oh yeah. As soon as they know I am gone, they just ransack the place. So. And that's one of the biggest problems. It's hard to hold on to anything tangible out here. You can't have a locked box, you can't, you can't bury things. It's hard to hold on to anything.

IHP 14: Like say paperwork. Especially. As I was gone, it rained real bad. And my whole area is a flood zone.

CPZ: Uh huh.

IHP 14: And everything got flooded.

CPZ: Where you were. Your van and everything.

IHP 14: Fortunately, the van is high enough off the ground, that the river ran through it

underneath the van. But uh, when I came back I still couldn't find anything. I do have my birth certificate still. But everything else is gone. My backpack that I had, got taken. Fortunately I held on to my birth certificate. So I just have that. Fortunately. Nobody else can use it but me.

Fourteen of 32 IHPs said they did not have health insurance that is accepted in Hawaii. Lack of identification was a barrier to getting health insurance for IHP 7, IHP 8, and IHP 14; and for IHP 16, and IHP 24. Four IHPs were not interested in getting health insurance. Individual homeless person 1 did not want the complications and costs associated with health insurance. Individual homeless person 2 distrusted the system, and did not want health care expenses. Individual homeless person 9 felt she could get it if she wanted it, but heals herself with herbs and fresh air. Individual homeless person 24 had no identification, and expressed indifference to getting health insurance. Nine IHPs who did not have health insurance were interested in getting it. They were IHP 4, IHP 7, and IHP 8; IHP 13, IHP 14, and IHP 16; and IHP 19, IHP 21, and IHP 31.

Fourteen IHPs mentioned they lacked enough money to be able to get health care services. Individual homeless persons 1, IHP 2, IHP 7 and IHP 8 said it was too expensive to afford. Individual homeless person 8 said she worked part time, so does not generate a lot of income. Individual homeless person 3 described being impulsive, and said he did not manage money well. Individual homeless person 10 cannot afford to pay the fines for her missed appointments. Individual homeless person 16 had all her money stolen. Individual homeless person 18 could not afford prescription medications including inhalers to treat her asthma, and the vaccines for her children that were not covered by their insurance. Individual homeless person 24, who had no insurance, could not afford prescription medications. Individual homeless person 17 could not afford dentures. Individual homeless person 20 said she could not pay one thousand dollars for the dental care she needed, and could not afford the foods needed for her diabetic diet. Individual homeless persons 10, IHP 26, and IHP 32 did not have money for bus fare to pick-up prescriptions, or to go to MIKOHC.

Sixteen IHPs said they did not have a phone of their own. Individual homeless person 20, who had diabetes and lived in a car that did not run, said that she had her phone stolen. She said it was hard without a phone because she could not call her doctor, and often missed appointments. She liked to have friends with phones stay with her to be able to call 911 for her in

case her blood sugar level dropped.

None of the IHPs said they had a vehicle of their own that was legal, and in drivable condition. Most walked to get where they needed to go, or took the bus. Individual homeless person 30 said he was sometimes late or missed an appointment because he had to make the money for bus fare to get from Lahaina to Wailuku for the medical appointment. Individual homeless person 7 said he saw homeless persons with insurance and medical problems who just didn't go in for care because of transportation problems. Individual homeless person 27 wanted to find someone who would pick him up and drive him around.

Not having a mailing address interfered with getting identification. This excerpt from the interview with IHP 14 pertains to that:

> IHP 14: Even having mail delivered here is a situation. Because without a physical address, it's hard to get a physical I.D.
>
> *CPZ: How do you deal with that?*
>
> IHP 14: [Laughs] I just don't. I haven't. I can't get paid any checks. I can't get a job. Basically, my social security card was stolen.

Individual homeless person 24 was receiving assistance from Salvation Army to replace his identification. When he was told to use the Salvation Army address, as his address, to receive the identification, he hesitated. He did not want the stigma associated with using that address. Individual homeless person 15 said that it was hard to get a medical appointment when you say you have no mailing address.

Seventeen IHPs reported difficulty making or keeping appointments. Individual homeless person seven said that not having a phone complicated making appointments for homeless persons. Eight IHPs reported difficulty keeping appointments because of transportation problems. Making sure she returned to the shelter in time to get in for the night, kept IHP 18 from making some appointments. Individual homeless person 17 and IHP 31 said they were forgetful about appointments.

Appendix AS

Homeless Persons Lack of Basic Requirements for Health Care Services per Individual Key Stakeholders and Group Stakeholders

Group stakeholders, who are hospital social workers (GS), spoke about what a barrier lack of identification is to getting services for a person who is about to be discharged from the hospital. Here is a quote from their comments:

> GS: IDs - they are always losing their IDs. It is impossible for us to get while they are in hospital - can't leave to go to DMV [Department of Motor Vehicles]. Need SS [social security] card or birth certificate to get, and many don't have that. It makes it difficult to get other services, airplane flights, pick up medications etc.

Individual key stakeholder 11 spoke about how a person who seeks services at MIKOHC is handled if that person lacks identification:

> *CPZ: Okay. And then what kind of barriers do you [see] that think homeless people on Maui have in facing, in getting health care services? What barriers or blockages that prevent them from getting services?*
>
> IKS 11: Uh here, like at our clinic, we're like the, we see everybody, so we don't turn anybody away.
>
> *CPZ: You don't turn anybody away. How about if, you know I am ... I am finding with a lot of the people that I've talked to that they've either lost their ID*
>
> IKS 11: OK.
>
> *CPZ: Or they've had it stolen, or they've had it destroyed.*
>
> IKS 11: That's exactly where I was going. Yes.
>
> *CPZ: What happens then if someone comes in and they has some need And they go "Well, my backpack got stolen last night, and I don't have any ID. This is who I am, but I don't have any ID." What happens then?*
>
> IKS 11: Well, usually our member services people help them get that ball rolling. You know, sometimes they have to start from scratch, whether they can go to the state,
>
> *CPZ: Uh huh*
>
> IKS 11: and get a state ID,
>
> *CPZ: So if someone comes in with an acute problem, like let's say...hmm... let's say they have a wound that looks really infected*

IKS 11: Hmm huh

CPZ: And they don't have any ID, can they be, can they be seen and the process started and then treated, or do they just have to go to the ER, and get treated over there?

IKS 11: That's where it gets shakey, that's where it kind of gets

CPZ: Gets so tricky

IKS 11: Usually um, sometimes the doctor, or the lead doctor will come out, and make that decision, if that person should

CPZ: Based on the person's need

IKS 11: Yeah, like if they should go to the ER

CPZ: Uh huh

IKS 11: while they figure this out. Or he may say, you know what, he or she may say "You know what, let's get this person"

CPZ: treated?

IKS 11: "together and then we'll work on that." So.

CPZ: I know Salvation Army, they have a case worker over there whose helping people get their ID, but he's told me it could take three weeks, six weeks something like that. It takes a while sometimes.

IKS 11: It does take a while.

CPZ: So as far as ID goes, there is someone here who can help them get ID, and then depending on their health care condition, they may be treated temporarily and then referred to the ER, or treated temporarily while their ID is in process. Is that it?

IKS 11: Yeah

CPZ: Is it on a case-by-case basis?

IKS 11: I would say case-by-case.

CPZ: Okay.

IKS 11: That's almost how you have to treat a lot of things that come up you know.

CPZ: Yeah.

IKS 11: Sometimes it's not just this way or that way. You have to look at the [indecipherable].

CPZ: Look at the person. Yeah.

IKS 11: Whether it be somebody that comes in.

CPZ: I guess if it was someone that... I saw the sign downstairs about bring your ID every time. If it was someone that was a regular patient here, that you had known and just

IKS 11: Hmm huh

CPZ: And just got their stuff stolen, but you recognized the patient. It might be different than someone you'd never seen before.

IKS 11: Uh definitely. We have our...we have a lot of people that I know don't have their ID on them, but we know who they are.

CPZ: Uh huh.

IKS 11: You know they just input their birthdate or their name and it comes right up so.

CPZ: Uh huh.

IKS 11: We don't really like to turn away people ... or not see somebody. I'd say like this is like the last...a lot of other places, tell people, you know what, go see us.

CPZ: This is the safety net.

IKS 11: Yeah. We're the only ones on the island that see this type of patients.

CPZ: It's kind of a last stop.

IKS 11: Last stop.

CPZ: Here or the ER. [Both Laugh]

Individual key stakeholder 6 commented on the cost of identification replacement as a barrier to replacing the identification.

IKS 6: Or they'll go to the place and the place requires an I.D. so they can't get their

CPZ: Uh huh

IKS 6: You know we were just talking about I.D.s in the Homeless Alliance meeting today, whereas right now only Salvation Army has funds in order to help people get I.D.s. Now anybody can help people with I.D.s. They just have to be willing to pay for the guys I.D., unless you can figure out a way for the guy or the girl to pay you back for it. But that is not likely the case. There's going to besome reason why they can't pay you back. You know.

Homeless persons may have insufficient literacy, or limited fluency in the English language, and need assistance in applying for health insurance. Individual key stakeholder 11 described how staff at MIKOHC assist patients:

IKS 11: I think there's a lot of people out there that need medical insurance that just don't know where to go.

CPZ: To get signed up?

IKS 11: Or they might be not really afraid, but they just don't know if they can go through the process. Or they don't understand the process. But once they come in through the door, our staff in that department is really good at setting them up. It's just a matter of them sitting down with them and helping them fill out the paperwork, and going over whatever they have and just

CPZ: So they have to do that step before...it's kind of a whole intake process

IKS 11: Yeah.

CPZ: before they can get an appointment.

IKS 11: Before they can get an appointment.

Individual key stakeholder 8 described how hospital nurse case managers assist homeless persons with getting Medicaid coverage while they are hospital inpatients. She explained how easily homeless persons can lose their insurance once they are discharged, if they do not follow-up with paperwork requirements. She is quoted in Appendix AQ.

Not having enough money for health care services can be a barrier to compliance with a treatment plan. Individual key stakeholder 6 commented on the impact of insufficient funds:

IKS 6: A lot of times even if they do go to the clinic and they get seen by a doctor and they get given a prescription, then how is their prescription going to get paid for? So then the client doesn't go and get the prescription. They don't start taking the medicine, so they can't get any better.

Group stakeholders suggested that monthly bus passes might help homeless persons, who do not have money, to keep their follow-up appointments. They also pointed out that it would be necessary to find a way to prevent homeless persons from losing the bus passes, or selling the bus passes, for that intervention to be useful.

Communication with health care providers is compromised when homeless persons do not have a phone. Individual key stakeholder 10 commented:

IKS 10: [Groans] Trying to follow them with a regular appointment. I think you can't.

CPZ: Yeah.

IKS 10: Okay. Because they don't have transportation.

CPZ: So all these things

IKS 10: Oh. Phones too, to tell them. If I could call them and say, "Hey, remember I treated you for that." Just some follow-up here.

Transportation difficulties interfere with follow-up. Individual key stakeholder 9 commented about the need for intensive case management that would include making sure to facilitate the patient getting to the follow-up appointment:

IKS 9: They need intensive outpatient services or what's called an ICRS - intensive community rehabilitation services, or something, where you have a clinic that's connected to the county, whether the county wants to contract it out, it doesn't matter, but it's connected to them, and that they have a team of people who are following all these people. And if the patient has an appointment, I used to work for one of these, then a case worker goes out there picks up the patient, and makes sure they come to their appointment.

Individual key stakeholder 6 commented on how lack of a mailing address interferes with a homeless person getting insurance and benefits:

IKS 6: Or anybody can come up and say: "Well I want assistance", but they might not even be homeless. So you see, these things need to be verified. But at least, this way, somebody has an address for these things to be sent to. Or what happens a lot, as well, is the doctors will say, "Well you missed, you missed your last five appointments." And sometimes they don't even remember they had an appointment. Or they'll say [imitates the provider] "Well, we tried to call you." And they never had a phone number to begin with. Or they'll say, "We sent you a letter." They never got the letter because they don't live there anymore. They haven't lived there inyears, or months, or weeks, or

CPZ: Did…

IKS 6: they're having trouble with someone they lived with. They have a TRO [temporary restraining order]. Or the person just never gives them their mail, or now they're living in central or they used to live on the west side, or something like that.

Individual key stakeholder 4 recognized the good fit of walk-in services for homeless persons who have difficulty keeping appointments when he said, “If you have issues, you can come on in. Basically the same thing we do [at the ED].”

Appendix AT

Commentary on Knowledge, Experiences, Attitudes and Behaviors as Barriers to Access to Health Care Services per Individual Homeless Persons

Individual homeless person 12 reflected on his health care experiences, and said providers were “rude and abrupt”. He described the depersonalization experience of getting health care services this way: “It is like getting your oil changed. It makes you feel worse." Individual homeless person 20 had privacy concerns and said that even though she feels depressed, she does not want help from Mental Health Kokua because, “They get too much into your life.” Individual homeless person 6 said he and other homeless persons resent feeling judged. Here is an excerpt from the interview with him:

> *CPZ: You know what I mean when I say barrier? Like a block, something that keeps you from getting what you need with health care.*
>
> IHP 6: Yeah. Okay. I can help you with that. Well, I know a lot of people who get high barriers, because they don't want to feel, ... they don't want to be judged, like. "Oh, yeah cuz you homeless you should get help. You should get [indecipherable], you should get mental health service. Some people don't want that … [then further along in the interview]
>
> *CPZ: Health care providers need to have more heart.*
>
> IHP 6: They gotta have more heart. Cuz they gotta understand, they don't know their dark secrets. They don't know how long they been on the streets.
>
> *CPZ: Yeah.*
>
> IHP 6: They don't know what lifetime they seen. You know… [then further along in the interview, he continued]
>
> IHP 6: I try to take my life every chance I get.
>
> *CPZ: Well... I'm sorry to hear that.*
>
> IHP 6: Why?
>
> *CPZ: Because I would rather see people happy.*
>
> IHP 6: Oh no you can't...There's no... Oh you probably could catch a couple of homeless people happy, if they're on their fix. You know, their medication.
>
> *CPZ: Yeah.*

IHP 6: You could see their happiness. But deep down inside, no, they're like crying, they're hurt. They're painful. They just put on a show to make everybody "all right. He's happy. Let him go." But deep inside he's really hurting.

CPZ: He's really hurting.

IHP 6: He's really tear down. He really want to give up. He's really "do not care anymore".

CPZ: Don't care anymore.

IHP 6: For me, I care. [emphasis] I understand there is life. And

CPZ: You like it here.

IHP 6: Oh yeah. I do.

Individual homeless person 9 also felt judged by health care providers. Here is an excerpt from the interview with her:

CPZ: How about attitudes of those that are providing services, is that a barrier at all, like if you go into the hospital?

IHP 9: Oh. I don't go to those services much...Um ...But you definitely get attitude at places. You know. Like sometimes people look at you like they don't need to know but they make assumptions about you because you don't have [emphasis] what people have [emphasis]. You know. You're a have not! [emphasis and laughter].

CPZ: Just assumptions, really.

IHP 9: The assumptions are pretty heavy.

Individual homeless person 15 described what she felt like when she was nicknamed by health care providers and labelled. She reacted to it by injuring herself and cutting herself. Here is an excerpt from the interview with her:

IHP 15: And I'll give you an example. I went in. I went in to... uh ... the Clubhouse after I had my surgery and I had a catheter bag and the staff people called me "pee girl".

CPZ: Yeah. Not good huh.

IHP 15: And how do you think I felt. I didn't want to go back there. And they nick named me because I cut. They nicknamed me "The [insert place name] Cutter".

CPZ: So nicknames are a no no.

IHP 15: Yeah. People don't want to be labelled with names like that.

CPZ: So

IHP 15: And I would just tell them "Excuse me but my name is [gives her actual name], not “[insert place name] Cutter", but they continued to call me that. I went there for two years and I finally realized that I had to stop going there, because the only time I was cutting was when I was going there. They would hurt my feelings so bad that when I would leave there, I would cut.

CPZ: And you would release the pain that way.

IHP 15: And now I haven't cut since I haven't been going there. I haven't cut once.

CPZ: So nicknames - because you mentioned that people don't go sometimes to get health care because they feel stigmatized, being given a nickname and disparaged, is one of the reasons people don't go.

IHP 15: Right. Right. Exactly. It's like people see you wearing a backpack they assume that you're homeless - which most of them are, but even though, they are still entitled to the same quality of health care.

Individual homeless person 18 spoke about how frustrated she felt in trying to get doctors to hear what she had to say about her asthma:

C*PZ: How about the attitudes of people who are providing the health care. Are they okay?*

IHP 18: I ran into some nice people who actually cared about their patients. And then I been on the other end where doctors are leaving, they got their tenure [her word choice], they're about to retire and they just give off this I don't care attitude. Like "Okay. You need that, here. Go away." kinda thing. So. So I would say that needs to be like... adjusted. Because I've had maybe three doctors that actually sat down, listened and did stuff. And I've had like another five that were just like "I'm leaving in three weeks. I'm just here to give you what you need right now to get you through. Here's the paper. Get out of my office." And not address anything or deal with what I'm accustomed to when I'm in there with a full blown asthma attacks. It's just write on paper, give it, and go. And not try to fix the problem or let me know what else I can do to try to get my asthma under control. It's been rough. I've actually stopped going to doctors. This is the first time in about two years that I've actually had to see a doctor.

CPZ: You stopped going because it was frustrating.

IHP 18: Yeah. I would see one doctor and then I would go to another

doctor to get a second opinion.

CPZ: Yeah.

IHP 18: And they were like not as bad as the first doctor I went to, but not that helpful. So I'd have to redo everything all over.

CPZ: Explain it all again.

IHP 18: And by that time, they're like oh...okay. We're going to try this. And we're going to reduce this or we're going to pump this up.Yeah. It doesn't work. And so I either end up in the hospital, or I might go to a different island to see another doctor to shift again cuz I don't want to see him it's just because I'm not getting that help that [She was teary eyed through some of this conversation].

CPZ: The help you need.

IHP 18: Yeah that I think any doctor should give when they are dealing with any patient, you know.

CPZ: Okay...It sounds like some people don't care anymore and they just give up. It sounds like you still care though.

IHP 18: Well I care. I do try to care and I have my babies and I want them to see that doctors are good and they are there to help but nowadays it's just getting worse - like they don't care anymore. Either the patients don't care or the doctors don't care. They're like at their end, just waiting to get out of there. They already made their money and they want to split. And that's the kinda vibes that I get.

CPZ: That you get.

IHP 18: Yeah.

Individual homeless person 20 spoke about having a "phobia" about doctors after the experience she had when her husband died. Here is an excerpt from the interview with her:

IHP 20: You see I had a phobia with doctors.

CPZ: Yeah. What were you afraid of?

IHP 20: I just didn't like them because of what I went through when my husband died in my arms of cancer. And the way they treated me.

CPZ: So the way you were treated...they didn't care about your feelings or?

IHP 20: or this because they couldn't do the surgery. He had like a tennis ball tumor in his kidney, and they couldn't do anything because his pancreas was swollen and they

released him from the hospital.

CPZ: They sent him home with you.

IHP 20: Uh...he was really bad and they just sent him home because they needed the bed for someone - one other patient - with more money I guess. And that really made me mad. And that made my husband go back to work the next day, which he shouldn't have done. But the doctor wouldn't talk to me. I chased him through the hospital. [Laughs] He ran away from me.

CPZ: You have a different doctor now.

IHP 20: Yeah.

CPZ: One you trust?

IHP 20: For me -yeah. Yeah.

Individual homeless person 28 said his experience with health care was "half and half". He said that it is difficult to find people that aren't going to judge.

Individual homeless person 17 said she loved her doctor and her doctor explains treatments to her. Individual homeless person 24 found that health care professionals really wanted to help him. Individual homeless person 27 was happy with the people who provide his health care. He said he had known them for years.

Many IHPs were able to articulate fears they had about accessing health care services. Individual homeless person 11 was afraid his sister in the mainland would find out from a health care provider that he was homeless. Here is an excerpt from the interview with him:

IHP 11: I wonder sometimes if people would be reluctant to seek help because if it gets serious, they make you fill forms out, they want to inform a significant relative, and they may not always want...

CPZ: There might be questions asked they don't want to answer.

IHP 11: They might make a phone call to tell them that you're homeless and sick and need help. A lot of people wouldn't

CPZ: Yeah. It's a sense of pride.

IHP 11: Sense of pride. Get in the way of that. I mean I wouldn't want someone to call up my sister and tell her I'm homeless. She knows I'm struggling but she doesn't know I'm homeless.

CPZ: She's not here in the islands.

IHP 11: No. No.

CPZ: So you'd rather not have that communicated.

IHP 11: Yeah.

CPZ: Yeah.

IHP 11: I think some of these people are reluctant to...a lot of people don't have others in their lives anymore. They don't even like to admit that they're homeless. "I'm houseless not homeless!"

CPZ: Houseless. Maybe I should change my terms and say "houseless anymore".

IHP 11: We used to reserve that for people who have a vehicle as a place to live, because you can always sleep in a vehicle. But it's against the law to sleep in a vehicle on Maui, which can be a barrier.

CPZ: Yeah.

Individual homeless person was concerned that health care providers might share information with the police. Individual homeless person 15 was afraid she might be treated unkindly. Individual homeless person 16 had a history of being sexually abused, and was afraid of an exam "down there". She had only had one vaginal exam in her life, and although she was past the age of 50, had never had a mammogram. Individual homeless person 27 said he was afraid to go in for medical care because something might happen, and he might die. Individual homeless person 28 witnessed a family member having side effects from psych medications. He stopped taking his psych medications because he was afraid of possible side effects. Individual homeless person 30 was afraid that he might get angry with health care providers. Here is an excerpt from the interview with him:

IHP 30: Oh what I afraid of...yeah.

CPZ: What?

IHP 30: Getting pissed off at them. [Laughs] For swearing at them.

CPZ: You're afraid you might get angry at them.

IHP 30: Yeah.

CPZ: Okay.

IHP 30: Always.

CPZ: You're afraid about your temper. If they don't give you what

you want you mean.

IHP 30: No. No. No. They not gonna give me what I want. Just give me help. Sometimes it just takes too long. And by the time I have the money, and the time to go over...[Sound distortion]

CPZ: I see. It takes a long time. And you then get the money together, and you get on the bus, and then they're closed.

IHP 30: Yeah. All that doing the steps.

CPZ: Uh huh. Too many steps.

IHP 30: Yeah. Too long it takes.

CPZ: And you're afraid that's going to make you angry.

IHP 30: No. It just pisses me off.

CPZ: You don't want to be pissed off

Individual homeless person 2 that he would just have his money taken from him if he got health care services, and IHP 31 thought the staff was all about money, and not about helping people. Individual homeless person 19 was concerned about being victimized again.

Three IHPs described the frustration of cumbersome procedures. Individual homeless person 15 said that everybody sends you to a different place and it leads nowhere. Here is an excerpt from the interview with her:

CPZ: How about transportation. How do you get ...

IHP 15: I usually don't leave far from here because it's hard for me to walk. But I am supposed to meet with a lady from Ohana [name of insurance]. She's going to see about getting me a walker. And see like it's hard for people that have braces or walkers or wheelchairs to get access to them.

CPZ: You mean if it breaks, to get it replaced?

IHP 15: No. Just to get one.

CPZ: Just to get one.

IHP 15: I've never had one. But I actually need one. But, it's hard to get access to these things because everybody sends you to a different place and it leads nowhere.

Individual homeless person 28 felt he got the "runaround" when he was trying to get glasses. Here is an excerpt from the interview with him when he explains that:

CPZ: And you mentioned need for glasses. For what reading or distance?

IHP 28: I have astigmatism in both my eyes. So my vision is very poor.

CPZ: Okay. Let's see. Have you tried to get services here for glasses?

IHP 28: I have but they gave me the runaround.

CPZ: What do you mean they give you the runaround?

IHP 28: They would tell me to go to this place and do this. And I'd go there, and they'd tell me to go to this place. And I'm not familiar with the island, so I just kind of gave up.

CPZ: Oh. Okay. So you didn't get clear directions about where you needed to go, or what you needed to do.

IHP 28: Yes m'am.

CPZ: It would have been helpful if somebody had explained things more clearly.

IHP 28: Yeah. It would be more clarify itself.

CPZ: Uh huh.

IHP 28: That would help a lot.

Many IHPs spoke about feeling like they do not care anymore, at least sometimes. Individual homeless person 4 who had lost custody of her son due to her alcohol abuse and her homelessness said:

IHP 4: Sometimes I felt like that.

CPZ: Sometimes.

IHP 4: I really didn't care at one point about getting any help. But as of right now I miss my child so much, I try to change everything about me.

CPZ: That's a real motivator. Huh? You want to see your child more, so you'll make some changes to be able to get that cleared up.

IHP 4: That's why I keep his picture on my phone every day.

Individual homeless person 5 described what he noticed about how he treated health care providers when he felt like he didn't care anymore:

CPZ: Does feeling like you want to give up, or you don't care anymore, does that effect wanting to get services?

IHP 5: In a way, when I really get really ill. I mean, I thought I was going to die the other day. And uh ... In one aspect, I became like uncaring. I just followed my inhibitions. And I would start joking with the nursing staff, and the doctors in an inappropriate way. Kind of a bad sense of humor. Kind of an uncaring sense of humor.

Individual homeless person 20 spoke about how it was for her when she felt like she didn't care anymore:

IHP 20: I do go into stages where I get so depressed I don't want to live or nothing. Just take what I get. I sleep in my car all day, and not do anything.

CPZ: Uh huh.

IHP 20: Just try to sleep until my time comes.

CPZ: Oh. Oh.

IHP 20: Yeah. I'm tired already. I did my time.

CPZ: I'm so sorry.

IHP 20: I did my time.

Individual homeless person 28 spoke with a fatigue and resignation. Here is an excerpt of the interview with him:

CPZ: How about "don't care anymore", do you have that attitude? Some people have that attitude.

IHP 28: Sometimes. If the situation gets better, it gets better. If it don't, it don't.

CPZ: Uh huh.

IHP 28: Yeah...You only can do so much. I don't know. I feel like my body's not going to shut down. It's not just gonna die out on me. If I get the help, I get it. If I don't, I don't.

CPZ: Uh huh.

IHP 28: That's just my attitude for stuff. So I'm not going to go out and beg for it. At the same time, I'm not going to deny it if it comes up. You know.

CPZ: Uh huh.

IHP 28: You pretty much put on there, it is what it is. You know, it is what it is. It's not that I don't care completely, but I won't put a whole bunch of effort into it, you know. It takes, it takes energy to go out and get information, and sometimes that's energy that you can't afford to lose, you know. So. I don't know how you'd word that on your paper.

CPZ: Well...It sounds like if you feel people aren't going to be judging you, you'd want the care, want the health care. Is that about it?

IHP 28: Yes m'am. It's just hard to find the people that aren't going to judge.

CPZ: Yeah...So you must be someone then that watches first and then decides whether or not you want to get involved.

IHP 28: That's why I came over and sat down and

CPZ: and watched. [Both laugh] *Okay. Well I guess I passed the test then.*

IHP 28: Yes m'am.

Individual homeless persons spoke about other priorities they have that may interfere with seeking health care services. Individual homeless person 4 and IHP 26 said they did not quite know how to give up the "party life". Individual homeless person spoke about how the stress of homelessness can push people to not caring about anything except drinking alcohol. Here is an excerpt from the interview with IHP 7:

CPZ: For some people having to get food, or having to get beer or alcohol or drugs – it comes first before getting health care.

IHP 7: Oh yeah.

CPZ: Is that an issue for you?

IHP 7: Um ... I not too sure. But I like alcohol.

CPZ: You like alcohol.

IHP 7: If I have a chance to get it, I will [emphasis] get it.

CPZ: Yeah. Any other kinds of barriers that you can think of that keeps you yourself or others from getting health care? It sounds like maybe alcohol.

IHP 7: Alcohol for sure. The homeless at the beach ... The homeless at the beach, they always drink, they always drink you know. They don't care. Those guys, they don't care. Yeah. Those the kind I think you looking for. You know what I mean. They just gon drink, drink, drink. First thing they wake up. They hit all the dumpsters. Get all the recycles. Go recycle. Grab themselves 40s [40 ounce bottles of beer] as much as they can, and get back down on the beach, and just drink.

CPZ: Uh huh.

IHP 7: That's it. And just drink.

CPZ: Until they pass out.

IHP 7: Until they pass out. Yeah. Ultimately. That's what they do. So I don't know if that would be considered a barrier.

CPZ: I guess so.

IHP 7: The addiction. Yeah.

CPZ: I guess so. Don't have time to get to the doctor.

IHP 7: The addiction. They only have one thing set on their mind.

That's it.

CPZ: Get the beer.

IHP 7: Maybe that's the only thing they live for. Some people get to the point. They don't care. Feel good.

CPZ: But not you. You're not there.

IHP 7: Sometimes I get there. I do get there sometimes. Living out here pushes you to that point, sometimes [emotion].

Individual homeless person 22 explained that taking care of her husband, who also had diabetes and kidney problems, and of her extended family living in the park, took priority over getting herself to the doctor. The campground at the park was scheduled by the county for closure in two weeks, and the family was very stressed, as they had nowhere else to go. Getting food was more important to IHP 27 than getting health care services. Getting rest was more important to IHP 28 than getting health care services. He was often tired because he was awake at night, watching out for thieves and avoiding assaults. Individual homeless person 31 identified getting marijuana, cigarettes and beer as taking priority over getting health care services. Individual homeless person 32 was looking for work so she could “get back on her feet again”.

Individual homeless persons spoke about behaviors that interfered with getting health care services. Missing appointments and not taking insulin to manage her diabetes were behaviors IHP 20 mentioned. Individual homeless person 28 decided to stop taking his psych meds for bipolar disorder and schizophrenia. Behaviors that interfered with health care follow-up are described in Table 4.45 and Appendix AP.

Appendix AU

Knowledge, Experience, Attitudes and Behaviors of Homeless Persons that are a Barrier to Accessing Health Care Services per Individual Key Stakeholders

Per IKS 1, homeless persons are often hesitant to apply for insurance. Per IKS 1, IKS 6, and IKS 11, at Salvation Army, Family Life Center and MIKOHC, there are forms available, and persons to help complete the paperwork. The staff help homeless persons who have literacy problems, or feel overwhelmed by the paperwork. Per IKS 2, IKS 3, and IKS 12, homeless persons need education about self-care, particularly about wound care. Individual key stakeholder 4 thought homeless persons need more education on when it is appropriate to go to the ED, and when it is not appropriate. Here is an excerpt from the interview with him:

> IKS 4: Well it all boils back to taking care of themselves to begin with and not waiting uh... til whatever it is they have going on gets to the point of where it's at. You know there's some people that come in here [at the ED] because they have a little superficial whatever, and there's other people that come in and you go, "My God, why weren't you here two weeks ago?"
>
> *CPZ: Yeah*
>
> IKS 4: That knowledge of when it's appropriate for them to come in. I think that would reduce the lengths of stay.

Per IKS 4, it may not be that homeless persons lack knowledge of resources but rather they choose not to take advantage of them. Here is an excerpt from the interview with him:

> IKS 4: ...and they are not stupid people. They know how to scam. They know how to get their needs met. They know that, [He imitates homeless person's thought process] "I would rather be homeless than to give part of my money for HUD housing. Cause...if I...that means I have to spend this much money for a place to stay, I'm okay being homeless." So again, it's not a lack of services, it's the person making bad choices.
>
> *CPZ: Yeah. Yeah. So... Um*
>
> IKS 4: They been doing what they been doing for a long time. You know. There's very few things that I tell these people that they don't know already. Again, I can use the example of: "If you clean up, you can get shelter. You gotta give 'em a clean urine, and don't drink any alcohol." [He imitates homeless person] "Oh, I know. But I don't want to go because they won't let me drink." or [Changes voice tone to imitate another person]

"I don't want to go because I have this horrible back pain and I need my narcotics."

Individual key stakeholder 4 also spoke about how much providing an incentive can influence behavior:

IKS 4: I think the no insurance. But you know, that is such an easy thing. I mean here in the state of Hawaii, if you were to come in now, and didn't have insurance, our insurance people would sign you up today.

CPZ: Uh huh

IKS 4: And I think that is something that within the homeless community, is very well known.

CPZ: Yeah.

IKS 4: You know. "Just go down here. Sign-up." I think that it is more it is not a priority at whatever time it is going on.

IKS 4: That you know it's like... if you were... if you have an appointment for somebody... and you said: "We're serving free drinks there. Make sure you're on time."

CPZ: [Laugh]

IKS 4: They'll be there on time.

CPZ: They'll be on time.

IKS 4: Nature of the beast. Right?

CPZ: Uh huh. Yeah.

IKS 4: If you give them something that makes it worth them being there. "I'll be there." You know.

CPZ: Make it worthwhile.

IKS 4: No matter what the barriers are.

CPZ: Yeah

IKS 4: They'll be there early.

CPZ: So barriers get overcome with incentives. Is that it?

IKS 4: Right. Right.

Individual key stakeholder 1, IKS 2 and IKS 6 spoke about how past experience of prejudice or bias against them in the health care setting that homeless persons have had, can discourage them from seeking care when they need it. Here is an excerpt from the interview with IKS 2:

CPZ: What do you think would help homeless people on Maui get their health care needs met better?

IKS 2: I think it would be, the main thing is that service providers are willing to spend the time with people to learn what their needs are, and be willing to push [emphasis] to get those needs met.

CPZ: So you mean doctors and nurses when they come in...

IKS 2: So doctors and nurses... and not just turn someone away because they may be homeless, or unsheltered.

CPZ: Have dirty clothes.

IKS 2: Have dirty clothes or whatever.

CPZ: Yeah.

CPZ: That's the main thing - not turning people away.

IKS 2: I think that's the biggest issue right there. Prejudice and preconceived notions about people. Bias about people because they're homeless.

CPZ: Umm. So it sounds like the biggest intervention to help people get their health care needs met really has to do with a change in understanding from the health care provider's point of view?

IKS 2: I think so.

Per IKS 7, health care professionals just need to overcome their prejudices. Here is an excerpt from the interview with him:

IKS 7: I certainly just like everybody else carry "Oh gees. Why don't they help themselves?" But bottom line is, we need to get over the fact that people are drinking, and they require help regardless of their disease of addiction.

Experiencing cumbersome requirements to access health care services, and the experience of getting the “runaround” can discourage homeless persons from seeking services. Here is an excerpt from the interview with IKS 6:

IKS 6: So now, the bus made it a little bit easier for people. Um, but a lot of times, they just don't know how to access these different things, or there's so much paperwork involved and so much running around. You'll go to one office. They'll say "Well, you have to do this." And you go to another office and they'll say: "Well, you have to do that." And then they'll go to another office, and they'll say, "You have to do that." So it

gets, you know...it becomes overwhelming and then basically the client just says: "Ah, screw it!". You know,

"I'll just wait until I get really sick, or really bad...".

CPZ: And go to the ER.

Individual key stakeholder 3 said Caucasian homeless persons may experience racial discrimination from local health care service providers. Individual key stakeholder 12 said that illegal immigrants may avoid health care services for fear of problems with the law, or deportation. He recalled a young woman who was an illegal immigrant who was injured in a motor vehicle accident, and initially refused to go to the hospital for that reason. The young woman appeared to him to have internal hemorrhaging. He persuaded her to go to the ED.

Individual key stakeholder 3, IKS 5, and IKS 12 observed that homeless persons who demonstrate a sense of entitlement to services that health care providers perceive as inappropriate, can alienate health care providers. Here is an excerpt from the interview with IKS 5:

IKS 5: The ones I've seen that are really difficult to manage are the ones who feel they are entitled...

CPZ: Entitlement. Yeah. So the entitlement is really kind of a barrier, right, because it alienates the care providers.

IKS 5: Uh huh. Yes. Yes, and if they start demanding things that they don't need

CPZ: Yeah.

IKS 5: "This is what you need but you want something else." Well it's like okay, now if you don't follow...One thing is the difficulty to comply with what we want the program. "This is what you need to do." But they say: "I don't want to do this, because this is what I want." You know. You don't need that, you don't need this.

Six IKSs commented on how homeless persons' rule averse attitudes can be a barrier to accessing health care services, and also staying at a shelter where there are rules against drinking alcohol and using drugs. Here is an excerpt from the interview with IKS 3:

IKS 3: Um... and homeless, I mean do I think if we had like just bigger shelters and maybe a little more assistance to these people, would it help? Sure. I do. We don't have any place for people ... But then the places we do have, have rules. And most of these people don't like to follow rules.

Here are some comments from IKS 11:

> IKS 11: Now with that drug abuse and alcohol abuse, and given the limited resources for housing for them, a lot of the homeless I've encountered I've had conversations with, they're hesitant about going to these shelters or places where they can actually spend the night or stay, because they're not allowed to drink
>
> *CPZ: Right*
>
> IKS 11: Or do the drugs that they want to do
>
> *CPZ: Uh huh.*
>
> IKS 11: So they prefer to be just out in the streets
>
> *CPZ: Out in the open?*
>
> IKS 11: Out in the open, here.

The attitude that health care is not a priority can be a barrier to accessing services. Here is an excerpt from the interview with IKS 4:

> IKS 4: The incentive to feel better isn't necessarily that much of a priority because you don't feel that bad to begin with. "I can sit here under this coconut tree and split a 40 [40 ounce beer] with my friend, or I can go see someone about my leg here. Ah, my leg's okay. Let's finish the 40." You know, that population, their mind sets are very different than ours. You say something like...that's very reasonable - and it may be very reasonable to me and you, but to them it's not - because their priorities are totally different. You know it's like "Well what kind of an idiot would do this?" An idiot who would rather get drunk. You know...It's like...
>
> *CPZ: I guess that's why some of the people are so sick sometimes when they come in here - because they just delay [emphasis]*.
>
> IKS 4: Wait, wait, wait...Or other people want to come in here so that we can take care of them...

Individual key stakeholder 10 described a hypothetical interaction with a homeless person that shows how getting health care may be a low priority. Here is an excerpt from the interview with him:

> *CPZ: And then patients having the attitude "don't care anymore".*
>
> IKS 10: Yeah. Yeah. Just put medical care is a low priority. Because it's all “treatment as needed”.

CPZ: Yeah. Treatment as needed. That's the way they think, huh.

IKS 10: If you actually say "Can you not do this?" [Then he providespatient response] "Well look, man, I don't even know what I'm gonna eat, where I'm gonna sleep. I need transportation too." [His question to homeless person] "To what, to go to a medical appointment?" [Imitated response] "No. To go to the bank, man, cuz somebody's sending me money. And then my friends have a good time after that." So it's a very low priority.

Homeless persons can just give up hope and not care enough anymore to seek health care services. Here is an excerpt from the interview with IKS 12:

IKS 12: And we slowly see them die. Or we'll see them walk into traffic. You know we've had two of them, death by throwing themselves in front of a car.

CPZ: Intentionally? Really?

IKS 12: And one gentleman I took care of for years [Emphasis], he'd always tell me "I'm just going to throw myself in front of a car. No one will help me." [Imitating the voice of the homeless person] And I go: "Don't do that." [His response] And one day, he did it. He threw himself in front of a car. The poor tourist couple thought they'd killed this poor old guy who was walking on the road. And I said: "No. I'm sure he threw himself in front of your car."

CPZ: Wow.

IKS 12: "Because he always said he would do it."

Individual key stakeholder 2 thought that homeless persons may hesitate to disclose their chronic disease problems such as infection with HIV or hepatitis C. That hesitation results in lack of treatment. Individual key stakeholder 3 said she thought many homeless persons lacked a sense of purpose sufficient to be self-reliant, and get themselves out of their difficulty. Here is an excerpt from her interview:

IKS 3: You have to be able to be your own advocate, you have to be empowered...and I think...

CPZ: So the barrier is disempowerment, and stigma as you mentioned earlier.

IKS 3: There's stigma. And a lot of times just... and I know good, I don't mean good people, but people with circumstances. We're all... I believe we're all open to that. I mean you take away my circumstances. I mean you take my livelihood.

CPZ: Ere but for fortune go you and I. Yeah. [Laugh. IKS 3 did not laugh]

IKS 3: I'm not exempt from any of that. But what I'd like to think is that I would still kind of take care of myself somehow even if I was impoverished.

CPZ: You would have that much self-respect and ability

IKS 3: Right

CPZ: to keep it together

IKS 3: Right

CPZ: that you would survive the difficulty,

IKS 3: Yeah

CPZ: get to the other side of it.

IKS 3: And if you don't have some purpose in your life, you know. And I don't know how we give that to people. I believe people need to be productive. They need to contribute to something. And you don't have that. So I think there's so many things...

CPZ: It's kind of a psych issue

IKS 3: Yeah. Yeah. You know if people had to get out and work daily. And then they got meals. They had a place. You know if you had a huge farm, and everybody had their own bunk, or their own space. And they had to work. And they had to contribute. And you build self-esteem and they feel like they matter. I think it's when you don't care. Like I said, I'm not exempt. I would like to think not, but I'm not so sure that I wouldn't just well...Well, I would think not...

CPZ: Well, you could have very adverse circumstances, but you could find your way through it.

IKS 3: Hopefully.

CPZ: Yeah.

All IKSs commented on homeless persons' behavior as a barrier to accessing health care services. Discordant and disruptive behaviors make someone unwelcome in the health care environment. Here is an excerpt from the interview with IKS 12 in which he comments on that:

IKS 12: Yeah. We have a few that do that. The people don't care. But, I think so many of them are so abusive and demanding, that they're getting cut off. You know, so that the one's that we see, it's like: "We can see why they don't care about you, because you've been so evil for so long..."

[Laughs]

CPZ: Yeah.

IKS 12: They're over you already.

CPZ: Yeah.

IKS 12: And I tell every single one that's sick: "Be nice."

CPZ: Yeah.

IKS 12: "Go in there and be nice. Act like you want to be helped."

CPZ: Uh huh.

IKS 12: "Don't yell and scream, and people will probably be nice to you." [His advice to a homeless person seeking health care services]

CPZ: Uh huh.

IKS 12: But so many of them are in there yelling and cussing. And they [health care professionals] just want them out of there. So they get rid of them.

CPZ: Uh huh.

Individual key stakeholder 10 also commented on how homeless persons' behavioral problems can be a barrier to accessing health care services:

IKS 10: To me the hardest problem is actually behavioral issues

- okay?

CPZ: Yeah.

IKS 10: A lot of these folks, it might not be outright psychosis

CPZ: Yeah

IKS 10: You know, delusions and all

CPZ: Yeah.

IKS 10: It might not be like that.

CPZ: Yeah.

IKS 10: It might just be horrible anti-social skills -okay?

CPZ: Yeah.

IKS 10: And so for the few that were homeless, are homeless, are soon going to be homeless, you know. These people don't have good anger-management skills - okay?

CPZ: Yeah.

IKS 10: And they ... you cannot really help them - medically or anything. They're just unstable. They get angry. They have poor rapport with people. Sometimes they're angry, sometimes they're just how do you say? - detached. But now, like I said, if they truly have a psychiatric diagnosis, they're fine. We can do whatever we have to do - medicate them. Some of these people are not truly psychiatrically ill. They just have personality defects.

CPZ: Uh huh.

IKS 10: So...behavioral problems. Yeah. How you gonna help 'em? In all aspects ... he just happens to be homeless. How are you gonna help him get a home, medical things, get an ID?

CPZ: Yeah.

IKS 10: Get food, anything. So, that's like problem number one. [Emphasis] And if you say, "Well look here's my data, that's like only 10% of the people". First of all, it's not like 10% of the people. I think it's like 40%. And this, even if it were 10%

CPZ: Forty percent with poor social skills

IKS 10: Forty per cent that cause 90% of your problems. They're just unreliable - da, da, da.

CPZ: Uh huh.

IKS 10: That's like just repeated, repeated, [and] repeated.

According to IKS 2, intoxicated persons may be refused service, unless it is at the ED or with EMS. Individual key stakeholder 4 and IKS 6 commented on how intoxicated persons may not care for themselves and have poor hygiene. Individual key stakeholder 2 recalled a person who was covered with flies, had open wounds, and no place to stay who was refused service. Here is an excerpt from the interview with IKS 6:

IKS 6: I have a client that has been homeless in Kihei for 20 some odd years, in the same spot. He has severe MRSA [methicillin resistant staph aureus]. And he often ends up in the hospital septic, because he drinks. That's all he does is drink and smoke cigarettes. He lives off of beer and cigarettes. And, you know, he doesn't even take care ... he can't even reach the spots to take care of himself.

Here is an excerpt from IKS 4 that alludes to that behavior that is a lack of self-care, and obviously offensive to health care providers:

IKS 4: Oh yeah. I mean, if you were able to get the substance abuse under control, you would get a lot of things taken care of. Um... Someone who is clean and sober is much more likely to take care of his personal medical needs, than someone who is intoxicated and lies in their incontinence for days.

Primary care providers don't welcome homeless persons that will scare away their paying patients. Here is a quote from IKS 12:

But even some of the docs that I've known for years, they don't want the homeless people slopping down on their couch and scaring away these visitors [tourists] that are paying most of their bills.

CPZ: Uh huh.

IKS 12: So yeah. They're [homeless persons] not encouraged to do that.

CPZ: Yeah.

IKS 12: So you'd almost need something that was funded that you could say "Look, this is for you." [What he would say to a homeless person]

CPZ: This is for you. These are services directed at you. Wound care, dental, mental health, substance abuse.

IKS 12: "And even if you stink and you look wrong, we're going to take care of you." [What he might say, both laugh]

Individual key stakeholders' themes on homeless persons' lack of follow-up and lack of support systems can be found in Table 4.46. Their comments can be found in Appendix AQ.

Appendix AV

Ideas for Solutions per Individual Homeless Persons

Three IHPs thought that health care service needs of homeless persons would be better met if health care service providers were nonjudgmental. Individual homeless person 15 thought that medical needs of homeless persons could be better met with more comprehensive services that welcomed them. Here is an excerpt from the interview with her:

> IHP 15: They want 'em in and out. A lot of times they don't recognize ... That's why so many people that are homeless die on the streets, because their medical needs are not addressed.
>
> *CPZ: So what could health care providers do to make people feel more welcome.*
>
> IHP 15: Well I'll tell you what, in Santa Cruz California, they have a health care, it's called Health Care for the Homeless.
>
> *CPZ: Yeah.*
>
> IHP 15: And they have doctors from the community that come there three times a week. They address all their medical needs there. And if they don't have insurance, then they pay for it.
>
> *CPZ: Uh huh. They help you get insurance if you don't have it.*
>
> IHP 15: And they have a pharmacy right there. And Hawaii needs something just like the model of Santa Cruz, California – Health Care for the Homeless. They need something like that.
>
> *CPZ: So...*
>
> IHP 15: They need a place where the homeless can
>
> *CPZ: More comprehensive services for people that don't have homes.*
>
> IHP 15: Right. And they also have a mobile dental van.
>
> *CPZ: Dental.*

Individual homeless person 7 said he thought medical outreach would help to meet homeless persons' health care needs. Here is an excerpt from the interview with IHP 7:

> *CPZ: Uh huh. So do you have any other ideas about what would make for better health care services for people here on Maui that don't have a home?*

IHP 7: Yeah. That health van that drives around.

CPZ: Health van. Okay.

IHP 7: Straight off.

CPZ: Okay.

IHP 7: If you want a better solution, that's the one. You not gonna get any better than that. Go to those people, if you have someone who cares enough, for them. For us people.

CPZ: Right now the van goes out. Yeah, but not much health care with it. We don't have that set up yet. You think that...The thing that comes to my mind are things like wound care.

IHP 7: Wound care.

CPZ: For people living out in the bushes.

IHP 7: Wound care is the number one.

CPZ: Wound care.

IHP 7: Wound care is the number one [emphasis]. These guys take cuts. And they no shower.

CPZ: And there's a lot of flies.

IHP 7: Even if they do shower, still yet. You battling the elements, every day, all day long. It's not like you can lay down in one clean bed at night. They ain't laying down in a clean bed at night. Mostly laying on the floor. Which leads to infection - you have bugs, a lot of flies, dirty clothes.

Transportation assistance was named by six persons. Many suggested bus passes. Individual homeless person 27 said he needed someone to give him a ride. Individual homeless persons 10 and IHP 26 wanted to get their vehicles running. Individual homeless person 30 suggested more doctors and fewer homeless persons would help. Here is an excerpt from the interview with him:

C*PZ: All right. Well. Is there anything else you want to say about health care needs?*

IHP 30: They doing a good job.

CPZ: They're doing a good job. Okay. That's good.

IHP 30: You just need more of them, and less of us. [Laughs]

CPZ: That's a good insight need more of them and less of us?

IHP 30: Yeah. Less homeless people.

CPZ: Less homeless people.

Other suggestions from IHP 9, IHP 10, and IHP 12 included a public bath house so people can better attend to their hygiene needs, hot showers and 24 hour bathrooms. Individual homeless person 11 thought allowing homeless persons to sleep in the park would help them be more rested and prepared to work the following day. Individual homeless person 10 suggested free phones to help with communication.

Appendix AW

Ideas for Solutions from Individual Key Stakeholders and Group Stakeholders

All IKSs and GS had ideas for solutions to better meet homeless persons' needs for health care services. One idea expressed was that existing services should take homeless persons, or take more homeless persons. With regard to MIKOHC which is a federally qualified health center, IKS 7 and the DNP student had this conversation:

> IKS 7: And wouldn't it be nice basically a situation where you actually had a clinic that had people that were interested in seeing the underserved, and they actually had a social worker there, and they actually had a case manager there. And they had some people that knew some resources, and "you know dude if you really would like, here's several suggestions on places that you could receive help from, for all of the problems that are associated with your homelessness." [He imagined what a social worker might say.] I just don't know that, that exists … [Then, later in the interview, he continued as follows here.]
>
> IKS 7: Opening up community clinic. I just don't know what the barrier is. Is it a money thing? Is it a red tape thing? I just don't know
>
> what it is.
>
> *CPZ: I'm going to try to interview over there.*
>
> IKS 7: That would be really cool.
>
> *CPZ: All my efforts to interact and stuff, have been shut off.*
>
> IKS 7: Yeah. Shut off.
>
> *CPZ: I'm going to keep trying.*
>
> IKS 7: Is there something... is there some way that their funding comes down to them? Do they have some paper requirements that are very difficult for them? I mean is there a way that they could be more open and receiving of anybody that we manage to drag over there, or manage to drag themselves over there for medical care? I don't know.

Individual key stakeholder 9 commented that Community Mental Health Center is not taking new patients. Here is an excerpt from the interview with IKS 9:

> *CPZ: Yeah. So what would that look like for something that would help them [homeless persons] before they have to be hospitalized?*
>
> IKS 9: Well, the biggest thing is that at least from our people, all right, Community Mental Health, the county's Community Mental Health needs to be taking these people

in. They haven't taken a new patient in about two and a half years.

CPZ: Really?

IKS 9: Really.

More doctors willing to accept homeless persons as patients was mentioned by three IKSs. Individual key stakeholder 12 said that clinic services, especially tailored for homeless persons, should be offered. Here is an excerpt from the interview with him:

IKS 12: But even some of the docs that I've known for years, they don't want the homeless people slopping down on their couch and scaring away these visitors that are paying most of their bills.

CPZ: Uh huh.

IKS 12: So yeah. They're [homeless persons] not encouraged to do that.

CPZ: Yeah.

IKS 12: So you'd almost need something that was funded that you could say, "Look, this is for you." [What he would say to a homeless person]

CPZ: This is for you. These are services directed at you. Wound care, dental, mental health, substance abuse.

IKS 12: "And even if you stink and you look wrong, we're going to take care of you." [What he might say, both laugh]

Eight IKSs thought that walk-in clinic services, where a homeless person could wait, and be seen by a health care provider without an appointment, would help in meeting the needs of homeless persons. Walk-in wound care, mental health, and pain management services, where a person could be seen without having identification, and given free services would help providers stabilize persons, help avoid complications due to lack of primary care treatment, and avoid inappropriate use of the ED. Outpatient detox was suggested by IKS 8. Individual key stakeholder 1 suggested locating walk-in clinics in Central Maui, Kihei, Lahaina, and Upcountry to improve availability of health care services.

Six IKSs and GS suggested health outreach as a way to better meet needs. Per IKS 10, “Now, the solution is actually go out. Help them. They not gonna come to you.” Individual key stakeholder 7 suggested that outreach services be multi-disciplinary e.g., medical, nursing and social work. He suggested that outreach workers could follow-up on patients that were discharged from the hospital. Individual key stakeholder 10 suggested health outreach services

would be a way to meet needs of persons in congregate housing. He had this to say about meeting homeless persons' needs with frequent follow-up:

CPZ: What can we do to better meet their needs?

IKS 10: It's not, it's not their needs. It's what we can do to better meet them.

CPZ: That's what I mean, meet their needs.

IKS 10: Oh yeah. No, no, no. If I can meet them,

CPZ: Yeah

IKS 10: I can help them.

CPZ: Yeah.

IKS 10: On a consistent thing. You've got to see them frequently, in short doses.

Intensive case management for mental health patients was stressed by IKS 9 to help patients persist through treatment, avoid destabilization and avoid visits to the ED.

Four IKSs and GS included wound care as an outreach service.

Five IKSs mentioned the need for more substance abuse treatment programs. Three IKSs mentioned the need for empathic, nonjudgmental care from health care professionals. Services that would help the marginalized re-integrate include a call center where persons could make and receive calls and receive messages, a mail service, and assistance with paperwork and insurance application. Also helpful, per GS, would be simplification of the process of replacing lost or stolen identification and the issuance of a basic state identification. Two IKSs thought case workers at other agencies could start homeless persons with the registration process at MIKOHC. The DNP student checked on this. Per the Member Services Coordinator at MIKOHC, it is not possible to register persons for MIKOHC at other locations. It must be done at the MIKOHC facility (personal email communication, November 12, 2015).

Ten IKSs commented on ways to help homeless persons avoid inappropriate use of the ED. Ideas included redirecting patients to primary care services. Walk-in clinics for the homeless were noted as an important means of reducing inappropriate ED visits. Individual key stakeholder 4 had this to say about the similarity of service availability in walk-in clinics, to the availability of services in the ED, "If you have issues, you can come on in. Basically the same thing we do [referring to what they do at the ED]." Walk-in clinics that provided free services to those without money or insurance, services to persons without identification, wound care and mental health would decrease the burden on the ED. Health outreach was also identified as a way

to help avoid inappropriate ED use. Better hygiene, per IKS 4, IKS 10, and IKS 12 would help homeless persons avoid some of the wound complications that bring them to the ED. Per IKS 2, helping persons get health insurance would provide other service choices besides the ED. Housing first or congregate housing with support services would reduce the number of problems that people have, that bring them to the ED, per IKS 7 and IKS 10. Per IKS 3, a juvenile detention center, drunk tank and the repeal of the COBRA-EMTALA Law would reduce inappropriate ED visits.

Seven IKSs commented on ways to reduce acute care hospital lengths of stay. Here is an excerpt from the interview with IKS 4:

> *And what would reduce unnecessary hospital lengths of stay?*
>
> IKS 4: Well it all boils back to taking care of themselves to begin with and not waiting uh... 'til whatever it is they have going on gets to the point of where it's at. You know there's some people that come in here because they have a little superficial whatever, and there's other people that come in and you go "My God, why weren't you here two weeks ago?"
>
> *CPZ: Yeah*
>
> IKS 4: That knowledge of when it's appropriate for them to come in. I think that would reduce the lengths of stay.

Six IKSs commented that not having an appropriate place to discharge homeless persons to, was one of the main reasons for prolonged acute care hospital lengths of stay. Having an appropriate facility to discharge them to would reduce lengths of stay. Individual key stakeholder 7 had these ideas about medical respite:

> IKS 7: Where you literally had a dormitory type style, where you could take five or six guys, or whatever some six to 10 people post hospital stay. And go "Look. We're going to take care of your wounds here, give you some meals, and so forth." I like that. That would be reallycool…[Later, he continued]
>
> IKS 7: And your points well taken, because you don't need a ton of training. And people don't need a ton of training to take care of that situation. You can have people with basically oral antibiotics, perhaps other medication, and then basically, relatively simple dressing changes. That they could even teach me how to do. [Laughs]

Individual key stakeholder 8 had comments about the difficulty of finding a place to discharge

homeless patient to. She also had ideas about what would be required. Here is an excerpt from the interview with her:

> IKS 8: Correct. If their length of stay - okay so if we had a place where they didn't have to stay here, or they could go directly to SNF [skilled nursing facility], it would save. The problem is SNF, for Kula [Kula Hospital] and Hale Makua, they have a concern with disposition. I know Kula took a homeless patient once who was very responsible. I know they rarely take somebody who is, who does nothave a disposition, because they're afraid that once the wound, the skilled need is done, they'll end up staying there. And who is going to pay for that?
>
> *CPZ: Yeah.*
>
> IKS 8: And they don't meet criteria to stay. Right?
>
> *CPZ: Yeah.*
>
> IKS 8: So that's one of the obstacles. And also for length of stay, if we did have like some place they could go safely, and clean, so they could have follow-up. We could arrange outpatient. Right?
>
> *CPZ: Home health nursing.*
>
> IKS 8: Or Lanai North [name of hospital unit]. Because we do outpatient IV antibiotics on Lanai North or wound care. Then the patient could be over at wherever.
>
> *CPZ: Could get picked up.*
>
> IKS 8: Malama I Ke Ola or whatever that would be there and then they could go daily to their outpatient appointments.
>
> *CPZ: Uh huh. That of course would mean someone could give them a ride.*
>
> IKS 8: And then we do that too. We set up appointments. We set up transportation.

Individual key stakeholder 9 recognized that the problem of where to discharge a patient to is not necessarily solved by having a shelter, but requires permanent housing options.

> IKS 9: All right. And so whether it's not enough, you know the patient has a bad stigma, things like that...uh...especially when you're talking about chronic illness. It's not like okay, to get you out of the hospital, we'll send you to a shelter for you know, a few days, and then it's not our problem again. It becomes our problem again because the patient's brought back to the emergency department because there's nowhere else to go, and then many times that patient is unable to go back to that location [shelter].

CPZ: Uh huh. Yeah.

IKS 9: And so, we need to start to develop many more sort of long term uh...places...uh

CPZ: Yeah.

IKS 9: You know.

CPZ: Not just transient shelters.

IKS 9: We're talking like houses, where they've been taken over but the people running them are professionals who deal with, for example mental health patients.

Per IKS 8, nurse case managers can assist homeless persons who are from a geographic area other than Maui, to return to that area when they are discharged from the hospital. Nurse case managers can help if family members will care for the person, or if there is a shelter willing to take the person, and if there are funds available to cover the costs. She also thought that Salvation Army should resume offering shelter services to the homeless. Group stakeholders wished that Family Life Center (FLC) would make some beds available to patients that required intravenous antibiotic therapy, or who were using devices for their care such as wound vacuums that needed an electrical connection. Per IKS 6, medical care is not part of the stated mission of FLC. He said that FLC is only an overnight shelter.

Per IKS 1, getting more housing includes an ethical choice on the part of developers and landowners. They must choose what is right rather than what is most profitable. Individual key stakeholder 11 suggested a way to get more housing would be to get land donations from the county or wealthy landowners, and then get the help of volunteer contractors to build the housing.

Others IKSs spoke more about the need for housing rather than ways to acquire it. Individual key stakeholder 2 and IKS 5 suggested that having more housing that is affordable would help people get housing. Individual key stakeholder 2 pointed out the need for jobs that pay enough for people to be able to afford housing. Individual key stakeholder 6 pointed out the need for permanent housing not just shelters. He specifically spoke about the need for sober living housing for people who have completed substance abuse treatment programs. Individual key stakeholder 10 spoke about the need for congregate housing with support services. Individual key stakeholder 3 suggested a work program with housing in a farm setting to help people be productive.

Individual key stakeholder 6 recognized that sometimes the service providers are working harder than the clients at getting clients housed because the clients have given up. He suggested that part of getting people housed is uncovering and supporting their motivation. Where the housing is located may be a concern. Individual key stakeholder 5 said that the housing may be at a distance from where people work, so it may not be helpful to them. Individual key stakeholder 12 pointed out that finding a place to build housing may be a problem if residents and business persons do not want housing for homeless persons, or housing with support services, located in their neighborhoods.

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