

Winter 4-30-2014

# Barriers to care

Krista Nyssen

King's University College, knyssen@uwo.ca

Follow this and additional works at: [https://ir.lib.uwo.ca/psychK\\_uht](https://ir.lib.uwo.ca/psychK_uht)



Part of the [Psychology Commons](#)

---

## Recommended Citation

Nyssen, Krista, "Barriers to care" (2014). *Undergraduate Honors Theses*. 2.  
[https://ir.lib.uwo.ca/psychK\\_uht/2](https://ir.lib.uwo.ca/psychK_uht/2)

This Dissertation/Thesis is brought to you for free and open access by the Psychology at Scholarship@Western. It has been accepted for inclusion in Undergraduate Honors Theses by an authorized administrator of Scholarship@Western. For more information, please contact [tadam@uwo.ca](mailto:tadam@uwo.ca), [wlsadmin@uwo.ca](mailto:wlsadmin@uwo.ca).

Barriers to Care

Krista Nyssen

Honors Thesis  
Department of Psychology  
King's University College  
At Western University  
London, Canada

April 9, 2013

Thesis Advisor: Cathy Chovaz, Ph.D

### Abstract

There is a large demand for health care within the homeless population. Priorities for the homeless population are firstly more basic needs such as shelter, food, and safety followed by health needs and lastly followed by mental health needs. This raises the question how easy is it for this population to access the care should they seek it? Barriers to care can be divided into three categories: physical, emotional, and financial. There is a paucity of studies regarding the homeless and low-income populations even though they are at the highest risk of health problems due to their living conditions. The current study examined what barriers people visiting the London Centre of Hope Family Health Team face when trying to access care, their demographics, how often they used the emergency department versus the family health team, and what resources they think will help them access care easier. Participants were clients of the London Centre of Hope Family Health Team. Forty participants partook in the study; 18 males and 22 females. A feedback form that was originally used by the family health team was revised for this study and was given to clients upon visiting the clinic. The results showed that there are some barriers to care that the clientele feel strongly affect them and that physical and emotional barriers were the most common barriers selected. The results also reveal that the family health team was used almost ten times more than the emergency room in the past year and that expenses for bussing and shorter wait times are the most commonly expressed resources clients think would help them access care easier. Further research into barriers to care for the homeless population is needed.

### Barriers to Care

Statistics Canada (2011) reported that 12.9% of all persons living in Canada were living with a low-income. However, Statistics Canada (2013) also reports that it does not survey the homeless population. Levy & O'Connell (2004) suggest that around 3.5 million people each year experience homelessness in the United States. Canada's statistic mirrors that of the United States at approximately three million people; or one in nine (Proudfoot, 2010). So based on this statistic, it means there are around three million people in the country who are not surveyed by Statistics Canada. Thus, the statistic 12.9% of all persons living in Canada are living with a low-income is actually much higher than reported. There is also the concept of the "hidden homeless" that are left out of view and are ignored by society (Garland, Richards, & Cooney, 2010). If we include the "hidden homeless" in our data, Levy & O'Connell (2004) suggest that the number of people experiencing homelessness would probably be much higher.

Link (1994) reports that 26 million people have experienced at least one episode of homelessness in their lifetime in the United States. Clearly, determining how many people are homeless is very hard and many sources will obtain different results. However, it doesn't seem to matter what researcher looks at the number of homeless, the number is always significantly high. This shows just how problematic homelessness is and how many people are suffering every day because of it.

Priorities for the homeless and low-income population become shelter, food and safety. Other needs, such as their health, come secondary. These populations are less concerned with what is going on with their health and worry more about their current situation, such as what their next meal is going to be or where they are going to stay the night. There is also a high rate

of mental illness among this population due to their living circumstances and/or traumatic past events that lead them to homelessness (Vazquez & Munoz, 2001). Approximately 80% of homeless individuals are struggling with a mental illness alongside their everyday struggles. However, their mental health comes even lower in terms of priorities (Vazquez & Munoz, 2001).

This idea can be related to Maslow's (1970) hierarchy of needs. The homeless population need to take care of unsatisfied needs and some of the lower needs have to be satisfied before they can move on to satisfying higher needs. Lower needs would include the basics such as food and shelter. They have to satisfy these lower basic needs before they can focus on satisfying higher needs such as their physical and mental health.

Even with health being a low priority to the homeless and low-income population, there are still some who seek health care. Due to this population's daily struggles, this raises the question of if they can access health care easily. Statistics Canada (2011) reported that around 2,800,000 people had difficulties accessing care, but as previously stated, this statistic would be much higher if the homeless population were surveyed.

The amount of individuals having difficulties accessing care is evident, however, there is no real supports in place to resolve this ongoing issue. To combat the difficulty people are having accessing routine care, the government created inner-city health teams and clinics to give this population a better overall lifestyle while also focusing on their health needs. Inner city health teams were designed to assist homeless and low-income individuals access routine health care easier, as all services provided are located in one area and each service aims to target a unique need experienced by homeless people in the community (Wansbrough, 2002). The teams are comprised of multiple health professionals such as nurses, social workers, psychiatrists, and

doctors. They also incorporate multiple health programs into their clinics. In order to give this population a better life overall, all the complex aspects of their lives need to be examined. Some of the professionals in an inner city health team can assist the individual obtain an income, shelter, and food while the other professionals can help them gain a better overall health and focus on their mental health problems.

Even though inner city health teams were created to assist the homeless and low-income individuals in accessing care, there are still a lot of barriers that prevent these people from accessing the care. One reason for this is that this population faces more barriers and more severe barriers than those living in the middle to high class population due to their living conditions (Martin, 2003).

Parker & Albrecht (2012) explored this topic further using a case-control study but the pilot to their study is most relevant to this study. The pilot for their study was exploratory research that examined the demographics of homeless people residing in shelters, their service needs and the barriers they have to overcome to obtain service. After receiving the results, Parker & Albrecht (2012) classified the barriers people reported they faced into three categories: physical, financial, and emotional. Some examples of physical barriers that they found people are facing are mobility issues, pain, not being able to go to the clinic during their business hours, no transportation, and long wait times. Financial barriers include not being able to afford bus tickets, not being able to take time off of work, unstable housing, and not having any identification. Emotional barriers comprise of no motivation, forgetting about appointments, feelings as though no one cares, or putting other things ahead of their health. The current study will also be classifying the barriers into these three categories.

Hwang and colleagues (2010) also examined this issue. They administered a survey to 1,169 homeless individuals in Toronto, Ontario to assess the demographics of the homeless population, the unmet needs they feel they have, and the barriers accessing health care that they face. Similar to the study previously described above, results found that unmet needs were significantly more common amongst homeless individuals and that they encountered multiple barriers to care such as competing priorities, lack of transportation, and feeling stigmatized.

As it is shown, the variety of barriers and the complexity of them create a major problem for this population as they are not receiving the care that they need. Rabiner & Weiner (2012) suggest that trips to the emergency department are more easily accessed by this population than routine care. This is problematic because emergency department staff do not have a comprehensive understanding of the individual's previous health concerns or background as a routine family doctor would. Rabiner and Weiner (2012) explain that this can lead to the duplication of tests and can lead to conflicting treatment plans. If the barriers to care were resolved, lessened, or made easier so these individuals could receive routine care, individuals would receive care plans that do not conflict with each other and thus, the individual's problems would be treated at a higher degree.

In terms of psychology, some of the inner city health teams have psychologists and some do not (S. Abdolzahraei, personal communication, November 18, 2013). This is problematic given the high rate of mental illness among this population (Vazquez & Munoz, 2001). The teams usually have one psychiatrist that is funded by OHIP but one individual is not nearly enough to serve the amount of people that require mental health services. Psychologists could strongly be used in all family health teams to assist those individuals with mental health issues.

There is a high rate of addiction and selling drugs on the street amongst this population so being prescribed a drug for their mental illness by a psychiatrist is not the best option for some people (Parker & Albrecht, 2012). Psychology could play an important role in lessening the emotional barriers to accessing care, such as examining why the person has no motivation to access care. Using specialized expertise, psychologists could look at these barriers to facilitate solutions that will work with the client's abilities in order to get them care. If there was a psychologist covered by insurance plans (such as Ontario's Health Insurance Plan) in every inner city health team, this population would have the opportunity of receiving the help they need for their mental illnesses and give them a better quality of life.

In London, the London Centre of Hope Family Health team is located in the Salvation Army Building downtown. The London Centre of Hope Family Health Team reports that 20% of Ontarians receive primary care through one of the 200 family health teams in the province (London Centre of Hope Family Health Team, 2013). The London Centre of Hope Family Health Team serves the downtown London Area with a focus on homeless people, people at risk of homelessness, and people with other barriers to care (London Centre of Hope Family Health Team, 2013). The current study will be conducting research at the London Centre of Hope Family Health Team Clinic.

There is a paucity of studies regarding the homeless and low-income populations even though they are at the highest risk of health problems because of their living conditions (Rabiner & Weiner, 2012). More research needs to be done on the barriers that this population faces when trying to access care. The current study will examine what barriers (physical, financial, and emotional) people visiting the London Centre of Hope Family Health Team face when trying to



access care. The current study will also be exploring the demographics of the population visiting the London Centre of Hope Family Health team, and what resources these people think will help them access care easier. Questions have been added to the London Centre of Hope Family Health Team's feedback form for research purposes. The feedback forms will be administered at the London Centre of Hope Family Health Team clinic to clients.

### **Method**

#### **Participants**

Clients attending the London Centre of Hope Family Health Team clinic were invited to participate in this study. The London Centre of Hope Family Health Team is a group of professionals that collaborate to provide treatment and assistance to a variety of complex needs experienced by the homeless population. Participants' socioeconomic status typically fell on or below the poverty line. Participants partook in the study on a voluntary basis and if they agreed to participate, were given a consent form and a feedback form to complete. A debriefing form was available for the participant to read following completion of the feedback form. The duration of completion of the feedback form was approximately fifteen minutes.

The study consisted of forty participants (N=40). There were eighteen males and twenty-two females. The mean of the age ranges selected by the participants was 40-59 years for both males and females. The range of age ranges selected for males was under 18 years up to 76+ years and the range of age ranges for females was the 18-25 years category up to the 60-75 years category.

## **Materials**

A feedback form previously used by the London Centre of Hope Family Health Team was revised with the addition of three questions and distributed for this study. The feedback form had three demographic questions, and seven general health questions. The current study used the 3 demographic questions, one of the general health questions, and the 3 questions that were added to the original survey. The feedback form was comprised of closed-ended, multiple choice and open-ended questions. A copy of the feedback form can be found in Appendix A.

## **Procedure**

Participants completed the survey in the waiting area in a hallway in front of the clinic's front desk. Participants returned the survey to the researcher or the secretary upon completion. A debriefing form was available for them after completion, and they were thanked for their participation. Some of the marginalized people that filled out the feedback form had reading, language comprehension, and/or writing difficulties. Thus, the researcher was available at all times in the clinic when the form was being distributed to assist those individuals with the consent form, feedback form, and the debriefing form.

## **Results**

Frequencies and means were examined for the number of visits that participants made to the London Centre of Hope Family Health Team in the past year and for the number of visits the participants made to the emergency department in the past year. The mean number of visits to the London Centre of Hope Family Health Team in the past year was  $M= 10.45$  and the mean number of visits to the emergency department in the past year was  $M= 1.43$ . A paired samples t-test was conducted and the result indicated that the difference between the means was significant

$t(39) = -2.22, p < 0.001$ . This shows that the participants visited the London Centre of Hope Family Health Team approximately ten times more in a year than the emergency department.

Table 1 displays this information.

Table 1

*Mean number of times the clients visited the emergency room in the past year versus the mean number of times the clients used the family health team in the past year*

Emergency Room Visits/year	Family Health Team Visits/year
X= 1.43	X= 10.45

\*\*  $p < 0.001$

Frequency analyses were conducted for each barrier individually. Table 2 on the next page provides an overview of the frequencies of physical barriers that were asked about on the survey. The results revealed that 52.5% of the participants believed pain is a barrier to care that affects them and 25% believed that long wait times affects them.

Table 2

*List of physical barriers and their associated frequencies*

Physical Barrier	n	%
Mobility Issues	7	17.5
Too ill to come	5	12.5
Pain	19	47.5
Hours the clinic is open	6	15
Location of clinic is not near where you live	4	10
No transportation	5	12.5
Do not know where to receive care	3	7.5
Long wait times for care	10	25

Table 3 on the next displays an overview of the frequencies of emotional barriers selected by participants. 30% of participants expressed that having no bus tickets is a barrier to care.

Table 3

*List of financial barriers and their associated frequencies*

Financial Barrier	n	%
No bus tickets	12	30
Cannot take time off of work	5	12.5
Issues with housing	2	5
No identification	2	5

Table 4 indicates the frequencies of emotional barriers that participants selected. 37.5% of the participants suggested that having no motivation is a barrier to care, 27.5% believed forgetting about appointments is a barrier, and 30% believed that no one will listen.

Table 4

*List of emotional barriers and their associated frequencies*

Emotional Barrier	n	%
No motivation	15	37.5
Forgetting about appointments	11	27.5
Don't like "the system"	5	12.5
No one will listen	12	30
No one cares	11	27.5
Other things come first	7	17.5

A frequency analysis was conducted for each barrier category (i.e. physical, financial, and emotional) to indicate which categories were selected most often by participants. These results can be viewed in Tables 5, 6, and 7 respectively. The results showed that physical and emotional barriers were selected more often than financial barriers as 22.5% of participants selected two or more barriers in each of these.

Table 5

*Number of physical barriers that were selected by a participant and the frequency of participants that selected that many physical barriers from the given list*

Number of selected physical barriers	n	%
0	8	20
1	15	37.5
2	9	22.5
3	6	15
4	2	5

Table 6

*Number of financial barriers that were selected by a participant and the frequency of participants that selected that many financial barriers from the given list*

Number of selected financial barriers	n	%
0	21	52.5
1	17	42.5
2	1	2.5
4	1	2.5

Table 7

*Number of emotional barriers that were selected by a participant and the frequency of participants that selected that many emotional barriers from the given list*

Number of selected emotional barriers	n	%
0	11	27.5
1	13	32.5
2	9	22.5
3	2	5
4	2	5
5	2	5
6	1	2.5

A qualitative analysis was conducted on the resources people think will help them access care to search for common themes. The analysis revealed that expenses for bussing and shorter wait times for care are main resources participants feel would help them access care easier.

### **Discussion**

This study was an exploratory study examining the demographics of the population visiting the London Centre of Hope Family Health Team, the barriers to care that this population believe affects them, how many times per year the population visited the emergency room versus the family health team, and what resources the population believe would help them access care easier.

The implications of the findings suggest that the barriers to care need to be examined in

more detail. The barriers to care affect many homeless and low-income individuals. Since this population has one of the highest general health and mental health needs, barriers to care need to be reduced so access to care will increase (Vazquez & Munoz, 2001). Physical and emotional barriers are more commonly experienced than financial barriers. Part of this is consistent with Parker and Albrecht's (2012) previous findings which indicate that the barriers to care selected most commonly by their sample were physical barriers. The results are also consistent with Rabiner and Weiner's (2012) study that suggested that physical barriers are the most common barrier selected. The current study found emotional barriers are commonly selected as an obstacle to receiving care, which is largely inconsistent with previous research.

This study's findings on resources that client's think will help them access care better is consistent with Ensign and Panke's (2002) study, whose results yielded that expenses for bus tickets and shorter wait times in the clinic are just some of the resources that their sample believed would help them better access care. Typically, clinics are located downtown. However, since mobility issues and pain are barriers to care, walking to the clinics may not be an option for some within this population. Some people may also live on the opposite side of town than the clinic and may be a long walk for them to access the clinic. So bussing is the most inexpensive option to assist them in their travel yet, they cannot afford bus fare. A solution to this must be worked out in order for them to afford to get to the clinic. The emergency departments and some clinics are understaffed due to funding issues within the health care system. Having a more diverse team and adding professionals, such as psychologists, to the teams would decrease wait times as these people are able to be filtered to the appropriate resources faster.

Friedman and Levine-Holdowsky (1997) suggest that the barriers to care experienced by



the population exist because of a failure in the system. They suggest that the current system is laid out in a fashion that each program or services is targeted towards people who are similar in nature. For example, shelters are created to target the issue of people not having a home. The problem arises when an individual has many barriers to care. The current services and programs that are available typically only target one barrier that a person may be experiencing, yet homeless individuals face a variety of obstacles as this study has shown. Even if one barrier is removed from an individual trying to obtain services, such as pain, this still leaves many other barriers to care the person and thus, access to care may still be difficult. Therefore, the current health care system needs to be adjusted to tackle the numerous, diverse, and complex barriers to care experienced by the homeless population.

Ensign and Panke (2002) suggest that the theory of cultural competency could greatly reduce the barriers to care. Cultural competency is described as a set of behaviours, attitudes, and policies that work together in a system to allow them to work effectively in cross-cultural situations. Homelessness can be viewed as another culture apart from those in the middle to high class (Ensign & Panke, 2002). Cultural competency applied to the health and mental health care systems implies that policies, agencies, and professionals need to understand all aspects of the culture of homelessness in order to provide adequate care for the homeless population. If more agencies, policies, and professionals were able to use cultural competency effectively, barriers to care would be recognized and reduced. Such experts with cultural competency would have the knowledge and understanding to better equip the homeless population with resources to help them obtain the specific area(s) of care they require. Simultaneously, this education process allows for a greater understanding of the needs and obstacles experienced by homeless and low

income individuals.

Family health teams are used more frequently than the emergency department by this population. An increased need for funding and family health teams is clear from the research to provide these at risk individuals with a greater opportunity to decrease their physical and mental health symptoms. The wait times in the hospitals' emergency departments would greatly reduce as more people could access regular care from family health teams meaning those people would not be using the emergency department for basic health concerns. Family health teams provide free, continuous, accessible care to this population (Wansbrough, 2002). In this aspect, family health teams can also ensure that individuals can receive care for a variety of needs from one location rather than from multiple resources. This would also ensure that treatment plans for the individual do not conflict (Rabiner & Weiner, 2012). The inter-disciplinary approach used by family health teams is a positive change in the typical health care system as it is able to overcome many more barriers to care versus the current health care system. Social workers within the teams can work on all three barrier categories, medical professionals can work some physical barriers, and mental health professionals can work on emotional barriers. Family health teams can be the change in the overall health care system that Friedman and Levine-Holdowsky (1997) suggested. Family health teams would be a beneficial change as they are able to facilitate many barriers to care experienced by the homeless population which is more effective than clinics that just focus on one.

There is stigma within the emergency department surrounding homelessness and mental illness, however, since family health teams are designed for people that are homeless or low-income and thus, there is significantly less discrimination and judgement present (Wansbrough,

2002). The homeless population would feel more comfortable in a place that would not judge them, such as a family health team, rather than a place full of stigmatization.

One limitation of this study was that the sample was only taken from one clinic. If the sample had been taken from more than one clinic, there may have been a better understanding as to what barriers are most apparent throughout the city. In addition, the sample was taken from a health clinic, meaning that the sample is already accessing care by visiting the London Centre of Hope Family Health Team, it may mean that there are fewer barriers to care that affect them compared to individuals who are not accessing any care at all.

Another limitation of this study was the length of the survey. The survey consisted of quite a few questions and if it had been comprised of less items, participants may have paid more attention to the added research questions and may have taken more time to think about the questions. By the time the participants got to the last page with the additional questions, they may have been fatigued and no longer cared about answering the questions thoroughly.

Finally, the way in which the survey was distributed may have been a limitation for this study. The survey was handed to participants from behind a desk and through a slot in a plastic window. This was a formal way of distributing the survey and may have been intimidating to the clients which may have been a barrier itself. If the survey was handed to the clients in a more personal, informal way, perhaps clients may have been more willing to participate and may have felt less intimidated to ask for reading or comprehension assistance.

Further research needs to be done on barriers to care for the homeless and low-income populations. Such barriers could be examined in more detail versus a general matter. This study was examining what barriers to care were present among this population, but further studies may

look into why different barriers to care exist and what makes it a barrier. Research could also look at the different components of a barrier and break it down into further, smaller barriers which may be easier to examine ways that the barriers can be reduced. To obtain more detailed information, interviews could be conducted rather than distributing a survey. This also would help alleviate the limitation of formality. Interviewing a participant is a more personal and informal way of researching. This would build a higher rapport between the researcher and the participant leading to the participant being more willing to share information about what barriers to care they experience with the structure of our current health care system.

Canada reports that we have a universal health care system that promotes equality for all. This is clearly not correct because the homeless and low-income population cannot access the care equally when compared to higher class individuals. The barriers to health care experienced by the homeless and low-income population need to be addressed, examined, and attempted to resolve in order to make Canada's health care system truly equal.

## References

- Ensign, J., & Panke, A. (2002). Barriers and bridges to care: Voices of homeless female adolescent youth in Seattle, Washington, USA. *Journal of Advanced Nursing*, *37*, 166-172.
- Friedman, B. D., & Levine-Holdowsky, M. (1997). Overcoming barriers to homeless delivery services: A community response. *Journal of Social Distress and the Homeless*, *6*, 13-28.
- Garland, T. S., Richards, T., & Cooney, M. (2010) Victims hidden in plain sight: the reality of victimization among the homeless. *Criminal Justice Studies*, *23*, 285-301
- Hwang, S. W., Ueng, J. J. M., Chiu, S., Kiss, A., Tolomiczenko, G., Cowan, L., Levinson, W., & Redelmeier, D. A. (2010). Universal health insurance and health care access for homeless persons. *American Journal of Public Health*, *8*, 1454-1461
- Levy, B. D., & O'Connell, J. J. (2004). Health care for homeless persons. *N Engl J Med*, *23*, 2329-2332
- Link, B. G., Susser, E., Stueve, A., Phelan, J., Moore, R. E., & Struening, E. (1994). Lifetime and five-year prevalence of homelessness in the United States. *Journal of Public Health*, *84*, 1907-1912.
- London Centre of Hope Family Health Team. (2013). Re: Executive Director [Online job posting]. Retrieved from <http://www.knighthunter.com/job.aspx?jid=d210ce9f-c42d-4451-96c5-d5b74130aba7>
- Martin, B. (2003). Assisting homeless individuals to access health care. *Nursing & Allied Health Source*, *5*

- Parker, R. D., & Albrecht, H. A. (2012). Barriers to care and service needs among chronically homeless persons in a housing first program. *Professional Case Management, 17*, 278-284
- Proudfoot, S. (2010). Homeless rate in Canada ‘sobering’; One in nine has landed on streets or come close: Survey. *The Ottawa Citizen*
- Rabiner, M., & Weiner, A. (2012). Health care for homeless and unstably housed: Overcoming barriers. *Mount Sinai Journal of Medicine, 586-592*
- Statistics Canada. (2011). *Table 105-3067 – Difficulties accessing routine or on-going care, among those who required care at any time of day, household population aged 15 and over, Canada, provinces and territories, occasional, CANISM (database)*
- Statistics Canada. (2011). *Table 202-0802 – Prevalence of low income shows the proportion of people living below the low income cut-offs within a given group, CANSIM (database)*
- Statistics Canada. (2013). Retrieved from Does Statistics Canada collect this information?: [www.statcan.gc.ca/help-aide/collection-eng.htm](http://www.statcan.gc.ca/help-aide/collection-eng.htm)
- Vazquez, C., & Munoz, M. (2001). Homelessness, mental health, and stressful life events. *International Journal of Mental Health, 30*, 6-25
- Wansbrough, G. (2002). Inner-city programs effective. *Medical Post, 38*



1. The last time you were sick, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually SAW him/her or someone else in their office?

Same day  
Next day  
2-19 days (enter number of days: \_\_\_\_\_)  
20 or more days  
Not applicable

2. When you see your doctor or nurse practitioner, how often do they or someone else on the team give you an opportunity to ask questions about recommended treatment?

Always  
Often  
Sometimes  
Rarely  
Never  
Not applicable

3. When you see your doctor or nurse practitioner, how often do they or someone else on the team involve you as much as you want to be in decisions about your care and treatment?

Always  
Often  
Sometimes  
Rarely  
Never  
Not applicable

4. When you see your doctor or nurse practitioner, how often do they or someone else on the team spend enough time with you?

Always  
Often  
Sometimes  
Rarely  
Never



5. A) Are you able to come to appointments between 8:00 am and 4:00pm Monday to Friday?
- Yes  
No
- B) If you answered “**no**”, which of the extended hours below would be most convenient for you?
- Evenings (4-8 pm)  
Saturday Mornings (9:00 am -1:00 pm)  
Other \_\_\_\_\_
6. A) How many times have you used the Emergency Department in the past year?
- B) How many times have you used the Family Health Team in the past year?
- C) How many times have you used the Family Health Team instead of the Emergency Department in the past year?
7. Do you have any other comments you would like to add about the Family Health Team that would help us improve our services?

The following questions are for research purposes only:

- 1) Which of these barriers do you feel make it hard for you to access care? (Check all that apply to you)

Physical Barriers

- Mobility issues (e.g. no wheelchair)
- Too ill to come
- Pain
- Hours the clinic is open
- Organization is not located near where you live
- No means of transportation
- Do not know where to get care
- Long wait time for care

Financial Barriers

- No bus tickets
- Can't take time off of work
- Issues with housing
- I do not have I.D.

Emotional Barriers

- No motivation
- You forget about appointments
- Don't like "the system"
- No one will listen to you
- No one cares
- Other things come first

- 2) Do you have any comments or any barriers that apply to you that are not listed?

- 3) What resources do you think would help you access care better?