Health Care Services in Alameda County: Homeless Individuals Describe Their Experiences

2023-2024

Alameda County Health

Public Health

Housing and Homelessness Services
Health Care for the Homeless

For more information please visit: ALAMEDA COUNTY HEALTH CARE FOR THE HOMELESS - Alameda County Health Care for the Homeless (achch.org)

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Acknowledgements

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Project Leadership:

Amy Garlin, AC Health, H&H, ACHCH
Andrea Zeppa, AC Health, H&H, ACHCH
David Modersbach, AC Health, H&H, ACHCH
Hanna Toda, AC Health, H&H, ACHCH
Liz Maker, AC Health, PHD, Community Assessment, Planning & Evaluation (CAPE)
Lucy Kasdin, AC Health, H&H, ACHCH
Luella Penserga, AC Health, H&H, ACHCH
Lynette Ward, AC Health, H&H, ACHCH
Phil Clark, AC Health, H&H, ACHCH

Project Supporters:

Abode Services
Bay Area Community Services (BACS)
Women's Daytime Drop-in Center
Building Futures with Women and Children
CityServe of the Tri-Valley
Cornerstone Fellowship
Damon Francis, Alameda Health System, Homeless Health Center
East Oakland Community Project
First United Methodist Church
First Presbyterian Church Castro Valley
Homeless Action Center
Insight Housing
Multicultural Institute
Operation Dignity
South County Wellness Center
St. Vincent de Paul of Alameda County

About Us

Alameda County Health Care for the Homeless (ACHCH) is a Federally Qualified Health Center (FQHC) and division of Housing and Homelessness Services (H&H) within Alameda County Health (AC Health). Since 1988, ACHCH has addressed the needs of Alameda County residents experiencing homelessness by directly providing health care services and managing a contracted network of providers to provide low-barrier, culturally responsive, and linguistically relevant homeless health care services. ACHCH services include primary care, specialty care, mobile health, shelter health, street health, substance use disorder services, drug overdose prevention, dental and optometry care, medical respite, communicable disease response, and environmental health.

The ACHCH mission is to improve the health of Alameda County residents experiencing homelessness by ensuring access to culturally informed, whole-person health care and housing services. One of our core strategies is to improve the health of people experiencing homelessness (PEH) and mitigate the detrimental health impacts of displacement from housing.

The Report

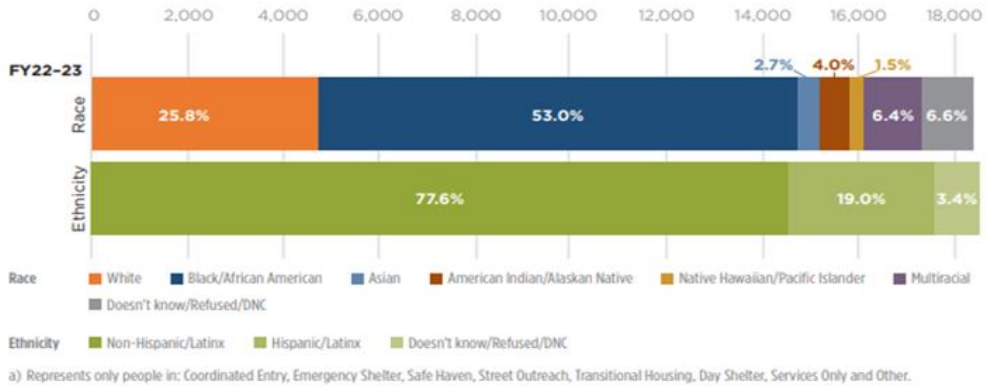
In the spring of 2023, two Alameda County Health programs- Health Care for the Homeless (ACHCH) and Public Health Community Assessment, Planning, and Evaluation (CAPE) leadership collaborated on a project to better understand health care access and services provided to People Experiencing Homelessness (PEH) in Alameda County. This report reflects the self-reported experiences of individuals with prior and current lived experience of homelessness across Alameda County.

Background: Homelessness in Alameda County

With an estimated population of just under 1.65 million, Alameda County contains the cities of Alameda, Albany, Berkeley, Dublin, Emeryville, Fremont, Hayward, Livermore, Newark, Oakland, Piedmont, Pleasanton, San Leandro, Union City and Unincorporated County (U.S. Census Bureau, 2022).

According to the 2024 Alameda County Point-in-Time-Count (PITC, 2024) 9,450 people are estimated to be experiencing visible homelessness on a single night, with 33% in shelter projects (3,107) and 67% (6,343) in unsheltered settings. Additionally, there are thousands of people in Alameda County who remain uncounted because they are doubled-up (i.e., couch-surfing, sharing spaces with others but not on the lease), as these do not meet HUD's (Housing and Urban Development) definition of homeless.

Homelessness in Alameda County reflects racial inequities that disproportionately impact people of color. For example, for participants in the Coordinated Entry System, Black/African American people, who comprise just over 10% of the general population, represent more than half, 53%, of the homeless population" (Alameda County, 2024).

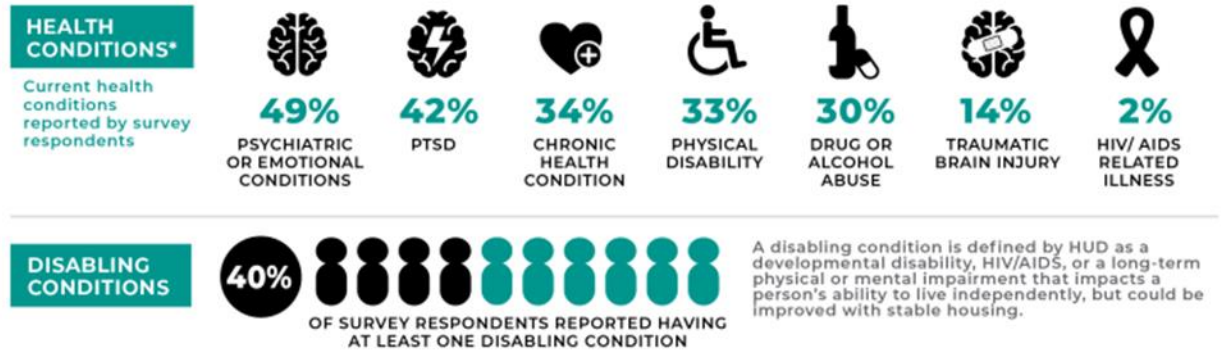


(Alameda County, 2023)

Homelessness & Health

Access to safe, affordable housing is a key social determinant of health. The impact of homelessness on people's health is profound; poor living conditions increase vulnerability to illness and disease and decrease access to care, often compounding complex health problems.

Self-reported health and disabling conditions from the 2022 Point-In-Time Count demonstrate the complex needs of an underserved population, who face multiple barriers accessing care, and often distrust a medical system that has caused and compounded traumatic harm (Alameda County, 2022).



Health, health care, and housing are interwoven. PEH have worse health outcomes than individuals who are stably housed. For all causes of death, mortality rates are many times higher for people experiencing homelessness than the general population (Alameda County, 2022). According to the 2022 Alameda County Homeless Mortality Report, the age-adjusted mortality rate for people experiencing homelessness in Alameda County was 5.4 times that of the general population of Alameda County.

People experiencing homelessness have unique health needs and benefit from innovative care delivery models such as street health programs and flexible, drop-in clinic hours-which minimize barriers and increase access. Most importantly, services provided through a health-

equity and trauma-informed lens are key components to foster trust and relationship building. Health care for people experiencing homelessness also requires improved data sharing and collaboration to facilitate continuity of care and increased access.

Health Equity

ACHCH envisions a just society, in which all persons have meaningful access to quality health care and housing. This belief of health equity is the foundation of our mission - to improve the health of persons in Alameda who are homeless or at-risk of homelessness by ensuring access to culturally informed whole-person health care and housing services. To achieve this, we must first and foremost acknowledge the health inequities that impact our communities. The key drivers of these inequities are often referred to as the social determinants of health, which are the conditions in which people are born, grow, work, pray and age - all of which are shaped by distribution of money, power and resources at global, national and local levels are influenced by policies and regulations (WHO, 2018).

The impact is pervasive and deeply embedded in our society. Out of those who are impacted, it is particularly communities of color who are at greatest risk of poor health outcomes. A growing body of research shows that centuries of medical racism in this country has had a profound and negative health impact on communities of color. On their Minority Health page, the Center for Disease Control (CDC) writes the following:

> The data show that throughout the United States, racial and ethnic minority groups experience higher rates of illness and death across a wide range of health conditions, including diabetes, hypertension, obesity, asthma, and heart disease, when compared to their White counterparts. Additionally, the life expectancy of non-Hispanic/Black Americans is four years lower than that of White Americans (para. 3).

According to a 2013 study completed by Alameda County Public Health, many low-income residents and communities of color in Alameda County face barriers to good health, such as poor air quality, dilapidated housing, limited access to healthy food and parks, underfunded schools, and few economic opportunities. These community conditions are linked to higher rates of asthma attacks, obesity, diabetes, heart disease, and mortality. For instance, an African American born in West Oakland can expect to die almost 15 years earlier than a white child born in the Oakland Hills area (Carlson, 2014).

Focus Group Design

Between May 2023 and March 2024, ACHCH Homeless Services Regional Coordinators facilitated focus groups and one-on-one interviews in collaboration with partnering community-based organizations. These meetings took place in multiple settings, including homeless encampments, emergency shelters and drop-in centers, with an objective to engage with a representative sample of people experiencing homelessness in Alameda County. They spoke with 157 participants at 16 different sites (Appendix A) to learn about their experiences of accessing and utilizing health care services.

Focus group participants were asked about their experience receiving health care in various settings: check-ups and routine care, emergency care, dental care, specialist care, mental health and substance use services. We wanted to learn: What health care services do patients use the most? What have patients' experiences been using the health care system? What challenges have patients experienced in accessing and utilizing health care? Where are there gaps or unmet needs? How can Health Care for the Homeless work with other health and service providers to improve health care for PEH?

For more details on the main themes of the focus groups and interviews and quotes, see Appendix E.

Data collection methods included an Alameda County researcher who took notes, made recordings, and reviewed findings. See Appendix B for more information about methods and limitations.

The questions asked in the focus group are as follows:

1. What types of health care services have you used in the past two years?
2. Where have you gotten these services? If not, what were the barriers?
3. Do you have a regular place where you receive health care from a doctor or a nurse?
4. What kinds of resources or support make it easier for you to get the health care that you need?
5. Have you had trouble getting any of the health care services that you needed?
6. Have you had any concerns about your safety when getting health care services?
7. Are there any other resources or services that you need, but have been unable to get?
8. Has a doctor, nurse or other health care provider given you referrals or linkages to other health care services or resources?
9. Have you met with a doctor, nurse, counselor or other provider by telephone or online in the past year?

Methods & Limitations

Methods

Under the direction of an evaluation consultant, four ACHCH Homeless Services Regional Coordinators worked with partner agencies serving PEH to conduct 13 focus groups and 4 sessions of key informant interviews (KII) at 16 different sites throughout Alameda County, reaching 157 participants.

Regional Coordinators worked with partners to select host sites serving a diverse range of PEH – sheltered and unsheltered. They also chose sites with a wide range of patients, by location, housing situation, race/ethnicity, gender, and age.

To guide development of focus group questions and methods, ACHCH convened discussions with the Alameda County Health Care for the Homeless Commission, ACHCH Community Advisory Board (CAB), and a core group consisting of ACHCH staff, Regional Coordinators, and

the Evaluation Consultant from CAPE. They identified top concerns and worked together to write and edit focus group questions (See Appendix D for the Focus Group Protocol which provides the main topics and specific focus group questions).

Although the original goal was to do focus groups, site staff felt strongly that some participants could not be reached via a group, due to factors such as street noise at encampments and differing schedules. At four of the sites, the core group decided to switch tactics to do KII with PEH. After reviewing the first group, they worked with the Evaluation Consultant to streamline multi-part questions to make the KII less cumbersome for participants.

Staff from host sites assisted with logistics and participant recruitment. They identified convenient times and places to convene and provided outreach to their clients. To increase chances of successful recruitment, the core group created colorful flyers. To facilitate recruitment and to thank participants for their time and valued input, ACHCH provided $50 supermarket gift cards to each participant and brought refreshments.

At each of the 16 sites, an average of 7-10 PEH participated, with the smallest group comprised of 6 people, the largest of 16. Regional Coordinators facilitated all the groups in pairs, with the exception of the Spanish-language KII at the Multicultural Institute, which were facilitated by fluent Spanish-speaking staff from ACHCH. At focus groups, participants filled out a brief demographic questionnaire which asked for their age, gender identity, race/ethnic identity and living situation during the past 30 days. Either Regional Coordinators or the Evaluation Consultant took extensive notes during groups and were able to tape records and transcribe 12 of out of the 16.

The evaluation consultant entered notes and transcriptions into a qualitative software analysis program (Dedoose) and conducted a thematic analysis. Code words and phrases for identifying and calling up common themes were created “a priori” based on the topic areas and “in vitro,” emerging from the text.

On review and analysis of focus group reported data, staff realized that we were not able to organize/stratify focus group data and patient input by race of individual respondents. We realized that in future focus groups, we must take steps to systematically develop our data collection by race to be able to effectively review the input of people most marginalized and impacted by homelessness and in homeless services.

The Evaluation Consultant presented preliminary results to the core group and garnered feedback on the accuracy and relevance of themes generated during the analysis. The core group crafted the response to the findings, including next steps for ACHCH. As the findings are written up and presented to different audiences, particularly participants and other PEH, they will be revised to better reflect the intended meaning.

Limitations

The focus groups and Key Informant Interviews (KII) provided rich information, but they were labor intensive. Even with 16 sites and 157 participants, we did not have a fully representative sample of PEH by race/ethnicity, immigration status, age, length of time homeless, whether people have children or parents living with them and other factors. When compared with

demographic data from larger samples of PEH, we reached fewer unsheltered people. To ensure their input would not be underrepresented, we provided some separate analysis for groups that had a majority unsheltered participants.

We were unable to recruit the desired number of unsheltered participants due to the logistics associated with encampment settings, including the ability to create a space that accounted for distractions, privacy, and noise, resulting in more focus groups but with fewer individuals participating in each. See Appendix C for charts describing who we spoke with in more detail.

We were able to note different views for women, Black, indigenous or people of color (BIPOC), seniors, people experiencing disabilities and unsheltered people. While we were able to stratify data by sex and housing status of focus group participants, a striking limitation of the focus group data was that we were not able to stratify patient data by race of people responding. As Black persons -- especially men -- are a disproportionate near-majority of people living in homelessness we must acknowledge this limitation and build in efforts in future focus groups to center the needs and words of people most marginalized and impacted by homelessness.

The staff and advisory groups who devised the questions wanted to know as much as they could but ended up with ten multi-part questions that were sometimes difficult for participants to understand. Written prompts, such as listing some potential things that could make accessing care easier, were especially helpful in explaining the meaning of the questions. According to the Spanish-speaking facilitators, some concepts did not translate well, and they suggested streamlining the questions for all PEH going forward.

Focus groups do not work for all people. Some people do not want to share personal information in groups, or with people they do not know well. KII were a better way to gather the opinions of some PEH, but they lack the advantage of the group setting, which helps participants understand and articulate their own opinions after they hear from their peers.

In the future, ACHCH will consider more participant-friendly ways to hear from PEH, including training PEH to conduct the focus groups and KII.

We raised expectations for host agencies and participants to take action steps to address the issues raised in focus groups and are committed to providing results in a user-friendly written form, through presentations, or other methods.

The 2024 PIT Count accounted for 9,450 people experiencing homelessness in Alameda County on a single night. Due to the challenges of timeline and staffing, this project's sample size is small when considering the scale of homelessness across Alameda County

Who Did We Reach?

One hundred fifty-seven (157) PEH at 16 sites throughout Alameda County participated. Brief, written demographic questionnaires, collected for 151/157 participants, demonstrate that we spoke to people who were similar in age and gender to the wider population of PEH. However, it is important to acknowledge the limitation that we spoke to a lower proportion of unsheltered PEH (41%) than were reported unsheltered in the 2024 PITC (67%[i]).

See Appendix C for charts describing who we spoke with in more detail.

Gender Identity: 60% of participants identified as Male, 38% as Female, and 2% as Transgender/2-spirit, and 2% unreported.

Figure 2: Participant Gender Identity
(n=151 Demographic Survey Responses)

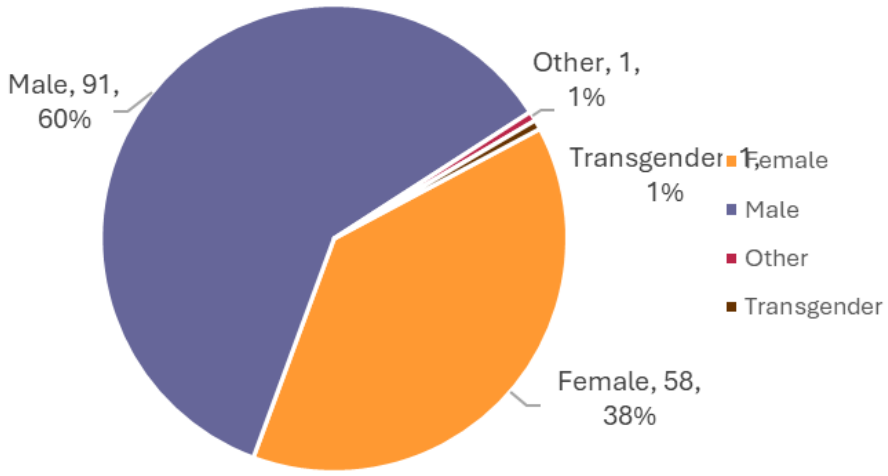
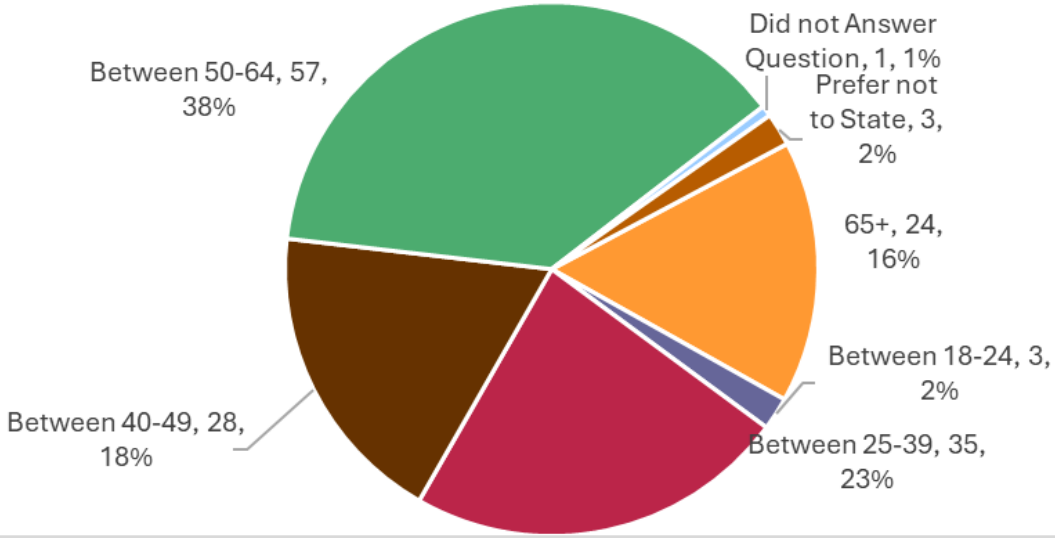


Figure 4: Participant Age
(n=151 Demographic Survey Responses)



Race/Ethnicity: 30% of participants identified as Black/African American, 24% White, 17% Hispanic/Latino,14% Multi-Race, 7% Asian, 2% Other, 2% Native Hawaiian/Pacific

Islander, 1% American Indian (1/151) and 3% preferred not to state.

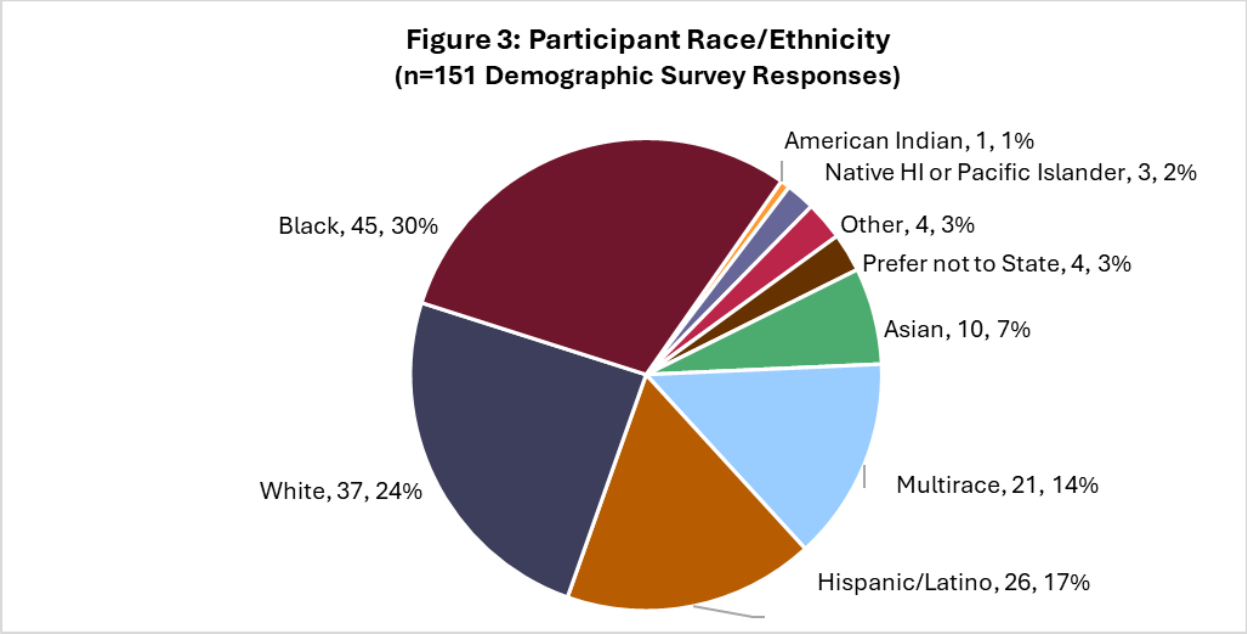
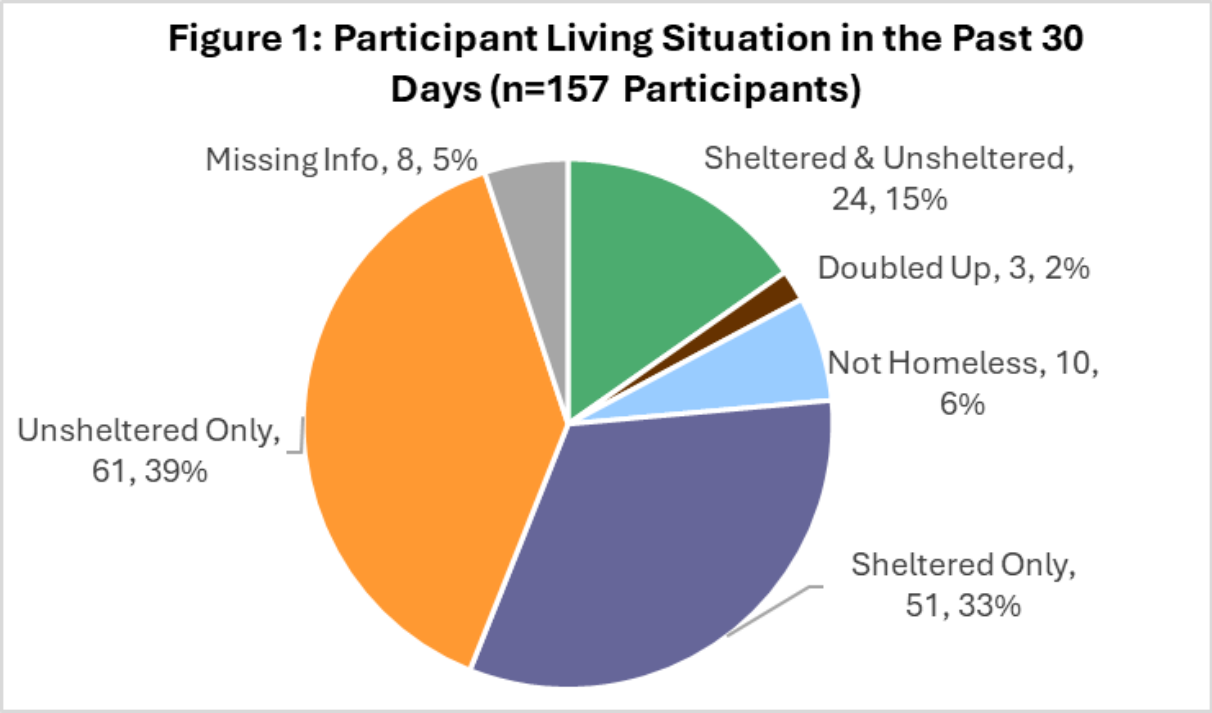


Figure 1 shows participant living situations in the prior 30 days in the following categories:

- 39% Unsheltered- living outside, in cars/RVs, tents and other areas not suited for habitation.
- 33% Sheltered – living in their homes/apartments, in a homeless shelter, in transitional housing or a drug/alcohol rehabilitation program.
- 2% Doubled Up – living in the homes of friends or family.
- 17% Combo – Living in a combination of unsheltered, sheltered and doubled up situations.
- 7% Not Homeless – Living in their own home or apartment



Findings: Access, Bias and System Navigation

During the focus groups and interviews, participants discussed at length the structural barriers they faced when trying to access care including primary care, specialty care, substance use services and behavioral health. A common theme among the responses were discrimination based on homeless status in health care settings, inferior services, and distrust in health care providers. When able to access care, they spoke about the poor quality of the care they received.

System Navigation and Access to Care

Participants cited denial of care access due to lack of health insurance, necessary paperwork, the technology needed to apply for medical insurance, and access, skill and understanding of computerized application and scheduling systems. Many of the respondents reported confusion about their health insurance status, and medical care options, particularly those who have Medi-Cal and Medicare.

"We get cut off from one signature being missed."

Participants experienced the consequences of what they perceived as a lack of communication and coordination among their providers in coordinating specialty care. As patients, they were asked to repeat the same information to multiple providers, and received conflicting referrals, including conflicting instructions/advice from consultants, care team members and other agencies or specialists they were referred to for care. Respondents reported "getting the runaround" and being sent to multiple providers and agencies for care.

Consistency of Care

About one-third to half of the participants in each group reported having a medical home. The most common types of health care facilities used were community health centers, hospitals and

"Seeing a new person when in pain is very scary. Not the opportune time. There is a human bias – people give better care to people they know and care about."

hospital-based emergency departments (most often at Wilma Chan Highland Hospital in Oakland) and mobile health care services. People who qualified for supplemental or more complete health coverage, such as pregnant women, veterans and seniors were most likely to have a medical home.

Those who reported having a medical home or having used medical care stated similar challenges as what is typically reported among the housed population. This included participants who knew their medical home and had established care – participants reported experiencing challenges seeing their doctor regularly as well as long wait times to secure an appointment with a primary care provider. Most people said that they were not able see the same provider, due to provider turnover and lack of availability.

Bias, Discrimination and Safety

Participants described experiencing racism and bias related to homeless status, which at times resulted in denial of access to care. Some noted the assumption by staff and providers that they were using and/or seeking drugs. In nearly all the groups, participants expressed suspicion about the motives of health care providers and viewed health care as a profit-seeking system that is unwilling to provide them necessary care.

"We have people traumatized by the medical system."

"Whenever they deem it's an owie or a trivial issue, they'll kick you out of the hospital and if you have any objections, their security is on you."

"I was assaulted getting into an elevator in a garage at [health center]. Safety concerns are constant for slow walkers"

Participants who identified as women spoke about the discrimination that they experienced due to their gender, especially when combined with race, particularly women who identified as black, indigenous or pacific islander (BIPOC). In one focus group, a black woman described her lack of trust in health care providers:

"My fear of doctors is part of the reason I have not had children. [There are] horror stories of how they treat black women."

Seniors and people experiencing disabilities reported greater issues with safety at health provider sites and more difficulty accessing technology.

Lack of Trust in Service Providers

"...Maybe the next doc will be racist or people practicing on us as lab rats."

Other reported systemic issues that diminished trust in service providers included:

- Inconsistent primary care provider /Provider turnover
- Need to establish care with multiple providers
- Miscommunication and conflicting instructions/advice about their care
- Repeating the same information to multiple providers
- Inconsistency in treatments

Quality Issues/Inferior Services

In most groups, participants shared stories about receiving inferior and even dangerous care in the past, citing medication errors, and being discharged before a serious health problem was adequately addressed. Several participants interpreted a question originally meant to ask about their sense of safety at health care locations as a question about whether they felt the health care that they received was safe.

> *"…I hear about like, people who have access to private health care who are wealthier. We are getting like maybe similar care, but we're not getting treated with the same type [of] sensitivity."*

Additional issues reported were the belief that health care provided to homeless individuals was inferior and harmful, lack of follow-up care, long wait times to see a provider, penalization for missed appointments, and a lack of understanding from providers and systems regarding the challenges faced by people experiencing homelessness.

Experiences with Telehealth

Participants were asked whether they had used or would be willing to try telehealth. The most common method by which they had used telehealth was by telephone calls, followed by video calls on smartphones, tablets or computers. Participants recognized that telehealth is becoming more prevalent and may even involve AI (artificial intelligence).

Participants described several advantages and disadvantages to telehealth, including bypassing the need for transportation, and usually shorter wait-times between time of scheduling and the appointment than in-person. To discuss some difficult subjects, some participants expressed that it may be more comfortable to use telehealth. Participants suggested that telehealth is most suitable for mental health appointments.

> *"I liked that I did not have to jump up and run around...Saves time and money, anxiety and stress."*
>
> *"I'm an eye contact person. Don't trust it, and I'm digitally challenged with all the technology."*

The most frequent challenges described by participants about telehealth were technical. Some people were confused or overwhelmed by computers and software. Others did not have access to a suitable device or a private location in which to conduct an audio or video call. Having an unreliable telephone or source of electricity posed another technological challenge. For some conditions, people preferred face-to-face contact, and did not feel that an audio or video call was sufficient to understand their health needs.

Participants identified preferences and recommendations for telehealth. Several people reported that they preferred telephones to computers or tablets, particularly if they needed to download software.

Barriers to Treatment

Participants shared perceptions that providers and systems did not understand their situations and the challenges they faced accessing health care and associated services.

Housing Instability: One notable barrier is medical respite. Medical respite care is acute and post-acute care for persons experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital. It is a short-term residential care that allows individuals experiencing homelessness the opportunity to rest in a safe environment while accessing medical care and other supportive services (National Health Care for the Homeless Council, n.d.). One participant reported that their provider was not able to perform orthopedic surgery on them because they lacked a consistent and safe home in which to recuperate. If the provider was aware of the respite resource, they would have been able to receive the needed surgery.

Lack of Transportation: Participants discussed the challenges of traveling long distances within Alameda County which presented a barrier in getting to medical and social service appointments challenging.

Technological Challenges: Participants also reported missing appointments due to common circumstances of PEH such a lacking a phone on which to receive reminders, resulting in communication gaps and long wait times to be rescheduled.

Missing Services

Participants identified specific health needs that remained unmet even after seeking care (Table D5). In order of frequency, the most common unmet health care needs were:

- Behavioral health/psychiatric care
- Dental health beyond basic, such as specialty care or restoration as opposed to extraction
- Affordable and easily accessible medications, especially for blood pressure, psychiatric conditions, and Attention Deficit/Hyperactivity Disorder (ADHD)
- Primary care, particularly preventive services
- Adjunct and alternative care, such as chiropractic, acupuncture, and herbal medicine.

* Psychiatric care and dental health were of particular concern for unsheltered groups.

Lacking Resources

All participants, particularly unsheltered, identified a wide range of practical resources that are needed in order to travel to access medical care or social services including housing service providers (Table D6). These resources include the following:

- Car repair
- Childcare
- Electricity to charge devices
- Clothing
- Phones
- Food
- Showers

Participants described services that made it easier to get health care (Table E7). Transportation to appointments or having health care come to them via a mobile van, helped all people, particularly unsheltered. Participants described greater motivation to come to health care appointments when they could get other needs met at the same time and location, such as food and access to computers, and when staff were friendly and helpful. Participants described the importance of having health insurance that covered a wide range of services. Another resource that was reported as helpful was a care coordinator or resource navigator, provided that the coordinator or navigator knew about local services and could maintain a consistent relationship.

For more details on reported barriers and experiences, see the following tables:

- System Navigation and Denial of access to health care (Table D1)
- Discrimination and lack of trust (Table D2)
- Quality issues/inferior services (Table D3)
- Lack of communication and coordination from providers (ED4)

Recommendations from People Experiencing Homelessness

To improve health care for people experiencing homelessness (PEH), participants recommended:

- Improve access to medical homes, for both new and existing patients so that PEH can develop trust with providers.
- Foster a welcoming, judgement-free environment with friendly and helpful staff
- Create targeted medical services for PEH
- Offer flexible hours at medical clinics
- Outreach to PEH where they live to provide and inform of available services
- Create a “one-stop-shop” for health and resource needs
- Provide care coordinators or resource navigators to work one-one one with patients
- Simplify paperwork for social services and health insurance
- Transportation to medical and social service appointments

For more details on participant recommendations, please see Table D8.

Next Steps for Improving Health Care Services for People Experiencing Homelessness

The findings reinforce the urgency in successfully achieving the goals in the ACHCH 2024-2027 Strategic Plan.

Key Recommendations:

- Continuous quality improvement in health care services and delivery must include ongoing, substantive input from PEH.
- Patient experience, future focus group data and patient input must be stratified by race, to be able to effectively review the input of people most marginalized and impacted by homelessness and in homeless services.
- Earning and deserving the trust of PEH should be a central aim and organizational goal of health care providers like ACHCH.
- We must work to identify and reduce systemic complexities that create barriers for people who seek immediate help with basic human needs, including health care.
- We must prioritize relationships, including longitudinal, one-on-one relationships with care coordinators and peer navigators, both to provide support and surmount barriers created by systemic complexities.
- Bring services to people in a way that invites engagement, shares information, and provides care in the community.
- To address stigma, exclusion and racism, require unconscious bias training for all new hires and adopt hiring practices that are fair and equitable.

Appendix A: Where We Spoke to PEH

Locations, Dates and Participation 12 Focus Groups and 4 Rounds of Key Informant Interviews (KII)			
Partner Agency	**Location**	**Date**	**Participants**
First Presbyterian Shelter	Castro Valley	May 1, 2023	12
East Oakland Community Project (EOCP)	Oakland	May 15, 2023	11
Women's Daytime Drop-in Center	Berkeley	May 19, 2023	7
CityServe	Pleasanton	May 24, 2023	6
Cornerstone Fellowship	Livermore	May 26, 2023	6
Insight Housing	Berkeley	May 30, 2023	7
Sunrise Village	Fremont	May 31, 2023	14
Bay Area Community Services (BACS) South County Wellness Center	Fremont	Jun 9, 2023	12
First United Methodist Church	Hayward	Jun 27, 2023	9
Building Futures for Women and Children– Davis Street	San Leandro	Jun 29, 2023	7
71st Street RV Parking Site	Oakland	Aug 29, 2023	10
St. Vincent de Paul	Oakland	Sept 7, 2023	10
Multicultural Institute (KII)	Oakland	Oct 2, 2023	10
East 12th Median (KII)	Oakland	Jan 23, 2024	18
Mosswood Park (KII)	Oakland	Feb 8, 2024	8
Peralta Park	Oakland	Mar 2, 2024	10
Total # of Participants			**157**

Majority unsheltered focus groups are shaded light **blue**

Appendix B: More Information About Participants

Definitions: In the 30 days prior to the focus group or interview, participant was:

- **Unsheltered**- living outside, in cars/RVs, tents and other areas not suited for habitation.
- **Sheltered** – living in their homes/apartments, in a homeless shelter, in transitional housing or a drug/alcohol rehabilitation program.
- **Doubled Up –** living in the homes of friends or family.
- **Combo –** Living in a combination of unsheltered, sheltered and doubled up situations.
- **Not Homeless –** Living in their own home or apartment
- **Missing –** Participant did not fill out a demographic survey or skipped the question about their living situation.

Figure 1: Living Situation by FG

	Unsheltered Only	Sheltered Only	Sheltered & Unsheltered	Doubled Up	Missing Info	Not Homeless
CityServe Pleasanton	50%		50%			
Cornerstone Fellowship	17%		50%			33%
Mosswood Park	75%				25%	
Women's Daytime Drop-In Center	29%	43%	14%			14%
BFWC-Davis St.	14%	43%	43%			
Insight Housing		86%			14%	
Saint Vincent de Paul		60%	10%		30%	
First United Methodist	45%	33%	22%			
Peralta Park	70%		20%		10%	
71st St .RV Parking	90%		10%			
Multicultural Institute				30%		70%
EOCP	18%	73%	9%			
BACS South County Wellness Center	67%		25%		8%	
First Presbyterian Shelter	8%	75%	17%			
Sunrise Village		86%	14%			
E. 12th Median	94%	6%				

Figure 1: Living Situation in the Past 30 Days by Focus Group or Interview Site (n=157 Participants)

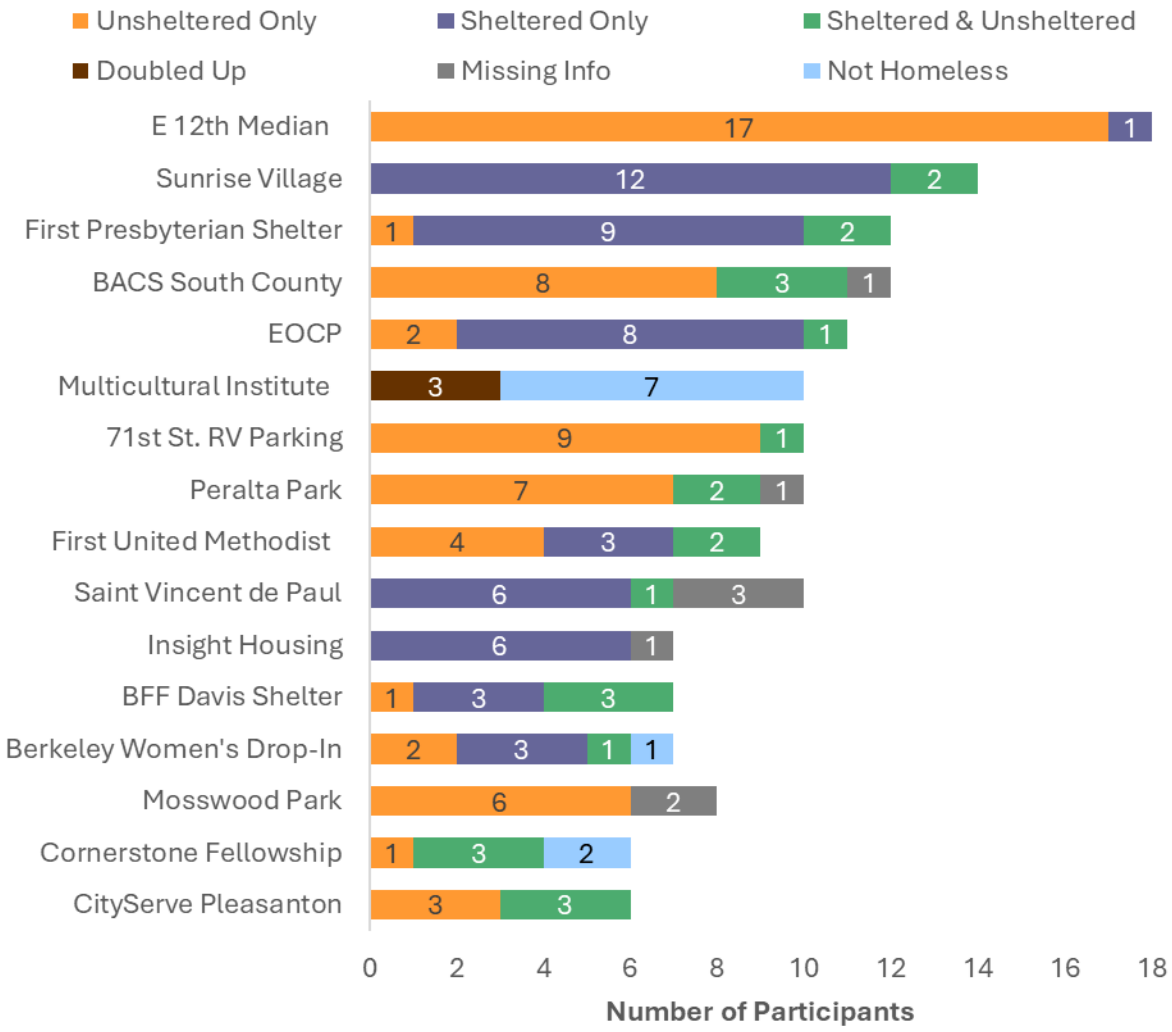


Figure 2: Participant Gender Identity
(n=151 Demographic Survey Responses)

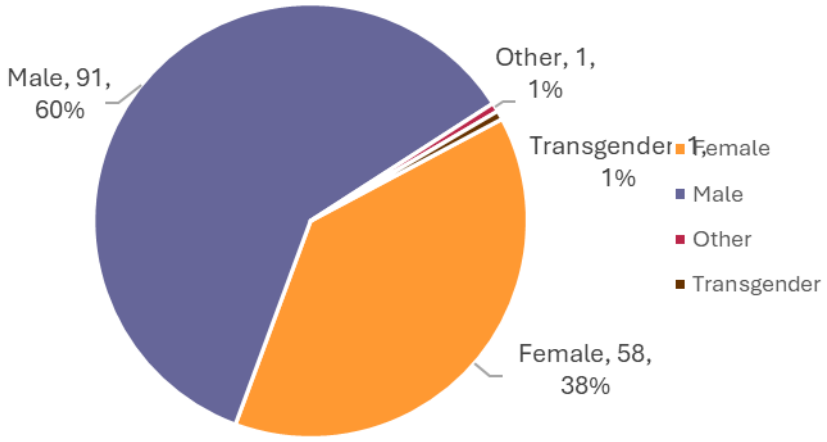


Figure 3: Participant Race/Ethnicity
(n=151 Demographic Survey Responses)

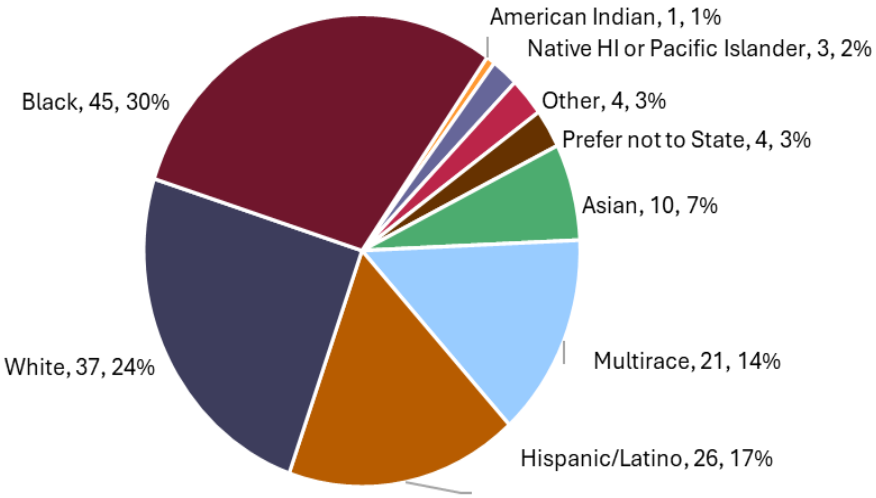
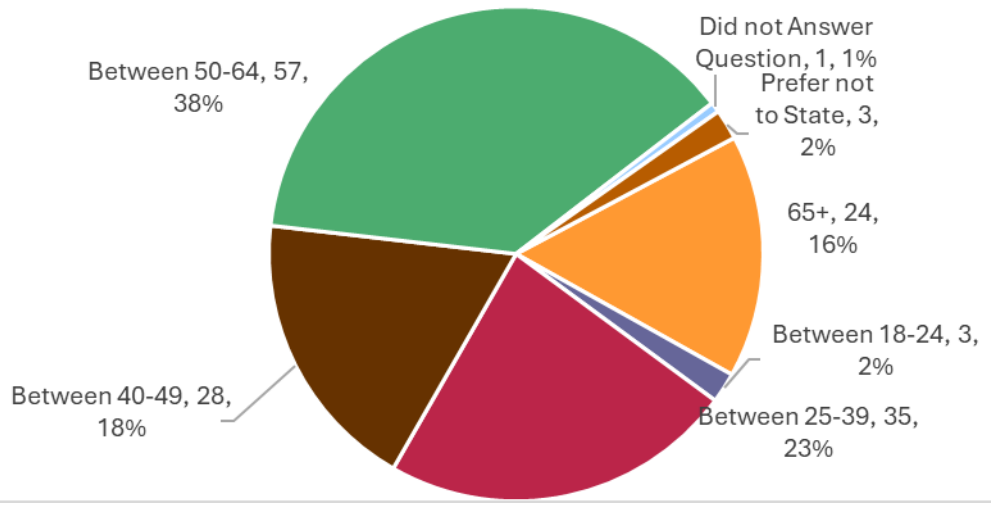


Figure 4: Participant Age
(n=151 Demographic Survey Responses)



Appendix C: ACHCH Client Focus Group on Health Care Protocol

I. Background, Introductions and Settling in (15 mins)

1. Thanking Participants
2. Purpose of the Focus Group
   - We invited you here today to share your experiences getting health care in Alameda County.
3. Who we are (HCHP & CAPE, relationship to host site)
   - We work for the Alameda County health Care Services Agency. Lynette and Andrea are Regional Coordinators for the Health Care for the Homeless Program. Liz works on data and research projects and is helping to guide the focus group process.
   - The HCHP program is speaking with about 10 different groups of people who have experienced homelessness to learn more about how we can increase health care access and improve services.
4. Housekeeping
   - This focus group will be about one hour long.
   - Location of bathrooms
   - At the end of the focus group, please see Hanna to sign for your gift card.
5. Informed Consent
   - This focus group is confidential. Your name, or information that identifies you will not be written down or shared with anyone outside of this group.
   - This group is voluntary – you do not have to participate.
   - You can stop participating at any time or skip questions.
   - Is it OK if we use this tape recorder to help us remember your answers? We will erase the recording once we are finished with all of the focus groups.
6. Ground Rules
   - Before we get into our discussion, I have a few reminders and requests.
     - There are no right or wrong answers
     - All responses are valued.
     - It is okay to have different opinions. We do not all have to agree.
     - Speak one at a time.
     - Do not repeat what you hear to others outside of the group. What is said in here should stay in here.
     - Does anyone have anything to add?

Topic	II.A. General Questions for Patients (45 Minutes)
1. Types of services that they use	• We are interested in hearing about your experiences of getting and using health services such as doctors, nurses, mental health and SUD treatment services? *(Can edit list of services for each group)* • What types of health care services have you used in the past two years?
2. Where they get services	• Where have you gotten these services? *(Prompt: Street health, mobile clinic, "brick and mortar)* If not, where are the barriers?

Topic	II.A. General Questions for Patients (45 Minutes)
3. Medical home/ Continuity of care	• Do you have a regular place where you receive health care from a doctor or a nurse? **By regular, we mean a place where you return more than once for the same services,** such as routine checkups or care for a specific condition? • **If yes**, where do you get your regular health care? *(Prompt: Street health, mobile clinic, "brick and mortar" building?)* • Are you able to visit your nurses or doctors as often as you would like? • Are you able to see the same nurses and doctors each time you visit? • How do you think this has affected your health care? *(Prompt: Having to tell your story to new people each time; having to make new relationships; getting past "triage" to the services you need).*
4. Facilitators/what makes it easier?	• What kinds of resources or support make it easier for you to get the health care that you need? For example, varied clinic hours, friendly staff, Health Care Navigators.
5. Challenges and barriers	• Have you had trouble getting any of the health care services that you needed? Which services? • What kinds of challenges or barriers did you face? • How did you get around those barriers?
6. Safety	• Have you had any concerns about your safety when getting health care services? Please describe.
7. Capacity, gaps and needs	• Are there any other resources or services that you need, but have been unable to get? Which ones?

Topic	II.B. More Specific Questions for Patients (20 Minutes)
8. Referrals and linkages	• Has a doctor, nurse or other health care provider given you referrals or linkages to other health care services or resources? Which ones? • Were you able to access those services or resources? Why or why not?
9. Experiences with telehealth	• Have you met with a doctor, nurse, counselor or other provider by telephone or online in the past year? (This is sometimes called "telehealth")?
If yes to telehealth	• How did you connect? (Prompt: dial-in phone call, Smartphone, tablet (iPad) with Wi-Fi, computer with Wi-Fi) • What did you like about using telehealth? • Were there any downsides or barriers you had?
If no to telehealth	• Would you be interested in meeting with a doctor or nurse by telephone or online? (this is sometimes called "telehealth") • Why or why not?

Topic	II.C. Other Comments
10. Other	• Is there anything else that you want to tell us about your health care?

II. Wrap-Up (5 Minutes + extra to pick up gift cards)

1. Thank you
2. Instructions for Getting Gift Cards
3. Report will be finished in Fall of 2023

Appendix D: Findings by Focus Group Theme

- Note: Within each table, themes are listed in order of frequency they were discussed during focus groups and key informant interviews.
- Themes of particular concern for unsheltered populations are starred (discussed at 3 or more of the 5 majority unsheltered focus groups or key informant interview sites).

Table D1: Barriers to Care – System Navigation and Denial of Access to Health Care

Theme	Sample Quotes
*PEH are denied care due to lack of health insurance	• "I was denied GA, Medi-Cal and no referrals from SSA. I was overwhelmed by the GRID (list of services in Hayward)." (First united Methodist) • "I went to Kaiser, and the second they found out that I don't have the coverage, they didn't come out to take the IV out of my arm." (E 12th Median)
* PEH are denied health care due to lack of access to required technology or skills to use it	• "Cuss them out, cry sometimes, give up. Sometimes I'll turn it around and ask them for a .pdf, so it already has the info, all I have to do is DocuSign and send it back. I don't even know what a .pdf is." (Cornerstone Fellowship) • "I went and applied for GA I did everything that they required me to do. And then it came down to Scantron thing, for unemployment, but you had to, to call a particular number and then it tells you the website." (Oakland RV Parking)
PEH are denied care due to lack of paperwork	• "We get cut off from one signature being missed." (Building futures – Davis St)

Table D2: Barriers to Care - Perceived Discrimination (Bias) and Lack of Trust	
Theme	**Sample Quotes**
PEH do not trust the health care system or providers	• "People want to perpetuate the problem to perpetuate their employment. As long as there's a homeless problem, good job, I can be working on it. That's why we get the runaround. Entities compete over money. Don't let it get to folks." (Women's Daytime Drop-in Center) • "Doctors and pharmacies are in a conspiracy." (Berkeley Drop-in Center)
* PEH are labelled and accused of drug use or crime	• "So many stereotypes – no drugs or criminal record… Unhealthy for mind and body." (First Presbyterian) • "Providers ask what are you here for drugs? I don't need pain medication – I tell them right away. I've been on it for more than 20 years. Always trying not to take it". (Women's Daytime Drop-in Center)
PEH experience racism from health care providers and systems	• "Not having a steady doctor that I go to and see every other month or so. Figure out what to do. Maybe the next doc will be racist or people practicing on us as lab rats. (Seems to have general agreement based on head nods." (First Presbyterian) • Note that racism plays a role in many other themes, such as poor-quality health care, communication problems and trust with providers.

Table D3: Barriers to Care-PEH Reported that They Receive Inferior Services	
Theme	**Sample Quotes**
* Health care given to PEH is inferior and even harmful	• "I think they're gonna kill us every time. They give me the wrong medications sometimes. (E 12th St. Median) • "Whenever they deem it's an "Owie" or a trivial issue, they'll kick you out of the hospital and if you have any objections, their security is on you" (Mosswood Park) • "We have people traumatized by the medical system." (Women's Daytime Drop-in Center) • "Like where I hear about like, people who have access to private health care who are wealthier. We are getting like maybe similar care, but we're not getting treated with the same-type sensitivity
Providers and systems do not follow up with patients	• "I got a referral for orthopedic surgeon. They never called me back. They never even ordered me. But now I still have to wait another two weeks before I can call them. And then I never got a call back, so I said screw it. My hand still hurts." (South County
Patients Have Long Wait Times to See a Provider; Penalized for Missed Appointments	• "I get better help from AHS or la Clinica. Hard to get on because of long wait times (South County wellness) • "Hard to make it to appointments. If you miss out more than 2 or 3 times, maybe they just kind of write you off." (Cornerstone
* Providers and systems do not understand challenges faced by PEH	• "I also think that a lot of health care professionals in general are not necessarily sensitive to their patients' individual situations or mental states or just the categories they fit in." (South County Wellness) • I need surgery on my shoulder, but they won't give me because I am homeless. I can lie to them. Said if not staying in a house, can't get the surgery that I want. Place to shower, clean the

Table D4: Barriers to Care- Lack of Communication and Coordination from Providers	
Theme	**Sample Quotes**
Providers and organizations do not provide adequate information to PEH	• "Communication can be a barrier. Can cause misconceptions or false directions." (First Presbyterian) • "Give you food stamps and don't tell you have them. How are you supposed to spend them?" (Building Futures with Women and Children – Davis Street)
* "Getting the Runaround" Patients Were Sent to Multiple Providers and Agencies for care	• "Getting referrals is hard- trying to get primary care, and I'm going in circles even trying to find the office and even think about taking an application. I thought I signed up for Medi-Cal and it's been circles. I've had Med-Cal for 2 years and I don't have a PCP." (E. 12th Median)
* Patients need to give the same information to multiple providers	• "Sometimes when you call to make an appointment, they ask for all of your information. Every time that I call, I have to give them all the info. I just tell 'em I already gave it to you. Look it up." (Cornerstone Fellowship)
Providers do not communicate with each other about the patient	• "Give you referrals, (the providers) Don't get together about it. Ain't nobody know nothing." (East Oakland Community Project) • "You get one doc saying don't worry about it, it's nothing, and the other tells you it is serious. Conflicting messages." (South County Wellness)

Table D5: Top Unmet Health Care Needs Mentioned	
Theme	**Additional Information**
* Behavioral health/psychiatric care	• Hard to find therapists for patients and children. • Limited # of visits.
* Dental care beyond basic	• Needs specialty dental care. Can have teeth extracted, but not saved.
Pharmacy/medications	• Most common medications mentioned: Blood pressure, cardiac, psychiatric, ADHD. • High costs, not covered by medical insurance. • No way to get to pharmacy.
Primary care/medical home	• Described more in Medical Home Section. "Revolving Door" of providers. Lack of preventive Care.
Adjunct & alternative care	• Chiropractic, acupuncture, herbal medicine, homeopathy. • Sometimes trusted more than "Western Medicine." • Patients used it for "self-treatment" to bypass medical system
Other unmet health care needs	• Asthma or COPD, high blood pressure, cardiac, care coordination/navigation (if knowledgeable), dermatology, diabetes management, diagnostics - XRAY, MRI, blood work, drug treatment programs, ENT/hearing, injury, mobile van/street outreach, orthopedic care, other specialty, pain, physical therapy, surgery, urgent care

Table D6: Top Unmet Needs for Resources	
Theme	**Additional Information**
Housing	• Described evictions, difficulty with eligibility requirements. Described wanting "stable housing," and a "place of my own." • "Social worker was supposed to help with housing, and they never got back to me. I have always addressed with them that I was unhoused. It is affecting my mental, physical health and Blood Pressure." (Women's Drop-in Center)
Transportation	• "One big barrier is transportation to appointments much anxiety around how to get to places you need, distances."
* Other practical supports, often need more than one at the same time	• Car repair, childcare, clothing, computer or technical assistance, education. electricity to charge device, food, legal representation (especially for citizenship), phones, shower and personal hygiene, help or replacement for stolen or lost items

Table D7: What Makes it Easier to Get Health Care?	
Theme	**Additional Information and Quotes**
*Resources and Supports Provided Along with Health care	• Housing, transportation, food (See unmet resource needs)
Having adequate health insurance	• Able to access their health plan and get coverage for needed services.
Effective care coordination and systems navigation	• Care is consistent and builds relationships over time • Effective resource navigators are available
Friendly and helpful staff	• "Being pleasant when folks come in" (Operation Dignity)
Having a medical home with a regular primary care provider	• Consistent place for health care • Able to see same provider • "It makes it easier to ask for help when you have rapport with the doctor/RN." (Mosswood Park)
* Mobile van and street outreach where PEH are	• "They (mobile van) knew they were dealing with homeless and poor people. Had an interest in helping. Makes a difference." (South County Wellness Center)

Table D8: Recommendations from Participants	
Theme	**Additional Information and Quotes**
* Provide services via a mobile van	• Alameda Health Care Bus –would like regular visits @ encampment (E 12th Median) •
Design health services around the needs of PEH	• "A general practitioner who can only take care of the homeless community. Whenever we need something, they go straight there. Can make the referrals. It's a link. Easy to go and be heard. Use same specialists. Almost like a family doctor." (South County Wellness Center) • "Need a 'one-stop-shop.'" (First Presbyterian) • "Flea market for doctors" (Sunrise Village) • "Have wealth of knowledge, wealth of experience in this group and all those groups. Let them tell their story and try to figure out where we can do a little bit more, where we can change it." (Oakland RV Parking)
Make changes that increase access for PEH	• Increase health insurance coverage for PEH • Reduce waiting times to get primary and specialty care • Provide health care during more flexible times • Provide transportation to health care appointments • Provide some services by telephone
Communicate with PEH in ways that they understand and trust	• Employ staff who speak the language, and who share culture and lived experience with PEH. • Hire more staff who are women and people of color • "The problem is, if somebody misses an appointment or gives generic responses, that counselors should reach out to somebody who is an advocate…. And somebody more in their level of communication rather than a doctor or therapist or somebody, you would feel threatening them". (Oakland RV Parking)
Provide effective care coordination/navigation	• "Like an advocate. I am old school; I would rather speak to them than go on a website. Creates more jobs having advocates." (Sunrise Village) • Provide assistance with technology to fill out forms and access medical care.
Provide targeted outreach to PEH	• Outreach to PEH where they are: • For People Experiencing Homelessness in tents. Put plastic flyers on poles where they can see it. (Sunrise Village) • Need outreach specific to homeless community. Health care is confusing for people in general, even more so for the homeless. It seems unattainable (copays, paperwork if you don't have someone guiding you). (South County Wellness Center)

Table D8: Recommendations from Participants	
Simplify processes and paperwork	• "The communicating this point that it's gotten so overwhelming for the people that are trying to take care of us. Our frustration is getting so intense. It's, you know, we're, there's gotta be simplicity." (Women's Daytime Drop-In Center) • "I mean, how do you guys don't just use like, just one database where your, that's where your file is stored. So whenever you go to this doctor over here who, who might not even be in the same network." (South County Wellness Center)

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